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Addressing the Declining Child Sex Ratio Through Prevention, Treatment, and Rehabilitation: A Qualitative Study of Social Work Interventions in Wanaparthy District, Telangana

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ABSTRACT

India's Child Sex Ratio (CSR) remains quite below the biologically natural range despite three decades of legislative intervention through the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994, indicating that legal enforcement by itself is insufficient to generate sustained behavioural change. This paper reports a qualitative, practice-based study explores whether three-tiered social work methods as intervention framework which includes prevention, treatment, and rehabilitation, operationalised through social case work, social group work, and community organisation can shift attitudes and practices around son preference and the devaluation of daughters. The study was conducted in three mandals of Wanaparthy District, Telangana, selected to represent high, medium, and low child-sex-ratio disparity. Data were generated through six in-depth social case work interventions, three typologies of social group work (adolescents, newly married couples, and parents of girl children), and one mandal-level community organisation programme, using in-depth interviews, family assessment interviews, collateral interviews, direct observation, and process documentation. Findings suggest meaningful, if early-stage, shifts at the individual, family, and community levels: increased spousal support for gender equality, greater openness in family-planning discussions among young couples, strengthened emotional bonding between parents and daughters, and expanded institutional engagement with schools, health centres, and panchayat bodies. The study concludes that sustainable change in CSR requires concurrent, multi-level intervention, combining individualised casework, peer-based group processes, and community mobilisation , rather than any single strategy alone, and identifies male engagement, institutional integration, and longer-term follow-up as priorities for future practice.

Keywords: Child Sex Ratio; Social Work Intervention; Prevention-Treatment-Rehabilitation; Qualitative Research; Wanaparthy District; Gender Equality

1. Introduction

The Child Sex Ratio (CSR) , the number of girls per 1,000 boys in the 0–6 years age group , is one of the most sensitive indicators of gender equity in India. Under normal biological conditions this ratio remains stable at roughly 950 to 975 girls per 1,000 boys; sustained deviation from this range is, in almost all documented cases, attributable to sex-selective practices rather than natural variation (Guilmoto, 2009). Amartya Sen's most cited estimate of over 100 million "missing women" across Asia first drew global attention to the scale of this phenomenon, and subsequent research confirms that sex-selective abortion, rather than differential female mortality, accounts for the majority of the deficit in India (Jha et al., 2011). The 2011 Census recorded a national CSR of 919 girls per 1,000 boys, and NFHS-5 (2019–21) placed the sex ratio at birth at 929 females per 1,000 males nationally , an improvement, but still not closure to the natural benchmark.

India's principal legislative response, the PCPNDT Act, 1994, prohibits the use of diagnostic techniques for sex determination. Yet empirical evidence consistently shows that legal prohibition alone is not sufficient to generate sustained behavioural change, given the deeply entrenched patriarchal norms, dowry-linked economic control, and inconsistent enforcement that sustain son preference (Tabaie, 2015; Nandi & Deolalikar, 2013). This gap between legal framework and lived behaviour points to the need for practice-based, community-based interventions capable of engaging directly with the attitudes and decision-making processes that result in gender-biased outcomes.

Wanaparthy District, Telangana, demonstrates these dynamics. Persistent gender bias rooted within patriarchal social structures has contributed to sex-selective practices, including prenatal sex determination and gender-biased

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abortion, within a predominantly rural, agrarian district. This paper reports findings from Objective 4 of a larger doctoral study , "To identify strategies and suggest measures to curb the problem of declining child sex ratio through prevention, treatment, and rehabilitation approaches" , presenting the qualitative evidence generated through a three-tiered social work intervention implemented across nine villages in three mandals of the district.

2. Theoretical Framework

The intervention was structured within a prevention-treatment-rehabilitation framework drawn from public-health and social-work practice. Prevention comprised primary interventions targeting behavioural modification before problematic practices occur, emphasising legal awareness of the PCPNDT Act, the health consequences of sex-selective practices, and the intrinsic value of girl children. Treatment comprised secondary interventions providing direct clinical and psychosocial support to individuals and families already experiencing or perpetuating gender bias, through individual counselling, family therapy, crisis intervention, and attitudinal reorientation. Rehabilitation comprised tertiary interventions aimed at reinforcing behavioural change, preventing relapse into discriminatory patterns, and supporting families transitioning toward egalitarian perspectives through sustained follow-up and community integration.

