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ABSTRACT

Based on an in-depth study of 125 mothers of young infants in both urban and rural areas of Wisconsin, this study analyzed the utilization of preventive medical services for the infant. The hypothesis that "mothers who are more socially integrated will be more likely to use preventive medical services than those who are less integrated, controlling for socioeconomic status" was tested. Ninety-one urban and 34 rural mothers were interviewed when their babies were approximately 3-months old. Data were obtained on the mother's state of health, attitudes and feelings toward her life, use of the system for both well and sick care for herself and her infant, happiness, social activities, who she called on for help with the baby, and contacts with friends and relatives. Items were basically of three types: baby's preventive medical services--baby physical checkup since leaving the hospital (diphtheria, pertussis, tetanus, and polio shots received); social integration item--family and secondary ties; and background characteristics--residence, mother's education, family income, poverty level of family, whether the mother had private health insurance, medicaid, or no health insurance. Findings included: the hypothesis was not confirmed; rural-urban differences emerged which seemed to be related to availability and accessibility of services; and mother's education was the only factor which helped explain utilization patterns. (NQ)

An Examination of the Concept of Social Integration as Related to Preventive Medical Care in Poverty Families in Rural and Urban Areas

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Abstract

This report is based on an in-depth study of 125 mothers of young infants in both urban and rural areas of Wisconsin. The utilization of preventive medical services for the infant was analyzed. The hypothesis that mother's social integration affects medical utilization was not confirmed. Instead, rural-urban differences emerged which seemed to be related to availability and accessibility of services. Education of mother was the only other factor which helped explain utilization patterns.

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An Examination of the Concept of Social Integration as Related to Preventive Medical Care in Poverty Families in Rural and Urban Areas

I. Purpose of Paper

I would like to share with you today some interesting findings which address the subject of the effect of social integration on obtaining preventive health care. But first, let me tell you a little about the path I took to this end.

In previous work, based on a sample of black mothers in Washington, D.C. I found that mothers who were more socially integrated on both family and community levels were more likely to use preventive medical services -- controlling for their socioeconomic status (Slesinger, 1976).

This finding was in part the basis for a new research endeavor, which is currently in progress. I designed a study to explore certain important, but fuzzy aspects of infant health and development. By "fuzzy," I mean those aspects of infant care and handling which are essential to growth, but often elusive in our ability to measure them -- such as mother's warmth toward child, her judgement in feeding and clothing the child, her active involvement in stimulating the physical and mental processes of the infant, and so forth. Other aspects of infant care were easier to quantify. For example, did the mother take the infant for the recommended physical checkup? Did the baby get the DPT (Diptheria, Pertussis, Tetenus) shots?

In order to pursue this line of research I worked closely with five (one urban and four rural) public health departments in Wisconsin in order to find families where "mothering" might be a problem to the infant. This meant concentrating on a fairly small group of mothers, and getting a great

deal of information about their home life, over an extended period of time. The result was the identification of urban and rural families where the mother had given birth to a baby within the period of May through December 1974. Public health nurses were given training in interviewing on this project, and visited the mothers in their homes when the baby was approximately 3, 12 and 18 months old. They conducted the interviews and also examined the babies at each visit.[1]

Let us now go back a moment to the concept of social integration. We are talking here of integration at two levels: the family and the community.

The Family

Present American society has both nuclear families and extended-kin families. The literature on familism suggests that both the nuclear and extended families serve the same functions, to integrate the family member into a delimited group with rights and obligations distributed among the members. The distribution of these types of families, in the past, was thought to be that urban families tend toward nuclear families, while rural families tend toward the extended-kin type. This is no longer true. Regional variations exist in rural areas, as Heller and Quesada (1975) note. Their research shows that the nuclear family predominates in the rural Southwest, while the extended-kin family is more prevalent in rural families in the Southeast United States. In addition, there is much evidence that black families in urban areas often live in extended-kin households.

There is another aspect of family composition which complicates the picture even further. From the above comments about nuclear and extended families, we may classify members into two groups: they may be integrated into a family of procreation (with husband and children), or a family of

orientation (with their parents and siblings). Some may be living in a household which includes both. In addition, their levels of integration may vary so that, for example, a woman may be highly integrated into the unit with her husband, but excluded from that of her parents.

