「低所得家庭을 위한 統合的家族計劃의 一部로서의 社会事業 봉사, 美国內 経験의 一例」

抄

美国에서의 家族計劃運動은 産児制限만이 아니라 家庭의 福利增進을 또한 指向하고 있다. 国民 스스로의 出産調節은 貧困을 予防 내지 줄일 수 있다는 信念에다가 家族計劃政策에 根據를 두고 있는데 美国議会는 이러한 根據에 수반하여 国民各自에게 同等한 医療惠澤賦與(母子保健医療를 包含), 家庭生活의 強化, 児童들의 発育을 위한 適正한 條件提供, 人權 특히 女權伸張을 実施한다는 條件下에 同家族計劃政策을 正当化하였다.

그리하여 家族計劃은 특히 低所得層을 위한 公衆保健 및 社会奉仕団体들의 正規事業의 一部로 되고, 社会事業家들이 家族計劃施術에 参與하게 된것이다. 家族計劃 주변에서 作用하는 各種 社会的 및 心理的 要因들에 대한 認識이 漸高함에 따라 社会事業家들은 施術課程에서 매우 뚜렷한 役割을 맡게 되었다.

이러한 性格을 띤 美国家族計劃運動의 趣意는 低所得家庭을 위한 政府支援 母子 保健事業에서 잘 나타나 있다. 社会事業과 家族計劃봉사는 이 綜合的無料保健事業의 主要部分으로 되어있는 것이다.

本論文은 이 事業의 一例를 들어 社会事業家가 同事業을 통하여 취급하는 人間問題, 社会事業施術方法, 社会事業이 低所得層의 어머니와 未婚母들을 위해 가지는 意義等에 관하여 現地実態를 들어 論議하였다.

低所得家庭의 어머니들은 家族計劃이외에도 여러가지 문제를 갖고있다. 社会事業家는 이들 어머니들이 필요로하는 各種 社会的, 経済的, 教育的, 助援 및 医療惠澤을 받을 수 있도록 주선해 준다.

家族計劃은 保健써비스 가운데 하나에 불과하다. 그러나 家族計劃은 많은 低所得家庭들이 겪고있는 健康上 및 社会心理的 苦難을 予防 내지 減少할수 있는 커다란 潜在力을 가지고 있는 것이다. 따라서 家族計劃은 社会事業家들이 불우한 사람들의 苦悩와 受難을 治療予防하는데 필요한 또 하나의 方便을 提供하게 된 것이다.

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SOCIAL WORK AS AN INTEGRAL PART OF FAMILY PLANNING SERVICE FOR LOW-INCOME FAMILIES: AN EXAMPLE OF U.S. EXPERIENCE

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INTRODUCTION

In the United States, the policy to foster family planning was influenced by a conviction that voluntary fertility control can be a significant instrument in the prevention and reduction of poverty. There were other grounds on which the policy was justified by the U.S. Congress: providing equal access to medical care (including maternal and infant care),strengthening family life and fostering optimum conditions for child development, basic human rights and, especially women's rights[1]. The target group of the family planning program is "medically indigent" or those who can not afford private medical care and a family of four or more children with the lowest level of income[2].

The objective of the family planning movement in the United States is thus not only to regulate numbers of children but also to promote the welfare of low-income families. Therefore, family planning assistance has become a standard component of health and welfare services, and the assistance is added to the responsibilities of agencies providing these services. The agencies include those serving special groups: the mentally ill, the retarded, and the alcoholic, for whom additional pregnancies may constitute a risk and burden to themselves, their families, and their communities. As a consequence, social workers are involved in the delivery of family planning services.

Because of the growing recognition of the importance of social factors in the delivery and utilization of family planning service, social workers play a much more prominent role in the delivery of the service. This recognition has led other professions in the service, including nursing and medicine, to prepare at least some of their practitioners to analyze and intervene in the social environment. However, social work is the only profession in the service that has taken social assesment and social intervention as a primary concern.

