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“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

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2020-038932
Article Type:	Original research
Date Submitted by the Author:	29-Mar-2020
Complete List of Authors:	Funk, Tjede; Karolinska Institute, Global Public Health Källander, Karin; Karolinska Institutet, Department of Global Public Health Abebe, Ayalkibet; Malaria Consortium Alfvén, Tobias ; Karolinska Institute, Department of Global Public Health Alvesson, Helle; Karolinska Institute, Department of Global Public Health
Keywords:	Community child health < PAEDIATRICS, QUALITATIVE RESEARCH, PUBLIC HEALTH

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3 1 “I also take part in caring for the sick child” - A qualitative study on fathers’ roles
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6 2 and responsibilities in seeking care for children in Southwest Ethiopia
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12 4 Tjede Funk^{1*}, Karin Källander^{1,2,3}, Ayalkibet Abebe⁴, Tobias Alfvén^{1,5#}, Helle Mølsted
13
14 5 Alvesson^{1#}
15
16
17
18 6
19
20

- 21 7 1 Department of Global Public Health, Karolinska Institute, Stockholm, Sweden
22
23 8 2 Malaria Consortium, London, United Kingdom
24
25 9 3 UNICEF, New York, USA
26
27 10 4 Malaria Consortium, Addis Ababa, Ethiopia
28
29 11 5 Sachs’ Children and Youth Hospital, Stockholm South General Hospital, Stockholm,
30 12 Sweden
31

32 13 # These authors have contributed equally to this work
33

34 14 * Corresponding author: Email: tjede.funk@ki.se
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38 15 Key words: Fathers, Child, Care-seeking, Ethiopia, Qualitative Research
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3 18 **ABSTRACT**
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6 19 **Objectives:** Fathers play an important role in household decision making processes and child
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8 20 health development. Nevertheless, fathers are underrepresented in child health research,
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10 21 especially in low-income settings. Not much is known about what roles fathers play in the care
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12 22 seeking processes or how fathers interact with the health system when their children are sick.
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14 23 This study therefore aimed to understand Ethiopian fathers' roles and responsibilities in caring
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16 24 for their children when they fall ill.
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21 25 **Design:** Qualitative study using semi-structured interviews with fathers.
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23
24 26 **Setting:** This study was conducted in three districts of the Southern Nations, Nationalities and
25
26 27 People's Region, Ethiopia.
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29 28 **Participants:** Twenty-four fathers of children under five years old who were enrolled in a
30
31 29 cluster randomised controlled trial.
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33
34 30 **Results:** The overarching theme was "Changing perceptions of paternal responsibilities during
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36 31 children's ill health". It constituted three sub-themes, namely "Fathers' burden of earning
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38 32 money for care", "Fatherhood entails advocating children's health care needs" and "Investing
39
40 33 in children's health can benefit the family in the future". Fathers described that they were the
41
42 34 ones mainly responsible for the financial arrangement of care. This financial responsibility can
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44 35 involve stress when resources are scarce. Fathers knew what health services were available and
45
46 36 accessible to them and they were in different ways involved in the care-seeking of the child.
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48 37 Changes in the importance ascribed to child health were expressed by fathers who were more
49
50 38 alert to children's ill-health and directly involved in seeking childcare.
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56 39 **Conclusion:** Fathers play different roles in the care-seeking process during children's illness
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58 40 episodes. This demonstrates the importance of including fathers in future interventions on
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3 41 maternal and child health. The inability to organise necessary resources for care can lead to
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5 42 involuntary delays in care-seeking for the child.
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10 11 44 **STRENGTH AND LIMITATIONS OF THE STUDY**

- 15 45 • This study distinguishes itself from others by only focusing on fathers and their
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17 46 perceived roles and responsibilities in the care seeking for sick children, which is an
18
19 47 underrepresented area in child health research.
- 22 48 • This study used a nested stratified sample and includes 24 fathers from highest and
23
24 49 lowest socio-economic quintiles and with few or many children.
- 26 50 • Interviews were conducted by male interviewers in two local languages using a semi-
27
28 51 structured interview format.
- 31 52 • We did not conduct interviews with mothers to confirm the responses of the fathers.

34 53 35 36 37 54 **INTRODUCTION**

40 55 Household decision making processes regarding child health care are complex. Although
41
42 56 mothers have historically been seen as responsible for their children and their health, multiple
43
44 57 studies from low-resource settings show that women have relatively low decision-making
45
46 58 power when it comes to health care decisions for themselves and their children [1-4]. A study
47
48 59 from The Gambia [5] states that mothers took decisions on when to take the child to the hospital
49
50 60 for cerebral malaria in only around 7% of the cases. Other studies confirm that it is mainly the
51
52 61 father who makes the final call on where and when to seek health care [5-7].

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57 62 The important role of fathers in child health and development are becoming better understood
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59 63 and appreciated. Literature shows that involved fathers are associated with different positive

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3 64 outcomes, such as knowledge of newborn danger signs among mothers, skilled birth attendance
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5 65 and attendance of antenatal care visits [8-10]. Some countries have started to address this issue
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8 66 and mentioned the involvement of men in their road maps to reduce maternal and child
9
10 67 morbidity and mortality [11, 12]. Yet, in low-and middle-income countries only a minority of
11
12 68 fathers has been said to be engaged with their children [13].

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15 69 Nevertheless, different forms of engagement and types of fathers exist. A study conducted in
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17 70 Ethiopia categorised fathers into three different groups, depending on their perceptions,
18
19 71 practices, and challenges towards routine child care and feeding [14]. 1) Traditional fathers who
20
21 72 “do not feel part of routine child care, and they fully believe child care is only the mothers’
22
23 73 responsibility”; 2) Transitional fathers who “perceive child care as being both the mothers’ and
24
25 74 fathers’ responsibility”, but under different conditions (e.g. availability of the father or occupied
26
27 75 mother), meaning the father does not completely feel responsible for child care and 3) Modern
28
29 76 fathers who “perceive child care and child feeding as a shared responsibility between mother
30
31 77 and father” and who are totally involved in their child’s life. This indicates that not all fathers
32
33 78 are alike and that changes in the community and family roles might be happening.

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39 79 Even though different studies have shown that fathers often are the main decision-maker or the
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41 80 breadwinner of the family and responsible to pay for healthcare costs [6, 7], not much is known
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43 81 otherwise about what roles they take on in the care seeking process for their children or how
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45 82 fathers interact with the health system when their children are sick. This study therefore aims
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47 83 to understand fathers roles and responsibilities in care-seeking for children in rural areas of the
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49 84 Southern Nations, Nationalities and People’s Region in Ethiopia.

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88 MATERIALS AND METHODS

89 The reporting of the methods has been guided by the criteria for reporting qualitative research
90 (COREQ) guidelines [15].

91 Setting

92 Interviews were conducted in three *woredas* (districts) of the Southern Nations, Nationalities
93 and People's Region (SNNPR) of Ethiopia, namely Damot Gale, Boloso Sore and Halaba
94 Special Woreda. Together these *woredas* are estimated to have a population of around 750,000,
95 of which the vast majority (~80%) lives in rural areas. At the time of this study, there were 150
96 health posts in the study area with a total of 284 health extension workers (HEWs) working in
97 them. HEWs are women with at least a grade 10 education. Usually two HEWs work in pairs
98 at one health post and serve an estimate of 3,000 - 5,000 people. However, travel distances to
99 these health posts can vary from a few minutes to an hour or more walking distance [16].

100 According to the Demographic and Health Survey report 2016 [17] the child mortality rate in
101 the SNNPR is 88 per 1,000 live births, which was above the national average (69/1,000). A
102 minority of married women (40%) used modern contraceptives (incl. sterilisation, contraceptive
103 pills, condoms and implants), and even fewer, less than 30%, give birth in a health facility.

104 It is estimated that 31% of the Ethiopian population live below the international poverty line of
105 \$1.90 per day [18]. To get help and (financial) support, *Idir*, a financial organisation
106 arrangement, has been established among many rural neighbourhoods. Members of *idir* are
107 contributing a small amount of money on a regular basis and are in return able to borrow some
108 money in case of need [19]. This provides these rural and poor populations with a limited form
109 of self-arranged insurance system.

110

111 **Study design and data collection**

112 This qualitative study was nested within a community-based cluster randomised controlled non-
113 inferiority trial (cRCT). The design and results of this trial are published elsewhere, as is the
114 qualitative evaluation of HEW's and caregivers' perception of the recommendations [20-22].

115 For this study, twenty-four semi-structured interviews were conducted with fathers of children
116 recruited for the cRCT. Two of the interviews were not completed due to time constraints of the
117 father. Half of the interviews (n=12) were conducted in Halaba *woreda*, eight in Boloso Sore
118 and four in Damot Gale. Boloso Sore and Damot Gale are culturally and linguistically similar
119 which is why they together represent half of the fathers interviewed.

120 The sampling method was based on the assumptions that health seeking practices and fathers'
121 decision-making power could differ by socio-economic position and number of children. We
122 therefore used stratified sampling to select half of the fathers from the lowest and the other half
123 from the highest socio-economic quintile. Socio-economic quintiles based on caregivers'
124 responses to questions about household assets (e.g. material of the house, toilet facility used,
125 availability of TV/radio or electricity in general). It should be kept in mind that a high socio-
126 economic quintile in this study is not equivalent to a high socio-economic status. Within the
127 two strata, fathers with few children (1-2) and fathers with multiple children (3 or more) were
128 invited for an interview to maximise the level of heterogeneity among the fathers. However,
129 the information on number of children reported in the cRCT did not always tally with the
130 number of children mentioned by the father during the interview, which is why most fathers
131 (n=19/24) in this study had three or more children.

132 An interview guide was developed covering themes such as utilisation of health services, fever
133 in children, decision making around health services and drivers and conditions that influence

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3 134 health care seeking. The interview guide was informed by literature on health care seeking and
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5 135 gender roles. It was prepared in English and subsequently translated into Amharic.
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8 136 Three male interviewers conducted the interviews, two in Boloso Sore and Damot Gale and one
9
10 137 in Halaba. The interviewers were selected based on their experience in qualitative research,
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12 138 English proficiency, and educational background in health sciences. In Halaba, a male
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14 139 interpreter was additionally recruited for translations from Amharic to Halabigna (local
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16 140 language of Halaba). In Boloso Sore and Damot Gale interviews were conducted in Wolaitegna
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18 141 by two interviewers who were from the district and thus familiar with the area and language.
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20 142 No interviewer met the fathers before the conduction of the interviews.
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25 143 All interviewers and the interpreter received a half-day training from authors TF and AA. After
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27 144 the training, every interviewer conducted one pilot interview. Changes to the interview guide
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29 145 were made accordingly and interviewers received feedback on how to improve their
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31 146 interviewing.
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35 147 The interviews were conducted in March 2017 and took between 34 and 70 minutes, with
36
37 148 interviews using an interpreter taking longer. All interviews were conducted in a quiet place
38
39 149 outside; the majority taking place close to the father's home. Fathers were aged between 20 and
40
41 150 50 years and the number of children ranged between one and fourteen (see Table 1). In Halaba,
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43 151 multiple fathers had two wives. The majority of fathers were farmers.
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48 152 All 24 interviews were digitally recorded, transcribed and translated into English. After their
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50 153 participation in the interview, fathers received 122.5 Birr in cash (~5.5 USD) to compensate for
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52 154 their time. This amount equals the common local Malaria Consortium lunch allowance.
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3 **158 Table 1 Characteristics of study participants**
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10 **161 Patient and public involvement**
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12 162 There was no involvement of patients/interviewees or the public in setting the research agenda
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15 163 or formulating interview guides.
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21 **165 Data analysis**
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24 166 The transcripts were read multiple times and codes to the material applied using the qualitative
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26 167 data structuring software Nvivo version 11. Interviews were analysed using content analysis
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28 168 [23]. The analysis was an iterative process involving reading of literature and repeated reading
29
30 169 of interview transcripts. The coding process was done in steps. TF conducted the initial coding
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32 170 and discussions took place with HMA. After each meeting, changes to the codes were made.
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34 171 Finally, codes were grouped, and themes identified, which were again discussed between
35
36 172 authors TF and HMA. All father interviews were analysed together, meaning that no
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38 173 stratification by socio-economic quintiles and number of children of fathers (strata used for the
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40 174 sample selection) took place for the analysis. However, after the coding of the data was done,
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42 175 it was checked whether fathers from different strata were represented in each theme.
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48 **176 Ethical approval**
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51 177 This study is part of a cRCT which was approved by the SNNPR Health Bureau Research
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53 178 Ethical Review Committee (P02-6-19/4511). The trial is registered as NCT02926625. Written
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55 179 and oral consent was obtained from all study participants. Confidentiality was ensured and the
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3 180 aim of the study was explained to the fathers prior to the interview and they were informed
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5 181 about the possibility to decline participation or drop out of the interview.
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15 184 **RESULTS**