At any rate, the social support attainable from the primary unit is often thought to influence the health-seeking behavior of the members in a positive manner.

Becker and Green (1975) review a number of studies that indicate social integration is clearly related to compliance with medical regimes. For example, the regime of exercise prescribed to patients with coronary heart disease was much more likely to be followed if the patient's wives had positive attitudes toward the regime (Heinzelmann and Bagley, 1970). Donabedian, et al. (1964) studied a group of chronically ill disabled who were discharged from the hospital. Examining the regimes prescribed for each patient (diet, medications, exercise, etc.) and the resulting record of compliance after two to three months, he noted that about 50% of the group did not comply with one or more of the recommendations made to them upon leaving the hospital. Only two variables appeared to distinguish among this group--"patients who have help available to them in the home," that is, patients who presumably have social support in the home, and those with more severe disabilities (who were more likely to be in nursing homes).

Evidence that feelings of social isolation affect help-seeking behavior is also starting to accumulate. Bullough (1972) and Morris, et. al., (1966) noted that mothers who expressed feelings of social isolation were less likely to obtain immunization for their infants, or post-partum check-ups for themselves. They were also less likely to seek family planning information.

Also, in my research mentioned above, I found that mothers who lived alone with their child or children tended to use fewer medical services than mothers who lived with their husbands. In addition, those single parent families who lived with extended kin used more services than those living alone, while husband-wife unions living with extended kin used somewhat more than the former, but less than the middle class pattern of husband-wife living alone with their children in one household (Slesinger, 1976).

The Community

Another level of social integration is that which concerns involvement with non-family members: that having to do with friends and the community. Burgess in 1945, and many since, suggested that another type of tie was likely to replace the kinship ties in urban areas. This relationship was based on companionship and sentiment. Friends, then, can become the basis of social support, and can provide ties to the larger community.

Secondary ties to community institutions also may contribute to social integration. Here we assume that persons who are actively involved or closely tied to society's institutions are more likely to feel a part of the society, and internalize the values of the society. Thus we hypothesize that those who participate in varied activities such as churches, clubs, etc. will be more likely to use medical institutions.

From the foregoing, therefore, we would like to address the following hypothesis:

> Mothers who are more socially integrated will be more likely to use preventive medical services than those who are less integrated, controlling for socioeconomic status.

and thus, rural-urban differences in preventive medical utilization will be

explained by differences in social integration, controlling for socio-economic status.

Analyzing the characteristics and behavior of women who have just given birth is particularly useful for this problem. This is a period in the life of a woman when active medical attention is recommended by physicians and most often sought by women. Prenatal care, to be started as early in pregnancy as possible, is considered important; a post partum checkup is invariably recommended. Infants are examined at birth and mothers are told to have their child examined within six to eight weeks after birth. Virtually all women give birth in a hospital, and thus have been active participants in the medical system. Mothers of three month old babies have all had recent exposure to medical institutions.

In the woman's life it also is a time when family support systems are often called into play. Her husband, her mother, her sisters all rally around to help with the newborn. It is often a time of joy and pleasure, and families often derive satisfaction from the addition of a new member.

Many times, however, this picture of familial support is nonexistent. The mother has no husband, relatives may be absent from the scene, the baby is unplanned and sometimes unwanted, and the mother is left to shift for herself.

The group chosen for this research includes both well integrated and isolated mothers. Thus we will be able to test whether variation in social integration affects the utilization of health services for women in similar economic circumstances, living in urban and rural areas.

II. Data Source

A. Study Population

As mentioned above, data comes from part of an exploratory study of "Mothering as Related to Infant Health." Analysis for this paper will be restricted to 91 urban and 34 rural mothers who were interviewed when their babies were approximately three months old.[2] In the interviews, data were obtained from the mother about her own state of health, attitudes and feelings toward her life, using the medical system, happiness, social activities, who they call on for help with the baby, contacts with friends and relatives, and so forth. In addition, medical utilization for both well and sick care was obtained from the mothers about themselves and their infants.

B. Operationalization of Concepts

The items to be included in this paper are basically of three types: baby's preventive medical services, social integration items, and background characteristics.

1. Baby's preventive medical services

Baby physical checkup since leaving the hospital; Diptheria, Pertussis and Tetenus (DPT) shots, polio vaccine received.