Earlier, the Delegate Assembly of the National Association of Social Workers adopted a resolution which included the following statement about social workers' responsibility in family planning[3]:

> "Social workers should take professional responsibility to assist clients in obtaining whatever help and information they need for effective family planning. Because in their day-to-day work social workers are knowledgeable about family and community resources, they have many opportunities to help clients obtain desired services. Individual social workers also have a professional obligation to work with a variety of groups on the domestic and international fronts for the establishment of family planning programs on a level adequate to insure the availability and accessibility of family planning services to all who want them."

What social work brings to the family planning field are methods to reduce and resolve the incidences of the client's social problems that hinder her family planning efforts, and support her to maintain a normal social and family life.

Lack of family planning in a poor family is likely to create health and social crises in the life of the family[4]. Therefore, family planning and social work have a common objective: to strengthen family life and in so doing to exert efforts to prevent critical social and health problems. Social workers themselves now perceive that many of their clients' health and social crises are related

directly to problems associated with family planning. Therefore, they give their backing to the national program to make family planning service available to all Americans, including sex education and contraceptive service to teen-agers[5].

More and more social workers are employed in family planning agencies, including Planned Parenthood and federal–and state –supported family planning agencies. Social welfare departments of local governments, agencies concerned with the welfare of children and youth, psychiatric and general hospitals, public schools, correctional services, and private family service agencies are also major employers of social workers. Now social workers, serving in these diverse settings, assume a more responsible and active role in family planning. The involvement of social workers through the networks of social service agencies is greatly facilitating the acceptance and delivery of family planning service.

SOCIAL WORK AS PART OF HEALTH CARE SERVICE

Social work service is provided in most maternity and infant care programs in the United States. The MIC-PRESCAD (Maternal and Infant Care; and Preschool, School, and Adolescent) Program in Detroit, a large Midwestern city, is a typical example of such program. In this paper, we see the problems that social workers are handling in this program, how their services are being delivered, and what significance the services have to the family planning service for the poor[6].

Family planning service is part of the maternity and infant care program authorized by the 1963 Amendments to the U.S. Social Security Act. Since then such programs, supported by the Children's Bureau of the Federal Government, have been established in urban and rural poverty areas throughout the United States. Quality comprehensive care has thus become not available before. Detroit's experience in the program has much in common with similar programs in other parts of the United States.

The MIC-PRESCAD Program provides services through two hospital-based and eleven neighborhood-based clinics. The clinics are located in the inner-city area of Detroit–a poverty area which has high rates of infant mortality, illegitimate births, fetal deaths, and other indexes of health problems. All clinics form a large health care system wherein the large hospital-based clinics supply medical personnel, equipment and supplies to the small neighborhood-centered clinics, and receive referrals from these small clinics. Clinics provide comprehensive prenatal, delivery, and postpartum care to medically indigent women from the area. Pediatric care is provided to infants of these women. Ambulatory care is provided to children and adolescents of low-income families, who will be referred to the clinics for continuous care to age 21. The care includes most of the services offered to the mothers plus vision, speech, and hearing services. The program's objectives are to strengthen family life, to improve the quality of parental care, and to achieve physical, emotional, and social well-being of the mothers and children of the indigent families.

The broad objectives of the social work service are to reduce the number of socioeconomic barriers that prevent the patient's utilization of comprehensive health care service, and to assist in the alleviation of problems of teen-age mothers.

Closely tied to these objectives is family planning service – a major component of the program. Family planning service helps all indigent women determine the number and spacing of their children and makes comprehensive family planning service available. The comprehensive family planning service represents an attempt to deal with health, social, and economic problems associated at least in part with the occurrence of unwanted and mistimed pregnancies and to serve as an essential component in the maternal and child care system.

Other goals of the program's social work service are to carry out community development activities, to provide in-service training for the ancillary clinic personnel, and to provide professional education for social work students by arranging field placements.

