


BMJ Open 'I also take part in caring for the sick child': a qualitative study on fathers' roles and responsibilities in seeking care for children in Southwest Ethiopia

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ABSTRACT

Objectives Fathers play an important role in household decision-making processes and child health development. Nevertheless, they are under-represented in child health research, especially in low-income settings. Little is known about what roles fathers play in the care-seeking processes or how they interact with the health system when their child is sick. This study aimed to understand Ethiopian fathers' roles and responsibilities in caring for their children when they are or become ill.

Design Qualitative study using semistructured interviews with fathers.

Setting This study was conducted in three rural districts of the Southern Nations, Nationalities and People's Region of Ethiopia.

Participants Twenty-four fathers who had at least one child between 2 and 59 months who visited a health extension worker with fever.

Results The overarching theme of this study was 'changing perceptions of paternal responsibilities during children's ill health'. It constituted three subthemes, namely, 'fathers' burden of earning money for care', 'fatherhood entails advocating children's healthcare needs' and 'investing in children's health can benefit the family in the future'. Fathers described that they were the ones mainly responsible for the financial arrangement of care and that this financial responsibility can involve stress when resources are scarce. Fathers knew what health services were available and accessible to them and were involved in different ways in the care seeking of the child. Changes in the importance ascribed to child health were expressed by fathers who described being more alert to children's ill-health.

Conclusion Fathers play various roles in the care-seeking process during children's illness episodes. This included, for instance, arranging resources to seek care, (co)-deciding where to seek care as well as accompanying the child to the health facility. The inability to organise necessary resources for care can lead to involuntary delays in care seeking for the child. This demonstrates the importance of including fathers in future interventions on maternal and child health.

INTRODUCTION

Annually approximately 5.3 million children die worldwide before reaching their

Strengths and limitations of this study

- This study distinguishes itself from others by only focusing on fathers and their perceived roles and responsibilities in the care seeking for sick children, which is an under-represented area in child health research.
- This study used a nested stratified sample and included 24 fathers from highest and lowest socio-economic quintiles and with few (one to two) or many children (three or more) in order to provide rich information.
- We sought to mitigate a social desirability bias by having the interviews conducted by male interviewers in two local languages.
- We did not conduct interviews with mothers to confirm the fathers' responses.

fifth birthday. Most of these deaths occur following the neonatal period and are caused by diseases such as malaria, pneumonia and diarrhoea.¹ It is further estimated that malnutrition contributes to almost half of child deaths under the age of 5 and that many of the childhood deaths could have been prevented with simple, effective and available interventions.¹ Nevertheless, caregivers of sick children in poor communities often face obstacles in seeking healthcare such as lack of money or distance to the care facility.^{2, 3} Evidence from Ethiopia shows that only 35% of children with fever and 44% of children with diarrhoea in the previous 2 weeks were brought for treatment.⁴

Decision-making processes regarding child healthcare are complex. Although mothers have historically been seen as responsible for their children and their health, multiple studies from low-resource settings show that women, as compared with men, have relatively low decision-making power when it comes to healthcare decisions for themselves and their

children.^{5–8} A study from The Gambia⁹ states that mothers decided when to take the child to the hospital for cerebral malaria in only around 7% of the cases. Other studies confirm that it is mainly the father who makes the final call on where and when to seek healthcare.^{9–11}

The important role of fathers in child health and development is becoming better understood and appreciated. Literature shows that involved fathers are associated with different positive outcomes such as knowledge of newborn danger signs among mothers, skilled birth and attendance of antenatal care visits.^{12–14} Some countries have therefore started to address the involvement of fathers in their road maps to reduce maternal and child morbidity and mortality.^{15 16} Yet, in low- and middle-income countries, only a minority of fathers have been said to be engaged with their children.¹⁷ Nevertheless, different forms of engagement and types of fathers exist. In a study conducted in Ethiopia, fathers were categorised into three different groups, depending on their perceptions, practices and challenges towards routine child care and feeding¹⁸: (1) traditional fathers who ‘do not feel part of routine child care, and they fully believe child care is only the mothers’ responsibility’; (2) transitional fathers who ‘perceive child care as being both the mothers’ and fathers’ responsibility’, but under different conditions (eg, availability of the father or occupied mother), meaning the father does not completely feel responsible for child care and (3) modern fathers who ‘perceive child care and child feeding as a shared responsibility between mother and father’ and who are totally involved in their child’s life. This suggests that not all fathers are alike and that differences in their roles can exist between them.

