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Beyond the Stethoscope: Humanising Child Health Through Qualitative Inquiry (A Translational Method Review)

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Abstract

Child survival remains a major priority in Nigeria and other low- and middle-income countries, yet proven interventions do not always translate into consistent uptake or better outcomes. Quantitative research is indispensable for describing burden, risk, and trends. Still, it often cannot explain why caregivers delay care, why adolescents disengage, or why technically sound services fail in everyday practice. This narrative review examines qualitative inquiry as a practical scientific method for addressing those gaps in paediatric care and programme delivery. A reproducible narrative review approach was used, with targeted searches of PubMed/MEDLINE, Scopus, Web of Science, African Journals Online, and Google Scholar, supplemented by citation tracking of key methodological and implementation sources. Sources were purposively selected and synthesised around four questions: what qualitative inquiry contributes to translational child health; which methods are feasible for clinicians and trainees; how rigour and ethics should be handled; and how findings can inform service redesign. The review shows that qualitative inquiry strengthens paediatric practice by clarifying acceptability, feasibility, trust, hidden costs, and workflow realities across child, facility, and policy levels. It provides clinician-facing guidance on interviews, focus group discussions, observation, sampling, analysis, trustworthiness, and safeguarding, and demonstrates how qualitative findings can be translated into practical redesign actions. Qualitative inquiry should be treated as a core method in paediatric implementation and training, not as an informal add-on.

Keywords: *Child Health, Ethics, Focus Group Discussion, Implementation Science, Qualitative Inquiry, Trustworthiness.*

Introduction

Child survival remains a central priority for paediatric practice and policy in Nigeria and other low- and middle-income countries. National surveys and policy documents continue to show marked variation in outcomes across states and communities, indicating that the burden is uneven and that uniform implementation responses are unlikely to be sufficient.^{1,2} For clinicians and programme teams, the challenge is therefore both

scientific and practical: how to translate proven interventions into care that families can use consistently.

A persistent challenge is the gap between evidence and uptake. Many child health interventions are technically sound, yet uptake, continuity, and completion remain suboptimal because cost, transport, prior experiences, social norms, communication style, and trust shape decisions. Implementation research has shown

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that evidence reaches impact through context and behaviour, not guidelines alone.³ Quantitative methods estimate burden and outcomes, but they often leave unanswered the mechanism-level questions clinicians face daily: why families delay, why adolescents disengage, and why discharge plans fail in practice.

Qualitative inquiry is designed to address these questions because it examines meaning, experience, interaction, and context in real settings. This review is written as a clinician-facing and trainee-oriented narrative review. It explains what qualitative inquiry contributes to translational child health, how to choose and apply common qualitative approaches, how to demonstrate rigour and ethical integrity, and how to translate findings into practical service improvement.⁴⁻⁶

Methods

This manuscript is a narrative review with a translational method focus, not a systematic review or meta-analysis. The purpose was to produce a reproducible, clinician-usable synthesis of qualitative approaches in paediatrics. A formal Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA)-compliant workflow was not required, as the aim was conceptual and methodological integration rather than exhaustive effect estimation. Still, the search and synthesis process was documented for transparency.

Targeted searches were conducted in PubMed/MEDLINE, Scopus, Web of Science, African Journals Online, and Google Scholar using combinations of terms related to qualitative research, paediatrics, child health, caregivers, adolescents, implementation, acceptability, trust, ethics, interviews, focus groups, and observation. Seminal methodological and reporting sources were identified by citation tracking and hand-searching reference lists, including qualitative

methods texts, implementation science frameworks, and reporting standards.

Sources were selected purposively by a single reviewer to address four predefined review questions: the contribution of qualitative inquiry to translational paediatrics; feasible methods for clinicians and trainees; rigour and ethics in studies involving children and families; and translation of findings into service redesign. Priority was given to methodological guidance, implementation frameworks, and applied child health examples relevant to hospital and programme settings, especially in low- and middle-income countries.

Data were extracted into a narrative evidence matrix capturing source type, key concepts, practical recommendations, and translational implications. Findings were synthesised thematically and organised into clinician-facing sections on framing, methods, sampling, analysis, rigour, ethics, and implementation use. No formal risk-of-bias scoring was applied because the review prioritised methodological utility and conceptual integration over quantitative effect comparisons.