2. Social integration items

Family ties: All persons living in the household with the mother and baby at the time of the interview were noted. Household composition was classified into 1) mother, father and baby (and other children); 2) mother and baby (and other children) with no father or husband present; 3) mother, father and baby with extended family; 4) mother and baby with extended family. The extended family could include the mother's parents, siblings, in-laws, cousins, nephews, etc.

Secondary ties: A Social Integration Index was created from the following five items, with each item contributing 1-5 points, depending on the frequency of occurrence:

About how often do you attend religious services?
Do you belong to any social clubs or organizations?
How often do you go out for eating, drinking, or seeing a movie?
Do you read any newspapers regularly?
How often do you get together informally with relatives or friends?

An open ended question was also included to elicit any source of support identified by the mother. It was the question, "If you need help or advice about your baby, are there people around to help? [IF YES] Who is that?"

3. Background characteristics

Rural-urban residence, education of mother, family income, poverty level of family, and whether the mother had private health insurance, medicaid (the Wisconsin program for medically indigent), or no health insurance.

C. Description of families

Three types of variables appear to be distributed differently in the urban and rural areas: household composition, socio-economic status, and health insurance (see table 1).

1. Household composition

The first thing we note in this group of families is the variety of living arrangements. Three-fourths of the rural group and 36 percent of the urban families live in nuclear family arrangements; with no other relatives. An additional 15 percent of the rural and 7 percent of the urban households consist of mother-father units, but with other relatives also present.

The remainder are mothers living without husbands or fathers. Almost one-third of the urban families are female-headed households; 9 percent of the rural families are in this category. An additional 25 percent of the urban families consist of mothers and children who live with relatives in extended families. The difference in distribution between the urban and rural samples is statistically significant.[3]

2. Socioeconomic status

Both education of mother and poverty status of family indicate that the rural families tend to be of somewhat higher socioeconomic status, although the differences in distribution barely attain statistically significance. There is a larger proportion of women who have not finished high school in the urban population, and a larger group of families who are below the poverty level. Poverty status is measured here by a combination of income and family size, with different levels in farm and non-farm families (CSA, 1975).[4]

3. Health insurance

The distribution of health insurance is considerably different in the rural and urban samples. Among the rural group, 18 percent of the families have no health insurance, and 50 percent have private insurance, with coverage often limited to hospitalization only. On the other hand, almost 75 percent of the urban group had Medicaid benefits. In addition, while about one-third of rural families receive food stamps and about the same proportion are on AFDC, over half the urban families receive food stamps and two-thirds are on AFDC. This sample confirms what other statistics have often shown, that rural people are less likely to receive welfare aids, regardless of their eligibility (U.S. Bureau of the Census, 1970). Among the reasons for the lower levels of welfare aids among rural families are

lack of anonymity in the small towns, lack of information about the availability of some programs, possible difference in values in accepting welfare, difficulties in the application process, and so forth.

III. Results

A. Rural Urban Differences in Social Integration

1. Family ties

Reviewing the household composition, we see that about 9 out of 10 rural mothers live with their husbands, compared with 43 percent of the urban group. When a rural mother lives in an extended family, her husband is likely to be present in the same household. This is not the case among our urban families, where mothers in extended family settings are not likely to have the husband (or father) present. Thus we would expect the rural mothers to be highly integrated; only 9 percent of them live alone with their child or children, compared with 32 percent of the urban mothers.

Table 2 shows the responses to the question asked of, "If you need help or advice about your baby, are there people around to help?" The distributions of the rural and urban group are remarkably similar. About one-third of the mothers say they would call on their own mothers for help. Another fourth would call on a sister or other female relative (e.g. mother-in-law, aunt). About the same proportion said they would call their doctors or the nurse. The remaining 14 percent would call other relatives and friends; including husbands. (Out of 60 women with husbands; only 14 mentions of husband were given.)

2. Secondary ties

Let us now examine each of the measures included in the social integration index by rural and urban residence. Table 3 shows us that only two of

the items show a significant difference. One is church attendance, where a much higher proportion of rural women attend church frequently, and a lower proportion of rural women never attend. The second item that shows some difference in distribution is club membership. Only 10 percent of urban women, but about 25 percent of rural women, belong to one or more social clubs or organizations.