A number of studies from Africa have shown that fathers are often the main decision-maker or breadwinner of the family and responsible to pay for healthcare costs.^{10 11} Yet little is known otherwise about what roles they take on in the care-seeking process for their children or how fathers interact with the health system when their children are sick. Therefore, this study aims to understand fathers’ roles and responsibilities in care seeking for children in rural areas of the Southern Nations, Nationalities and People’s Region (SNNPR) in Ethiopia.

MATERIALS AND METHODS

The reporting of the methods has been guided by the criteria for reporting qualitative research (COREQ) guidelines.¹⁹

Setting

The interviews were conducted in Damot Gale, Boloso Sore and Halaba Special Woreda, three *woredas* (districts) of the SNNPR of Ethiopia. The population of Ethiopia, similar to these three *woredas*, is predominantly (~80%) living in rural areas. SNNPR is a very ethnically diverse region, inhabited by more than 80 different ethnic groups. To improve primary healthcare services in the country, particular in rural areas, Ethiopia has been

implementing a health extension programme since 2003.²⁰ Central to the programme are health extension workers (HEW) who are trained for 12 months and subsequently employed by the government to work in health posts directly in and with the community.^{20 21} HEWs are women with at least a grade 10 education. Typically, two HEWs are assigned to one health post, serving an estimate of 3000–5000 people.^{20 21} HEWs provide key health promotion and prevention services as well as a selection of curative services; all services are free of charge.^{21 22} Although health posts are placed directly in a community, travel distances can vary from a walking distance of a few minutes to an hour or more.²³ At the time of this study, there were 150 health posts in the study area with a total of 284 HEWs.

Child mortality rates in Ethiopia have been decreasing over the years and currently stand at 55.2 per 1000 live births, with mortality rates in SNNPR being higher than the national average.^{4 24} Traditional gender roles persist, particularly in rural areas, with a minority of women reporting having the right to decide on their first marriage and having their husband help with household chores. Around 40% of women use modern contraceptives including sterilisation, contraceptive pills, condoms and implants, and even fewer, less than 30%, give birth in a health facility.⁴ Twenty-eight per cent of women and 73% of men aged 15–49 years in the region work within the agricultural sector.

Study design and data collection

This qualitative study was nested within a community-based cluster randomised controlled non-inferiority trial (cRCT). The design and results of this trial are published elsewhere, as is the qualitative evaluation of HEW’s and caregivers’ perception of the recommendations.^{25–27}

For this study, 24 semistructured interviews were conducted with fathers who had at least one child aged 2–59 months presenting to the HEW with fever. Half of the interviews (n=12) were conducted in Halaba *woreda*, 8 in Boloso Sore and 4 in Damot Gale. Boloso Sore and Damot Gale are culturally and linguistically similar which is why they together represent half of the fathers interviewed.

The sampling method was based on the assumption that healthcare-seeking practices and fathers’ decision-making power could differ by socioeconomic position and number of children. We therefore used stratified sampling to select half of the fathers from the lowest and the other half from the highest socioeconomic quintile. Socioeconomic quintiles were based on caregivers’ responses to questions about household assets, for example, material of the house, toilet facility used, availability of TV/radio or electricity in general. It should be kept in mind that a high socioeconomic quintile in this study is not equivalent to a high socioeconomic status. Fathers in the high socioeconomic quintile can still be considered poor. Within the two strata, fathers with few children (one to two) and fathers with multiple children

(three or more) were invited for an interview to maximise the level of heterogeneity among the fathers. However, the information on number of children reported in the cRCT did not always tally with the number of children mentioned by the father during the interview, which is why most fathers (n=19/24) in this study had three or more children. Once the father was randomly selected within each stratum, contact was established through the HEWs and fathers were personally visited in their community. When fathers were not at home, contact was established via phone or with help of the HEWs in the community. Fathers were asked whether they would be willing to participate in the study and written and oral consent were obtained from all study participants. All 24 fathers agreed to participate but two were not able to complete the interview due to time constraints.

An interview guide was developed informed by literature on healthcare-seeking and gender roles. It started with introductory questions about the father and the household to explore fathers' educational background, profession and family composition. While this part was rather structured, the interview guide then followed with open-ended questions regarding fathers' practices on the following issues: seeking advice or discussing health matters with other family or community members; fever in children and fathers' understanding of fever; fathers' knowledge on health providers in the community; their decision-making around health services and drivers who influenced their seeking healthcare. The interview ended with asking fathers to compare care seeking between different households and changes in practices and roles of fathers over time. The interview guide was prepared in English and subsequently translated into Amharic.