Review Questions and Scope

This review is framed as a translational methods primer for paediatric clinicians, trainees, and programme teams. That focus is particularly relevant in Nigeria because the national child-survival policy emphasises equity, evidence use, community engagement, and measurable implementation progress. At the same time, routine survey systems provide essential indicators but, by themselves, do not explain why uptake succeeds in one setting and fails in another.^{1,2}

The review is guided by four interlocking questions: what qualitative inquiry contributes to the translation of child-health evidence into practice, which qualitative approaches are

feasible for paediatric clinicians and trainees, how rigour and ethics should be handled when children, adolescents, and caregivers are involved, and how qualitative findings can be used to redesign systems at micro, meso, and macro levels. The scope is intentionally practice-oriented and focuses on qualitative and mixed-method applications that explain interpretation, acceptability, resistance, adaptation, and normalisation of interventions in real service settings, rather than re-estimating epidemiological burden or pooled effects.

What Qualitative Inquiry Is and Is Not

Qualitative inquiry is a systematic approach to understanding how people make sense of illness, care, and health services within their social and institutional contexts. In paediatrics, it helps explain how caregivers interpret symptoms, how adolescents experience treatment and stigma, and how staff implement policy under real constraints. The analytic aim is not merely to collect opinions, but to generate structured explanations of experience, process, and context that can improve care and implementation decisions.⁷⁻⁹

It is therefore important to distinguish qualitative inquiry from anecdote. A memorable clinical

story can be persuasive, but it does not become qualitative evidence unless it is generated through an explicit design, documented systematically, analysed transparently, and interpreted through a defensible analytic pathway. High-quality qualitative work requires a clear question, purposeful sampling, disciplined data collection, coding procedures, and a clear link between participants' accounts and conclusions. This is especially important in child health, where emotionally compelling narratives can easily overshadow methodological rigour if methods are not made explicit.¹⁰⁻¹²

For paediatric clinicians, the practical value of qualitative inquiry lies in complementarity rather than competition with quantitative methods. Quantitative studies answer questions of burden, frequency, and association. Qualitative studies explain how and why care succeeds or fails in context, for whom, and under what conditions. Table I contrasts the questions, outputs, strengths, and limitations of quantitative and qualitative approaches. At the same time, Table II provides a simple clinician-facing comparison of quantitative and qualitative answers to common paediatric service problems.

Table I: Contrasting quantitative and qualitative approaches in child health research

Approach	Questions Addressed	Typical Outputs	Strengths	Limitations
Quantitative	What is the burden? How frequent? What associations exist?	Rates, trends, risks, p-values, confidence intervals.	Generalisable; measures scale and impact; tests hypotheses.	May overlook context, meaning, and why patterns occur.
Qualitative	How and why does it happen? What meanings and experiences?	Themes, narratives, mechanisms, contextual explanations.	Depth on behaviour, acceptability, and feasibility; explains gaps.	Not statistically generalisable; time-intensive; subjectivity risks.

Qualitative Approaches in Clinician Language

In qualitative inquiry, method choice should follow the problem to be solved. A paediatrician asking why caregivers delay presentation is asking a different question from a programme team investigating immunisation rumours or a

ward team examining discharge failures. Matching the question to the method improves feasibility and usefulness. Table III provides a clinician-facing guide to common qualitative methods. Figure 2 presents a decision pathway to help paediatric clinicians and programme teams

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select the most appropriate qualitative method for common clinical and implementation problems.

Table II: Clinical questions in paediatrics and the complementary contributions of quantitative and qualitative inquiry

Paediatric clinical question	What quantitative inquiry contributes	What qualitative inquiry contributes	Translational value when combined
Immunisation timeliness and dropout	Coverage; timeliness rates; dropout patterns; regional inequities; predictors of delay	How caregivers interpret schedules; trust in services; hidden costs, and reasons appointments are missed	Improves counselling, reminder design, clinic flow, and outreach strategy
Fever care-seeking and delayed presentation	Time to presentation; severity at arrival; admission outcomes; socioeconomic correlates	Symptom meaning; household decision pathways; fear, transport barriers, and prior care experiences	Supports earlier care-seeking messages and context-sensitive triage communication
Adolescent treatment adherence	Missed doses; missed visits; control indicators; interruption rates	Stigma, disclosure concerns, identity issues, treatment fatigue, privacy concerns, and school constraints	Guides adolescent-friendly clinic redesign, privacy, timing, and communication style
Missed follow-up after discharge	No-show rates; readmission risk; mortality; diagnosis-specific patterns	What discharge instructions mean in practice; workability of plans; family constraints; communication gaps	Improves discharge planning, return pathways, and early follow-up support
Discharge against medical advice (DAMA)	DAMA rate; timing; diagnosis profile; payment status; readmission, and outcome patterns	How uncertainty, cost, trust, and communication break down across the admission pathway	Enables early risk triggers, staged communication, and social support escalation
Uptake of a new child-health service	Coverage trends; refusal rates; dropout rates; geographic variation	Rumours, trust pathways, messenger credibility, perceived fairness, and hidden costs	Strengthens community engagement, message design, and implementation strategy

Quantitative inquiry defines burden, frequency, and associations; qualitative inquiry explains meaning, mechanism, acceptability, and feasibility. Together, they strengthen translational paediatrics and service redesign.