From the onset of the MCI-PRESCAD program, social work service was an integral part of the program. Under the program administrator, the director of social services (a professional social worker with the master of social work degree) coordinates, and supervises the social work service delivered at the thirteen clinics.

The social work service is delivered in four different ways in most U.S. clinics: (a) A clinic without social worker refers its patients to other agencies for social work service; (b) Several clinics share one or more social workers; (c) Each clinic has its own social workers; (d) Each clinic has paraprofessional social-worker-aides, and one or more professional social workers supervise these aides. Clinics, with limited resources, adopt (b) or (d). The case of the Detroit clinics falls on (c). The Detroit clinics use written guidelines for delegation of social work responsibilities to other agencies and for follow-up as well as for identification of patient's social work service needs.

Social workers are assigned to each of the thirteen clinics alone with interdisciplinary staff consisting of physicians, nurses, health assistants, nutritionist, dentist, dental hygienist, community worker, and secretary. The program has 18 full-time social workers at the 13 clinics (16 with the master of social work degrees and two with baccalaureate degrees). Each of the two hospital-based clinics has three social workers and one large clinic has two. Other clinics have one worker. All provide casework service, and limited group work and community development services. Clinics are open five days a week from eight in the morning to four in the afternoon.

PROBLEMS OF THE PATIENTS SERVED

The clinics receive referrals for various services for both mothers and children from hospitals, the public welfare department, and private physicians. Some are self-referrals. Within each clinic, the patient is referred to the social worker by the public health nurse who screens the patients and identifies their problems. The social worker, in turn, refers to the nurse and other medical personnel

those patients who decide to practice family planning and who desire other medical services. Although doctors, nurses, nutritionist, and others may contribute to the social work assessment, the social worker, who has training and expertise in analyzing an individual's sociopsychological condition and functioning, is responsible for the assessment. From this assessment, the social worker plans with the mothers, teen-agers, and children for solving or alleviating their problems.

The patient's problems are identified as follows: abortion, adoption, aggressive-destructive behavior, anxiety, child abuse or neglect, childcare need, discipline problem, emotional dysfunction, family planning need, impairment of family relationship, financial problem, impairment of growth and development, home management, housing, recognition and management of illness, language development, learning disabilities, need for legal services, need for food provision, non-compliance to the physician's advice, nonparticipation in care program, impairment of parenting, impairment of peer relationship, psychosomatic, school dropout and other school problems, discrepancies in self-determination, sexual development concerns, and disruption of social development. The problems which occur most frequently are financial, housing, child care, family planning, family, anxiety, school, parenting impairment, and lack of illness recognition.

SOCIAL WORK SERVICES

Indigent woman is beset by many problems. In easing this complexity, the concerns of the social worker extend from the intrapsychic forces and interpersonal relationships of a woman to the institutional and environmental factors that contribute to the woman's problems.

Many women, particularly unmarried and teen-age mothers, fall into financial difficulties. The social worker, to resolve their problems, tries to locate outside funds. She would ask social welfare agencies, churches, or community service agencies for financial assistance. An example of a housing problem is a situation where a young mother with children lives in a rat-infested, substandard apartment. The social worker plays the advocacy role with the housing authority in an attempt to house the mother in a public housing project. The worker would also ask real estate agencies, lawyers, or other influential persons for assistance. For mothers having problems in child caring, pediatric care (which includes feeding, nutrition, sanitation, and training) and day-care services are arranged. For a child whose mother is mentally ill, the worker would intervene to support the strengths in the family, or, in some cases, remove the child from the home. Many factors underlie physical abuse and poor quality of child care. Severe cases are referred to family service agencies for in-depth analysis and treatment. Some mothers resist medical care for themselves as well as for their children, and the social worker assists such mothers to recognize their illnesses and receive medical care services. Legal problems include adoption, child custody, child abuse, apartment lease, eligibility for welfare assistance, and so forth. The social worker assists her client through close interactions with the parents, the police, the lawyer, and the court. Most family problems and anxiety cases are related to pregnancy, childbirth, parenting, environmental concerns, and