Three male interviewers conducted the interviews, two in Boloso Sore and Damot Gale and one in Halaba. The interviewers were selected based on their experience in qualitative research, English proficiency and educational background in health sciences. In Halaba, a male interpreter was recruited for translations from Amharic to Halabigna (local language of Halaba) as the interviewer was not familiar with the local language. In Boloso Sore and Damot Gale, interviews were conducted in Wolaitigna by two interviewers who were from the district and thus familiar with the area and language. No interviewer met the fathers before the conduction of the interviews.

All interviewers and the interpreter received a half-day training from authors TF and AA. The training provided insights into the research background, the aim of the study and the sampling of fathers. In addition, the interview procedure was thoroughly explained and the interview guide and all questions were reviewed and discussed in detail. The importance of probing and non-leading questions was emphasised. At the end of the training, any remaining language issues were addressed as the interview guide was prepared in Amharic but the interviews were conducted in the local language. After the training, every interviewer conducted one pilot interview and changes to the interview guide were made accordingly. Based on

the pilot interviews, interviewers received oral feedback on how to improve their interviewing and the purpose of certain questions was repeated in order to improve the direction of their probing questions.

The interviews were conducted in March 2017 and took between 34 min and 70 min, with interviews using an interpreter taking longer. All interviews were conducted in a quiet place outside; the majority took place close to the father's home. Fathers were aged between 20 and 50 years and the number of children ranged between 1 and 14 (see [table 1](#)). In Halaba, multiple fathers had two wives. The majority of fathers were farmers.

All 24 interviews were digitally recorded, transcribed in Amharic and translated into English. The interviewers in Boloso Sore and Damot Gale preferred to transcribe the interviews directly in Amharic instead of Wolaitigna due to the difficulty in writing the local language. After their participation in the interview, fathers received 122.5 Birr in cash (~US\$5.5) to compensate for their time. This amount equals the common local Malaria Consortium lunch allowance.

Patient and public involvement

There was no involvement of interviewees or the public in setting the research agenda or formulating interview guides.

Data analysis

All 24 father interviews were included in the analysis, although 2 fathers did not complete the interview. As these two fathers did answer a number of questions, it was seen as appropriate to include the material provided by them in the analysis, even though it was not fully completed. The transcripts were read multiple times and codes to the material were applied using the qualitative data-structuring software Nvivo V.11. Interviews were analysed using content analysis.²⁸ The analysis was an iterative process involving reading of literature and repeated reading of interview transcripts. The coding process was done in steps. TF conducted the initial coding and discussions took place with HMA. After each meeting, changes to the codes were made. Finally, codes were grouped, and themes were identified, which were again discussed between authors TF and HMA. All father interviews were analysed together, meaning that no stratification by socio-economic quintiles and number of children of fathers (strata used for the sample selection) took place for the analysis. However, after the coding of the data was done, it was checked whether fathers from different strata were represented in each theme.

RESULTS

Three subthemes emerged from the data: (1) fathers' burden of earning money for care, (2) fatherhood entails advocating children's healthcare needs and (3) investing in children's health can benefit the family in the future. The results are presented according to these themes and

**Table 1** Characteristics of study participants

ID	Age	Woreda	Socioeconomic quintile	Reported number of children	Language interview was conducted in*	Length of interview (min)
1	45–54	Halaba	Highest	11	Halabigna	50
2†	35–44	Halaba	Lowest	8	Halabigna	40
3	45–54	Boloso Sore	Highest	12	Wolaitegna	59
4	45–54	Boloso Sore	Lowest	7	Wolaitegna	60
5	25–34	Boloso Sore	Lowest	6	Wolaitegna	39
6	35–44	Damot Gale	Highest	8	Wolaitegna	52
7	25–34	Halaba	Lowest	2	Halabigna	61
8	35–44	Damot Gale	Lowest	9	Wolaitegna	51
9	35–44	Halaba	Lowest	12	Halabigna	55
10	25–34	Boloso Sore	Highest	4	Wolaitegna	49
11	45–54	Boloso Sore	Lowest	7	Wolaitegna	49
12†	35–44	Halaba	Lowest	14	Halabigna	40
13	25–34	Halaba	Highest	3	Halabigna	64
14	<25	Boloso Sore	Lowest	1	Wolaitegna	46
15	<25	Boloso Sore	Lowest	1	Wolaitegna	51
16	35–44	Halaba	Highest	8	Halabigna	70
17	35–44	Damot Gale	Highest	3	Wolaitegna	51
18	35–44	Damot Gale	Highest	7	Wolaitegna	46
19	35–44	Halaba	Highest	6	Halabigna	40
20	45–54	Halaba	Highest	3	Halabigna	50
21	25–34	Halaba	Highest	9	Halabigna	45
22	N/A	Boloso Sore	Highest	2	Wolaitegna	34
23	35–44	Halaba	Lowest	5	Halabigna	45
24	25–34	Halaba	Lowest	2	Halabigna	50

*Interviews in Halaba were conducted using an interpreter (from Halabigna to Amharic).

