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Fathers' involvement in the healthcare of their children: a descriptive study in southwest Nigeria

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Abstract

Objective This study aims at determining why fathers do not follow their children to the clinic or hospital and exploring the factors that will promote father's participation in healthcare of their children.

Design Descriptive cross-sectional study.

Setting Community (Sagamu township of Sagamu Local Government Area of Ogun State {LGA}, Nigeria).

Participants All fathers ≥ 18 years that have ever had children, selected from 3 wards in Sagamu township of Sagamu LGA.

Results A total of 416 fathers participated in the study. The mean age of participants was 42.0 ± 12.7 years. Forty-four-point five percent (44.5%) had secondary education, while 36.6% were unskilled workers. Forty-two-point three percent (42.3%) said it is a woman's job to take children to the hospital, while about half of the respondents said following a child to the hospital is time-consuming. About 2/3rd of the participants said waiting time in the hospital is too long, while 53.6% will rather go in search of money than go with a child to the hospital. Thirty-nine-point nine percent will need paternity leave to be more involved.

Conclusion The major individual factors influencing father's involvement in the healthcare of their children in this study are semi-skilled occupation, marital status, and work schedule. Majority do not think paternity leave is required before fathers can be involved in the healthcare of their children. Intensive health education by healthcare practitioners will improve male participation in children's health.

Keywords Father's involvement, Healthcare, Children

Background

Male involvement in maternal and child health issues has been at the forefront of discussions and programmatic actions with conscious efforts at highlighting its several benefits and desirable outcomes [1, 2]. All through antenatal period, delivery, newborn care until school age, the importance of fathers' involvement, or that of other significant males in healthcare is well reported in literature [3, 4].

Over the years, the involvement of fathers in child-rearing has traditionally been framed as the role of "provider," [5] having almost nothing to do with other

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aspects of care and wellbeing of children [6, 7]. In recent times, there has been an increased interest in the role of fathers in the care and development of their children, with emphasis on their long-term health and psychosocial wellbeing [8]. Researchers have reported the increasing evidence and advantages for improved involvement of fathers and other significant male figures in child care and upbringing [9–12]. The result of such studies has resulted in modification of practices making it possible for fathers to take family leave to support their bonding and attachment to their children [12].

In terms of child health, the natural roles of the family are provision of food, provision of a safe environment, provision of a means of preventing infections and diseases, provision of access to healthcare services when necessary, and supporting the woman of the house to fulfil her own roles such as giving support to the wife in breastfeeding their infants appropriately. By implication, ready access to adequate nutrition and safe water, clean and safe environment, and ready access to health services will promote child health and prevent childhood diseases and deaths. The traditional family setting in Nigeria is one in which the father has the authority and takes most decisions for the family. The father needs to be gainfully employed in order to have enough funds to fund healthcare seeking for his family [6, 7]. The role of the man is in determining care seeking, translating to delays, and increasing the risk of morbidities and mortality.

In Nigeria, although the fathers are rarely available when the children present at any clinic, they are the ones that often dictate the uptake of treatment of any child whether available at the time this is prescribed or not. Some of the factors that have been found to affect fathers' involvement in healthcare of their children include inconvenient office hours, lack of time away from work beyond newborn period, and nature of employment [12].

Understanding the nature and effect of fathers' involvement on the health and well-being of children could help inform policies aimed at improving family psychological and health outcomes [5]. Most of the studies on the involvement of men or fathers in child's health in sub-Saharan Africa including Nigeria are focused mainly on family-based HIV prevention and reproductive, maternal, and child health intervention [5]. There have been very little documented findings on father's involvement in child health from low- and middle-income countries, including Nigeria [9].

This study is aimed at determining the pattern of involvement of Nigerian fathers in healthcare seeking for their children and the associated factors.

Methods

A descriptive cross-sectional study was carried out among fathers in Sagamu township of Sagamu Local Government Area (LGA). Sagamu LGA comprises twenty geopolitical wards from which representative councilors are elected. The study population comprised of fathers aged ≥ 18 years that have ever had children, fully resident in Sagamu and were willing to participate in the study. Sample size was calculated to be 412 using Fisher's formula.

A multistage sampling technique was used for the selection of study participants. The first stage involved the selection of three wards out of the existing 10 wards in Sagamu township of Sagamu Local Government Area by simple random sampling. This was followed by the selection of streets from the preselected wards. Three streets were then selected from each preselected ward, also using simple random sampling technique. The next stage involved selection of houses from the earlier selected streets by systematic sampling, following determination of an appropriate sampling interval. One household was selected in each house, and the father was recruited into the study. Where more than one household lived in one house, the final selection of the study participant was by simple random sampling. Data was collected using a self-administered pretested questionnaire designed purposely for the study. The questionnaire was divided into two sections: section A obtained information on the sociodemographic characteristics of participants; section B obtained information on the attitude of the fathers to attending hospitals with their children. Ethical approval was obtained from HREC-OOUTH with approval certificate number 362/2020AP. Participation was fully voluntary. Written informed consent was obtained from study participants prior to onset of data collection.