young mothers' problems. The social worker assists the mother in adjusting to family life and trains in parental skills. School and career counseling are offered to the school dropout. When continuing in school is not feasible for the young mother, vocational training or rehabilitation service is arranged for. For emotional dysfunction, the worker, in consultation with the psychiatrist and the psychologist, provides counseling and protective services, or refers the client to a mental health clinic. A couple with genetic diagnosis and genetic risks for future children are helped to consider birth control methods.

Both from the viewpoints of education and actual service, family planning is related to most of these services to mothers. Hence, in each of the services, there is an opportunity for the social worker to introduce family planning.

There is, however, no single strategy that will resolve the mother's problems. It usually takes a combination of services and methods. The social worker employs a variety of methods: casework, group work, family counseling, consultation, community planning, and any combination of these methods depending on the mother's problems and the nature of the situation surrounding the mother[7].

Conditions that call for individual discussion of family planning services include repeated births out of wedlock, unwanted pregnancies, mental retardation, numerous and closely spaced previous births. the physical and emotional inability of the mother to care for her existing children, persistent physical or emotional disability of the mother, or marital conflict related to the earlier birth of unwanted children.

The social worker intervenes in a situation where a mother is unable to handle stressful encounters with one or more of such conditions or where the mother is found to have certain conditions which may lead to a stressful situation. Whatever the point of entry, the social worker first assesses the mother's social and psychological situation.

The social worker, through casework (the person-by-person approach), tries to involve the mother and her husband and let each play a major role in the consideration of family planning. The social worker helps to increase communication between the couple and finds out about subjects including: how many children they now have; how many children they want; did they plan the children they have; what meaning additional children has to them; have they been able to adequately care for the children; are they aware of family planning service available from free clinics; are they knowledgeable about family planning methods; do they have fears or confusions about the use of family planning methods; are they able to discuss family planning with each other; are there any religious or cultural factors constraining their family planning. Their discussions usually lead them to such common concerns as: the parents' desire to provide better living conditions and better education for the children they already have; the husband's desire to protect his wife from hazards of frequent pregnancies; or the parents' desire to have only children they want.

Having assessed the couple's problems based on information on these and other related matters, the social worker assists the woman and her husband in clarifying their life goals related to family size and spacing of child births as well as alleviating their fears and confusions regarding the use

of family planning methods. Many indigent women are unable to use the free family planning service because of lack of information on the availability of the service and motivation to use this service. The social worker informs the parents of available services and refer them to the nurse and the physician, or to other agencies for family planning and other services. Thereafter, the social worker's follow-up persists to help the parents hold onto family planning practice and overcome certain barriers that may hinder their practice. The social worker's perception of both parents' problems, professional skills, and personal empathy toward the parents help to determine the outcome of such casework service.

The psychiatrist and the psychologist, as consultants, assist the social workers in the development of care plans that deal with needed behavioral changes.

Group work supplements casework. The group approach not only furthers the social worker's diagnostic understanding of the conflicts, strength, and needs of the women, but also improves the women's ability to work together on their problems. Group approaches are applied to educational and preventive goals, related to sexuality, pregnancy, contraceptive usage, child care, and continuing school; and are directed to problem groups such as teen-agers, unwed mothers, high-risk women, and postpartum patients. An example of the group approaches is introduced in the following section.

The social worker provides family counseling to families of pregnant unwed-teenage girls. In family counseling, all members including the father are present, and the counseling social worker brings them into discussions on their problems with their teenage daughters. The counselor assesses intrafamilial communication, the neighborhood, the school, and other environmental conditions to which the family is exposed. Then, through individual counseling or group discussions, the social worker helps them cope with the crisis and reach best possible decision as to what sort of medical care the girl should receive. If needed, the members are referred to appropriate social, health, and educational services. The social worker coordinates these services.

