

Original Research Article

Sociocultural and economic determinants of adolescent fatherhood among Particularly Vulnerable Tribal Groups in Eastern India: a qualitative study from Jharkhand

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ABSTRACT

Background: Adolescent fatherhood among Particularly Vulnerable Tribal Groups (PVTGs) is an underexplored public health issue in India. Existing research has focused predominantly on adolescent mothers, leaving pathways to early fatherhood among tribal boys largely unexamined. This study explores the socio-cultural and economic determinants of adolescent fatherhood among PVTGs in Jharkhand.

Methods: A qualitative study was conducted from December 2025 to February 2026 in Patamda block, East Singhbhum, Jharkhand. Thirty-four males (aged 14-34 years) from Sabar, Birhor, and Pahariya PVTG communities were enrolled using purposive and snowball sampling. Semi-structured interviews, focus group discussions, and field observations were conducted; thematic analysis continued until saturation.

Results: Early marriage was identified as the primary and socially normalised pathway to adolescent fatherhood, with 51.6% of participants having married before the age of 18 years (mean age at marriage: 18.0±3.5 years). All 34 participants (100%) reported no awareness of family planning methods prior to becoming fathers. Tobacco use was reported in 91.2% and alcohol use in 82.4% of households. Educational discontinuation was near-universal (97.1%), with financial constraints and early entry into wage labour as predominant reasons. A substantial proportion reported peer (64.7%) and sibling (61.8%) exposure to adolescent parenthood. All participants (100%) expressed a desire that the next generation should not become adolescent parents.

Conclusions: Adolescent fatherhood in this context is shaped by structural poverty, early marriage norms, educational discontinuation, and absence of reproductive health services. Gender-inclusive, community-embedded interventions engaging adolescent boys, and improvements in education, livelihood, and health systems are urgently needed.

Keywords: Adolescent fatherhood, Early marriage, Jharkhand, Qualitative study, PVTG, Reproductive health

INTRODUCTION

Adolescence, defined as the period between 10 and 19 years of age, is a critical developmental window characterised by rapid physical, cognitive, and psychosocial transformation. In India, adolescent health policy and programming have historically prioritised

girls, particularly in relation to early marriage, teenage pregnancy, and maternal mortality. While this focus addresses genuine vulnerabilities, it has simultaneously resulted in the systemic neglect of adolescent boys, especially in the context of reproductive and sexual health.

Adolescent fatherhood, defined as biological fatherhood occurring during or following adolescence, is a phenomenon that carries substantial public health significance. Young fathers are frequently underprepared for parental responsibilities, face economic precarity, and lack access to reproductive health information. Beyond individual consequences, early fatherhood intersects with cycles of intergenerational poverty, poor child health outcomes, and reduced educational attainment.¹

India is home to approximately 253 million adolescents aged 10-19 years, of whom a significant proportion reside in tribal and rural communities.² National Family Health Survey-5 (NFHS-5) data indicate that 9.8% of women aged 15-19 years in Jharkhand are already mothers or pregnant, compared to the national average of 6.8%.^{3,4} These figures signal a concentrated reproductive health burden in specific ecological and socio-cultural contexts.

Particularly Vulnerable Tribal Groups (PVTGs) represent the most marginalized segment of India's tribal population, characterized by a pre-agricultural economy, extremely low literacy, declining or stagnant population, and limited access to essential services.⁵ In Jharkhand, scheduled communities such as the Sabar, Birhor, and Pahariya constitute recognised PVTGs. Within these communities, the normative frameworks governing marriage and family formation are distinct from the broader population, with early marriage and early entry into adult roles deeply embedded in cultural practice.