DAMA - Discharge against medical advice.

In-depth interviews are best for sensitive or sequential decisions, such as caregiver interpretation of danger signs, adolescent stigma, or reasons for poor follow-up. Focus group discussions are better for social norms, rumours, and collective expectations because participant interaction is part of the data. Observation is essential when reported behaviour may differ from actual practice, such as triage flow, counselling quality, or ward routines. Case-based qualitative work is especially useful for complex pathways, including delayed referral or repeated missed opportunities, when interviews, records, and observation are triangulated.

Methodological traditions can be explained in simple terms. Ethnography helps study care culture and unwritten rules in homes, clinics, and

communities. Grounded theory is useful when the aim is to build an explanatory model of a process, such as adherence over time. Phenomenology is most suitable when the main question concerns lived experience and meaning, such as caregiving for chronic illness or adolescent experience of stigmatised conditions.^{8,13}

Sampling Logic and Sample Adequacy

Qualitative sampling should be described as purposive and question-driven rather than random. The goal is not statistical representativeness but analytic depth and useful variation. In paediatric work, purposive sampling often means deliberately including different caregiver types, age groups, clinical trajectories, facility levels, or user and non-user experiences.

Common strategies include maximum variation sampling to capture diversity, typical case sampling to describe common patterns, and deviant or extreme case sampling to uncover mechanisms hidden in average cases.^{8,14} Table IV summarises practical sampling strategies relevant to paediatric qualitative studies, including when each is useful, paediatric examples, analytic value, risks and mitigation approaches, and cues for judging sample adequacy.

Sample adequacy should be justified through analytic sufficiency. For clinician audiences, the concept of information power is especially helpful because it links sample size to the specificity of the study aim, the relevance of the participants, the quality of the interviews, and the depth of analysis, rather than to arbitrary numerical targets.¹⁵ Saturation may still be mentioned, but it should be explained as part of a broader judgment about whether the data are rich enough to support a credible interpretation.

Data Generation and Analysis

Qualitative data generation should begin with a clearly defined clinical or implementation problem. Interview and focus group guides should be built from the service question itself and should use open-ended prompts and sequenced probes that allow participants to narrate events and meanings in their own terms. In child health, tools should be adapted to age, literacy, caregiver-child dynamics, and topic sensitivity, especially for stigma, bereavement, or financial strain.

Piloting and cultural adaptation are essential. In multilingual Nigerian settings, translation and back-translation should preserve meaning rather than literal wording. Field procedures should be described with the same seriousness used for clinical methods, including interviewer preparation, role boundaries, note-taking,

privacy, audio recording, distress management, and referral procedures.

Analysis should be presented as a transparent sequence from transcription to coding to theme development. The manuscript should state who transcribed the data, how transcripts were checked, whether coding was inductive or deductive, how a codebook was developed, and how disagreements were resolved. Thematic analysis and the Framework Method are often especially practical for clinician-led teams because they support structured comparison while preserving interpretive depth.^{11,16}

Analytic transparency also requires an audit trail that includes codebook revisions, theme decisions, and analytic memos. Figure 3 illustrates the clinician-facing workflow that links a defined paediatric clinical or programme problem to actionable service redesign through sequential qualitative steps, guide development, data generation, coding, thematic synthesis, and interpretation.