In the last two years, the social workers served yearly average 59 percent of all the mothers who received maternity care and average 27 percent of all the children who received pediatric care

Most mothers and children were from multi-problem families and received more than one type of service. Financial problem posed the largest problems followed by anxiety, family problems, school dropouts, pregnancy, child care, family planning problems, housing problems, and parental impairment. Over the past two years, the most dramatic increase in the number of women served by social workers occurred in family planning problems (an over 160 percent increase). As in the case of mothers, financial problems occupied the largest share of children's problems followed by family problems and school problems.

Another role of the social worker in the clinic is consultation. The social worker consults the public health nurse who carries out the initial screening of social problems of the patients. It is a constant challenge for the social worker to help the nurse limit her responsibility to working with those social problems that are within her competence.

The social worker, when necessary, participates in planning and execution of community health education programs designed to provide the hard-to-reach women with more effective information

and persuasive education about services available to them. The social worker with experience in staff training supervises and trains para-professionals employed from the clinic area, such as receptionist, clerk, nurse-aide, and community outreach worker. The director of social service, meanwhile, maintains liaison between the clinics and various organizations in the community, including schools, courts, social service agencies, and clinics and hospitals, to achieve more effective coordination and to balance the clinics' resources. The director also plans and organizes advisory committee comprising of civic leaders and concerned citizens.

SERVICE TO UNWED MOTHERS

A major target population of the Detroit program is the group of unmarried pregnant girls. Teen-age pregnancy is indeed a major concern for social workers[9].

In the United States, the birth rate for younger teen-agers, 15-17 years old, has not followed the general decline in the nation's fertility. The rate actually increased slightly from 35.8 births per 1,000 in 1966 to 36.6 births in 1975. 95.7 percent of these girls were unmarried school-age girls[10].

An out-of-wedlock pregnancy in a young teen-ager signals not only various health hazards but also the beginning of a cycle consisting of failure to continue her education, dependence on the public welfare system, never creating her own stable family, and continuation of the reproduction of illegitimate offsprings[11].

Through individual and family counseling, group discussions, school arrangements, and family planning, the social worker attempts to help these girls before pregnancy or after delivery to continue their education, learn more about themselves and the care of their children, and control additional births out of wedlock.

Social workers occasionally participate in health educational activities. Through workshops, rap sessions, and seminars at various schools and clubs where youths are gathered, the social workers attempt to improve the youths' understanding of their own sexuality, to encourage them to take personal responsibility for their sexual relationships, to teach them how to use contraceptive methods, and to help them understand the legal implications and responsibilities of parenthood.

Since interaction between peers is an important factor in the youngsters' development, treatment methods using peer-group dynamics have a high potential for success. Therefore, group work approaches are most widely used.

During the first visit to the clinic, the group program is explained and the pregnant girl is invited to participate. If she is interested, the social worker arranges with the parents for her to visit the clinic for the remainder of her pregnancy. The girl is then assigned to a group of five to ten girls, all of whom are due for delivery at about the same time. Often fathers, or alleged fathers, of the babies are invited to this group, and the father's role is discussed. At the group meeting, the worker and the girls discuss subjects prompted by the pregnancy, e.g., sex, social, and psychological

changes since pregnancy, and the course of labor and delivery. The girls are free to bring up any material they wish. The only restriction is that they not discuss content outside the group. The social worker provides insight and understanding whenever possible. Occasionally, role playing and psychodrama are used when the worker feels that such tools may help to clarify feelings in a particular situation. In some group sessions, films about "growing up," care of children, and family planning concepts are shown.

Three to ten weekly sessions were offered during last summer. Clinics implemented group of about ten unmarried pregnant girls. Through these programs, the clinics served over 400 adolescents between 14-17 years old[12].