†Interview was not completed.

fed into the overarching theme of ‘changing perceptions of paternal responsibilities during children’s ill health’.

Fathers’ burden of earning money for care

Fathers described their roles and responsibilities in care seeking for children mostly in terms of financial responsibilities. They explained that their main role as father was to work and earn money to be able to finance healthcare costs and, when necessary, transportation to the facility. Fathers felt strongly that ‘money matters’ when it comes to seeking care for children. Nevertheless, it was explained that they often did not have the necessary resources at hand to finance healthcare costs. This was expressed by fathers from both socioeconomic strata, lowest and highest socioeconomic quintiles. Most fathers interviewed mentioned that healthcare costs are financed through work or selling goods, animals or land. When not enough money could be arranged, fathers would make other arrangements such as borrowing money to pay for healthcare costs. Fathers would either borrow money through *idir* (a financial community support system

where members can regularly contribute small amounts of money and in return are able to borrow some money in case of need) or from family and friends. Mothers were often, but not always, described as not having their own income source that could contribute to healthcare expenses. Furthermore, mothers generally were described as having difficulties in borrowing money as even though they would try to obtain a loan, they would often not receive one (through *idir*). Consequently, the burden on arranging resources for treatment was, according to the fathers, mainly placed on them. The financial stress that fathers experience was described by this father:

We have *idir* where we save some amount of money regularly. I have to pay back the money within 10 to 15 days. In case they don’t allow me [to borrow money] due to some inconveniences, I borrow from friends, relatives, particularly from my grandmother. But the reality is that I borrow again before I paid back the first loan. (ID 8; lowest socio-economic quintile; 3+ children)

One father also emphasised that it was easier for fathers with a better financial situation to borrow money compared with fathers with few resources, which further emphasised the financial worries that fathers were faced with.

The father with better financial resources can take his children to health providers easily. Even if he doesn't have the money, he can borrow it easily because people believe that he can pay it back. But if the poor wants to borrow money from friends or other people, people are not happy to give him [money] because they are wondering 'from where is he going to pay me back?' (ID 4; lowest socio-economic quintile; 3+ children)

In addition, fathers also mentioned that care seeking for their child can be delayed if they have no money at hand, and sometimes it could take several days to find the necessary resources to finance healthcare costs. Consequently, it was expressed that even if a father wanted to seek care immediately, this was not always possible. Fathers from both socioeconomic strata mentioned such financial worries and constraints.

[...] if we go to [name of] hospital, we may pay up to 1000 birr (~36USD). Even if we only stay one night there, they charge us 700 up to 800 birr (~25–30USD). The more we stay there, the more money we are expected to pay. If we don't have money, we are left with staying home with the sick child and praying to God. (ID 15; lowest socio-economic quintile; 3+ children)

Fatherhood entails advocating children's health care needs

Fathers were well aware of the different health services available to their children, whether it was the health post, health centre, private or traditional providers. They stated that they discussed with their wives on what actions to take and where to take the child when sick. However, many of them still saw themselves as the ultimate decision-maker whose suggestion will be followed.

Since I bear more responsibility as father on my family's affairs, it is my decision that needs to be adhered to. Since she [wife] doesn't have an income generating work and we solely depend on the income I get, it is me who decides over issues. (ID 15; lowest socio-economic quintile; 3+ children)

Different factors can influence the choice to which provider a child is taken. The type of illness the child has can be such a factor. When the child was suspected of having a bone fracture or a dislocation, multiple fathers explained that traditional healers also referred to as 'bone setter' are the first choice of treatment. If the traditional treatment is not effective, other sources of treatment will be sought. For other types of illnesses, a father would directly take the child to a different health provider such as the health post.

Money was also explained to be a decisive factor in the care-seeking process. According to fathers, the availability of money and resources provides a freedom in choosing a health provider for the child's health condition. This freedom is constrained if resources are scarce.