Data was saved into personal computer and analyzed using SPSS version 23. Descriptive statistics were calculated and reported as frequencies, proportion means, and standard deviation. Association between categorical variables was carried out using chi-square test as well as Fisher's exact test with level of significance (p) set at ≤ 0.05 .

Attitudinal score was calculated with a total of 50 points. A score below 25 was regarded as poor, while those above 25 were regarded as good. Participants were thus dichotomized based on the score following which inferential statistics were calculated.

Results

A total of 416 fathers participated in the study. The mean age was 42.0 ± 12.7 years; age ranged from 23 to 90 years. The most common age group was 50 years and above,

constituting 159 (38.2%). One-hundred and sixty (38.5%) respondents were semiskilled workers, while 151 people (36.3%) were unskilled. Educational status of the fathers in the study was mostly secondary education 185 (44.5%) and tertiary education constituting 110 (26.4%). More than two-thirds of the participants were married, 284 (68.3%) had one wife, and 303 (72.8%) had between 0 and 4 children (see Table 1).

Ever gone to the hospital with the child was significantly associated with sociodemographic characteristics of respondents such as semiskilled occupational status ($\chi^2=8.030$, p -value=0.045) and being participants ($\chi^2=13.450$, p -value=0.009) only.

The children of more than two-thirds of the participants had been admitted before.

One-hundred and seventy-six (42.3%) of participants said it is a woman's job to take a sick child to the hospital, and 223 (53.6%) said a man ought to go in search of money rather than accompanying a sick child to the hospital (see Table 2).

Three-hundred and three (72.8%) had good attitude, while 113 (27.2%) had poor attitude. There was no statistically significant association between attitude and demographic characteristics (see Table 3).

There was significant statistical association between ever gone to the hospital with your child and ever admitted into the hospital in the past ($\chi^2=27.670$, p -value=0.003), ($\chi^2=3.345$, p -value=0.042) and ever attended antenatal care with wife before and being invited by healthcare provider for discussion because of your child ($\chi^2=7.803$, p -value=0.020).

There was statistically significant association with semiskilled occupational participants ($\chi^2=8.030$, p -value=0.045) and married participants ($\chi^2=13.450$, p -value=0.009) (see Table 4).

Discussion

This study revealed that majority of fathers were aged 50 and above with a mean of 42.0 years, a bit lower than that of Zvara [13] who reported a mean of 30 years. This is probably because of the large population size in this study. It is indicated that the middle-aged is the most prevalent age group of people with young children, and that most are semi-skilled and unskilled. That semi-skilled and unskilled workers are more prevalent among the fathers may be a pointer to the higher good attitude and practice as they are likely to be more available at home to attend to family issues unlike professionals. The fact that secondary education was the most common among them also corroborates this.

In her study, Muheirwe et al. [11] found that men's participation in maternal and child health is affected by multiple factors emanating from the community

Table 1 Sociodemographic characteristics of participants

Characteristics	Frequency	Percentage
Age		
20–29	32	7.7
30–39	107	25.7
40–49	118	28.4
50 and above	159	38.2
Mean age \pm SD = 42.0 \pm 12.7		
Occupation		
Retiree	32	7.7
Unskilled	151	36.3
Semi-skilled	160	38.5
Skilled/professional	73	17.5
Educational status		
None	22	5.3
Primary	99	23.8
Secondary	185	44.5
Tertiary	110	26.4
Child number (n = 409)		
0–4	303	72.8
5–10	92	22.1
> 10	14	3.4
Number of children living (n = 400)		
0–4	300	72.1
5–10	91	21.9
> 10	9	2.2
Number of children dead		
\leq 2	29	7.0
> 2	19	4.6
Number of wives number (n = 408)		
1	284	68.3
2–4	120	28.8
> 4	4	1.0
Marital status		
Married	379	91.1
Separated	17	4.1
Divorced	5	1.2
Widowed	6	1.4
Not married but has child	9	2.2

and health institutions such as sociocultural attitudes and perceptions and poor attitudes of health workers. This is similar to our findings in which more than half of the participants said taking a child to the hospital is time-consuming, and about two-thirds said hospital staff make you wait too long before being seen. It has reported that men's involvement in maternal and child healthcare was poor due to shortcoming in the healthcare service delivery such as poor attitudes of healthcare providers and ineffective programs [11]. Our