This framework was operationalised through three established social work methodologies. Social case work theory (Hamilton, 1951; Mathew, 1992) emphasises individualised assessment, diagnosis, and treatment of personal and social problems through one-to-one therapeutic engagement. Social group work theory (Konopka, 1963; Siddiqui, 2008) highlights peer influence, collective consciousness, and group dynamics as mechanisms for behavioural and attitudinal change. Community organisation theory (Ross, 1955; Gangrade, 1971) underscores participatory mobilisation, local ownership, and systemic engagement as pathways to sustainable social change. Together, these methodologies were intended to generate change concurrently at the individual, familial, and community levels, on the premise that gender-biased norms operate simultaneously at each of these levels and therefore cannot be addressed through single-level intervention alone.

3. Methodology

3.1 Research Design

An integrated qualitative design, combining intervention implementation with qualitative evaluation, was used to capture rich narrative accounts of lived experience, decision-making processes, and mechanisms of attitudinal and behavioural change.

3.2 Study Area and Population

The study was conducted in Wanaparthy District, Telangana, across three mandals selected to represent differential CSR disparity based on 2011 Census data: Gopalpeta Mandal (high CSR disparity), Revally Mandal (medium CSR disparity), and Pangal Mandal (low CSR disparity). Nine villages were engaged in total , Yedutla, Gopalpet, and Budharam in Gopalpeta Mandal; Kesampeta, Bandaraipakula, and Cheerkapalle in Revally Mandal; and Korakunta, Madhvaraopalle, and Vengalaipalle in Pangal Mandal.

Purposive sampling, supported by ASHA workers, Anganwadi workers, and community gatekeepers, was used to identify households and individuals for intervention. Selection criteria included families expressing explicit gender preference for male children, pregnant women experiencing gender-related family pressure, individuals or families demonstrating gender discrimination in resource allocation or celebration practices, couples actively engaged in family-planning decisions, and parents of girl children facing societal stigmatisation.

3.3 Intervention Methods

Three social work methods were applied. Social case work was delivered through six detailed cases, each requiring 14–18 hours of direct contact over 2–3 months and involving 4–8 home visits, structured through case identification, assessment, diagnosis, treatment planning, implementation, and follow-up. Social group work comprised three group typologies implemented across all three mandals: youth groups (adolescents aged 14–18) meeting fortnightly over three months, newly married couples (0–2 years of marriage) meeting monthly over three months, and parents of girl children meeting bi-monthly over three months. Community organisation was implemented as a single mandal-level action programme, the "Samaj Sammelan for Gender Equality and Child Sex Ratio," in Gopalpeta Mandal, engaging

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Sarpanch and Panchayat members, ASHA and Anganwadi workers, school teachers, Primary Health Centre staff, youth volunteers, women's self-help groups, and religious leaders through a phased process of stakeholder mobilisation, participatory community mapping, action planning, phased implementation, and sustainability planning.

3.4 Data Collection

Data were generated through in-depth semi-structured individual interviews with case clients; joint family assessment interviews to understand systemic dynamics; collateral interviews with ASHA workers, neighbours, and extended family members to triangulate reported change; direct observation of family interactions, group dynamics, and community engagement; detailed process documentation including case records, session notes, and progress reports; and pre- and post-intervention qualitative feedback from participants.

4. Results

4.1 Social Case Work: Six Illustrative Cases

Six detailed cases were undertaken, each addressing a distinct manifestation of gender bias linked to son preference. Table 1 summarises the presenting problem, core intervention, and primary outcome for each case.

Table 1: Social Case Work , Presenting Problems, Interventions, and Outcomes

Case	Presenting Problem	Core Intervention	Primary Outcome	Status
1	Familial pressure to conceive a male child; disappointment over daughter's birth	Individual and family counselling; mediation with in-laws	Husband showed increased support for gender equality; reduced familial pressure	Positive shift
2	Advanced pregnancy amid family pressure for a male child; health neglect	Supportive counselling; health education; family mediation	Family partially acknowledged health risks; improved engagement with care	Moderate progress
3	Forced gender-biased abortion; emotional distress; repeated pregnancy under pressure	Trauma-informed counselling; health education; community advocacy	Client developed assertiveness and self-advocacy capability	Ongoing support needed
4	Repeated pressure to conceive a son despite three daughters	Health education; family engagement; reframing family narrative	Husband prioritised maternal health over gender preference	Positive shift
5	Financial instability; traditional gender-role burden; limited economic independence	Skill-development referrals; microfinance linkage; shared-parenting counselling	Client linked to skill-building; husband engaged in parenting	Emerging change
6	Post-hysterectomy distress; husband's remarriage for a male heir	Trauma-informed counselling; family mediation; advocacy	Family acknowledged client's emotional worth beyond reproductive capacity	Gradual progress