Despite the significance of this issue, empirical evidence on adolescent fatherhood among PVTGs in India is virtually absent. A landmark case-control study by the present author and colleagues was conducted across rural Jharkhand and Odisha with 228 participants. It was found that while intergenerational cycles of adolescent motherhood are well-documented, no statistically significant intergenerational cycle was observed for adolescent fatherhood.⁶ However, that quantitative study identified alcohol use and cultural norms for early marriage as significant correlates, and recommended targeted qualitative inquiry to understand the contextual pathways underlying these associations. The present study responds directly to this gap. It aims to explore the socio-cultural and economic determinants of adolescent fatherhood among PVTGs in East Singhbhum district, Jharkhand, through in-depth qualitative engagement with adolescent and young adult fathers from Sabar, Birhor, and Pahariya communities.

METHODS

Study design and setting

A qualitative study design was employed, drawing on semi-structured interviews, focus group discussions (FGDs), and systematic field observations. The study was conducted between December 2025 and February 2026 in Patamda block of East Singhbhum district, Jharkhand.

Patamda block comprises 261 settlements across 27 panchayats, characterised by dispersed PVTG hamlets nestled amidst agricultural lands, forest patches, and the foothills of the Dalma Hills range. Livelihoods depend heavily on natural resources and seasonal wage labour. While functionally connected to Jamshedpur (approximately 26-30 km away), pockets of the block near the Dalma foothills experience considerable remoteness with poor road connectivity, particularly during the monsoon season, restricting access to education, health services, and markets. The study was conducted under the programmatic framework of the RISHTA (Regional Initiative for Safe Sexual Health by Today's Adolescents) program of Tata Steel Foundation (TSF), which has been implementing adolescent health initiatives across Jharkhand and Odisha.

Study population

The study population comprised males who had entered into marriage during adolescence and were residing in PVTG-dominated villages. Participants were drawn from three PVTG communities: Sabar (n=25), Birhor (n=7), and Pahariya (n=2). Although the original study focus was on adolescent fathers (below 21 years), the age range of participants extended to 34 years, as several men who had married during adolescence were identified through snowball referrals and provided valuable retrospective accounts.

Sampling and recruitment

Purposive and snowball sampling techniques were employed. Initial participants were identified through community health workers, ASHA workers, and RISHTA program volunteers embedded in PVTG villages. Subsequent participants were identified through peer referral. Inclusion criteria comprised: (a) male, (b) belonging to a recognised PVTG community, (c) married (irrespective of current parental status), (d) permanent resident of the study area for at least six months, and (e) provision of informed consent. Data collection continued until thematic saturation was achieved, at which point no new themes emerged from successive interviews. A total of 34 participants were enrolled.

Data collection

Data were collected through three complementary methods. Individual semi-structured interviews lasting 30-60 minutes were conducted with all 34 participants using a validated, pre-tested interview guide covering sociodemographic profile, marriage history, reproductive health knowledge, livelihood, education, family background, and health-seeking behaviour. Interviews were conducted in the local language (Ho, Mundari, or Santhali, with Hindi as a bridging language) by trained field staff, with support from community volunteers for translation. Interviews were audio-recorded with participant consent and supplemented by written field

notes. Two focus group discussions were conducted, one each with Sabar and Birhor participants to explore community norms, masculinity frameworks, and peer dynamics in relation to early marriage and fatherhood. Each FGD comprised six to eight participants and lasted approximately 90 minutes. Field observations at village, health sub-centre, and community gathering points provided contextual data on settlement patterns, livelihood contexts, and health service accessibility.

Data analysis

Audio recordings were transcribed verbatim and translated into English where necessary. Thematic analysis following the framework of Braun and Clarke was employed.⁷ An initial coding framework was developed deductively from the interview guide, and emergent codes were added inductively from the data. Codes were grouped into sub-themes and overarching themes through iterative discussion among the research team. Triangulation across interview data, FGD data, and field observations was used to enhance validity. Member checking was performed by sharing summary findings with key community informants.

A conceptual framework was developed to represent the pathways from structural context to adolescent fatherhood, drawing on the social determinants of health model and contextualised to the PVTG setting (Figure 1).