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18 185 Three sub-themes emerged from the data: 1) Fathers' burden of earning money for care, 2)
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20 186 Fatherhood entails advocating children's health care needs, and 3) Investing in children's health
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22 187 can benefit the family in the future. The results are presented according to these themes and fed
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24 188 into the overarching theme of "Changing perceptions of paternal responsibilities during
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26 189 children's ill health".
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31 32 33 191 **Fathers' burden of earning money for care**

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36 192 Fathers described their roles and responsibilities in care-seeking for children mostly in terms of
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38 193 financial responsibilities. They explained that their main role as father is to work and earn
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40 194 money to be able to finance health care costs and, when necessary, transportation to the facility.
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42 195 Fathers felt strongly that "*money matters*" when it comes to seeking care for children.
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44 196 Nevertheless, it was explained that they often did not have the necessary resources at hand to
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46 197 finance health care costs. This was the case for fathers from both socio-economic strata (lowest
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48 198 and highest socio-economic quintile). Most fathers interviewed mentioned that health care costs
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50 199 are financed through work or selling goods, animals or land. In cases where insufficient money
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52 200 could be arranged, fathers would make other arrangements, such as borrowing money to pay
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54 201 for health care costs. Fathers would either borrow money through *idir* or from family and
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56 202 friends. Mothers were often described to not have an own income source that could contribute
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3 203 to health care expenses. Furthermore, mothers generally were described to have difficulties in
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5 204 borrowing money and even though they would try, they would often not receive a loan [from
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7 205 *idir*]. Consequently, the burden on arranging resources for treatment was, according to the
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10 206 fathers, mainly placed on them.

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13 207 The financial stress that fathers go through was described by this father:

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16 208 *We have idir where we save some amount of money regularly. I have to pay back the money*
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18 209 *within 10 to 15 days. In case they don't allow me [to borrow money] due to some*
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20 210 *inconveniences, I borrow from friends, relatives, particularly from my grandmother. But the*
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22 211 *reality is that I borrow again before I paid back the first loan. (ID 8; lowest socio-economic*
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24 212 *quintile; 3+ children)*

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28 213 A father also emphasised that it was easier to borrow money for fathers with a better financial
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30 214 situation compared to fathers with few resources. This further emphasised the financial worries
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32 215 that fathers are faced with.

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36 216 *The father with better financial resources can take his children to health providers easily. Even*
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38 217 *if he doesn't have the money, he can borrow it easily because people believe that he can pay it*
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40 218 *back. But if the poor wants to borrow money from friends or other people, people are not happy*
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42 219 *to give him [money] because they are wondering 'from where is he going to pay me back?' (ID*
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44 220 *4; lowest socio-economic quintile; 3+ children)*

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48 221 In addition, fathers also mentioned that care-seeking of their child can be delayed if they have
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50 222 no money at hand and sometimes it could take several days to find the necessary resources to
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52 223 finance health care costs. Consequently, it was expressed that even if a father wanted to seek
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54 224 care immediately, this was not always possible. Fathers from both socio-economic strata
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56 225 mentioned such financial worries and constraints.

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3 226 [...] if we go to [name of] hospital, we may pay up to 1000 birr (~36 USD). Even if we only
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5 227 stay one night there, they charge us 700 up to 800 birr (~25-30 USD). The more we stay there,
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7 228 the more money we are expected to pay. If we don't have money, we are left with staying home
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9 229 with the sick child and praying to God. (ID 15; lowest socio-economic quintile; 3+ children)
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16 231 **Fatherhood entails advocating children's health care needs**

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19 232 Fathers were well aware of the different health services available to their children, whether it
20
21 233 was the health post, health centre, private or traditional providers.
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25 234 Fathers stated that they discussed with their wives on what actions to take and where to take the
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27 235 child when it is sick. However, many of them still saw themselves as the ultimate decision
28
29 236 maker whose suggestion will be followed.
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33 237 *Since I bear more responsibility as father on my family's affairs, it is my decision that needs to*
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35 238 *be adhered to. Since she [wife] doesn't have an income generating work and we solely depend*
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37 239 *on the income I get, it is me who decides over issues. (ID 15; lowest socio-economic quintile;*
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39 240 *3+ children)*
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43 241 Different factors can influence the choice to which provider a child is taken. The type of illness
44
45 242 the child has can be such a factor. When the child is suspected to have bone fractures or a
46
47 243 dislocation, multiple fathers explained that traditional healers (also referred to as "bone setter")
48
49 244 are the first choice of treatment. If the traditional treatment is not effective, other sources of
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51 245 treatment will be sought. For other types of illnesses, a father would directly take the child to
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53 246 another health provider, such as the health post.
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3 247 Money was also explained to be a decisive factor in the care-seeking process. According to
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5 248 fathers, the availability of money and resources provides a freedom of choosing a health
6
7 249 provider for the child's health condition. This freedom is constrained if resources are scarce.

9
10 250 *Rich [people] take sick children directly to hospital. But since poor [people] have no money,*
11
12 251 *they take [the child] to the health post. They only take [the child] to the hospital when its*
13
14 252 *condition is life threatening. (ID 8)*

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18 253 Multiple fathers seemed to prefer the health centre over the health post, because more and better
19
20 254 treatment is believed to be available there. It was stressed that the general perception is that
21
22 255 treatment is better in urban areas and also faster at private providers, though private providers
23
24 256 being expensive and described as business-oriented. Nevertheless, if the money is available,
25
26 257 some fathers still preferred their services over public facilities. Fathers observed a formal care
27
28 258 chain (or "hierarchy") in health care. They described that health centres expect them to go to
29
30 259 have a referral slip from the health post, making it harder for them to directly access treatment
31
32 260 at the health centre, which was seen as an obstacle.

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38 261 Bringing the child to a health post for treatment was, according to the fathers interviewed, often
39
40 262 first a responsibility of the mother. However, in different circumstances this responsibility was
41
42 263 less clear. Mothers were described to be responsible for bringing the children who are breastfed
43
44 264 to the health provider, whereas fathers claimed to mainly accompany older children that can
45
46 265 walk or sit on a motorcycle to the health provider. Whether or not a father brings or accompanies
47
48 266 a child to a health facility also depended on the health facility in question. One father explained
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50 267 that the mother can seek care at the health post alone, but fathers need to be consulted to seek
51
52 268 care at the health centre or higher-level facilities which often implies more severe illnesses.

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57 269 *When the mother notices that the child is sick, she takes her [the child] to health post. If the*
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59 270 *health post advises her [the mother] to take the child to the health centre [i.e. refers the child*

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3 271 *as the health problem is not identified or manageable at community level], she returns back*
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5 272 *and waits for my return. After I return back to home, we together take the child to the health*
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7 273 *centre together. (ID 15; lowest socio-economic quintile; 3+ children)*
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10 274 If the child needed to stay at the hospital, also a father described to stay with it. In addition, the
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12 275 arrangement of the transportation to the health facility was, according to some fathers, also the
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14 276 role of them.
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18 277 **Investing in children's health can benefit family in the future**

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21 278 Behaviours of fathers in regard to seeking care for children has been changing over time. It was
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23 279 explained that fathers today are more involved in child health matters compared to the past and
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25 280 that they do not leave this issue entirely up to the mothers anymore. Fathers stated to be more
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27 281 alert about changes in health status of their children and that they will not rely only on faith to
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29 282 cure the child.
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34 283 *I can say that the love I have to my children is stronger than the mother's love. Due to that*
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36 284 *reason, I also closely follow their [the children's] health situation. (ID 4; lowest socio-*
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38 285 *economic quintile; 3+ children)*
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41 286 A couple of fathers pointed out the value that children have and can bring in the future, for
42
43 287 instance through working and supporting the family financially. Consequently, fathers pay
44
45 288 more attention to their child's health status and make sure that they recover.
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49 289 *In past time, there were widely held assumptions among fathers that a child will grow by his*
50
51 290 *fate so that no worries are needed. But this belief is changing as those sons and daughters that*
52
53 291 *work at urban centres and abroad send [money] and augment their family's income. Children*
54
55 292 *now are believed to be assets and obtain great care. So fathers are alert whenever they observe*
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57 293 *changes in their children's health. (ID 18; highest socio-economic quintile; 3+ children)*
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3 294 Fathers also observed changes in the health services over time. They noticed that health posts
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5 295 that are now existing in their community have not been available in the past.
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20 300 **DISCUSSION**