Rich [people] take sick children directly to hospital. But since poor [people] have no money, they take [the child] to the health post. They only take [the child] to the hospital when its condition is life threatening. (ID 8)

Multiple fathers seemed to prefer the health centre over the local health post because more and better treatment was believed to be available there. It was stressed that the general perception is that treatment was better in urban areas and also faster at private providers, though private providers were expensive and described as business oriented. Nevertheless, if the money was available, some fathers still preferred private services over public facilities. Fathers observed a formal care chain (or 'hierarchy') in healthcare. They described that health centres expected them to have a referral slip from the health post, making it harder for them to directly access treatment at the health centre. This was seen as an obstacle in seeking care.

The responsibility for bringing or accompanying a sick child for treatment was unclear. Bringing the child to a health post for treatment was first seen as being a responsibility of the mother. Mothers were described to be responsible for bringing the children who were breastfed to the health provider, whereas fathers claimed to rather accompany older children who could walk or sit on a motorcycle to the health provider. Whether or not a father brought or accompanied a child to a health facility also depended on the health facility in question. One father explained that the mother sought care at the health post alone but fathers needed to be consulted to seek care at the health centre or higher level facilities, often implying more severe illnesses and higher costs.

When the mother notices that the child is sick, she takes [the child] to the health post. If the health post advises her [the mother] to take the child to the health centre [i.e. refers the child as the health problem is not identified or manageable at community level], she returns back and waits for my return. After I return back to home, we take the child to the health centre together. (ID 15; lowest socio-economic quintile; 3+ children)

If the child needed to stay at the hospital, a father described it as his role to stay with the child. In addition, the arrangement of the transportation to the health facility was, according to some fathers, also their role.

Investing in children's health can benefit the family in the future

Behaviours of fathers with regards to seeking care for children have changed over time. It was explained that

fathers today are more involved in child health matters compared with the past and that they do not leave this issue entirely up to the mothers anymore. Fathers stated being more alert about changes in health status of their children and that they will not rely only on faith to cure the child.

I can say that the love I have for my children is stronger than the mother's love. Due to that reason, I also closely follow their [the children's] health situation. (ID 4; lowest socio-economic quintile; 3+ children)

A couple of fathers pointed out the value that children have and can bring in the future, for instance, through working and supporting the family financially. Consequently, fathers stated they paid more attention to their child's health status and made sure that they recovered.

In past time, there were widely held assumptions among fathers that a child will grow by his fate so that no worries are needed. But this belief is changing as those sons and daughters that work at urban centres and abroad send [money] and augment their family's income. Children now are believed to be assets and obtain great care. So fathers are alert whenever they observe changes in their children's health. (ID 18; highest socio-economic quintile; 3+ children)

Fathers also observed changes in the health services over time. They noticed that health posts that are now existing in their community were not available in the past.

DISCUSSION

This study indicates that fathers are involved in the care seeking of their sick child in different ways. This includes bearing the main responsibility for arranging financial resources to enable a healthcare visit and this responsibility can imply stress and financial concerns when resources are scarce. Fathers are well aware of the health services available to their children and they described being involved in the care-seeking process in different ways, for example, (co)-deciding where to take the child or accompanying their child to the health facility. Fathers explained that changes in fathers' perception of children and their involvement have taken place. They described themselves being more aware of the health status of their children and more involved in child health matters compared with the past.

This transitional change in fathers' perceptions of their children has been described in another study conducted in Ethiopia.²⁹ Multiple fathers interviewed in this study would fit into the 'transitional fathers' category. According to them, child health issues are not seen as only a task of the mother anymore. It seems as if these fathers acknowledge these responsibilities as being part of their role as father. The findings of this study show that not all fathers take on the same roles in care seeking for children. This suggests that roles in these rural areas are changing and

that with continuous country efforts, fathers' roles as caregiver could be strengthened.

Also, the phrasing of the last theme 'investing in children's health can benefit family in the future' seems very timely, considering that a recently published report by the WHO-UNICEF-Lancet Commission highlights the importance and benefits of investing in children.³⁰ It is noteworthy that fathers did not only observe changes in paternal behaviour but also appreciated changes in the availability of health services, for example, the establishment of a health post in their community.