All of the remaining items show no differences, including the composite index. Thus we conclude that although church attendance and club membership differs, no apparent significant differences exist when we combine the items into a summary index. In addition, both rural and urban women call upon their mothers, sisters and other female relatives about the same amount. It is interesting to note that few women--urban or rural--mention calling on their husbands for help.

In summarizing the above section, then, we might conclude that mothers living in rural areas are more likely than urban mothers to be socially integrated because they more often live with the fathers of their babies, and less often live alone with their babies. They also are more likely than the urban group to attend church frequently and to belong to clubs in the community.

B. Rural Urban Differences in Medical Utilization

We now turn to an examination of rural urban differences in the baby's medical utilization. Table 4 presents the items asked, and responses given.

A very large proportion of both the rural and urban group, about 85 percent, report that their babies had been for a physical checkup since leaving the hospital. However, the other two items appear to be significantly different in rural and urban areas: more of the urban mothers had gotten both DPT immunizations and Polio vaccines for their babies than the rural ones.

A series of questions was asked of each mother mentioning various reasons why people delay going to see a doctor. Only two items indicated any significant differences among the urban and rural respondents. For one, more than twice as many rural than urban mothers indicated that lack of money was a barrier to seeing a doctor (44 percent to 21 percent). This supports the previous suggestion that rural mothers have less medical insurance and are less likely to be on Medicaid. The second had to do with whether transportation was a problem. Here, somewhat surprisingly, the situation was reversed. That is, for more than twice as many urban as rural mothers (38 percent to 15 percent) transportation was reported as a difficulty in seeing the doctor. Here we note that many urban mothers find transportation a serious problem even though there are city buses and taxies available. Rural mothers, however, who do not have public transportation available, do not mention as often that problems in transportation to the doctor has delayed them from going.

C. Medical Utilization and Social Integration

The three utilization variables: baby physical, DPT shots, and polio vaccine, as well as a summary index were examined by household composition, each social integration item, and the composite social integration index. In none of the comparisons did any differences in utilization emerge. That is, no significant differences occur between utilization and any of the measures of social integration.

D. Multi-variate analysis of the effect of background and social integration variables on baby's medical utilization.

In order to examine whether the rural-urban differences remained significant in utilization when the effect of other variables were controlled, data were submitted to multiple regression analysis. Outside of rural-urban

residence, only mother's education appears to have a significant relationship to utilization; the remaining correlations are very low. This finding that mother's education contributed a significant additional amount supports much previous work which indicates that education is the most useful socioeconomic indicator in explaining preventive medical utilization (Green, 1970).

In other words, rural-urban residence and education were the only variables which contributed to explaining utilization; none of the social integration items were significant.

IV. Discussion

Some Comments

Having a sample of only 125 mothers and infants may be a disadvantage when performing statistical maniuplations on the data. On the other hand, it is a decided advantage when doing exploratory research. The research director becomes more familiar with the respondents in the study, and the circumstances pertaining to the research.

From this perspective, I would like to share some comments on the findings.

1) Is there a rural-urban difference in preventive medical utilization for young infants? The data indicates that for preventive shots and vaccines there is, although for just baby well checkups there is not. These findings ring true; the city public health nurses are constantly reminding mothers to have their infants immunized; there is no cost, and the public health stations are quite conveniently located in the central city area.

For well-child checkups, however, there does not appear to be a rural-urban difference. In both settings about 85 percent of the mothers report that their child received a checkup. I suggest that this is because the

infants are only 3 months old at the time of this interview. Most mothers still have ties with the physicians who cared for them during pregnancy, or with the hospital outpatient clinic. In rural areas the physician is often a general practitioner, and will care for the infant as well as the mother. The fact that most of the mothers in both areas have taken their infants to a doctor for a checkup may reflect the lingering after-effects of being under a doctor's care during pregnancy. This effect, as I suggest below, should diminish as the babies get older.

2) Why does there appear to be little relationship between social integration and utilization in these data? I think that we have just begun to unravel the complexities of being integrated into a social unit. The usual questions sociologists ask (club membership, church attendance, etc.) may not be hitting the core of the concept.

To illustrate this, let me share with you some cases in the study.