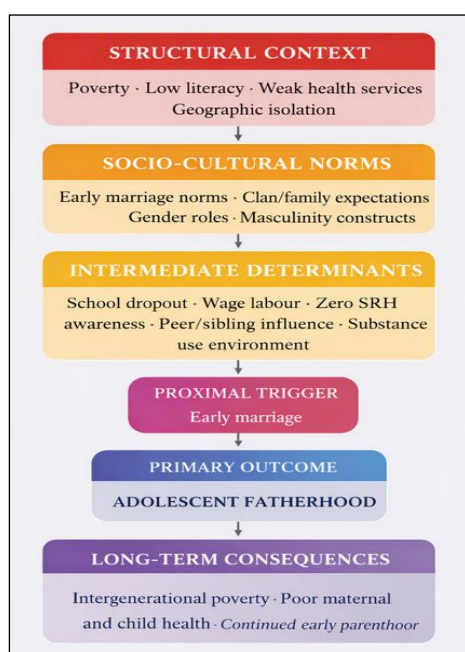


Figure 1: Conceptual framework.

Ethical considerations

Verbal informed consent was obtained from all participants prior to data collection, following a detailed explanation of the study objectives, voluntary nature of participation, and data use. For participants below 18

years of age, parental/guardian consent was additionally obtained. Confidentiality and anonymity were maintained throughout; no personally identifying information is reported. The study was conducted in accordance with institutional ethical standards governing community-based research within the RISHTA program.

RESULTS

Sociodemographic profile

A total of 34 participants were enrolled, with a mean age of 21.3 years (SD ± 4.3). The age distribution ranged from 14 to 34 years, with 29.4% aged 15-18 years, 35.3% aged 19-22 years, 20.6% aged 23-25 years, and 14.7% aged 26 years and above. The majority were from the Sabar community (73.5%), followed by Birhor (20.6%) and Pahariya (5.9%). All participants resided in East Singhbhum district, Jharkhand (Table 1).

Table 1: Sociodemographic and marriage profile of study participants (n=34).

Variable	Category	N (%)
Age group (years)	15-18	10 (29.4)
	19-22	12 (35.3)
	23-25	7 (20.6)
	≥ 26	5 (14.7)
Mean age (SD)	21.3 (± 4.3) years	
PVTG Community	Sabar	25 (73.5)
	Birhor	7 (20.6)
	Pahariya	2 (5.9)
Highest education level	Primary/middle school	28 (82.4)
	Secondary and above	6 (17.6)
Schooling status	Dropped out/discontinued	33 (97.1)
	Attended	1 (2.9)
Current occupation	Wage labour	32 (94.1)
	Other (skilled/semi-skilled)	2 (5.9)
Mean monthly income (SD)	₹7,415 ($\pm 3,045$)	
Type of marriage	Love marriage	30 (88.2)
	Arranged marriage	4 (11.8)
Age at marriage in years	Below 18	16 (51.6)*
	18-20	7 (22.6)
	21 and above	8 (25.8)
Mean age at marriage (SD)	18.0 (± 3.5) years	
Number of children	None (married, no child yet)	12 (35.3)
	One child	13 (38.2)
	Two children	6 (17.6)
	Three or more children	3 (8.8)

Educational discontinuation was near-universal: 97.1% had dropped out or discontinued schooling, with 82.4% having attained only primary or middle school level

education. The predominant occupation was daily wage labour (94.1%), with a mean monthly income of ₹7,415 (SD±3,045), reflecting chronic livelihood insecurity. Love marriage predominated (88.2%), consistent with PVTG community practice wherein young people exercise some agency in partner selection within traditional social structures. The mean age at marriage was 18.0 years (SD±3.5), and 51.6% of those with available data had married before the age of 18 years (Table 1).

Theme 1: Early marriage as a normalised social pathway

Early marriage emerged as the dominant and socially sanctioned pathway to adolescent fatherhood across all three PVTG communities. Participants consistently described marriage as an expected transition upon achieving early economic independence, irrespective of age. Community-level norms defined readiness for marriage primarily in terms of physical maturity and wage-earning capacity, rather than chronological age or educational achievement.