The responsibility of fathers for household finances and financing of care has been described in multiple previous studies.^{10 11 31-33} This study not only coincided with these findings but also shed light on the burden that this responsibility brings when a child is ill. The reality described by fathers was that often resources were not available to finance healthcare costs, and that in many cases, fathers needed to borrow money again before having paid back their first debt. It appears to be a vicious circle in which particularly very poor fathers are placed and demonstrates the difficult situations that these families go through in times of sickness. It is important to stress that both groups of fathers (highest and lowest socioeconomic quintiles) expressed concerns in arranging resources and money and would compare themselves with better-off fathers. The comparisons expressed by these fathers therefore do not refer to a comparison between the two socioeconomic quintile groups in this study.

The inability to arrange money to pay for healthcare costs can lead to involuntary delays in care seeking. The link between costs and delayed healthcare has been previously described in the literature.^{34 35} These findings suggest that besides educating parents on danger signs and when to seek care, it is very important to have healthcare infrastructure in place and health facilities accessible to the communities. The Sustainable Development Goal 3.8 touches on this as it aims to 'achieve universal health coverage, including financial risk protection [and] access to quality essential health-care services (...)'.³⁶ In order to further improve maternal and child health, health services should be made accessible to all, both physically and financially.³⁷

In this study, multiple fathers stated that they discuss and decide together with their wives on what to do when their child is sick. Nevertheless, many of these fathers still saw themselves as final decision-makers whose opinions should be adhered to. Literature supports that fathers often are the decision-maker of the household,^{9 11} which raises questions on the true influence of mothers' opinions on the decision-making processes. It is known that fathers play an important role in a children's development. Positive involvement of fathers can impact not only children's cognitive skills but also their social competences and behavioural or emotional outcomes.³⁸⁻⁴⁰ This shows, together with fathers' important role as decision-maker and breadwinner in the care-seeking process, that there is a strong need for including fathers in future

interventions aimed at improving maternal and child health. It is thereby crucial to consider that many fathers spend much of their time away from home because of their work. Interventions need to be formulated accordingly.

Another interesting finding of this study was that fathers were not only involved in household decision-making and finances but were also directly in contact with the health system for their children. Fathers were not only well aware of the different health providers available or accessible to them but also described bringing the child to the health facility or accompanying the mother in certain circumstances. We did not come across a study that discussed similar findings.

STRENGTHS AND WEAKNESSES

This study focused on fathers, of both low and high socio-economic quintiles, and thus contributes to current literature as fathers remain under-represented in child health research. We conducted interviews in the local language in Boloso Sore and Damot Gale, but in Halaba, we overcame language diversity through the use of a local interpreter. Two interviews in Halaba were not finalised due to other obligations of the father. As these selected fathers have not been replaced, some information was lost. However, due to the large number of interviews conducted, we have obtained sufficient information. Multiple findings of this study coincided with the previous literature. We thus assume that these findings are transferable to communities with similar family structures and cultural contexts and health systems. A social desirability bias (eg, father claiming to be more involved in the care-seeking process than they actually are) cannot be excluded with certainty in this study. Also, we did not conduct interviews with mothers to check or confirm fathers' responses. Nevertheless, we aimed to mitigate the chances of a desirability bias by using male interviewers. We therefore believe that the information provided does reflect their roles and perceptions well.

CONCLUSIONS

Fathers play an important role in the care-seeking process of their children. Not only do they have decision-making power and the financial responsibility but they are also otherwise involved in the care-seeking process, such as arranging transportation or accompanying the child at times to the facility. Fathers are familiar with the health services available to their children and even noticed positive changes in the paternal involvement in childcare as well as availability of health services through the establishment of health posts in their communities. Efforts need to be made to continue the observed positive trend in fathers' involvement in care seeking described in this study. Future research on maternal and child health needs continue considering and highlighting fathers' roles and responsibilities. The inability to organise necessary resources for care can lead to involuntary delays in care

seeking for the child. It is therefore crucial to continue strengthening healthcare systems and making health services more accessible to communities, both physically and financially.

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Contributors All authors were involved in conceiving and designing the study. TF, KK, TA and HMA developed the study plan and formulated the interview guide. TF and AA were training the interviewers and following the interview process. TF and HMA analysed the interviews. TF wrote the paper together with all other authors. All authors read and approved the final version of this paper.

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval This study was nested within a cRCT that was approved by the SNNPR Health Bureau Research Ethical Review Committee (P02-6-19/4511). The trial is registered as NCT02926625. Written and oral consents were obtained from all study participants. Confidentiality was ensured and the aim of the study was explained to the fathers prior to the interview. They were informed about the option to decline participation or drop out of the interview without any consequences.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All relevant data for this study are included in this paper. To protect the anonymity of our respondents, full transcripts will not be provided.

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