Source: Case records and process documentation, Objective 4 intervention study

Two cases illustrate the mechanisms through which change occurred. In the first, a 28-year-old client facing familial

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pressure to bear a son following her daughter's birth received individual and family counselling combined with mediation involving her in-laws; over three months and eight home visits, her husband moved from passive acceptance of extended-family pressure to active support for gender equality, and the client reported increased confidence in asserting her reproductive choices. In the sixth, a 35-year-old client experiencing acute psychological distress after a hysterectomy , compounded by her husband's remarriage in pursuit of a male heir , received trauma-informed individual counselling alongside family-level work challenging patriarchal beliefs about a woman's worth; over the intervention period, the family moved toward acknowledging her emotional needs and re-evaluating her value beyond reproductive capacity. Across all six cases, husbands and other family members demonstrated increased receptiveness to gender-sensitive perspectives, economic empowerment emerged as an important pathway to gender equity, and health-related crises frequently created openings for broader attitudinal discussion that would not otherwise have occurred.

4.2 Social Group Work

Three group typologies were implemented across all three mandals. Youth groups (adolescents aged 14–18), meeting fortnightly through interactive games, role-plays, group discussions, and storytelling from local female role models, produced increased critical thinking about gender roles among more than 85 per cent of participants, with over 40 per cent volunteering for community awareness campaigns. Newly married couples (0–2 years of marriage), meeting monthly around shared decision-making, reproductive health, financial planning, and legal awareness of the PCPNDT Act, reported improved communication about family planning in over 70 per cent of cases, with over half expressing willingness to resist extended-family pressure for a male child. Parents of girl children, meeting bi-monthly to share positive parenting experiences and celebrate daughters' achievements, reported increased emotional connection with daughters among over 90 per cent of participants, with three-quarters committing to educational investment in daughters regardless of gender.

4.3 Community Organisation

The "Samaj Sammelan for Gender Equality and Child Sex Ratio" programme in Gopalpeta Mandal mobilised Sarpanch and Panchayat members, ASHA and Anganwadi workers, school teachers, Primary Health Centre staff, youth volunteers, women's self-help groups, and religious leaders through preliminary stakeholder engagement, a participatory community-mapping workshop involving more than 50 stakeholders, democratic action planning, and phased implementation comprising a public awareness campaign, institutional engagement with schools and health centres, a monthly community-dialogue series, and the establishment of a local gender-equality committee for sustained ownership. The programme established institutional partnerships with more than eight schools, three health centres, and five panchayat bodies, engaged an estimated 3,000 or more community members through awareness activities, and generated positive local media framing of gender-equality issues.

5. Discussion

5.1 Mechanisms of Change

Findings suggest that change operated through distinct but interlocking mechanisms at three levels. At the micro level, intensive one-to-one engagement in social case work allowed for individualised contextualisation, built therapeutic alliance, and created a safe space for clients to explore and articulate perspectives on gender that they may not otherwise have voiced, producing enhanced self-awareness of internalised bias, increased confidence in asserting reproductive autonomy, and improved family communication. At the meso level, group processes generated shared realisation of gender injustice among peers, normative reinforcement of equitable beliefs, and emergent peer leadership, translating into youth questioning gender stereotypes in everyday conversation, couples discussing family planning without gender preference, and parents mobilising collectively to resist stigmatisation. At the macro level, participatory mobilisation through community organisation built institutional responsiveness across schools, health centres, and local governance, established public legitimacy for gender-equality discourse, and created a leadership pipeline for advocacy that extends beyond the intervention period.

5.2 Key Theoretical Insights

Four insights emerge from the findings. First, single-level interventions proved insufficient on their own; sustained

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change appeared to require concurrent work at the individual, family, and community levels, consistent with the study's underlying multi-tiered framework. Second, interventions grounded in local values and belief systems demonstrated greater receptiveness than externally imposed approaches, suggesting that cultural contextualisation is not merely a delivery consideration but a condition for effectiveness. Third, strategic timing of intervention , during adolescence, in the early years of marriage, or around health crises , significantly enhanced receptiveness to perspective change, indicating that certain life-course windows are more amenable to attitudinal work than others. Fourth, mobilisation of existing community resources, including ASHA and Anganwadi workers, local leaders, and peer networks, proved more sustainable than reliance on externally introduced resources, pointing to the value of working through, rather than around, existing community infrastructure.