23 301 This study indicated that fathers are involved in the care-seeking for their sick child in different
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25 302 ways. They explained that they bear the main responsibility to arrange financial resources to
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27 303 enable a health care visit and that this responsibility can imply stress and financial concerns
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29 304 when resources are scarce. Fathers were well aware of the health services available to their
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31 305 children and they described to be involved in the care-seeking process in different ways, e.g.
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33 306 (co-)deciding where to take the child or accompanying their child to the health facility. Fathers
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35 307 explained that changes in fathers' perception on children and their involvement have taken
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37 308 place. They described themselves to be more aware of the health status of their children and
38
39 309 more involved in child health matter as compared to the past.
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44 310 This transitional change in fathers' perceptions on their children has been described in another
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46 311 study conducted in Ethiopia [24]. Multiple fathers interviewed in this study would fit into the
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48 312 "transitional fathers" category. According to them, child health issues are not seen as only a
49
50 313 task of the mother anymore. On the other hand, some fathers also mentioned more traditional
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52 314 features. This could suggest that change is happening in these rural areas and that with
53
54 315 continuous efforts fathers' roles as caregiver could be strengthened. Additionally, the phrasing
55
56 316 of the last theme "Investing in children's health can benefit family in the future" seems very
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3 317 timely, considering that a recently published report by the WHO-UNICEF-Lancet Commission
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5 318 highlights the importance and benefits of investing in children [25]. It is interesting that the
6
7 319 recognition of this relevance has to a certain extent, and due to different reasons, also reached
8
9 320 the families. It is noteworthy that fathers did not only observe changes in their behaviour but
10
11 321 they also appreciated changes in the availability of health services, through e.g. the
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13 322 establishment of a health post in their community.
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18 323 Multiple studies have shown that fathers are often responsible for the household finances and
19
20 324 financing of care [6, 7, 26-28]. This study coincided with these findings, but also shed light
21
22 325 upon the burden that this responsibility brings along when a child falls ill. The reality described
23
24 326 by fathers was that often resources were not available to finance health care costs and that in
25
26 327 many cases fathers needed to borrow money again before having paid back their first debt. It
27
28 328 appears to be a vicious circle in which particularly very poor fathers are placed and
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30 329 demonstrates the difficult situations that these families go through in times of sickness. The
31
32 330 inability to arrange money to pay for health care costs can lead to involuntary delays in care-
33
34 331 seeking. The link between costs and delayed health care has been previously described in the
35
36 332 literature [29, 30]. These findings suggest that besides educating parents on danger signs and
37
38 333 when to seek care, it is very important to get the health care infrastructure in place and to make
39
40 334 health facilities accessible to the communities. The Sustainable Development Goal 3.8 touches
41
42 335 upon this as it aims to “achieve universal health coverage, including financial risk protection
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44 336 [and] access to quality essential health-care services (...)” [31]. In order to further improve
45
46 337 maternal and child health, health services should be made accessible to all, both physically and
47
48 338 economically [32].
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54
55 339 In this study, many fathers told that they discuss and decide together with their wives on what
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57 340 to do when their child is sick. Nevertheless, multiple of these fathers still saw themselves as
58
59 341 final decision-makers whose opinions should be adhered to. Literature supports that fathers
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2
3 342 often are the decision-maker of the household [5, 7], which raises questions on the true
4
5 343 influence of mothers' opinions on the decision-making processes. It is known that fathers play
6
7 344 an important role in a children's development. Positive involvement of fathers can impact not
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9
10 345 only children's cognitive skills, but also their social competences and behavioural or emotional
11
12 346 outcomes [33-35]. This shows, together with fathers' important role as decision-maker and
13
14 347 breadwinner in the care-seeking process, that there is a strong need for including fathers in
15
16 348 future interventions aimed at improving maternal and child health. It is thereby crucial to
17
18 349 consider that many fathers spend much time of the day away from home because of their work.
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21 350 Interventions need to be formulated accordingly.
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24 351 Another interesting finding of this study was that fathers were not only involved in household
25
26 352 decision-making and finances, but that they also were directly in contact with the health system
27
28 353 for their children. Fathers in this study were not only well aware of the different health providers
29
30 354 available or accessible to them, but also described to have direct contact with the health system,
31
32 355 by sometimes bringing the child to the health facility or accompanying the mother. We did not
33
34 356 come across a study that discussed similar findings.
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40 41 42 358 **STRENGTHS AND WEAKNESSES**

43
44 359 This study focussed on fathers only. This is adding to current literature as fathers are still
45
46 360 underrepresented in child health research. We conducted interviews in the local language in
47
48 361 Boloso Sore and Damot Gale. As this was not possible in Halaba, we tried to overcome
49
50 362 language diversity through a local interpreter. Two interviews in Halaba were not finalised due
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52 363 to other obligations of the father. As these selected fathers have not been replaced, some
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54 364 information was lost. However, due to the large number of interviews conducted we still
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56 365 consider having obtained enough information.
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3 366 A social desirability bias (e.g. father claiming to be more involved in the care-seeking process
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5 367 than they actually are) cannot be excluded with certainty in this study. We did not conduct
6
7 368 interviews with mothers to check or confirm the accuracy of fathers' responses. Nevertheless,
8
9 369 we aimed to mitigate the chances of a desirability bias by using male interviewers. We therefore
10
11 370 believe that the information provided does reflect their roles and perceptions well. Multiple
12
13 371 findings of this study coincided with previous literature. We thus assume that these findings are
14
15 372 transferable to communities with similar family structures and cultural contexts and health
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17 373 systems.
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23 24 25 375 **CONCLUSIONS**

26
27 376 Fathers' play an important role in the care-seeking process of their children. Not only do they
28
29 377 have decision-making power and the financial responsibility, but they are also otherwise
30
31 378 involved in the care-seeking process, such as arranging transportation or accompanying the
32
33 379 child at times to the facility. Fathers are familiar with the health services available to their
34
35 380 children and even noticed positive changes in the paternal involvement in childcare as well as
36
37 381 availability of health services through the establishment of health posts in their communities.
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39 382 Besides the important roles that fathers play in the care-seeking process, they are still today
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41 383 underrepresented in child health research and interventions. Efforts need to be made to continue
42
43 384 the observed positive trend in fathers' involvement in care seeking described in this study.
44
45 385 Future research on maternal and child health needs to step up on highlighting the role of fathers.
46
47 386 The inability to organise necessary resources for care can lead to involuntary delays in care-
48
49 387 seeking for the child. It is therefore crucial to continue strengthening health care systems and
50
51 388 making health services more accessible to communities, both physically and financially.
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390 **ACKNOWLEDGEMENTS**

391 We thank the Federal Ministry of Health in Ethiopia, the Regional Health Bureau in
392 SNNPR (in particular, our technical advisor, Dr. Habtamu Beyene), and the woreda offices in
393 Damot Gale, Boloso Sore and Halaba. We extend our thanks to all fathers we interviewed for
394 granting us their time and being willing to share their experiences. Finally, we would like to
395 acknowledge Tesfahun Tadesse, Muluken Tamirat, Tessema Awano for conducting the
396 interviews and Ahmedin Alemu for functioning as interpreter.

398 **FUNDING STATEMENT**

399 This work was part of the Translating Research into Action (TRAction) and funded by the
400 President's Malaria Initiative and United States Agency for International Development
401 (USAID) under cooperative agreement No.GHS-A-00-09-00015-00.

403 **COMPETING INTEREST**

404 The authors' declare that they have no competing interest.

406 **AUTHORS' CONTRIBUTION**

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

412

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COREQ (CONsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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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

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2020-038932.R1
Article Type:	Original research
Date Submitted by the Author:	25-May-2020
Complete List of Authors:	Funk, Tjede; Karolinska Institute, Global Public Health Källander, Karin; Karolinska Institutet, Department of Global Public Health Abebe, Ayalkibet; Malaria Consortium Alfvén, Tobias ; Karolinska Institute, Department of Global Public Health Alvesson, Helle; Karolinska Institute, Department of Global Public Health
Primary Subject Heading:	Global health
Secondary Subject Heading:	Global health, Qualitative research
Keywords:	Community child health < PAEDIATRICS, QUALITATIVE RESEARCH, PUBLIC HEALTH

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12 4 Tjede Funk^{1*}, Karin Källander^{1,2,3}, Ayalkibet Abebe⁴, Tobias Alfvén^{1,5#}, Helle Mølsted
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- 21 7 1 Department of Global Public Health, Karolinska Institute, Stockholm, Sweden
22 8 2 Malaria Consortium, London, United Kingdom
23 9 3 UNICEF, New York, USA
24 10 4 Malaria Consortium, Addis Ababa, Ethiopia
25 11 5 Sachs’ Children and Youth Hospital, Stockholm South General Hospital, Stockholm,
26 12 Sweden
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32 13 # These authors have contributed equally to this work
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34 14 * Corresponding author: Email: tjede.funk@ki.se
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38 15 Key words: Fathers, Child, Care-seeking, Ethiopia, Qualitative Research
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3 18 **ABSTRACT**
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6 19 **Objectives:** Fathers play an important role in household decision making processes and child
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8 20 health development. Nevertheless, they are underrepresented in child health research, especially
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10 21 in low-income settings. Little is known about what roles fathers play in the care seeking
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12 22 processes or how they interact with the health system when their child is sick. This study aimed
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14 23 to understand Ethiopian fathers' roles and responsibilities in caring for their children when they
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16 24 are or become ill.
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21 25 **Design:** Qualitative study using semi-structured interviews with fathers.
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24 26 **Setting:** This study was conducted in three rural districts of the Southern Nations, Nationalities
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26 27 and People's Region of Ethiopia.
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29 28 **Participants:** Twenty-four fathers who had at least one child between 2 and 59 months who
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31 29 visited a health extension worker with fever.
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34 30 **Results:** The overarching theme was "Changing perceptions of paternal responsibilities during
35
36 31 children's ill health". It constituted three sub-themes, namely "Fathers' burden of earning
37
38 32 money for care", "Fatherhood entails advocating children's health care needs" and "Investing
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40 33 in children's health can benefit the family in the future". Fathers described that they were the
41
42 34 ones mainly responsible for the financial arrangement of care and that this financial
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44 35 responsibility can involve stress when resources are scarce. Fathers knew what health services
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46 36 were available and accessible to them and were involved in different ways in the care-seeking
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48 37 of the child. Changes in the importance ascribed to child health were expressed by fathers who
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50 38 described being more alert to children's ill-health.
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56 39 **Conclusion:** Fathers play various roles in the care-seeking process during children's illness
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58 40 episodes. This included for instance arranging resources to seek care, (co-)deciding where to
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3 41 seek care as well as accompanying the child to the health facility. The inability to organise
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5 42 necessary resources for care can lead to involuntary delays in care-seeking for the child. This
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7 43 demonstrates the importance of including fathers in future interventions on maternal and child
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9 44 health.

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16 46 **STRENGTH AND LIMITATIONS OF THE STUDY**

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19 47
- 20 • This study distinguishes itself from others by only focusing on fathers and their
21 perceived roles and responsibilities in the care seeking for sick children, which is an
22 48 underrepresented area in child health research.
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24 49
 - 25 • This study used a nested stratified sample and included 24 fathers from highest and
26 50 lowest socio-economic quintiles and with few (1-2) or many children (3+) in order to
27 provide rich information.
 - 28 51
 - 29 • We sought to mitigate a social desirability bias by having the interviews conducted by
30 52 male interviewers in two local languages.
 - 31 53
 - 32 • We did not conduct interviews with mothers to confirm the fathers' responses.
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44 57 **INTRODUCTION**

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47 58 Annually approximately 5.3 million children die worldwide before reaching their fifth birthday.
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49 59 Most of these deaths occur following the neonatal period and are caused by diseases such as
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51 60 malaria, pneumonia and diarrhoea [1]. It is further estimated that malnutrition contributes to
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53 61 almost half of child deaths under the age of five and that many of the childhood deaths could
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55 62 have been prevented with simple, effective and available interventions [1]. Nevertheless,
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57 63 caregivers of sick children in poor communities often face obstacles in seeking healthcare, such
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64 as lack of money or distance to the care facility [2, 3]. Evidence from Ethiopia shows that only
65 35% of children with fever and 44% of children with diarrhoea in the previous two weeks were
66 brought for treatment [4].

67 Decision making processes regarding child health care are complex. Although mothers have
68 historically been seen as responsible for their children and their health, multiple studies from
69 low-resource settings show that women, as compared to men, have relatively low decision-
70 making power when it comes to health care decisions for themselves and their children [5-8].
71 A study from The Gambia [9] states that mothers decided when to take the child to the hospital
72 for cerebral malaria in only around 7% of the cases. Other studies confirm that it is mainly the
73 father who makes the final call on where and when to seek health care [9-11].