"Marriage happens early here. Once you start earning, the family expects you to marry. There is no question of waiting." (Participant, aged 20, Sabar community)

"In our community, if a boy is 16-17 and earns, the parents start looking for a match. It is considered normal it is our tradition." (FGD participant, Birhor community)

The mean community-perceived appropriate age for marriage among boys was reported as 18-20 years, with several participants noting that actual marriages routinely occurred earlier. Social pressure was reportedly diffuse rather than explicit only one participant (2.9%) acknowledged direct social pressure to become a father during adolescence, yet the broader social environment normalised and facilitated early marriage and consequent early parenthood.

Theme 2: Educational discontinuation and livelihood insecurity

Discontinuation of schooling emerged as a near-universal experience, with 97.1% of participants having dropped out or discontinued, predominantly at the primary level. Financial constraints, early entry into wage labour, and the limited perceived returns of continued education in the context of subsistence livelihoods were the primary drivers. This finding has direct implications for adolescent fatherhood, as educational discontinuation accelerates entry into adult economic and social roles, including marriage.

"I left school after class five because my father was unwell and I had to earn. There was no other option." (Participant, aged 19, Sabar community)

"School is far, and there is no benefit from it here. The children who study also end up doing labour. So why stay?" (FGD participant, Sabar community)

The mean monthly income was ₹7,415, reflecting precarious and irregular earnings predominantly from unorganised wage labour, with no participant reporting social security coverage or stable employment. Intergenerational occupational continuity was evident: fathers of participants were also predominantly wage labourers, and mothers had received no formal education in 67.6% of cases.

Theme 3: Absence of reproductive health knowledge and services

A striking and unanimous finding was the complete absence of reproductive health awareness prior to becoming fathers: all 34 participants (100%) reported no knowledge of family planning methods before fatherhood. This reflects both the exclusion of adolescent boys from reproductive health programming and the near-inaccessibility of health services in PVTG-dominated areas. While 76.5% of participants had visited the nearest health sub-centre at least once, these visits were primarily for curative rather than preventive or reproductive health purposes.

"We did not know about these things before marriage. Nobody told us-not the school, not the health worker, not the family." (Participant, aged 18, Birhor community)

"The health centre is 12 kilometres away. We go only when someone is very sick. There is no vehicle. We cannot go for small things." (Participant, aged 22, Sabar community)

The absence of SRH (sexual and reproductive health) information was compounded by social taboos around discussing sexuality and reproduction in the community. Adolescent boys described reproductive health as an area of adult or female concern, highlighting a gendered gap in service delivery.

Theme 4: Peer and sibling influence

Peer and sibling networks played a significant role in normalising early marriage and fatherhood. A majority of participants (64.7%) reported that their friends or peers were also adolescent fathers, and 61.8% reported siblings who had become parents during adolescence. These observations suggest a strong social contagion effect, where norms and behaviours are reinforced through proximal social networks.

"All my friends are married. Many have children. It felt strange not to be married at my age." (Participant, aged 20, Sabar community)

"My elder brother also married early, and my parents did the same with me. It is how our family does things." (Participant, aged 18, Birhor community)

Theme 5: Substance use in the household environment

Tobacco use was reported in 91.2% of households and alcohol use in 82.4%. These figures are consistent with patterns documented in tribal communities in Jharkhand and are relevant to the study in two respects. First, substance use may lower inhibition and reduce deliberative decision-making around marriage and reproductive choices. Second, household-level substance use is an indicator of broader socioeconomic vulnerability, reduced parental supervision, and health-

compromised family environments in which adolescents are embedded.

Theme 6: Aspirational shift-rejection of early parenthood for the next generation

A notable and affirming finding was the unanimous expression by all 34 participants (100%) of a desire that their children should not become parents during adolescence. This constitutes a significant generational aspirational shift, indicating that lived experience of the hardships associated with early parenthood has generated a critical awareness among these fathers, even in the absence of formal education or programmatic intervention.

Table 2: Key determinants and health-related findings among study participants (n=34).