Rigour and Trustworthiness

Rigour in qualitative research is best discussed in the language of trustworthiness. The central question is whether the findings are sufficiently grounded, transparent, and coherent to justify interpretation and application. This matters in paediatrics because qualitative studies may be immediately relevant to practice. Still, they are less likely to influence policy or service redesign if the manuscript does not clearly show how the findings were produced.^{9,14}

The core trustworthiness domains are credibility, transferability, dependability, and confirmability. Credibility is strengthened by adequate engagement, careful probing, iterative analysis, and active exploration of deviant cases. Transferability depends on a thick description of the context so readers can judge applicability to their own settings. Dependability requires

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traceable documentation of the research process, including methodological changes during fieldwork. Confirmability requires visible

grounding of interpretations in participants' accounts rather than unchecked assumptions.^{14,17}

Table III: Choosing a qualitative method for a paediatric problem

Method	Best Question Type	Typical Participants/Setting	Strengths	Limitations	Practice Output
In-depth interviews	Sensitive decisions, lived experience, adherence, stigma, care-seeking pathways.	Caregivers, adolescents, clinicians, social workers; clinic/home/community.	Depth, privacy, probing, sequencing of events and meanings.	Time-intensive; interviewer-dependent; social desirability remains a concern.	Counselling redesign; adherence support
FGDs	Shared norms, rumours, community narratives, staff culture, contested views.	Caregiver groups, adolescent groups (when safe), nurses, and community actors.	Reveals social norms and disagreement efficiently.	Dominant voices, less privacy, not ideal for sensitive disclosures.	Community messaging and engagement
Observation	Actual workflow, triage, counselling behaviour, waiting-room dynamics, workarounds.	Wards, clinics, pharmacies, and outreach sessions.	Captures what happens in practice, not only what is reported.	Needs access, strong field notes, and clear ethics planning.	Workflow and quality-improvement changes
Case study / case-pathway	Complex events (DAMA, delayed referral, readmission cycles).	Family, staff, records, and social welfare are linked to one pathway.	Integrates chronology and context for translational decisions.	It can become descriptive unless triangulated and analytically structured.	Pathway failure analysis and redesign
Ethnography	Clinic culture, care traditions, unwritten rules, institutional norms.	Facilities or communities over an extended engagement.	High contextual depth; identifies hidden practice culture.	Longer time requirement; high reflexivity demand.	Culture-informed implementation strategy
Grounded theory	Process explanation and model-building (e.g., adherence over time).	Participants are sampled iteratively as the theory develops.	Generates an explanatory model from data.	Analytically demanding; iterative sampling may be difficult.	Intervention design framework
Phenomenology	Meaning of illness/care experience for patients, caregivers, or clinicians.	Participants with direct lived experience.	Rich insight into suffering, identity, and meaning.	Less suitable for workflow/process mapping alone.	Experience-informed service design

FGD - Focus group discussion

Table IV: Practical sampling strategies and sample adequacy in paediatric qualitative studies

Sampling Strategy	When Useful	Paediatric Example	Analytic Value	Risks/Mitigation	Sample Adequacy Cues
Maximum variation purposive	Need diversity across people or settings.	Urban/rural caregivers; tertiary/district facilities; different child ages.	Shows patterns across contexts and improves transferability.	Risk shallow data; keep aim focused and interviews deep.	Major variations covered; later interviews deepen rather than change patterns.
Typical case	Need a picture of the common pathway.	Usual outpatient fever-care seeking and counselling pathway.	Clarifies routine barriers and practical norms.	May miss hidden mechanisms; add deviant cases.	The core pathway is repeatedly described in depth
Criterion	All participants must meet a defined condition.	Readmission within thirty days; documented non-adherence; DAMA episode.	High clinical relevance and actionability.	Too-narrow criteria reduce variation; test criteria early.	Criterion cases are adequately represented across key subgroups
Deviant/extreme case	Need to explain outliers or unexpected success/failure.	Repeated DAMA or unusually strong adherence.	Reveals mechanisms hidden in average cases.	Can over-weight rare stories; compare with typical cases.	Outlier mechanisms clearly contrasted with routine pathways
Homogeneous	Need social comfort or comparable group discussion.	Separate adolescent groups by age/sex; separate caregiver groups by clinic type.	Improves disclosure and within-group comparability.	Reduces diversity; use multiple groups to restore range.	Each key subgroup yields at least one rich dataset
Key informant	Need system insight on workflow or policy decisions.	Triage nurses, ward leads, social workers, and programme officers.	Clarifies operational bottlenecks and decision points.	Informants may present ideal practice; triangulate with users/observation.	Every critical decision point has an informed voice
Theoretical (grounded theory)	Emerging analysis determines who to interview next.	After early DAMA interviews suggest cost uncertainty, sample billing/social welfare staff.	Strengthens process model and explanatory depth.	Needs time and memoing discipline.	New cases no longer alter the explanatory model
Convenience (use cautiously)	Access is constrained, and the study is starting.	First available clinic caregivers before purposive expansion.	Improves feasibility in busy services.	Selection bias; document constraints and add purposive steps quickly.	Adequate only after obvious gaps are purposively filled

Sample adequacy should be justified by analytic sufficiency (for example, information power or thematic sufficiency), not statistical representativeness.