74 The important role of fathers in child health and development is becoming better understood
75 and appreciated. Literature shows that involved fathers are associated with different positive
76 outcomes, such as knowledge of newborn danger signs among mothers, skilled birth and
77 attendance of antenatal care visits [12-14]. Some countries have therefore started to address the
78 involvement of fathers in their road maps to reduce maternal and child morbidity and mortality
79 [15, 16]. Yet, in low-and middle-income countries only a minority of fathers has been said to
80 be engaged with their children [17]. Yet different forms of engagement and types of fathers
81 exist. In a study conducted in Ethiopia, fathers were categorised into three different groups,
82 depending on their perceptions, practices, and challenges towards routine child care and feeding
83 [18]: 1) Traditional fathers who “do not feel part of routine child care, and they fully believe
84 child care is only the mothers’ responsibility”; 2) Transitional fathers who “perceive child care
85 as being both the mothers’ and fathers’ responsibility”, but under different conditions (e.g.
86 availability of the father or occupied mother), meaning the father does not completely feel
87 responsible for child care and 3) Modern fathers who “perceive child care and child feeding as
88 a shared responsibility between mother and father” and who are totally involved in their child’s

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3 89 life. This indicates that not all fathers are alike and that differences in their roles can exist
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5 90 between them.
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8 91 A number of studies from Africa have shown that fathers are often the main decision-maker or
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10 92 breadwinner of the family and responsible to pay for healthcare costs [10, 11]. Yet little is
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12 93 known otherwise about what roles they take on in the care seeking process for their children or
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14 94 how fathers interact with the health system when their children are sick. Therefore, this study
15
16 95 aims to understand fathers' roles and responsibilities in care-seeking for children in rural areas
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18 96 of the Southern Nations, Nationalities and People's Region in Ethiopia.
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24 25 98 **MATERIALS AND METHODS**

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29 99 The reporting of the methods has been guided by the criteria for reporting qualitative research
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31 100 (COREQ) guidelines [19].
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35 36 37 102 **Setting**

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40 103 The interviews were conducted in Damot Gale, Boloso Sore and Halaba Special Woreda, three
41
42 104 *woredas* (districts) of the Southern Nations, Nationalities and People's Region (SNNPR) of
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44 105 Ethiopia. The population of Ethiopia, similar to these three *woredas*, is predominantly (~80%)
45
46 106 living in rural areas. SNNPR is a very ethnically diverse region, inhabited by more than 80
47
48 107 different ethnic groups. To improve primary health care services in the country, particular in
49
50 108 rural areas, Ethiopia has been implementing a health extension program since 2003 [20].
51
52 109 Central to the program are health extension workers (HEW) who are trained for 12-months and
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54 110 subsequently employed by the government to work in health posts directly in and with the
55
56 111 community [20, 21]. HEWs are women with at least a grade 10 education. Typically two HEWs
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1
2
3 112 are assigned to one health post, serving an estimate of 3,000 - 5,000 people [20, 21]. HEW
4
5 113 provide key health promotion and prevention services, as well as a selection of curative
6
7 114 services; all services are free of charge [21, 22]. Although health posts are placed directly in a
8
9
10 115 community, travel distances can vary from a walking distance of a few minutes to an hour or
11
12 116 more [23]. At the time of this study there were 150 health posts in the study area with a total of
13
14 117 284 HEW.

15
16
17 118 Child mortality rates in Ethiopia have been decreasing over the years and currently stand at 55.2
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19 119 per 1000 live births, with mortality rates in SNNPR higher than the national average [4, 24].
20
21
22 120 Traditional gender roles persist, particularly in rural areas, with a minority of women reporting
23
24 121 having the right to decide on their first marriage and having their husband help with household
25
26 122 chores. Around 40% use modern contraceptives including sterilisation, contraceptive pills,
27
28 123 condoms and implants, and even fewer, less than 30%, give birth in a health facility [4].
29
30 124 Twenty-eight per cent of women and 73% of men age 15-49 in the region work within the
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32 125 agricultural sector.
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38 39 40 127 **Study design and data collection**

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43 128 This qualitative study was nested within a community-based cluster randomised controlled non-
44
45 129 inferiority trial (cRCT). The design and results of this trial are published elsewhere, as is the
46
47 130 qualitative evaluation of HEW's and caregivers' perception of the recommendations [25-27].
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51 131 For this study, twenty-four semi-structured interviews were conducted with fathers who had at
52
53 132 least one child aged 2 to 59 months presenting to the HEW with fever. Half of the interviews
54
55 133 (n=12) were conducted in Halaba *woreda*, eight in Boloso Sore and four in Damot Gale. Boloso
56
57 134 Sore and Damot Gale are culturally and linguistically similar which is why they together
58
59 135 represent half of the fathers interviewed.
60

1
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3 136 The sampling method was based on the assumption that health seeking practices and fathers'
4
5 137 decision-making power could differ by socio-economic position and number of children. We
6
7 138 therefore used stratified sampling to select half of the fathers from the lowest and the other half
8
9
10 139 from the highest socio-economic quintile. Socio-economic quintiles were based on caregivers'
11
12 140 responses to questions about household assets, e.g. material of the house, toilet facility used,
13
14 141 availability of TV/radio or electricity in general. It should be kept in mind that a high socio-
15
16 142 economic quintile in this study is not equivalent to a high socio-economic status. Fathers in the
17
18 143 high socio-economic quintile can still be considered poor. Within the two strata, fathers with
19
20 144 few children (1-2) and fathers with multiple children (3 or more) were invited for an interview
21
22 145 to maximise the level of heterogeneity among the fathers. However, the information on number
23
24 146 of children reported in the cRCT did not always tally with the number of children mentioned
25
26 147 by the father during the interview, which is why most fathers (n=19/24) in this study had three
27
28 148 or more children. Once the father was randomly selected within each stratum, contact was
29
30 149 established through the HEW and fathers were personally visited in their community. When
31
32 150 fathers were not at home, contact was established via phone or with help of the HEW in the
33
34 151 community. Fathers were asked whether they would be willing to participate in the study. All
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36 152 24 fathers agreed to participate, but two were not able complete the interview due to time
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38 153 constrains.
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45 154 An interview guide was developed informed by literature on health care seeking and gender
46
47 155 roles. It started with introductory questions about the father and the household to explore
48
49 156 fathers' educational background, profession and family composition. While this part was rather
50
51 157 structured, the interview guide then followed with open ended questions regarding fathers'
52
53 158 practices on the following issues: seeking advice or discussing health matters with other family
54
55 159 or community members; fever in children and fathers' understanding of fever; fathers'
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57 160 knowledge on health providers in the community; their decision-making around health services
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1
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3 161 and drivers that influenced their seeking health care. The interview ended with asking fathers
4
5 162 to compare care-seeking between different households and changes in practices and roles of
6
7 163 fathers over time. The interview guide was prepared in English and subsequently translated into
8
9
10 164 Amharic.

11
12
13 165 Three male interviewers conducted the interviews, two in Boloso Sore and Damot Gale and one
14
15 166 in Halaba. The interviewers were selected based on their experience in qualitative research,
16
17 167 English proficiency, and educational background in health sciences. In Halaba, a male
18
19 168 interpreter was recruited for translations from Amharic to Halabigna (local language of Halaba)
20
21
22 169 as the interviewer was not familiar with the local language. In Boloso Sore and Damot Gale
23
24 170 interviews were conducted in Wolaitegna by two interviewers who were from the district and
25
26
27 171 thus familiar with the area and language. No interviewer met the fathers before the conduction
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29 172 of the interviews.

30
31
32 173 All interviewers and the interpreter received a half-day training from authors TF and AA. The
33
34 174 training provided insights into the research background, the aim of the study and the sampling
35
36 175 of fathers. In addition, the interview procedure was thoroughly explained and the interview
37
38 176 guide and all questions were reviewed and discussed in detail. The importance of probing and
39
40 177 non-leading questions was emphasized. At the end of the training, any remaining language
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42
43 178 issues were addressed as the interview guide was prepared in Amharic but the interviews were
44
45
46 179 conducted in the local language. After the training, every interviewer conducted one pilot
47
48 180 interview and changes to the interview guide were made accordingly. Based on the pilot
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51 181 interviews, interviewers received oral feedback on how to improve their interviewing and the
52
53 182 purpose of certain questions was repeated in order to improve the direction of their probing
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55 183 questions.

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3 184 The interviews were conducted in March 2017 and took between 34 and 70 minutes, with
4
5 185 interviews using an interpreter taking longer. All interviews were conducted in a quiet place
6
7 186 outside; the majority took place close to the father's home. Fathers were aged between 20 and
8
9 187 50 years and the number of children ranged between one and fourteen (see Table 1). In Halaba,
10
11 188 multiple fathers had two wives. The majority of fathers were farmers.

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15 189 All 24 interviews were digitally recorded, transcribed in Amharic and translated into English.
16
17 190 The interviewers in Boloso Sore and Damot Gale preferred to transcribe the interviews directly
18
19 191 in Amharic instead of Wolaitegna, due to the difficulty in writing the local language. After their
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21 192 participation in the interview, fathers received 122.5 Birr in cash (~5.5 USD) to compensate for
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23 193 their time. This amount equals the common local Malaria Consortium lunch allowance.
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31 197 **Table 1 Characteristics of study participants**

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34 200 **Ethical approval**

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38 201 This study was nested within a cRCT that was approved by the SNNPR Health Bureau Research
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40 202 Ethical Review Committee (P02-6-19/4511). The trial is registered as NCT02926625. Written
41
42 203 and oral consent was obtained from all study participants. Confidentiality was ensured and the
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44 204 aim of the study was explained to the fathers prior to the interview. They were informed about
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46 205 the option to decline participation or drop out of the interview without any consequences.
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57 206 **Patient and public involvement**

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3 207 There was no involvement of patients/interviewees or the public in setting the research agenda
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5 208 or formulating interview guides.
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11 210 **Data analysis**
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14 211 All 24 father interviews were included in the analysis, although two fathers did not complete
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16 212 the interview. As these two fathers did answer a number of questions, it was seen as appropriate
17
18 213 to include the material provided by them in the analysis, even though it was not fully completed.
19
20 214 The transcripts were read multiple times and codes to the material were applied using the
21
22 215 qualitative data structuring software Nvivo version 11. Interviews were analysed using content
23
24 216 analysis [28]. The analysis was an iterative process involving reading of literature and repeated
25
26 217 reading of interview transcripts. The coding process was done in steps. TF conducted the initial
27
28 218 coding and discussions took place with HMA. After each meeting, changes to the codes were
29
30 219 made. Finally, codes were grouped, and themes identified, which were again discussed between
31
32 220 authors TF and HMA. All father interviews were analysed together, meaning that no
33
34 221 stratification by socio-economic quintiles and number of children of fathers (strata used for the
35
36 222 sample selection) took place for the analysis. However, after the coding of the data was done,
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38 223 it was checked whether fathers from different strata were represented in each theme.
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51 226 **RESULTS**
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54 227 Three sub-themes emerged from the data: 1) Fathers' burden of earning money for care, 2)
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56 228 Fatherhood entails advocating children's health care needs, and 3) Investing in children's health
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58 229 can benefit the family in the future. The results are presented according to these themes and fed
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3 230 into the overarching theme of “Changing perceptions of paternal responsibilities during
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5 231 children’s ill health”.