Determinant/variable	Response	N (%)
Aware of family planning before becoming a father	No	34 (100.0)
Tobacco use (self or family member)	Yes	31 (91.2)
Alcohol use (self or family member)	Yes	28 (82.4)
Peers/friends who are adolescent fathers	Yes	22 (64.7)
Siblings who became parents during adolescence	Yes	21 (61.8)*
Experienced social pressure to become a father during adolescence	Yes	1 (2.9)
Would encourage next generation to become parents during adolescence	No	34 (100.0)
Ever visited nearest health sub-centre	Yes	26 (76.5)
Primary reason for school dropout	Financial constraints/family obligations	2 (6.1)
	Other (early marriage/economic work)	29 (87.9)
Mother's formal education	None	23 (67.6)
Father's occupation	Wage labour / informal	13 (38.2)

*Calculated for 30 participants with complete sibling data; school dropout reason percentages are of 33 dropouts, not total sample (n=34)

"I do not want my son to make the same mistake. I want him to study, work well, and marry at the right age." (Participant, aged 24, Sabar community)

"We suffered because of early marriage less money, more responsibility. I will not let this happen to my children." (Participant, aged 27, Sabar community)

This finding has direct programmatic implications, suggesting that fathers in PVTG communities may constitute an underutilised but receptive peer-education and behaviour-change communication resource.

DISCUSSION

This qualitative study provides a contextualised account of adolescent fatherhood among PVTG communities in East Singhbhum, Jharkhand, a setting largely absent from the existing literature on adolescent reproductive health in India. The findings reveal that adolescent fatherhood in this context is not an isolated behavioural outcome but a product of deeply interlocked structural, socio-cultural, and individual-level factors.

Early marriage emerged as the primary and normatively sanctioned pathway to adolescent fatherhood. With 51.6% of participants having married before 18 years of age and a mean age at marriage of 18.0 years, the study underscores the persistence of child marriage as a public health challenge in PVTG communities, despite legal prohibitions under the Prohibition of Child Marriage Act, 2006.⁸ The community-driven nature of this norm, where marriage is linked to economic productivity rather than age, presents a distinct challenge to programmatic interventions premised on legal or regulatory approaches alone. Lower educational attainment, poverty, and large household size have been identified as significant determinants of adolescent fatherhood in longitudinal evidence from India and other low- and middle-income countries, a pattern consistent with the structural pathways documented in the present study.⁹

Universal reproductive health unawareness 100% of participants had no knowledge of family planning prior to fatherhood is a finding of critical programmatic significance, reflecting the documented exclusion of adolescent boys from SRH programming under RKSK,

which despite its gender-inclusive mandate has been operationally skewed towards girls.¹⁰ The RISHTA program's four-pronged approach adolescent-centric, peer educator-led, collaborative, and community-centric directly addresses this gap, and the present study affirms the urgency of scaling such approaches in PVTG-specific contexts.

Educational discontinuation at primary level and near-universal dependence on wage labour document the structural underpinning of adolescent fatherhood in this population. These findings align with the broader evidence base establishing links between educational deprivation and early parenthood.¹¹ The intergenerational occupational pattern fathers predominantly in wage labour, mothers largely uneducated indicates structural entrenchment requiring interventions spanning livelihood and education alongside health.

Peer and sibling influence, reported by 64.7% and 61.8% of participants respectively, points to the role of proximal social networks in normalising early marriage and fatherhood. This echoes findings from quantitative studies on adolescent fatherhood in comparable settings, where social learning and normative reinforcement through peer and family networks constitute significant pathways.^{6,12} Programmatic approaches that engage young fathers as peer educators capitalising on their lived experience and the aspirational shift documented in this study may offer a culturally credible route to norm change.

High household prevalence of tobacco (91.2%) and alcohol use (82.4%) is consistent with existing data from tribal communities in Jharkhand and Odisha.¹³ Beyond direct health risks, these patterns reflect broader socioeconomic vulnerability in PVTG households and constitute an important contextual factor in the adolescent health environment.