Case One

One urban mother, Alice, with an extremely low score on the index (never goes to church, doesn't belong to any clubs or organizations, doesn't read a newspaper regularly, rarely visits friends or relatives and says she goes out to the movies or restaurants no more than a few times a year) is a 17 year old single woman, living with her mother, father and 5 siblings. Alice has not completed high school. There is a great deal of support in the home, and both her mother and sisters give advice and care for her baby. The baby has been for a checkup and has gotten DPT shots. While her social integration into formal organizations is low, her integration within the family is high.

Case Two

A farm family, on the other hand, consists of a woman, Cora, her husband and 11 children. She has a high school diploma. She goes to church once a week, belongs to church clubs, reads a newspaper regularly, and visits relatives and friends at least once a week. Cora's total life is centered around in her family. The baby, however, has not had a checkup nor any DPT shots or polio vaccine. She does not go to the doctor because the cost is too high, and although the family would qualify for medical assistance, the nurse comments that "they will not apply for it even though eligible because of the welfare stigma." Here we have a woman, highly integrated into her family and church. Yet her preventive medical utilization is very low because of the costs involved.

Case Three

Another farm family in the sample consists of a mother, Debbie, 27, her husband, 31, a 7 year old and the baby. The husband is a truck driver, and is away from home most of the week. This family was in a serious car accident about three years ago, where Debbie was burned and sustained multiple fractures, and two of their children were killed. To this date, she dislikes riding in cars, and will not drive. Debbie did not complete high school.

Debbie has a low integration index score; she goes to church a few times a year or less, belongs to no clubs, rarely goes out to the movies, doesn't read newspapers regularly, and sees friends or relatives a few times a year. No one else takes care of the baby but she can get help when needed from her mother, father, or sister who lives nearby.

The baby has not been for a checkup nor received any shots. Debbie feels that transportation is the main problem in taking her baby to the doctor.

Case Four

Another example of a woman with a very low integration summary score is Martha, an urban woman who is 32, living with her common-law husband. She has six children. She never goes to church, belongs to no clubs or organizations, rarely goes out, and rarely visits friends and relatives. She says she has no one to ask advice about her baby, and no one but herself takes care of her baby. Her baby had not been for a checkup nor received any of the DPT shots. The nurse commented that she has "nothing to do with the neighbor ladies," and rarely gets out of the house. This woman is not only poorly integrated into the community but receives virtually no social support from her family. She too, never completed high school.

Seventeen year old Alice, our first case, is an example of a young woman who has few secondary ties, yet has a strong social support system in her family, even though she has no husband in the household. Her baby's care, however, has been taken over by her mother, with whom she lives.

Cora, on the other hand, is deeply involved with her family and 11 children. She is high on all our measures of social integration, yet does not take her baby for preventive care because of the costs.

Debbie, the mother who was in the car accident, is low on the formal social integration measures. In addition, although she lives with her husband, she only sees him on weekends. What support she receives probably comes from her family of orientation, even though she does not live with them.

Martha, the 32 year old urban woman, is a social isolate. She has a low summary integration score, receives no support from her common-law-husband, and her baby has received no preventive care. She truly confirms our hypothesis.

3) The third area on which I wish to comment concerns two paradoxes we encountered in the data with regard to "accessibility." They are:

(1) Rural mothers; who are economically better off than urban ones, cite money as a reason they delay going to a doctor twice as often as the poorer urban mothers; and

(2) Urban mothers mention lack of transportation as a factor in postponing going to a doctor over twice as often as rural mothers, in spite of the fact that urban mothers have shorter distances to travel and have good public transportation available to them.

The first paradox merits a repetition of what was noted above: today, the near-poor have many more problems with paying for medical care than the very poor. Medicaid provides complete coverage for both ambulatory and hospital care for children. Those without insurance or with limited coverage from private insurance (who are likely to be in rural areas, especially the less well-off independent farmer) are at a decided disadvantage.

The second paradox, that transportation is given as a problem more often in the urban areas, reflects, perhaps, that neither "minutes" nor "miles" to the medical facility are necessarily appropriate measures of accessibility. In these cases the inconvenience of travelling on a bus, toting other pre-schoolers, may far outweigh the nearness of the facility of the frequent good bus service available.

These examples reflect the careful interpretation of accessibility measures which is necessary for analyzing its impact on medical utilization.