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12 233 **Fathers’ burden of earning money for care**

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15 234 Fathers described their roles and responsibilities in care-seeking for children mostly in terms of
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17 235 financial responsibilities. They explained that their main role as father was to work and earn
18
19 236 money to be able to finance health care costs and, when necessary, transportation to the facility.
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21 237 Fathers felt strongly that “*money matters*” when it comes to seeking care for children.
22
23
24 238 Nevertheless, it was explained that they often did not have the necessary resources at hand to
25
26 239 finance health care costs. This was expressed by fathers from both socio-economic strata,
27
28 240 lowest and highest socio-economic quintile. Most fathers interviewed mentioned that health
29
30 241 care costs are financed through work or selling goods, animals or land. When not enough money
31
32 242 could be arranged, fathers would make other arrangements, such as borrowing money to pay
33
34 243 for health care costs. Fathers would either borrow money through *idir* [a financial community
35
36 244 support system where members can regularly contribute small amounts of money and in return
37
38 245 are able to borrow some money in case of need] or from family and friends. Mothers were often,
39
40 246 but not always, described as not having their own income source that could contribute to health
41
42 247 care expenses. Furthermore, mothers generally were described as having difficulties in
43
44 248 borrowing money as even though they would try to obtain a loan, they would often not receive
45
46 249 one [from *idir*]. Consequently, the burden on arranging resources for treatment was, according
47
48 250 to the fathers, mainly placed on them. The financial stress that fathers experience was described
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50 251 by this father:

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57 252 *We have idir where we save some amount of money regularly. I have to pay back the money*
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59 253 *within 10 to 15 days. In case they don’t allow me [to borrow money] due to some*

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3 254 *inconveniences, I borrow from friends, relatives, particularly from my grandmother. But the*
4
5 255 *reality is that I borrow again before I paid back the first loan. (ID 8; lowest socio-economic*
6
7 256 *quintile; 3+ children)*
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9

10 257 One father also emphasised that it was easier for fathers with a better financial situation to
11
12 258 borrow money compared to fathers with few resources, which further emphasised the financial
13
14 259 worries that fathers were faced with.
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16

17
18 260 *The father with better financial resources can take his children to health providers easily. Even*
19
20 261 *if he doesn't have the money, he can borrow it easily because people believe that he can pay it*
21
22 262 *back. But if the poor wants to borrow money from friends or other people, people are not happy*
23
24 263 *to give him [money] because they are wondering 'from where is he going to pay me back?' (ID*
25
26 264 *4; lowest socio-economic quintile; 3+ children)*
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29
30 265 In addition, fathers also mentioned that care-seeking for their child can be delayed if they have
31
32 266 no money at hand, and sometimes it could take several days to find the necessary resources to
33
34 267 finance health care costs. Consequently, it was expressed that even if a father wanted to seek
35
36 268 care immediately, this was not always possible. Fathers from both socio-economic strata
37
38 269 mentioned such financial worries and constraints.
39
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42
43 270 *[...] if we go to [name of] hospital, we may pay up to 1000 birr (~36 USD). Even if we only*
44
45 271 *stay one night there, they charge us 700 up to 800 birr (~25-30 USD). The more we stay there,*
46
47 272 *the more money we are expected to pay. If we don't have money, we are left with staying home*
48
49 273 *with the sick child and praying to God. (ID 15; lowest socio-economic quintile; 3+ children)*
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55
56 275 **Fatherhood entails advocating children's health care needs**
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3 276 Fathers were well aware of the different health services available to their children, whether it
4
5 277 was the health post, health centre, private or traditional providers. They stated that they
6
7 278 discussed with their wives on what actions to take and where to take the child when it is sick.
8
9
10 279 However, many of them still saw themselves as the ultimate decision maker whose suggestion
11
12 280 will be followed.

13
14
15 281 *Since I bear more responsibility as father on my family's affairs, it is my decision that needs to*
16
17 282 *be adhered to. Since she [wife] doesn't have an income generating work and we solely depend*
18
19 283 *on the income I get, it is me who decides over issues. (ID 15; lowest socio-economic quintile;*
20
21 284 *3+ children)*

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23
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25 285 Different factors can influence the choice as to which provider a child is taken. The type of
26
27 286 illness the child has can be such a factor. When the child was suspected of having a bone fracture
28
29 287 or a dislocation, multiple fathers explained that traditional healers also referred to as “bone
30
31 288 setter” are the first choice of treatment. If the traditional treatment is not effective, other sources
32
33 289 of treatment will be sought. For other types of illnesses, a father would directly take the child
34
35 290 to a different health provider, such as the health post.

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40 291 Money was also explained to be a decisive factor in the care-seeking process. According to
41
42 292 fathers the availability of money and resources provides a freedom in choosing a health provider
43
44 293 for the child's health condition. This freedom is constrained if resources are scarce.

45
46
47 294 *Rich [people] take sick children directly to hospital. But since poor [people] have no money,*
48
49 295 *they take [the child] to the health post. They only take [the child] to the hospital when its*
50
51 296 *condition is life threatening. (ID 8)*

52
53
54
55 297 Multiple fathers seemed to prefer the health centre over the health post, because more and better
56
57 298 treatment was believed to be available there. It was stressed that the general perception is that
58
59 299 treatment was better in urban areas and also faster at private providers, though private providers

1
2
3 300 were expensive and described as business-oriented. Nevertheless, if the money was available,
4
5 301 some fathers still preferred private services over public facilities. Fathers observed a formal
6
7 302 care chain (or “*hierarchy*”) in health care. They described that health centres expected them to
8
9 303 have a referral slip from the health post, making it harder for them to directly access treatment
10
11 304 at the health centre. This was seen as an obstacle in seeking care.
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13
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15 305 The responsibility for bringing or accompanying a sick child for treatment was unclear.
16
17 306 Bringing the child to a health post for treatment was first seen as being a responsibility of the
18
19 307 mother. Mothers were described to be responsible for bringing the children who were breastfed
20
21 308 to the health provider, whereas fathers claimed to rather accompany older children that could
22
23 309 walk or sit on a motorcycle to the health provider. Whether or not a father brought or
24
25 310 accompanied a child to a health facility also depended on the health facility in question. One
26
27 311 father explained that the mother sought care at the health post alone, but fathers needed to be
28
29 312 consulted to seek care at the health centre or higher-level facilities, often implying more severe
30
31 313 illnesses and higher costs.
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36
37 314 *When the mother notices that the child is sick, she takes her [the child] to health post. If the*
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39 315 *health post advises her [the mother] to take the child to the health centre [i.e. refers the child*
40
41 316 *as the health problem is not identified or manageable at community level], she returns back*
42
43 317 *and waits for my return. After I return back to home, we together take the child to the health*
44
45 318 *centre together. (ID 15; lowest socio-economic quintile; 3+ children)*
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49 319 If the child needed to stay at the hospital, a father described it as his role to stay with the child.
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51 320 In addition, the arrangement of the transportation to the health facility was, according to some
52
53 321 fathers, also their role.
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57 322 **Investing in children’s health can benefit the family in the future**

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60 323 Behaviours of fathers with regards to seeking care for children has changed over time. It was

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3 324 explained that fathers today are more involved in child health matters compared to the past and
4
5 325 that they do not leave this issue entirely up to the mothers anymore. Fathers stated being more
6
7 326 alert about changes in health status of their children and that they will not rely only on faith to
8
9 327 cure the child.

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13 328 *I can say that the love I have to my children is stronger than the mother's love. Due to that*
14
15 329 *reason, I also closely follow their [the children's] health situation. (ID 4; lowest socio-*
16
17 330 *economic quintile; 3+ children)*

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21 331 A couple of fathers pointed out the value that children have and can bring in the future, for
22
23 332 instance through working and supporting the family financially. Consequently, fathers stated
24
25 333 they paid more attention to their child's health status and made sure that they recovered.

26
27
28 334 *In past time, there were widely held assumptions among fathers that a child will grow by his*
29
30 335 *fate so that no worries are needed. But this belief is changing as those sons and daughters that*
31
32 336 *work at urban centres and abroad send [money] and augment their family's income. Children*
33
34 337 *now are believed to be assets and obtain great care. So fathers are alert whenever they observe*
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36 338 *changes in their children's health. (ID 18; highest socio-economic quintile; 3+ children)*

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41 339 Fathers also observed changes in the health services over time. They noticed that health posts
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43 340 that are now existing in their community were not available in the past.

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51 343 **DISCUSSION**

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54 344 This study indicates that fathers are involved in the care-seeking of their sick child in different
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56 345 ways. This includes bearing the main responsibility for arranging financial resources to enable
57
58 346 a health care visit and this responsibility can imply stress and financial concerns when resources
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1
2
3 347 are scarce. Fathers are well aware of the health services available to their children and they
4
5 348 described being involved in the care-seeking process in different ways, e.g. (co-)deciding where
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7 349 to take the child or accompanying their child to the health facility. Fathers explained that
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9
10 350 changes in fathers' perception on children and their involvement have taken place. They
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12 351 described themselves being more aware of the health status of their children and more involved
13
14 352 in child health matters compared to the past.

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18 353 This transitional change in fathers' perceptions of their children has been described in another
19
20 354 study conducted in Ethiopia [29]. Multiple fathers interviewed in this study would fit into the
21
22 355 "transitional fathers" category. According to them, child health issues are not seen as only a
23
24 356 task of the mother anymore. It seems as if these fathers acknowledge these responsibilities as
25
26 357 being part of their role as father. The findings of this study show that not all fathers take on the
27
28 358 same roles in care-seeking for children. This suggests that roles in these rural areas are changing
29
30 359 and that with continuous country efforts, fathers' roles as caregiver could be strengthened.

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34 360 Also, the phrasing of the last theme "Investing in children's health can benefit family in the
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36 361 future" seems very timely, considering that a recently published report by the WHO-UNICEF-
37
38 362 Lancet Commission highlights the importance and benefits of investing in children [30]. It is
39
40 363 noteworthy that fathers did not only observe changes in paternal behaviour, but also appreciated
41
42 364 changes in the availability of health services, e.g. the establishment of a health post in their
43
44 365 community.

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49 366 The responsibility of fathers for household finances and financing of care have been described
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51 367 in multiple previous studies [10, 11, 31-33]. This study coincided with these findings, but also
52
53 368 shed light on the burden that this responsibility brings when a child is ill. The reality described
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55 369 by fathers was that often resources were not available to finance health care costs, and that in
56
57 370 many cases fathers needed to borrow money again before having paid back their first debt. It
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2
3 371 appears to be a vicious circle in which particularly very poor fathers are placed, and
4
5 372 demonstrates the difficult situations that these families go through in times of sickness. It is
6
7 373 important to stress that both groups of fathers (highest and lowest socio-economic quintile)
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9 374 expressed concerns in arranging resources and money and would compare themselves with
10
11 375 better-off fathers. The comparisons expressed by these fathers therefore do not refer to a
12
13 376 comparison between the two socio-economic quintile groups in this study.
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18 377 The inability to arrange money to pay for health care costs can lead to involuntary delays in
19
20 378 care-seeking. The link between costs and delayed health care has been previously described in
21
22 379 the literature [34, 35]. These findings suggest that besides educating parents on danger signs
23
24 380 and when to seek care, it is very important to have health care infrastructure in place and health
25
26 381 facilities accessible to the communities. The Sustainable Development Goal 3.8 touches upon
27
28 382 this as it aims to “achieve universal health coverage, including financial risk protection [and]
29
30 383 access to quality essential health-care services (...)” [36]. In order to further improve maternal
31
32 384 and child health, health services should be made accessible to all, both physically and
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34 385 economically [37].
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39 386 In this study multiple fathers stated that they discuss and decide together with their wives on
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41 387 what to do when their child is sick. Nevertheless, many of these fathers still saw themselves as
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43 388 final decision-makers whose opinions should be adhered to. Literature supports that fathers
44
45 389 often are the decision-maker of the household [9, 11], which raises questions on the true
46
47 390 influence of mothers’ opinions on the decision-making processes. It is known that fathers play
48
49 391 an important role in a children’s development. Positive involvement of fathers can impact not
50
51 392 only children’s cognitive skills, but also their social competences and behavioural or emotional
52
53 393 outcomes [38-40]. This shows, together with fathers’ important role as decision-maker and
54
55 394 breadwinner in the care-seeking process, that there is a strong need for including fathers in
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57 395 future interventions aimed at improving maternal and child health. It is thereby crucial to
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3 396 consider that many fathers spend much of their time away from home because of their work.
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5 397 Interventions need to be formulated accordingly.
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8 398 Another interesting finding of this study was that fathers were not only involved in household
9
10 399 decision-making and finances, but were also directly in contact with the health system for their
11
12 400 children. Fathers were not only well aware of the different health providers available or
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14 401 accessible to them, but also described bringing the child to the health facility or accompanying
15
16 402 the mother. We did not come across a study that discussed similar findings.
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20 21 403 **STRENGTHS AND WEAKNESSES** 22