Perhaps the most actionable finding is the universal aspiration (100%) that children should not become parents during adolescence. This shift emerging from lived hardship rather than formal intervention signals community receptivity for behaviour change communication, and positions these fathers as credible peer-level resources for norm change within PVTG communities.

The prior case-control study by the authors found no statistically significant intergenerational cycle of adolescent fatherhood.⁶ The present qualitative findings complement this: while vertical intergenerational transmission may be statistically modest, sibling and peer influence operates as horizontal social contagion, transmitting early marriage norms within proximal social networks.

This study has several limitations. The sample was purposive and restricted to East Singhbhum district, limiting generalizability to other PVTG areas. The

qualitative design precludes causal inference, and self-reported data may be subject to recall and social desirability bias. Perspectives of female partners, parents, and community leaders were not captured. Future mixed-methods studies with larger, representative samples and multi-stakeholder engagement are recommended.

CONCLUSION

Adolescent fatherhood among PVTG communities in Jharkhand is driven by an intersecting matrix of structural poverty, socio-cultural norms of early marriage, near-universal educational discontinuation, wage labour dependence, and complete absence of reproductive health awareness. Critically, these determinants are deeply contextual rooted in PVTG-specific livelihood realities, clan structures, and geographic isolation and require tailored, culturally embedded responses. The aspirational shift documented among all participants, rejecting early parenthood for the next generation, signals a window of community receptivity that programs such as RISHTA can leverage through male engagement strategies, peer educator networks of young fathers, and convergent action across health, education, and livelihood systems.

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REFERENCES

1. World Health Organization. Adolescent health, 2024. Available at: <https://www.who.int/health-topics/adolescent-health>. Accessed on 1 April 2026.
2. National Health Mission. Adolescent health. Available at: <https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=818&lid=221>. Accessed on 1 April 2026.

3. International Institute for Population Sciences (IIPS) and ICF. National Family Health Survey (NFHS-5), 2019-21: India. Mumbai: IIPS; 2021.
4. International Institute for Population Sciences (IIPS) and ICF. NFHS-5 State Fact Sheet: Jharkhand. Available at: http://rchiips.org/nfhs/NFHS-5_FCTS/Jharkhand.pdf. Accessed on 1 April 2026.
5. Ministry of Tribal Affairs, Government of India. Particularly Vulnerable Tribal Groups. Available at: <https://tribal.nic.in/pvtg.aspx>. Accessed on 1 April 2026.
6. Jagadeesh B, Minj RRP, Bhatnagar A. Roots of change: intergenerational cycle of adolescent fatherhood in rural Jharkhand and Odisha. *Int J Community Med Public Health*. 2023;10(12):4835-8.
7. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101.
8. Ministry of Women and Child Development, Government of India. Prohibition of Child Marriage Act, 2006. Available at: <https://wcd.nic.in>. Accessed on 01 April 2026.
9. Steinberg JR, Tschann JM, Grisso JA. Determinants and consequences of adolescent fatherhood: a longitudinal study in Ethiopia, India, Peru, and Vietnam. *J Adolesc Health*. 2020;67(4):491-8.
10. Ministry of Health and Family Welfare. Rashtriya Kishor Swasthya Karyakram (RKSK): Operational Framework. New Delhi: MoHFW; 2014.
11. Raj P, Srivastava S, Upadhyay AK. Determinants of school dropout among adolescents: evidence from a longitudinal study in India. *PLoS One*. 2023;18(3):e0282468.
12. Sipsma H, Biello KB, Cole-Lewis H, Kershaw T. Like father, like son: the intergenerational cycle of adolescent fatherhood. *Am J Public Health*. 2010;100(3):517-24.
13. Murmu J, Agrawal R, Manna S, Pattnaik S, Ghosal S, Sinha A, et al. Social determinants of tobacco use among tribal communities in India: evidence from the first wave of Longitudinal Ageing Study in India. *PLoS One*. 2023;18(3):e0282487.

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