V. Conclusions

We have noted two different levels of social integration: one into the family, a second into secondary groups in the community.

Although we noted that family structure varied by rural-urban residence, with many fewer husband-wife pairs in the city, we found that this had no effect on the preventive medical care obtained for the baby. We also noted that most women call upon their mothers or sisters for help or advice about their babies, regardless of where they live.

We also saw that participation in organizations outside the home tended to favor rural women, who attended church more regularly and were more likely to belong to clubs. Other measures of social integration, i.e. reading newspapers, going out to restaurants, visiting patterns, showed no urban-rural differences.

There was a difference in preventive medical utilization for the infants, however, with urban mothers getting more care for their babies than rural mothers. This finding remained, even when controlling for socio-economic variables as well as social integration scores. Mother's education was the only variable that explained variance in utilization.

An explanation of the difference in utilization was suggested which basically was a structural one. First, one should make the distinction between availability and accessibility of services, as has been done by other researchers (Hassinger and Hobbs, 1973). As concerns availability in the present study, there is little doubt that the urban areas have higher physician/patient ratios, and more well-baby and immunization clinics. Clearly, availability of services is greater in the urban areas.

With regard to accessibility, however, we have learned some interesting things. First, the subject of cost turned out to be complicated. In this

population, those who were financially better off were less well off in their ability to purchase health care.

Second, the topic of transportation was not a straight forward one. In areas where distance and time were minimal, and access to public transportation was good, respondents were more likely to state transportation as a problem.

And finally, we have the factor of what I will call "social facilitation." The city public health nurses can provide the link between the patient and the facility in the often bureaucratic and alien world of urban medical centers. Not only are these nurses able to suggest a course of action to the mothers; they are also able to provide the mother with a time and place for receiving the recommended medical service. Only rarely in rural areas are the county public health nurses in the position to be social facilitators because of lack of available medical services.

Because of both greater availability and accessibility of services, the sum of these factors weigh heavily on the side of urban mothers utilizing medical facilities for preventive care more than rural mothers.

VI. Directions for Further Analyses

This is only the first report on a data set which will include information at three time points in the first two years of infant's lives. The social integration concept will be further examined, and split into family and community components. An attempt will be made to classify mothers on various aspects of integration, expecting the classification to become somewhat complex, reflecting the nature of the concept.

In addition, additional data on the mother's medical utilization will be examined, not only to relate it to her integration score, but also to look for relationships between her own and her infant's use of doctors.

Because this report was based on activities when the infant was only three months old, it is expected that testing the hypothesis at a later time in the life of the infant may provide different results. That is, the further the elapsed time from the mother's medical involvement at birth, the greater will be the variation in utilization patterns of mothers and children, and the greater the impact of social factors such as social integration on those patterns.

Footnotes

[1]These families were not chosen in a random manner. Because of the explonatory nature of the topic under study, "quality of mothercraft," the nurses were instructed to select homes in poverty where a baby had just been born and there was some indication that 'mothering' would be a problem. Nurses could use previous information they had in their street files or school records; they could do a preliminary screening, or they could choose families where they observed undue pressure and/or problems--such as very short child-spacing intervals; very young mothers still in junior high school; very old mother with many children.

Because of the constraints on generalizability, I ask the reader to view the data presented as suggestive, and perhaps provocative, in the style of Glaser and Strauss (1967) "grounded theory."

[2]This research is still in progress, and only the data from the first interview are available at this time for analysis. Two-thirds of the urban families are black; all of the rural families are white. Although not included in this paper, race effects are being examined in on-going analyses.

[3]Data for the U.S. available from the March 1975 Current Population Survey indicates similar household distribution. That is, in families with children under 3, 89 percent of these families are husband-wife unions and 11 percent are female-headed households. In sub-areas of the U.S. these proportions are quite different. In rural farm areas 98 percent of the families consist of husbands and wives, and only 1 percent female-headed households. In central cities of SMSA's of one to three million people, for Negro families, the figures are 57 percent in husband-wife units; 39 percent in female-headed households. The remaining percents are other forms of

households, e.g. other families with male head.

[4]These same groups were classified at Time 2 (when the infants were 12 months old), however, and the rural-urban differences disappeared. Income is not apparently a stable item in this population with marginal employment and welfare aids.