23 404 This study focussed on fathers of both low and high socioeconomic quintiles in order to
24
25 405 contribute to current literature as fathers remain underrepresented in child health research. We
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27 406 conducted interviews in the local language in Boloso Sore and Damot Gale but in Halaba we
28
29 407 overcame language diversity through use of a local interpreter. Two interviews in Halaba were
30
31 408 not finalised due to other obligations of the father. As these selected fathers have not been
32
33 409 replaced, some information was lost. However, due to the large number of interviews conducted
34
35 410 we have obtained sufficient information. Multiple findings of this study coincided with previous
36
37 411 literature. We thus assume that these findings are transferable to communities with similar
38
39 412 family structures and cultural contexts and health systems. Furthermore, a social desirability
40
41 413 bias (e.g. father claiming to be more involved in the care-seeking process than they actually
42
43 414 are) cannot be excluded with certainty in this study. Also, we did not conduct interviews with
44
45 415 mothers to check or confirm fathers' responses. Nevertheless, we aimed to mitigate the chances
46
47 416 of a desirability bias by using male interviewers. We therefore believe that the information
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49 417 provided does reflect their roles and perceptions well.
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57 58 59 419 **CONCLUSIONS** 60

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3 420 Fathers play an important role in the care-seeking process of their children. Not only do they
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5 421 have decision-making power and the financial responsibility, but they are also otherwise
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7 422 involved in the care-seeking process, such as arranging transportation or accompanying the
8
9 423 child at times to the facility. Fathers are familiar with the health services available to their
10
11 424 children and even noticed positive changes in the paternal involvement in childcare, as well as
12
13 425 availability of health services through the establishment of health posts in their communities.
14
15 426 Efforts need to be made to continue the observed positive trend in fathers' involvement in care
16
17 427 seeking described in this study. Future research on maternal and child health needs continue
18
19 428 considering and highlighting fathers' roles and responsibilities. The inability to organise
20
21 429 necessary resources for care can lead to involuntary delays in care-seeking for the child. It is
22
23 430 therefore crucial to continue strengthening health care systems and making health services more
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25 431 accessible to communities, both physically and financially.
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34 433 **ACKNOWLEDGEMENTS**

35
36 434 We thank the Federal Ministry of Health in Ethiopia, the Regional Health Bureau in
37
38 435 SNNPR (in particular, our technical advisor, Dr. Habtamu Beyene), and the woreda offices in
39
40 436 Damot Gale, Boloso Sore and Halaba. We extend our thanks to all fathers we interviewed for
41
42 437 granting us their time and being willing to share their experiences. Finally, we would like to
43
44 438 acknowledge Tesfahun Tadesse, Muluken Tamirat, Tessema Awano for conducting the
45
46 439 interviews and Ahmedin Alemu for functioning as interpreter.
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55 56 442 **FUNDING STATEMENT**

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3 443 This work was part of the Translating Research into Action (TRAction) and funded by the
4
5 444 President's Malaria Initiative and United States Agency for International Development
6
7 445 (USAID) under cooperative agreement No.GHS-A-00-09-00015-00.
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12 13 14 447 **COMPETING INTEREST**

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17 448 The authors declare that they have no competing interest.
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22 23 450 **AUTHORS' CONTRIBUTION**

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26 451 All authors were involved in conceiving and designing the study. TF, KK, TA and HMA
27
28 452 developed the study plan and formulated the interview guide. TF and AA were training the
29
30 453 interviewers and following the interview process. TF and HMA analysed the interviews. TF
31
32 454 wrote the paper together with all other authors. All authors read and approved the final version
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34 455 of this paper.
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44 45 457 **DATA SHARING STATEMENT**

46
47 458 All relevant data for this study are included in this paper. To protect the anonymity of our
48
49 459 respondents, full transcripts will not be provided.
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66 67 463 **REFERENCES**

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COREQ (CONsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

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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

Journal:	<i>BMJ Open</i>
Manuscript ID	bmjopen-2020-038932.R2
Article Type:	Original research
Date Submitted by the Author:	03-Jul-2020
Complete List of Authors:	Funk, Tjede; Karolinska Institute, Global Public Health Källander, Karin; Karolinska Institutet, Department of Global Public Health Abebe, Ayalkibet; Malaria Consortium Alfvén, Tobias ; Karolinska Institute, Department of Global Public Health Alvesson, Helle; Karolinska Institute, Department of Global Public Health
Primary Subject Heading:	Global health
Secondary Subject Heading:	Global health, Qualitative research
Keywords:	Community child health < PAEDIATRICS, QUALITATIVE RESEARCH, PUBLIC HEALTH

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12 4 Tjede Funk^{1*}, Karin Källander^{1,2,3}, Ayalkibet Abebe⁴, Tobias Alfvén^{1,5#}, Helle Mølsted
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21 7 1 Department of Global Public Health, Karolinska Institute, Stockholm, Sweden

22 8 2 Malaria Consortium, London, United Kingdom

23 9 3 UNICEF, New York, USA

24 10 4 Malaria Consortium, Addis Ababa, Ethiopia

25 11 5 Sachs’ Children and Youth Hospital, Stockholm South General Hospital, Stockholm,
26 12 Sweden
27

28 13 # These authors have contributed equally to this work
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32 14 * Corresponding author: Email: tjede.funk@ki.se
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38 15 Key words: Fathers, Child, Care-seeking, Ethiopia, Qualitative Research
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3 18 **ABSTRACT**
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6 19 **Objectives:** Fathers play an important role in household decision making processes and child
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8 20 health development. Nevertheless, they are underrepresented in child health research, especially
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10 21 in low-income settings. Little is known about what roles fathers play in the care seeking
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12 22 processes or how they interact with the health system when their child is sick. This study aimed
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14 23 to understand Ethiopian fathers' roles and responsibilities in caring for their children when they
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16 24 are or become ill.
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21 25 **Design:** Qualitative study using semi-structured interviews with fathers.
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24 26 **Setting:** This study was conducted in three rural districts of the Southern Nations, Nationalities
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26 27 and People's Region of Ethiopia.
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29 28 **Participants:** Twenty-four fathers who had at least one child between 2 and 59 months who
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31 29 visited a health extension worker with fever.
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34 30 **Results:** The overarching theme was "Changing perceptions of paternal responsibilities during
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36 31 children's ill health". It constituted three sub-themes, namely "Fathers' burden of earning
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38 32 money for care", "Fatherhood entails advocating children's health care needs" and "Investing
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40 33 in children's health can benefit the family in the future". Fathers described that they were the
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42 34 ones mainly responsible for the financial arrangement of care and that this financial
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44 35 responsibility can involve stress when resources are scarce. Fathers knew what health services
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46 36 were available and accessible to them and were involved in different ways in the care-seeking
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48 37 of the child. Changes in the importance ascribed to child health were expressed by fathers who
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50 38 described being more alert to children's ill-health.
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56 39 **Conclusion:** Fathers play various roles in the care-seeking process during children's illness
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58 40 episodes. This included for instance arranging resources to seek care, (co-)deciding where to
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3 41 seek care as well as accompanying the child to the health facility. The inability to organise
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5 42 necessary resources for care can lead to involuntary delays in care-seeking for the child. This
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7 43 demonstrates the importance of including fathers in future interventions on maternal and child
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9 44 health.

10 11 12 13 45 14 15 16 46 **STRENGTH AND LIMITATIONS OF THE STUDY**

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19 47 • This study distinguishes itself from others by only focusing on fathers and their
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21 48 perceived roles and responsibilities in the care seeking for sick children, which is an
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23 49 underrepresented area in child health research.
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26 50 • This study used a nested stratified sample and included 24 fathers from highest and
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28 51 lowest socio-economic quintiles and with few (1-2) or many children (3+) in order to
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30 52 provide rich information.
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33 53 • We sought to mitigate a social desirability bias by having the interviews conducted by
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35 54 male interviewers in two local languages.
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38 55 • We did not conduct interviews with mothers to confirm the fathers' responses.

39 40 41 56 42 43 44 57 **INTRODUCTION**

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47 58 Annually approximately 5.3 million children die worldwide before reaching their fifth birthday.
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49 59 Most of these deaths occur following the neonatal period and are caused by diseases such as
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51 60 malaria, pneumonia and diarrhoea [1]. It is further estimated that malnutrition contributes to
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53 61 almost half of child deaths under the age of five and that many of the childhood deaths could
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55 62 have been prevented with simple, effective and available interventions [1]. Nevertheless,
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57 63 caregivers of sick children in poor communities often face obstacles in seeking healthcare, such
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64 as lack of money or distance to the care facility [2, 3]. Evidence from Ethiopia shows that only
65 35% of children with fever and 44% of children with diarrhoea in the previous two weeks were
66 brought for treatment [4].

67 Decision making processes regarding child health care are complex. Although mothers have
68 historically been seen as responsible for their children and their health, multiple studies from
69 low-resource settings show that women, as compared to men, have relatively low decision-
70 making power when it comes to health care decisions for themselves and their children [5-8].
71 A study from The Gambia [9] states that mothers decided when to take the child to the hospital
72 for cerebral malaria in only around 7% of the cases. Other studies confirm that it is mainly the
73 father who makes the final call on where and when to seek health care [9-11].

74 The important role of fathers in child health and development is becoming better understood
75 and appreciated. Literature shows that involved fathers are associated with different positive
76 outcomes, such as knowledge of newborn danger signs among mothers, skilled birth and
77 attendance of antenatal care visits [12-14]. Some countries have therefore started to address the
78 involvement of fathers in their road maps to reduce maternal and child morbidity and mortality
79 [15, 16]. Yet, in low-and middle-income countries only a minority of fathers has been said to
80 be engaged with their children [17]. Yet different forms of engagement and types of fathers
81 exist. In a study conducted in Ethiopia, fathers were categorised into three different groups,
82 depending on their perceptions, practices, and challenges towards routine child care and feeding
83 [18]: 1) Traditional fathers who “do not feel part of routine child care, and they fully believe
84 child care is only the mothers’ responsibility”; 2) Transitional fathers who “perceive child care
85 as being both the mothers’ and fathers’ responsibility”, but under different conditions (e.g.
86 availability of the father or occupied mother), meaning the father does not completely feel
87 responsible for child care and 3) Modern fathers who “perceive child care and child feeding as
88 a shared responsibility between mother and father” and who are totally involved in their child’s

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3 89 life. This indicates that not all fathers are alike and that differences in their roles can exist
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5 90 between them.
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8 91 A number of studies from Africa have shown that fathers are often the main decision-maker or
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10 92 breadwinner of the family and responsible to pay for healthcare costs [10, 11]. Yet little is
11
12 93 known otherwise about what roles they take on in the care seeking process for their children or
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14 94 how fathers interact with the health system when their children are sick. Therefore, this study
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16 95 aims to understand fathers' roles and responsibilities in care-seeking for children in rural areas
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18 96 of the Southern Nations, Nationalities and People's Region in Ethiopia.
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24 25 26 98 **MATERIALS AND METHODS**

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29 99 The reporting of the methods has been guided by the criteria for reporting qualitative research
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31 100 (COREQ) guidelines [19].
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35 36 37 102 **Setting**

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40 103 The interviews were conducted in Damot Gale, Boloso Sore and Halaba Special Woreda, three
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42 104 *woredas* (districts) of the Southern Nations, Nationalities and People's Region (SNNPR) of
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44 105 Ethiopia. The population of Ethiopia, similar to these three *woredas*, is predominantly (~80%)
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46 106 living in rural areas. SNNPR is a very ethnically diverse region, inhabited by more than 80
47
48 107 different ethnic groups. To improve primary health care services in the country, particular in
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50 108 rural areas, Ethiopia has been implementing a health extension program since 2003 [20].
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52 109 Central to the program are health extension workers (HEW) who are trained for 12-months and
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54 110 subsequently employed by the government to work in health posts directly in and with the
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56 111 community [20, 21]. HEWs are women with at least a grade 10 education. Typically two HEWs
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3 112 are assigned to one health post, serving an estimate of 3,000 - 5,000 people [20, 21]. HEW
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5 113 provide key health promotion and prevention services, as well as a selection of curative
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7 114 services; all services are free of charge [21, 22]. Although health posts are placed directly in a
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10 115 community, travel distances can vary from a walking distance of a few minutes to an hour or
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12 116 more [23]. At the time of this study there were 150 health posts in the study area with a total of
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14 117 284 HEW.