Table 2 Attitude and practice of participants towards involvement in child's health

Variables	Frequency	Percentage
It is a woman's job to take a sick child to the hospital		
Yes	176	42.3
No	240	57.7
Taking a child to the hospital is time-consuming		
Yes	212	51.0
No	204	49.0
I have more important things to do than visiting the hospital with my child		
Yes	114	27.4
No	302	72.6
Hospital staffs make you wait too long before being seen		
Yes	241	57.9
No	175	42.1
A man should go in search of money instead of accompanying a sick child		
Yes	223	53.6
No	193	46.4
Paternity/sick leave will be required before I accompany my child to the hospital		
Yes	166	39.9
No	250	61.1
A father will feel out of place in children's ward/clinic		
Yes	164	39.4
No	252	60.6
I cannot recommend that a father should follow his child to the hospital		
Yes	130	31.3
No	286	68.7
Has any of your children visited a hospital before?		
Yes	301	72.4
No	115	27.6
Ever gone to the hospital with your child on any occasion		
Yes	237	57.0
No	152	36.5
Yes, I have been to hospital with my child		
< 5	118	28.4
> 5	4	1.0
several times	3	.7
No, I have never been to the hospital with my child because of the following:		
It is a woman's job	21	5.0
Due to my work schedule	33	7.9
Not a man's job	30	7.2
I do not have time for that	23	5.5
Children been admitted into the hospital in the past		
Yes	182	43.8
No	218	52.4
I personally stay with him/her on admission		
Yes	135	32.5
No	146	35.1
No, I did not, because of the following:		
Because I travelled	17	4.1
Because of my work schedule	57	13.7
Because it is not man's job	38	9.1

Table 2 (continued)

Variables	Frequency	Percentage
I was sick	8	1.9
Ever attended antenatal care with your wife before?		
Yes	199	47.8
No	205	49.3
No, because of the following:		
Because I travelled	26	6.3
Because of my work schedule	53	12.7
Because it is not man's job	98	23.6
I was sick	12	2.9
Ever attended the delivery of your wife?		
Yes	288	69.2
No	117	28.1
Number of times		
≤ 4	154	37.0
> 4	38	9.1
Few times	11	2.6
All the time	12	2.9
No, because of the following:		
Because I travelled	25	6.0
Because of my work schedule	56	13.5
Because it is not a man's job	26	6.3
I was sick	3	.7
Ever attended immunization clinics/infant welfare clinics with your child before?		
Yes	161	38.7
No	240	57.7
No, because of the following:		
Because I travelled	18	4.3
Because of my work schedule	79	19.0
Because it is not man's job	134	32.2
I was sick	7	1.7
Healthcare provider ever invited you for discussion before of your child's health before?		
Yes	102	24.5
No	295	70.9
I went, when I was invited		
Yes	59	14.2
No	27	6.5
No, because of the following:		
Because I travelled	5	1.2
Because of my work schedule	16	3.8
Because it is not man's job	11	2.6
I was sick	2	.5

health institutions/health workers should therefore adopt strategies for time management that will improve fathers' participation in their family's healthcare as this may be one of the ways to achieving SDG 3, i.e., ensuring healthy lives and promoting well-being for all at all ages. Involvement of fathers in the healthcare of their

children will facilitate the engagement with healthcare providers and therefore presents opportunity for the men to acquire health education that will improve their encouraging family members and themselves in accessing health services [6, 14]. Other militating factors were social and cultural problems such as the women whose

Table 3 Cross tabulation of attitude and practice with demographic characteristics