A parents' group is organized at a large clinic. The aims of this group are to enable the parents to recognize the disruptive effect of their daughters' pregnancies on the family system; to strengthen the parents' "mothering" role by fostering self-awareness, building feelings of adequacy, and improving their communication with their daughters; and to acquire a feeling of solidarity through mutual interactions with other parents who are experiencing the same crisis. The gorup meets once a week for two hours over a three to four week period. The social worker and one or two supporting counselors serve the group. Open discussion is the primary technique, but role playing is also used occasionally. Both parents participate whenever possible.

During the postpartum period, the focus is on pediatric care, contraception, readjustment to family and school life, and vocational training if continuing school is infeasible.

Among the teen-agers, financial problems were again the number one problems, followed by anxiety, impairment of family relationships, school problems, and social development. According to the program report, about 23 percent of their problems were resolved or alleviated through the social work services.

DISCUSSION

The personal and social impediments and institutional barriers to family planning tend to reinforce each other, resulting in a heavy concentration of families in need of family planning in the lowest income group. Most women in this group, having problems in relation to the use of family planning service, tend to have problems in other areas of their lives. Social workers intervene in this situation to link the women to a range of social, economic, educational, and medical services which the women need. Without such links, the family planning gains will be short lived. These are also the women who require direct outreach contacts and continuous follow-up services by the social workers. A diffuse approach alone, such as the saturation of mass media or the door-to-door distribution of contraceptives, is not effective to them.

The utilization of family planning service depends not only on its availability but also on its acceptability to the women. The family planning service for the poor has often been criticized in both the United States and other countries for insufficient sensitivity to human needs beyond that

of technical birth control. The involvement of social workers in the service – whose practice is oriented toward the protection of the individual client's human rights, dignity, and privacy – may improve the quality of the human side of the service. So far, social workers' intervention is well accepted by their clients. The social workers, in their professional discussions about the subjects of family planning, encounter no hostility or hesitance from their clients[13].

Family planning service is, therefore, most effective when it is offered as part of a wide range of services which include social work service. A wide range of services tends to attract more indigent women and retain them in the program for a longer period of time than can a single-purpose program[14]. There are other technical and administrative advantages in integrating family planning into such a comprehensive program.

Family planning is only one of the health services. However, it has a far reaching potential for preventing and reducing the incidences of many of the most plaguing health and social problems of the indigent families[16]. Increasingly more social workers recognize this potential. Thus, family planning offers the social work profession additional resources that will make possible more effective treatment and prevention of the problems of the poor.

In the delivery of social work services, a significant portion of the problems appeared to be related to poor communication among members of the clinic staff. There was a definite need for clinic personnel and social workers to become more acquainted with each others' roles in order to better define the criteria of referral.

Besides, over a half of the social workers serving at the clinics did not have regular classes in family planning. They need education in family planning. As Rapoport[17]. stresses, education for social workers specialized in family planning should draw from a broader interdisciplinary base. Studies of poverty is especially relevant. Such educational endeavor could best be carried out through cooperation with the school of social work.

The social work professional, part of the health care program, is under pressure to meet the demand for public accountability. So far, the concern of the program has been with the number of social work assessments made, number of contacts made, and time spent on each patient. These criteria, however, would not accurately define effectiveness or quality of the social work service. A key part of the evaluation process should be the periodic analysis of the outcome of service delivery combined with follow-up of the patients to determine the effectiveness of the service.

Social work is still new to the family planning field. The increase in the workload and the potential effects of the problems caused by uncontrolled fertility, however, throw a great challenge to the social workers in the Detroit setting. The social work profession is to increase the validity of its approach in this field also. In order to do so, more recorded descriptions of the practice and generalizations derived from these are needed. Right now empirical evidence of what social workers do in such a setting is rather limited.