DAMA - Discharge against medical advice; FGD - Focus group discussion.

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Table V: Checklist for rigour, ethics, and safeguarding in paediatric qualitative inquiry

Checklist Item	What To Plan/Document	Evidence in Manuscript	Risk if omitted
Rigour			
Focused qualitative question	Question targets meaning, process, context, or mechanism.	Clear review or study question linked to the clinical problem.	Data collection becomes broad and unfocused.
Sampling rationale	Purposive strategy with explicit who/why/where logic.	Named sampling approach and participant range.	Findings appear anecdotal.
Triangulation	Use multiple participant groups, settings, or methods where feasible.	Explicit triangulation statement.	Contradictions and system factors may be missed.
Reflexivity or positionality	Researcher role, assumptions, and influence management.	Brief positionality statement.	Interpretive bias remains hidden.
Transparent analysis	Transcription checks, coding process, codebook, and theme development.	Stepwise analysis description.	Themes seem impressionistic.
Audit trail	Memos, code revisions, and decision logs.	Statement that an audit trail was maintained.	Dependability cannot be judged.
Reporting framework	Use COREQ and/or SRQR to guide reporting.	Named checklist(s) used.	Peer review may flag incomplete reporting.
Ethics			
Ethics approval	Committee name, approval number, and ethical standard.	Methods ethics statement.	Editorial rejection for weak ethics reporting.
Consent and assent	Caregiver consent, age-appropriate assent, and recording permission.	Clear consent and assent statement.	Risk of coercion or invalid participation.
Privacy and confidentiality	Private setting, confidentiality limits, and data handling explained.	Setting and confidentiality procedures are described.	Participants may withhold key information.
Safeguarding			
Distress response	Pause or stop the process, provide immediate support, and document the steps.	Distress-management protocol described.	Unsafe handling of emotional distress.
Referral pathway	Named services, thresholds, contacts, and documentation route.	Referral plan stated: who, when, and where.	Delayed response to disclosure of risk.
Data security	De-identification, secure storage, access control, and retention plan.	Audio or transcript security statement.	Confidentiality breach risk.
Safe dissemination	Use de-identified excerpts or composite vignettes where needed.	Note on de-identification in text or legends.	Participants or facilities may be recognisable.

COREQ - Consolidated Criteria for Reporting Qualitative Research; SRQR - Standards for Reporting Qualitative Research.

In practice, trustworthiness is demonstrated through concrete procedures such as a clear sampling rationale, triangulation across participants or methods, reflexivity statements, transparent coding decisions, and a documented audit trail, all of which are summarised in Table V (Rigour subsection). It is also important to adopt the reporting framework that applies to a particular study, preferably the Consolidated Criteria for Reporting Qualitative Research (COREQ) for interview and focus group studies and Standards for Reporting Qualitative Research (SRQR) for broader qualitative reports, while

making clear that checklists enhance transparency but do not substitute for strong analytic thinking and interpretation.^{9,12}

Ethics and Power in Paediatric Qualitative Inquiry

Ethics in paediatric qualitative inquiry should be treated as a continuous practice rather than a single approval step. Qualitative methods involve close engagement with participants, and in child health, this often includes people living with illness, dependency, stigma, grief, or financial strain. Ethical design should therefore be visible

throughout recruitment, interviewing, analysis, and dissemination.¹⁸⁻²⁰

Power asymmetries require explicit attention. Children and adolescents rarely participate on equal terms with adults; caregivers may control access, clinicians may hold authority, and

participants may fear that refusal could affect care. A strong manuscript should show how participation was separated from service decisions, how refusal and withdrawal were protected, and how interview settings reduced pressure and encouraged honest disclosure.