Characteristics	Attitude and practice		χ^2	p-value
	Good attitude and practice (%)	Poor attitude and practice (%)		
Age				
20–29	23 (7.6)	9 (8.0)	1.257	0.739
30–39	82 (27.1)	25 (22.1)		
40–49	86 (28.1)	32 (28.3)		
50 and above	112 (37.0)	47 (41.6)		
Occupation				
Retiree	22 (7.3)	10 (8.8)	0.908	0.824
Unskilled	113 (37.3)	38 (33.6)		
Semi-skilled	117 (38.6)	43 (38.1)		
Skilled/professional	51 (16.8)	22 (19.5)		
Educational status				
None	13 (4.3)	9 (8.0)	6.687	0.083
Primary	80 (26.4)	19 (16.8)		
Secondary	128 (42.2)	57 (50.4)		
Tertiary	82 (27.1)	28 (24.8)		
Child number (n = 409)				
0–4	217 (73.1)	86 (76.8)	0.719	0.698
5–10	70 (23.6)	22 (19.6)		
> 10	10 (3.4)	4 (3.4)		
Number of children living (400)				
0–4	216 (74.5)	84 (76.4)	0.221	0.895
5–10	67 (23.1)	24 (21.8)		
> 10	7 (2.4)	2 (1.8)		
Number of children dead				
≤ 2	22 (75.9)	7 (24.1)	2.195	0.334
> 2	11 (57.9)	8 (42.1)		
Number of wives number (n = 408)				
1	204 (68.7)	80 (72.1)	1.742	0.419
2–4	91 (30.6)	29 (26.1)		
> 4	2 (0.7)	2 (1.8)		
Marital status				
Married	276 (91.1)	103 (91.2)	0.400	0.983
0.983	12 (4.0)	5 (4.4)		
Divorced	4 (1.3)	1 (0.9)		
Widowed				
Not married but has child	7 (2.3)	2 (1.8)		

husbands accompanied to the hospital frequently being called witches and their husbands being scorned and termed bewitched [11].

That more than half of the participants said a father should rather go in search of money than accompanying a sick child to the hospital is also an example of the socio-cultural factors affecting fathers involving in healthcare of their children, and this may be corrected with intense health education of men and fathers on the importance of accompanying a sick child to the hospital and

in churches, mosques, and public gatherings like town hall meetings, campaigns on radio, television, and social media.

Fathers can participate in their children’s healthcare by taking the children to the hospital, accompanying wives to take children, or meeting all required needs to improve their health status. The statistical significance recorded on ever gone to hospital, children been admitted to the hospital in the past, and attending antenatal care and invited by healthcare provider for discussion because of

Table 4 Association between sociodemographic characteristics and practice of male involvement

Characteristics	Practice		χ^2	p-value
	Good practice (%)	Poor practice (%)		
Age				
20–29	23 (7.6)	9 (8.0)	1.257	0.739
30–39	82 (27.1)	25 (22.1)		
40–49	86 (28.1)	32 (28.3)		
50 and above	112 (37.0)	47 (41.6)		
Occupation				
Retiree	22 (7.3)	10 (8.8)	0.908	0.824
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Semi-skilled	117 (38.6)	43 (38.1)		
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Marital status				
Married	276 (91.1)	103 (91.2)	0.400	0.983
0.983	12 (4.0)	5 (4.4)		
Divorced	4 (1.3)	1 (0.9)		
Widowed				
Not married but has child	7 (2.3)	2 (1.8)		

your child showed that fathers in this environment do not accompany children to see healthcare providers for either routine clinic or when sick except when on admission or sent for by healthcare provider. This often delays the commencement of treatment as mothers usually wait to hear their opinion on any line of treatment; more so, they are the ones who provide the money for the uptake of treatment. A study conducted in Uganda revealed that men were more active in maternal healthcare than in child healthcare [15]. The major individual factors that

influence fathers' involvement in their children's health-care are semi-skilled occupation, marital status, and work schedule, though majority do not think paternity leave is required before fathers can be involved in the health-care of their children. Government and stakeholders' attention to ensure better work schedule in men, reduction of hospital stay time, and intensive health education of men/fathers will go a long way in improving fathers' involvement in the healthcare of their children.

Although cross-sectional in design, this study presents the views and practice of male involvement in child healthcare. The findings provide baseline information on which evidence-based interventions can be designed and implemented in southwest Nigeria. It further lays credence to assertions of previous researchers on the existence of cultural barriers to adequate paternal involvement in health-seeking behavior and utilization of child healthcare services.

Conclusion

Participants generally had a good attitude towards involvement in the healthcare of their children. Many still held on to traditional beliefs of the man being only a breadwinner. Individual factors that influenced fathers' involvement include the following: semi-skilled occupation, marital status, and work schedule. Behavior change communication and advocacy will go a long way in ensuring better involvement of fathers in the healthcare of their children.

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Authors' contributions

BOT — involved in study conception, design, data collection, data analysis, writing of the manuscript, and intellectual content. SOO — involved in study design, interpretation, writing of the manuscript, and intellectual content. JOA — involved in study design, data collection, and intellectual content. AHA — involved in study design and intellectual content. OTO — involved in study design and intellectual content. AEO — involved in study design and died before the conclusion of the project. All authors except AEO who died before the final manuscript were ready to read and approved the final manuscript.

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Availability of data and materials

The datasets used and/or analyzed during the current study are available with the corresponding author and can be produced on request.

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from HREC-OOOUTH with approval certificate number 362/2020AP. Written informed consent was obtained from all participants.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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