Social work is, however, expanding its base for practice. In the school of social work, new courses in sex education, maternal health, and family planning are offered; and lectures by specialists from other disciplines includng medicine, public health, nursing, sociology, psychology, law,

economics, and political science, are frequently arranged. Social work students are placed in family planning settings for field training. Joint training programs are held with schools of public health. Reading and teaching materials are published, such as introduced in the following. Researchers and practitioners in the field are developing ways of applying social work methods to the prevention and alleviation of problems related to family planning.

References

Gindy, Aida. 1971. Population I ıamics and Family Planning: A New Responsibility for Social Work Education. Proceedings of an International Conference on Social Work Education, Population, and Family Planning, Hawaii. New York: Council on Social Work Education.

Glasser, Paul H., Helen J. Hunter, and Henry J. Meyer (eds.). 1973. Social Work Education for Family and Population Planning: Topical Outlines and Annotated References Selected for Social Work Educators. Social Work Education and Population Planning Project, School of Social Work, University of Michigan, Ann Arbor, Michigan.

Gochros, Harvey L., and LeRoy G. Schultz. (eds.) 1972. Human Sexuality and Social Work. New York: Association Press.

Gorman, Joanna F. (ed.) 1970. The Social Work and Family Planning. Program in Public Health Social Work, University of California, Berkeley, California.

Haselkorn, Florence, (ed.). 1968. Family Planning: The Role of Social Workers. Garden City, New York: Adelphi University School of Social Work.

International Planned Parenthood Federation, Europe Region. 1974. Planned Parenthood in Social Work Education. Proceedings of a Meeting of a Joint International Association of School of Social Work. IPPF, Europe Regional Working Group, 18-20, March.

Kendall, Katherine A. (ed.). 1971. Population Dynamics and Family Planning: A New Responsibility for Social Work Education. Proceedings of an International Conference on Social Work Education, Population, and Family Planning (Honolulu, Hawaii, March 13-18, 1970). New York: Council on Social Work Education.

Lasan, Dolores B. 1973. Family Planning and Social Work Education through a Development Package in Floating Placements. Manila: The Philippine School of Social Work.

Manisoff, Mirriam T. (ed.). 1970. Family Planning Training for Social Service: A Teaching Guide for in-Service Training in Public Welfare Departments. New York: Planned Parenthood-World Population.

Oettinger, Katherine B. 1975, Social Work in Action: An International Perspective on Population and Family Planning. New York: International Association of Schools of Social Work, June.

Patankar, Pandit, and Lilian Dey. 1974. Social Communication in Family Planning: A Case Book. New Delhi, India: Orient Longman Ltd.

Rao, Mukunda. 1974. Community Organization Practice for Family and Population Planning. Social Work Education, and Family and Population Planning Project, School of Social Work, University of Michigan, Ann Arbor, Michigan.

Schlesinger, Benjamin. 1974. Family Planning in Canada: A Source Book. Toronto, Ontario, Canada: University of Toronto Press.

United Nations. 1974. Economic and Social Commission for Asia and the Pacific Regional Workshop on Social Welfare Aspects of Family Planning (12-21. December), Bangkok, Thailand, UNESCAP.

REFERENCES

1. Joseph Goldman and Leonard S. Kogan, "Public Welfare and Family Planning", *Family Planning Perspectives.* Vol. 3, No. 4, 1971, p. 19., and National Association of Social Workers, *Encyclopedia of Social Work.* Seventeenth Issue, Vol. 1, 1977, pp. 410-413.

2. Frederick S. Jaffe and Steven Polgar, "Family Planning and Public Policy: Is the "Culture of Poverty' the New Cop-out?," *Journal of Marriage and the Family.* Vol. 30, No. 2, 1968, p. 235. and Bernard Greenblatt, "Family Planning Goals and Social Work Roles," *Family Planning Perspectives.* Vol. 4, No. 1, 1972, p. 54.