5.3 Challenges and Limitations

Several limitations qualify these findings. The assessment period was too short to establish whether observed attitudinal shifts persist over the longer term. Deeply entrenched patriarchal beliefs required engagement well beyond the intervention window, and the absence of a dedicated, male-focused intervention track limited the scope of gender transformation achieved, given that much of the resistance to change resided in male decision-makers who were engaged only indirectly through family-level work. Community organisation outcomes, in particular, are likely to be measurable only after an extended gestation period beyond what this study could observe.

5.4 Implications for Practice and Policy

For social work practice, the findings indicate that practitioners require specific training in gender-transformative approaches, that timing-sensitive intervention windows should be deliberately identified and used, that community health workers such as ASHA and Anganwadi workers require capacity strengthening for gender advocacy roles, and that trauma-informed approaches are essential for clients who have experienced gender-based harm. For policy, the findings indicate that PCPNDT Act enforcement requires community engagement that extends beyond legal sanctions alone, that gender-equality content merits integration into school curricula, that coordination across health, education, and governance institutions is essential for systemic change, and that male engagement and the reframing of masculinity are necessary complements to interventions that have, to date, engaged women and families more directly than men.

6. Conclusion

This study demonstrates that the declining child sex ratio in a rural Indian district is amenable to structured social work intervention when approached through an integrated prevention-treatment-rehabilitation framework operating concurrently at the individual, family, and community levels. The six case studies, three group work typologies, and one community action programme collectively generated evidence of meaningful, early-stage attitudinal and behavioural change: increased spousal support for gender equality, greater openness among young couples in family-planning discussions, strengthened emotional bonding between parents and daughters, and expanded institutional engagement across schools, health centres, and local governance.

While quantifiable shifts in demographic indicators such as CSR itself would require a much longer observation window than this study allowed, the qualitative indicators of transformation documented here , increased dialogue, perspective shifts, leadership emergence, and institutional engagement , point to substantive, if early-stage, social change. The model presented offers a replicable, culturally grounded template for addressing child sex ratio challenges in comparable rural Indian contexts, provided it is sustained through long-term follow-up, strengthened engagement of men and boys, and deeper institutional integration beyond the life of any single intervention programme.

References

1. Akchurin, M., & Lee, M. (2013). Family-based interventions and gender equity. Social Work Review, 45(3), 234–256.
2. Gangrade, K. D. (1971). Community organization in India: Theory, principles, and practice. Popular Prakashan.
3. Guilmoto, C. Z. (2009). The sex ratio transition in Asia. Population and Development Review, 35(3), 519–549.

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4. Guthridge, S., et al. (2022). Adolescent receptiveness to gender-transformative education. Journal of Adolescent Health, 67(4), 512–521.
5. Hamilton, G. (1951). Theory and practice of social case work (2nd ed.). Columbia University Press.
6. Jha, P., Kesler, M. A., Kumar, R., Ram, F., Ram, U., Aleksandrowicz, L., ... & Bassani, D. G. (2011). Trends in selective abortions of girls in India: Analysis of nationally representative birth histories from 1990 to 2005 and census data from 1991 to 2011. The Lancet, 377(9781), 1921–1928.
7. Konopka, G. (1963). Social group work: A helping process. Prentice Hall.
8. Mathew, G. (1992). Case work in India: Perspectives for practice. Tata Institute of Social Sciences Press.
9. Nandi, A., & Deolalikar, A. B. (2013). Does a legal ban on sex-selective abortion improve child sex ratios? Evidence from India. Journal of Development Economics, 103, 216–228.
10. National Family Health Survey-5 (NFHS-5). (2021). India Fact Sheet. International Institute for Population Sciences, Mumbai.
11. Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994. Government of India, Ministry of Law and Justice.
12. Ross, M. G. (1955). Community organization: Theory, principles, and practice (Rev. ed.). Harper & Row.
13. Sen, A. (1990, December 20). More than 100 million women are missing. The New York Review of Books, 37(20).
14. Siddiqui, H. Y. (2008). Group work: Theories and practices in Indian context. Rawat Publications.
15. Tabaie, A. (2015). Sex-selective abortion and its implications for gender imbalance in Asia. Population and Development Review, 41(2), 309–324.
16. Wang, L., et al. (2022). Early marriage interventions and gender equity in family planning. International Journal of Public Health, 69(3), 1604–1618.