Table VIa: Translating qualitative themes into service redesign actions and measurable indicators across micro, meso, and macro levels

Level	Illustrative qualitative theme or mechanism	Redesign action	Implementation indicators (process)	Performance indicators (outcomes)	Data source and review cycle
Micro	Caregivers report unclear discharge instructions, fear of being blamed for returning, and uncertainty about what constitutes a danger sign.	Introduce a discharge bundle: plain-language counselling, teach-back, a written or visual take-home plan, and a clear return pathway.	Proportion of discharges with documented teach-back; proportion receiving a written or visual plan; proportion with a follow-up date documented.	Seven-day follow-up attendance; 30-day readmission rate; caregiver-reported understanding score.	Ward discharge checklist, clinic register, follow-up call log, and monthly review.
Micro	Adolescents describe stigma, privacy concerns, treatment fatigue, and clinic times that clash with school.	Create adolescent-friendly service windows, confidential counselling spaces, and shared decision-making scripts.	Average waiting time in adolescent clinic; proportion of visits in protected adolescent slots; counselling privacy checklist completion.	Missed appointment rate; adherence proxy such as visit or refill continuity; adolescent satisfaction or comfort score.	Clinic flow observation; appointment register; adolescent feedback tool; monthly or quarterly review.
Micro	Families delay fever care-seeking due to transport costs, misinterpretation of symptoms, and prior negative experiences.	Strengthen triage messaging and return advice, including transport and risk counselling, and use culturally familiar danger-sign communication.	Proportion of febrile visits with documented danger-sign counselling; proportion receiving return advice in the preferred language.	Median time from symptom onset to presentation; proportion presenting with severe signs; early re-attendance rate.	Triage forms; emergency register; brief caregiver exit interviews; monthly review.
Meso	Observation shows triage bottlenecks, role ambiguity, and workflow interruptions that delay assessment and treatment.	Redesign patient flow, clarify staff roles, and use shift huddles to coordinate workload.	Median triage-to-clinician time; proportion of high-risk patients assessed within the target time; huddle compliance rate.	Length of stay in the emergency area; caregiver complaints related to delays; proportion leaving before assessment.	Triage timestamps; duty rosters; quality-improvement huddle logs; weekly or monthly dashboard.

Suggested indicators should be adapted to the service context, baseline performance, and data availability. Programmes may select a small core set for routine monitoring and add context-specific indicators as needed.

Qualitative themes may be identified through interviews, focus group discussions, observation, document review, or mixed-methods approaches; the examples shown are illustrative of paediatric clinical and programme settings.

DAMA - Discharge against medical advice; FGD - Focus group discussion; QI - Quality improvement; SMS - Short message service.

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Table VIb: Translating qualitative themes into service redesign actions and measurable indicators across micro, meso, and macro levels

Level	Illustrative qualitative theme or mechanism	Redesign action	Implementation indicators (process)	Performance indicators (outcomes)	Data source and review cycle
Meso	Counselling quality varies across staff, and key messages are omitted during busy periods.	Standardise counselling with a brief script or checklist and supportive supervision with spot audits.	Counselling checklist completion rate; staff adherence to key messages; proportion of encounters audited.	Caregiver comprehension score; follow-up adherence; reduced avoidable return visits due to misunderstanding.	Counselling audit forms; exit interviews; clinic register; monthly supervision review.
Meso	Referral and post-discharge coordination are weak; families do not know who to call or where to go when problems recur.	Establish referral coordination and early follow-up contact by phone or SMS, with escalation pathways for high-risk children.	Proportion of high-risk discharges contacted within 48 hours; referral completion rate; documented escalation actions.	DAMA rate; unplanned readmission rate; missed specialist referral appointments.	Follow-up call register; referral logs; ward records; monthly multi-disciplinary review.
Macro	Community narratives reflect rumours, low trust, and concern about hidden costs for new child-health services.	Use co-designed community engagement with trusted messengers and a transparent explanation of costs, eligibility, and expected benefits.	Number of community dialogues conducted; proportion of messages delivered by trusted local actors; cost of information materials distributed.	Service uptake or coverage trend; refusal rate; trust or acceptability score from community feedback.	Programme outreach logs; service utilisation data; rapid community feedback rounds; quarterly review.
Macro	Programme design does not align with local routines, transport realities, and caregiver opportunity costs.	Adapt service hours, outreach locations, and appointment systems to local work and school patterns and transport access.	Proportion of sessions delivered at community-preferred times or locations; appointment flexibility uptake.	Timeliness of attendance; dropout rate; geographic equity in service use.	Programme schedule records; attendance data; area-level summaries; quarterly review.
Macro	Policy messages emphasise coverage targets but overlook respectful care and communication. Quality as adoption drivers.	Embed qualitative indicators such as trust, experience, and acceptability into programme monitoring and Supervisory feedback loops.	Routine reporting includes experience or acceptability indicators; proportion of supervisory visits that review qualitative feedback.	Improvement in trust-related indicators alongside coverage; reduced repeated resistance in Target communities.	Programme dashboard; supervision reports; periodic qualitative pulse checks; quarterly or Semi-annual review.