3. As quoted in Miriam F. Mednick, "The Social Worker's Responsibility," in Joanna F. Gorman (ed.). *The Social Worker and Family Planning.* Berkeley, California: Program in Public Health Social Work, University of California, 1970, p. 45.

4. See a summarized statement regarding the crises in: Kyu-taik Sung, "Integrating Nutritional and Family Planning Education with Food Services in Korean Day Care Centers – An Evaluation," *Public Health Reports.* Vol. 93, No. 2, 1978, pp. 177-178.

5. Henry J. Meyer and Judy Stone, "Family Planning in the Practice of Social Workers," *Family Planning Perspectives.* Vol. 6, No. 3, 1974, p. 193.

6. About the Detroit program, see: Kyu-taik Sung, "Patients' Evaluation of Family Planning Services: The Case of Inner-City Clinics," *Studies in Family Planning.* Vol. 8, No. 5, 1977, pp. 130-137. and Kyu-taik Sung, "The Role of Social Workers in a Comprehensive Health Care Program for Indigent Women and Adolescent Girls – With Specific Regard to Family Planning Services," *Health and Social Work.* (The National Association of Social Workers, New York), (In Press).

7. Regarding social work methods used in family planning services, see, Lydia Rapoport, "Educa-

tion and Training of Social Workers for Roles and Functions in Family Planning," *Journal of Education for Social Work.* Vol. 6, No. 2, 1970, pp. 27-38., and Bernard Greenblatt, "Family Planning Goals and Social Work Roles," *Family Planning Perspecitves.* Vol. 4, No. 1, 1972, pp. 56-58., and National Association of Social Workers, *Encyclopedia of Social Work.* Seventeenth Issue, Vo., 1, 1977, pp. 1309-1321.

8. DMIC-PRESCAD, *Report on MIC-PRESCAD: 1976-1977,* Detroit, Michigan, 1978.

9. Henry J. Meyer and Judy Stone, "Family Planning in the Pracitce of Social Workers," *Family Planning Perspecitves.* Vol. 6, No. 3, 1974, p. 181.

10. National Center for Health Statistics, "Teenage Childbearing: United States, 1966-1975," *Monthly Vital Statistics Report: Natality Statistics.* Washington, D.C., Department of Health, Education, and Welfare, Vol. 20, (Supplement), Vol. 20, September 8, 1977.

11. See for example, Philip M. Sarrel, "The University Hospital and the Teenage Unwed Mother," *American Journal of Poblic Health.* Vol. 57, No. 8, 1967, pp. 1308-1313.

12. DMIC-PRESCAD, *Report on MIC-PRESCAD: 1976-1977,* Detroit, Michigan, 1978.

13. Henry J. Meyer and Judy Stone, "Family Planning in the Practice of Social Workers," *Family Planning Perspectives.* Vol. 6, No. 3, 1974, p. 180.

14. Kyu-taik Sung, "Patients' Evaluation of Family Planning Services: The Case of Inner-City Clinics," *Studies in Family Planning.* Vol. 8, No. 5, 1977, pp. 135-136.

15. WHO, The Organization and Administration of Maternal and Child Health Services, *Fifth Report of the WHO Expert Committee on Maternal and Child Health,* WHO Technical Report Series, No. 428, World Health Organization, Geneva, 1969, pp. 20-21, and Helen M. Wallace, Edwin M. Gold, and Samuel Dooley, "Relationships Between Family Planning and Maternal and Child Health," *American Journal of Public Health.* Vol. 59, No. 8, 1969, pp. 1357-1358.

16. Florence Haselkorn, *The Responsibilities and Opportunities for Social Work in Family Planning.* Unpublished paper delivered at University of North Calorina, November 21, 1969, p. 2.

17. Lydia Rapoport, "Education and Training of Social Workers for Roles and Functions in Family Planning," *Journal of Education for Social Work.* Vol. 6, No. 2, 1970, pp. 27-38.