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16
17 118 Child mortality rates in Ethiopia have been decreasing over the years and currently stand at 55.2
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19 119 per 1000 live births, with mortality rates in SNNPR higher than the national average [4, 24].
20
21 120 Traditional gender roles persist, particularly in rural areas, with a minority of women reporting
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23 121 having the right to decide on their first marriage and having their husband help with household
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25 122 chores. Around 40% use modern contraceptives including sterilisation, contraceptive pills,
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27 123 condoms and implants, and even fewer, less than 30%, give birth in a health facility [4].
28
29 124 Twenty-eight per cent of women and 73% of men age 15-49 in the region work within the
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38 39 40 127 **Study design and data collection**

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43 128 This qualitative study was nested within a community-based cluster randomised controlled non-
44
45 129 inferiority trial (cRCT). The design and results of this trial are published elsewhere, as is the
46
47 130 qualitative evaluation of HEW's and caregivers' perception of the recommendations [25-27].

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51 131 For this study, twenty-four semi-structured interviews were conducted with fathers who had at
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53 132 least one child aged 2 to 59 months presenting to the HEW with fever. Half of the interviews
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55 133 (n=12) were conducted in Halaba *woreda*, eight in Boloso Sore and four in Damot Gale. Boloso
56
57 134 Sore and Damot Gale are culturally and linguistically similar which is why they together
58
59
60 135 represent half of the fathers interviewed.

1
2
3 136 The sampling method was based on the assumption that health seeking practices and fathers'
4
5 137 decision-making power could differ by socio-economic position and number of children. We
6
7 138 therefore used stratified sampling to select half of the fathers from the lowest and the other half
8
9
10 139 from the highest socio-economic quintile. Socio-economic quintiles were based on caregivers'
11
12 140 responses to questions about household assets, e.g. material of the house, toilet facility used,
13
14 141 availability of TV/radio or electricity in general. It should be kept in mind that a high socio-
15
16 142 economic quintile in this study is not equivalent to a high socio-economic status. Fathers in the
17
18 143 high socio-economic quintile can still be considered poor. Within the two strata, fathers with
19
20 144 few children (1-2) and fathers with multiple children (3 or more) were invited for an interview
21
22 145 to maximise the level of heterogeneity among the fathers. However, the information on number
23
24 146 of children reported in the cRCT did not always tally with the number of children mentioned
25
26 147 by the father during the interview, which is why most fathers (n=19/24) in this study had three
27
28 148 or more children. Once the father was randomly selected within each stratum, contact was
29
30 149 established through the HEW and fathers were personally visited in their community. When
31
32 150 fathers were not at home, contact was established via phone or with help of the HEW in the
33
34 151 community. Fathers were asked whether they would be willing to participate in the study. All
35
36 152 24 fathers agreed to participate, but two were not able complete the interview due to time
37
38 153 constrains.
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44

45 154 An interview guide was developed informed by literature on health care seeking and gender
46
47 155 roles. It started with introductory questions about the father and the household to explore
48
49 156 fathers' educational background, profession and family composition. While this part was rather
50
51 157 structured, the interview guide then followed with open ended questions regarding fathers'
52
53 158 practices on the following issues: seeking advice or discussing health matters with other family
54
55 159 or community members; fever in children and fathers' understanding of fever; fathers'
56
57 160 knowledge on health providers in the community; their decision-making around health services
58
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1
2
3 161 and drivers that influenced their seeking health care. The interview ended with asking fathers
4
5 162 to compare care-seeking between different households and changes in practices and roles of
6
7 163 fathers over time. The interview guide was prepared in English and subsequently translated into
8
9
10 164 Amharic.

11
12
13 165 Three male interviewers conducted the interviews, two in Boloso Sore and Damot Gale and one
14
15 166 in Halaba. The interviewers were selected based on their experience in qualitative research,
16
17 167 English proficiency, and educational background in health sciences. In Halaba, a male
18
19 168 interpreter was recruited for translations from Amharic to Halabigna (local language of Halaba)
20
21
22 169 as the interviewer was not familiar with the local language. In Boloso Sore and Damot Gale
23
24 170 interviews were conducted in Wolaitegna by two interviewers who were from the district and
25
26
27 171 thus familiar with the area and language. No interviewer met the fathers before the conduction
28
29 172 of the interviews.

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31
32 173 All interviewers and the interpreter received a half-day training from authors TF and AA. The
33
34 174 training provided insights into the research background, the aim of the study and the sampling
35
36 175 of fathers. In addition, the interview procedure was thoroughly explained and the interview
37
38 176 guide and all questions were reviewed and discussed in detail. The importance of probing and
39
40 177 non-leading questions was emphasized. At the end of the training, any remaining language
41
42
43 178 issues were addressed as the interview guide was prepared in Amharic but the interviews were
44
45
46 179 conducted in the local language. After the training, every interviewer conducted one pilot
47
48 180 interview and changes to the interview guide were made accordingly. Based on the pilot
49
50 181 interviews, interviewers received oral feedback on how to improve their interviewing and the
51
52 182 purpose of certain questions was repeated in order to improve the direction of their probing
53
54
55 183 questions.

184 The interviews were conducted in March 2017 and took between 34 and 70 minutes, with
 185 interviews using an interpreter taking longer. All interviews were conducted in a quiet place
 186 outside; the majority took place close to the father's home. Fathers were aged between 20 and
 187 50 years and the number of children ranged between one and fourteen (see Table 1). In Halaba,
 188 multiple fathers had two wives. The majority of fathers were farmers.

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

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197 **Table 1 Characteristics of study participants**

ID	Age	Woreda	Socio-economic quintile	Reported number of children	Language interview was conducted in*	Length of interview (in 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

198

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

±Interview was not completed

200 Ethical approval

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

206 Patient and public involvement

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

209

210 **Data analysis**

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

224

225

226 **RESULTS**

227 Three sub-themes emerged from the data: 1) Fathers' burden of earning money for care, 2)
228 Fatherhood entails advocating children's health care needs, and 3) Investing in children's health
229 can benefit the family in the future. The results are presented according to these themes and fed
230 into the overarching theme of "Changing perceptions of paternal responsibilities during
231 children's ill health".

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3 233 **Fathers' burden of earning money for care**
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6 234 Fathers described their roles and responsibilities in care-seeking for children mostly in terms of
7
8 235 financial responsibilities. They explained that their main role as father was to work and earn
9
10 236 money to be able to finance health care costs and, when necessary, transportation to the facility.
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12
13 237 Fathers felt strongly that “*money matters*” when it comes to seeking care for children.
14
15 238 Nevertheless, it was explained that they often did not have the necessary resources at hand to
16
17 239 finance health care costs. This was expressed by fathers from both socio-economic strata,
18
19 240 lowest and highest socio-economic quintile. Most fathers interviewed mentioned that health
20
21 241 care costs are financed through work or selling goods, animals or land. When not enough money
22
23 242 could be arranged, fathers would make other arrangements, such as borrowing money to pay
24
25 243 for health care costs. Fathers would either borrow money through *idir* [a financial community
26
27 244 support system where members can regularly contribute small amounts of money and in return
28
29 245 are able to borrow some money in case of need] or from family and friends. Mothers were often,
30
31 246 but not always, described as not having their own income source that could contribute to health
32
33 247 care expenses. Furthermore, mothers generally were described as having difficulties in
34
35 248 borrowing money as even though they would try to obtain a loan, they would often not receive
36
37 249 one [from *idir*]. Consequently, the burden on arranging resources for treatment was, according
38
39 250 to the fathers, mainly placed on them. The financial stress that fathers experience was described
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41 251 by this father:
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48 252 *We have idir where we save some amount of money regularly. I have to pay back the money*
49
50 253 *within 10 to 15 days. In case they don't allow me [to borrow money] due to some*
51
52 254 *inconveniences, I borrow from friends, relatives, particularly from my grandmother. But the*
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54 255 *reality is that I borrow again before I paid back the first loan. (ID 8; lowest socio-economic*
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56 256 *quintile; 3+ children)*
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3 257 One father also emphasised that it was easier for fathers with a better financial situation to
4
5 258 borrow money compared to fathers with few resources, which further emphasised the financial
6
7 259 worries that fathers were faced with.
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10
11 260 *The father with better financial resources can take his children to health providers easily. Even*
12
13 261 *if he doesn't have the money, he can borrow it easily because people believe that he can pay it*
14
15 262 *back. But if the poor wants to borrow money from friends or other people, people are not happy*
16
17 263 *to give him [money] because they are wondering 'from where is he going to pay me back?' (ID*
18
19 264 *4; lowest socio-economic quintile; 3+ children)*
20
21
22

23 265 In addition, fathers also mentioned that care-seeking for their child can be delayed if they have
24
25 266 no money at hand, and sometimes it could take several days to find the necessary resources to
26
27 267 finance health care costs. Consequently, it was expressed that even if a father wanted to seek
28
29 268 care immediately, this was not always possible. Fathers from both socio-economic strata
30
31 269 mentioned such financial worries and constraints.
32
33
34

35 270 *[...] if we go to [name of] hospital, we may pay up to 1000 birr (~36 USD). Even if we only*
36
37 271 *stay one night there, they charge us 700 up to 800 birr (~25-30 USD). The more we stay there,*
38
39 272 *the more money we are expected to pay. If we don't have money, we are left with staying home*
40
41 273 *with the sick child and praying to God. (ID 15; lowest socio-economic quintile; 3+ children)*
42
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48 275 **Fatherhood entails advocating children's health care needs**

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51 276 Fathers were well aware of the different health services available to their children, whether it
52
53 277 was the health post, health centre, private or traditional providers. They stated that they
54
55 278 discussed with their wives on what actions to take and where to take the child when it is sick.
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3 279 However, many of them still saw themselves as the ultimate decision maker whose suggestion
4
5 280 will be followed.
6
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8
9 281 *Since I bear more responsibility as father on my family's affairs, it is my decision that needs to*
10
11 282 *be adhered to. Since she [wife] doesn't have an income generating work and we solely depend*
12
13 283 *on the income I get, it is me who decides over issues. (ID 15; lowest socio-economic quintile;*
14
15 284 *3+ children)*
16
17

18
19 285 Different factors can influence the choice as to which provider a child is taken. The type of
20
21 286 illness the child has can be such a factor. When the child was suspected of having a bone fracture
22
23 287 or a dislocation, multiple fathers explained that traditional healers also referred to as "*bone*
24
25 288 *setter*" are the first choice of treatment. If the traditional treatment is not effective, other sources
26
27 289 of treatment will be sought. For other types of illnesses, a father would directly take the child
28
29 290 to a different health provider, such as the health post.
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33 291 Money was also explained to be a decisive factor in the care-seeking process. According to
34
35 292 fathers the availability of money and resources provides a freedom in choosing a health provider
36
37 293 for the child's health condition. This freedom is constrained if resources are scarce.
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41 294 *Rich [people] take sick children directly to hospital. But since poor [people] have no money,*
42
43 295 *they take [the child] to the health post. They only take [the child] to the hospital when its*
44
45 296 *condition is life threatening. (ID 8)*
46
47