Suggested indicators should be adapted to the service context, baseline performance, and data availability. Programmes may select a small core set for routine monitoring and add context-specific indicators as needed.

Qualitative themes may be identified through interviews, focus group discussions, observation, document review, or mixed-methods approaches; the examples shown are illustrative of paediatric clinical and programme settings.

DAMA - Discharge against medical advice; FGD - Focus group discussion; QI - Quality improvement; SMS - Short message service.

Consent and assent should be developmentally appropriate and should explain procedures, risks, audio recording, and limits of confidentiality.

Safeguarding should be explicit, including distress management, referral thresholds, named referral options, and documentation steps when

interviews reveal abuse or immediate risk. Data protection should cover de-identification, secure storage, restricted access, and careful use of composite or de-identified vignettes where

needed. Table V can summarise these ethics and power safeguards for paediatric qualitative studies.

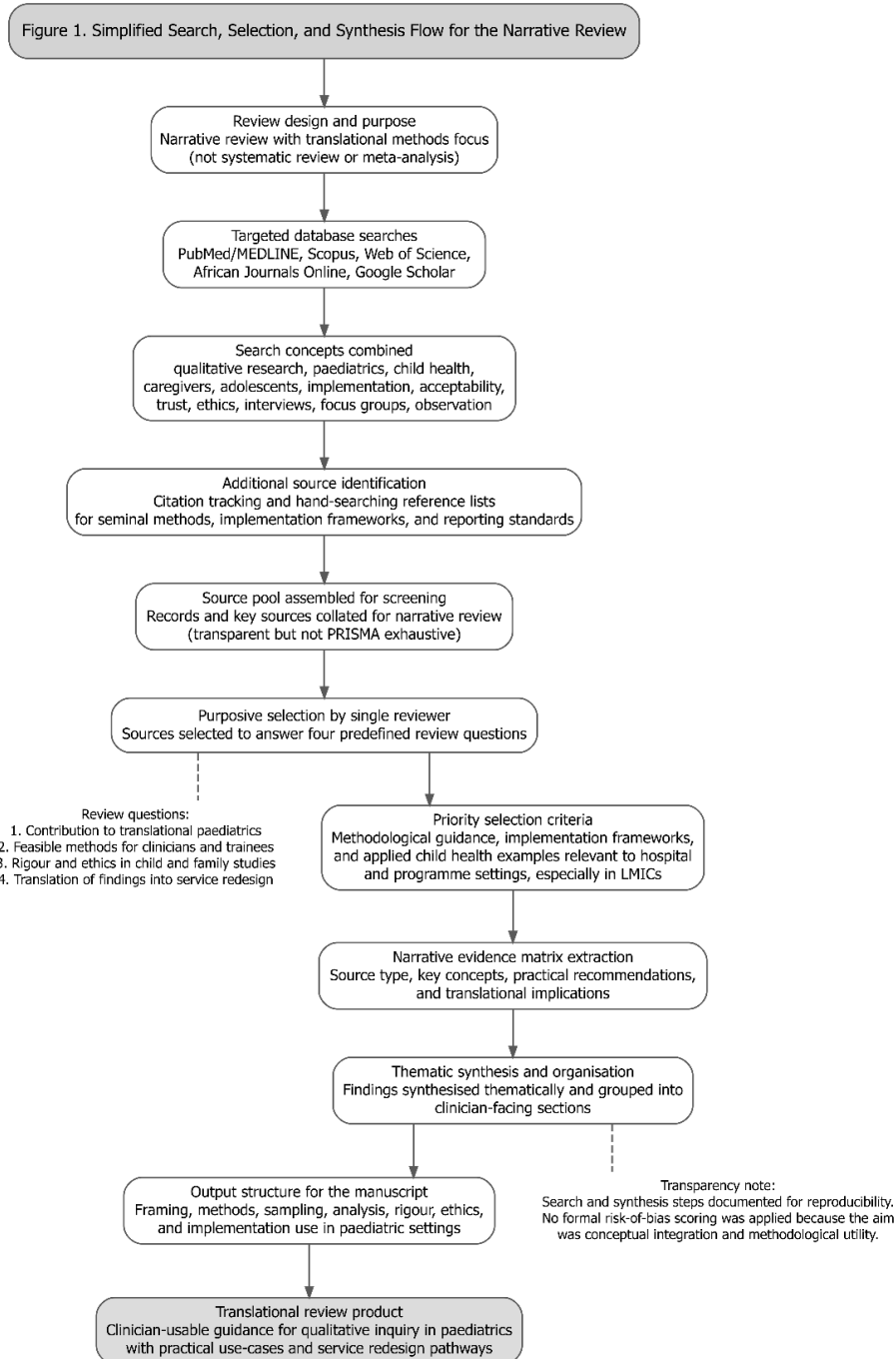


Figure 1: Simplified search, selection, and synthesis flow for the narrative review.