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Table 1. Background Chracteristics of Mothers by Rural-Urban Residence

Percent Distribution

	Rural (34)	Urban (91)	Total (125)
Household Composition			
Mother and Father	73.6	36.2	46.4
Mother and Father with extended family	14.7	6.6	8.8
Mother and Child(ren) living alone	8.8	31.9	25.6
Mother and Child(ren) with extended family	2.9	25.3	19.2
	100.0	100.0	100.0
	X^2=16.26	d.f.=3	p<.001
Poverty Status			
Income below 75% of poverty level	29.4	36.3	34.4
Income below 100%	11.8	26.4	22.4
Income below 125%	8.8	13.2	12.0
Income is 125% or more	50.0	24.2	31.2
	100.0	100.0	100.0
	X^2=6.53	d.f.=3	p=.089
Health Insurance			
Private	50.0	24.2	31.2
Medicaid	32.4	72.5	61.6
None	17.6	3.3	7.2
	100.0	100.0	100.0
	X^2=15.59	d.f.=2	p<.001
Education			
Less than high school graduate	44.1	67.8	61.3
High school graduate	47.1	24.4	30.6
College	8.8	7.8	8.1
	100.0	100.0	100.0
	X^2=5.30	d.f.=2	p=.071
Income			
Less than $3,000	20.6	20.0	20.2
$3,000-5,999	29.4	44.4	40.3
$6,000-8,999	26.5	21.1	22.6
$9,000+	23.5	14.4	16.9
	100.0	100.0	100.0
	Chi-square not significant		

Table 2. Who Mothers Call on for Help with Baby

Q: "If you need help or advice about your baby, are there people around to help?"

	Rural	Urban	Total
Mother	31.5	34.6	33.7
Sister or other female relative	29.6	20.3	23.0
Other: Husband, boyfriend, neighbor, friend, other relative	13.0	14.3	13.9
Medical people (doctor, public health nurse, etc.	25.9	29.3	28.4
No one	0	1.5	1.0
Total (%)	100.0	100.0	100.0
(N)	(34 women gave 54 responses)	(91 women gave 133 responses)	(125 women gave 187 responses)

Table 3. Social Integration Measures by Rural-Urban Residence

Percent Distribution

	Rural	Urban	Total
(N)=	(34)	(91)	(125)
Church Attendance			
Once a week or more	41.2	12.1	20.0
2-3 times/month	20.6	16.5	17.6
Once a month	8.8	12.1	11.2
Few times/year	20.6	33.0	29.6
Never	8.8	26.3	21.6
	100.0	100.0	100.0
	X^2=12.82 d.f. = 4 p= .012		
Clubs			
Belong	23.5	8.8	12.8
Doesn't belong	76.5	91.2	87.2
	100.0	100.0	100.0
	X^2=3.56 d.f. = 1 p= .016		
Newspapers			
Read	45.4	52.7	50.8
Don't read	54.6	47.3	49.2
	100.0	100.0	100.0
	Chi-square not significant		
Go Out			
Once a week or more	26.5	20.9	22.4
2-3 times/month	17.6	31.9	28.0
Few times/year	26.5	23.1	24.0
Rarely	29.4	24.1	25.6
	100.0	100.0	100.0
	Chi-square not significant		
Visit Relatives or Friends			
Once a week or more	67.6	56.0	59.2
2-3 times/month	26.5	26.4	26.4
Less often	5.9	17.6	14.4
	100.0	100.0	100.0
	Chi-square not significant		
Social Integration Index			
Low	47.1	60.4	56.8
High	52.9	39.6	43.2
	100.0	100.0	100.0
	Chi-square not significant		

Table 4. Medical Utilization by Rural-Urban Residence: Percentage Distribution

	Rural	Urban	Total
Baby Physical			
Yes	88.3	84.6	85.6
No	11.7	15.4	14.4
	100.0	100.0	100.0
	Chi-square not significant		
DPT Shots			
Yes	38.2	61.5	55.2
No	61.8	38.5	44.8
	100.0	100.0	100.0
	X^2=4.53	d.f.=1	p=.032
Polio Vaccine			
Yes	38.2	58.2	52.8
No	61.8	41.8	47.2
	100.0	100.0	100.0
	X^2=3.21	d.f.=1	p=.073