48
49 297 Multiple fathers seemed to prefer the health centre over the health post, because more and better
50
51 298 treatment was believed to be available there. It was stressed that the general perception is that
52
53 299 treatment was better in urban areas and also faster at private providers, though private providers
54
55 300 were expensive and described as business-oriented. Nevertheless, if the money was available,
56
57 301 some fathers still preferred private services over public facilities. Fathers observed a formal
58
59 302 care chain (or "*hierarchy*") in health care. They described that health centres expected them to
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1
2
3 303 have a referral slip from the health post, making it harder for them to directly access treatment
4
5 304 at the health centre. This was seen as an obstacle in seeking care.
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7

8 305 The responsibility for bringing or accompanying a sick child for treatment was unclear.
9
10 306 Bringing the child to a health post for treatment was first seen as being a responsibility of the
11
12 307 mother. Mothers were described to be responsible for bringing the children who were breastfed
13
14 308 to the health provider, whereas fathers claimed to rather accompany older children that could
15
16 309 walk or sit on a motorcycle to the health provider. Whether or not a father brought or
17
18 310 accompanied a child to a health facility also depended on the health facility in question. One
19
20 311 father explained that the mother sought care at the health post alone, but fathers needed to be
21
22 312 consulted to seek care at the health centre or higher-level facilities, often implying more severe
23
24 313 illnesses and higher costs.
25
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30 314 *When the mother notices that the child is sick, she takes her [the child] to health post. If the*
31
32 315 *health post advises her [the mother] to take the child to the health centre [i.e. refers the child*
33
34 316 *as the health problem is not identified or manageable at community level], she returns back*
35
36 317 *and waits for my return. After I return back to home, we together take the child to the health*
37
38 318 *centre together. (ID 15; lowest socio-economic quintile; 3+ children)*
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42 319 If the child needed to stay at the hospital, a father described it as his role to stay with the child.
43
44 320 In addition, the arrangement of the transportation to the health facility was, according to some
45
46 321 fathers, also their role.
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50 322 **Investing in children's health can benefit the family in the future**

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52
53 323 Behaviours of fathers with regards to seeking care for children has changed over time. It was
54
55 324 explained that fathers today are more involved in child health matters compared to the past and
56
57 325 that they do not leave this issue entirely up to the mothers anymore. Fathers stated being more
58
59 326 alert about changes in health status of their children and that they will not rely only on faith to
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3 327 cure the child.
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6 328 *I can say that the love I have to my children is stronger than the mother's love. Due to that*
7
8 329 *reason, I also closely follow their [the children's] health situation. (ID 4; lowest socio-*
9
10 330 *economic quintile; 3+ children)*
11
12

13
14 331 A couple of fathers pointed out the value that children have and can bring in the future, for
15
16 332 instance through working and supporting the family financially. Consequently, fathers stated
17
18 333 they paid more attention to their child's health status and made sure that they recovered.
19
20

21 334 *In past time, there were widely held assumptions among fathers that a child will grow by his*
22
23 335 *fate so that no worries are needed. But this belief is changing as those sons and daughters that*
24
25 336 *work at urban centres and abroad send [money] and augment their family's income. Children*
26
27 337 *now are believed to be assets and obtain great care. So fathers are alert whenever they observe*
28
29 338 *changes in their children's health. (ID 18; highest socio-economic quintile; 3+ children)*
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33
34 339 Fathers also observed changes in the health services over time. They noticed that health posts
35
36 340 that are now existing in their community were not available in the past.
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41 343 **DISCUSSION**

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47 344 This study indicates that fathers are involved in the care-seeking of their sick child in different
48
49 345 ways. This includes bearing the main responsibility for arranging financial resources to enable
50
51 346 a health care visit and this responsibility can imply stress and financial concerns when resources
52
53 347 are scarce. Fathers are well aware of the health services available to their children and they
54
55 348 described being involved in the care-seeking process in different ways, e.g. (co-)deciding where
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57 349 to take the child or accompanying their child to the health facility. Fathers explained that
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3 350 changes in fathers' perception on children and their involvement have taken place. They
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5 351 described themselves being more aware of the health status of their children and more involved
6
7 352 in child health matters compared to the past.
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10
11 353 This transitional change in fathers' perceptions of their children has been described in another
12
13 354 study conducted in Ethiopia [29]. Multiple fathers interviewed in this study would fit into the
14
15 355 "transitional fathers" category. According to them, child health issues are not seen as only a
16
17 356 task of the mother anymore. It seems as if these fathers acknowledge these responsibilities as
18
19 357 being part of their role as father. The findings of this study show that not all fathers take on the
20
21 358 same roles in care-seeking for children. This suggests that roles in these rural areas are changing
22
23 359 and that with continuous country efforts, fathers' roles as caregiver could be strengthened.
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28 360 Also, the phrasing of the last theme "Investing in children's health can benefit family in the
29
30 361 future" seems very timely, considering that a recently published report by the WHO-UNICEF-
31
32 362 Lancet Commission highlights the importance and benefits of investing in children [30]. It is
33
34 363 noteworthy that fathers did not only observe changes in paternal behaviour, but also appreciated
35
36 364 changes in the availability of health services, e.g. the establishment of a health post in their
37
38 365 community.
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42
43 366 The responsibility of fathers for household finances and financing of care have been described
44
45 367 in multiple previous studies [10, 11, 31-33]. This study coincided with these findings, but also
46
47 368 shed light on the burden that this responsibility brings when a child is ill. The reality described
48
49 369 by fathers was that often resources were not available to finance health care costs, and that in
50
51 370 many cases fathers needed to borrow money again before having paid back their first debt. It
52
53 371 appears to be a vicious circle in which particularly very poor fathers are placed, and
54
55 372 demonstrates the difficult situations that these families go through in times of sickness. It is
56
57 373 important to stress that both groups of fathers (highest and lowest socio-economic quintile)
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3 374 expressed concerns in arranging resources and money and would compare themselves with
4
5 375 better-off fathers. The comparisons expressed by these fathers therefore do not refer to a
6
7 376 comparison between the two socio-economic quintile groups in this study.
8
9

10
11 377 The inability to arrange money to pay for health care costs can lead to involuntary delays in
12
13 378 care-seeking. The link between costs and delayed health care has been previously described in
14
15 379 the literature [34, 35]. These findings suggest that besides educating parents on danger signs
16
17 380 and when to seek care, it is very important to have health care infrastructure in place and health
18
19 381 facilities accessible to the communities. The Sustainable Development Goal 3.8 touches upon
20
21 382 this as it aims to “achieve universal health coverage, including financial risk protection [and]
22
23 383 access to quality essential health-care services (...)” [36]. In order to further improve maternal
24
25 384 and child health, health services should be made accessible to all, both physically and
26
27 385 economically [37].
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31
32 386 In this study multiple fathers stated that they discuss and decide together with their wives on
33
34 387 what to do when their child is sick. Nevertheless, many of these fathers still saw themselves as
35
36 388 final decision-makers whose opinions should be adhered to. Literature supports that fathers
37
38 389 often are the decision-maker of the household [9, 11], which raises questions on the true
39
40 390 influence of mothers’ opinions on the decision-making processes. It is known that fathers play
41
42 391 an important role in a children’s development. Positive involvement of fathers can impact not
43
44 392 only children’s cognitive skills, but also their social competences and behavioural or emotional
45
46 393 outcomes [38-40]. This shows, together with fathers’ important role as decision-maker and
47
48 394 breadwinner in the care-seeking process, that there is a strong need for including fathers in
49
50 395 future interventions aimed at improving maternal and child health. It is thereby crucial to
51
52 396 consider that many fathers spend much of their time away from home because of their work.
53
54 397 Interventions need to be formulated accordingly.
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3 398 Another interesting finding of this study was that fathers were not only involved in household
4
5 399 decision-making and finances, but were also directly in contact with the health system for their
6
7 400 children. Fathers were not only well aware of the different health providers available or
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9 401 accessible to them, but also described bringing the child to the health facility or accompanying
10
11 402 the mother. We did not come across a study that discussed similar findings.
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14

15 403 **STRENGTHS AND WEAKNESSES**

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17
18 404 This study focussed on fathers of both low and high socioeconomic quintiles in order to
19
20 405 contribute to current literature as fathers remain underrepresented in child health research. We
21
22 406 conducted interviews in the local language in Boloso Sore and Damot Gale but in Halaba we
23
24 407 overcame language diversity through use of a local interpreter. Two interviews in Halaba were
25
26 408 not finalised due to other obligations of the father. As these selected fathers have not been
27
28 409 replaced, some information was lost. However, due to the large number of interviews conducted
29
30 410 we have obtained sufficient information. Multiple findings of this study coincided with previous
31
32 411 literature. We thus assume that these findings are transferable to communities with similar
33
34 412 family structures and cultural contexts and health systems. Furthermore, a social desirability
35
36 413 bias (e.g. father claiming to be more involved in the care-seeking process than they actually
37
38 414 are) cannot be excluded with certainty in this study. Also, we did not conduct interviews with
39
40 415 mothers to check or confirm fathers' responses. Nevertheless, we aimed to mitigate the chances
41
42 416 of a desirability bias by using male interviewers. We therefore believe that the information
43
44 417 provided does reflect their roles and perceptions well.
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52 53 419 **CONCLUSIONS**

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56 420 Fathers play an important role in the care-seeking process of their children. Not only do they
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58 421 have decision-making power and the financial responsibility, but they are also otherwise
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3 422 involved in the care-seeking process, such as arranging transportation or accompanying the
4
5 423 child at times to the facility. Fathers are familiar with the health services available to their
6
7 424 children and even noticed positive changes in the paternal involvement in childcare, as well as
8
9 425 availability of health services through the establishment of health posts in their communities.
10
11 426 Efforts need to be made to continue the observed positive trend in fathers' involvement in care
12
13 427 seeking described in this study. Future research on maternal and child health needs continue
14
15 428 considering and highlighting fathers' roles and responsibilities. The inability to organise
16
17 429 necessary resources for care can lead to involuntary delays in care-seeking for the child. It is
18
19 430 therefore crucial to continue strengthening health care systems and making health services more
20
21 431 accessible to communities, both physically and financially.
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29 433 **ACKNOWLEDGEMENTS**

30
31
32 434 We thank the Federal Ministry of Health in Ethiopia, the Regional Health Bureau in
33
34 435 SNNPR (in particular, our technical advisor, Dr. Habtamu Beyene), and the woreda offices in
35
36 436 Damot Gale, Boloso Sore and Halaba. We extend our thanks to all fathers we interviewed for
37
38 437 granting us their time and being willing to share their experiences. Finally, we would like to
39
40 438 acknowledge Tesfahun Tadesse, Muluken Tamirat, Tessema Awano for conducting the
41
42 439 interviews and Ahmedin Alemu for functioning as interpreter.
43
44
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47 440
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49 441
50

51 442 **FUNDING STATEMENT**

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54
55 443 This work was part of the Translating Research into Action (TRAction) and funded by the
56
57 444 President's Malaria Initiative and United States Agency for International Development
58
59 445 (USAID) under cooperative agreement No.GHS-A-00-09-00015-00.
60

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3 446
4
56 447 **COMPETING INTEREST**
7
89 448 The authors declare that they have no competing interest.
10
1112 449
13
1415 450 **AUTHORS' CONTRIBUTION**
16
17

18 451 All authors were involved in conceiving and designing the study. TF, KK, TA and HMA
19 452 developed the study plan and formulated the interview guide. TF and AA were training the
20 453 interviewers and following the interview process. TF and HMA analysed the interviews. TF
21 454 wrote the paper together with all other authors. All authors read and approved the final version
22 455 of this paper.

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3334 457 **DATA SHARING STATEMENT**
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37 458 All relevant data for this study are included in this paper. To protect the anonymity of our
38 459 respondents, full transcripts will not be provided.

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For peer review only

COREQ (CONsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.