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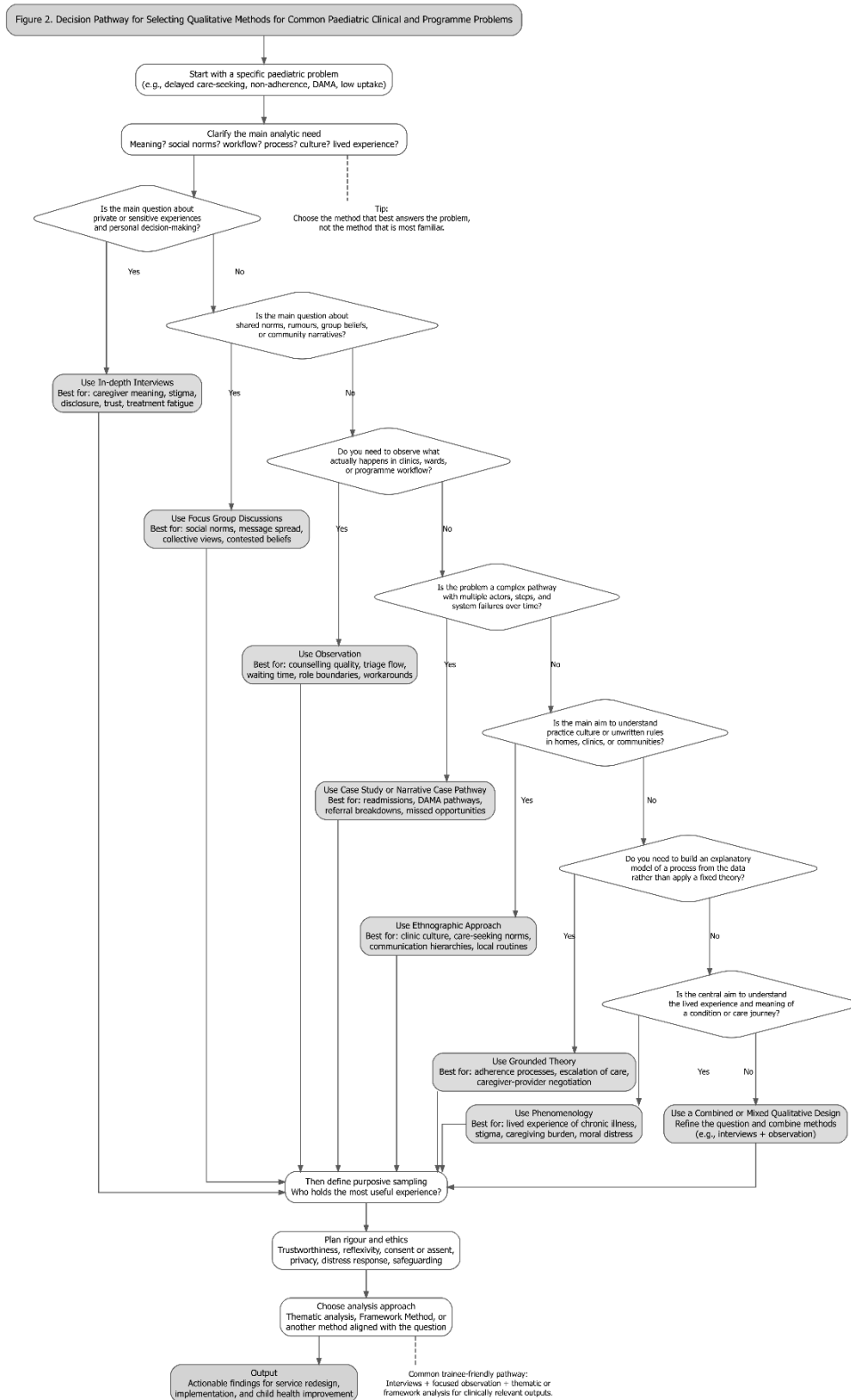


Figure 2: Decision pathway for selecting qualitative methods for common paediatric clinical and programme problems.

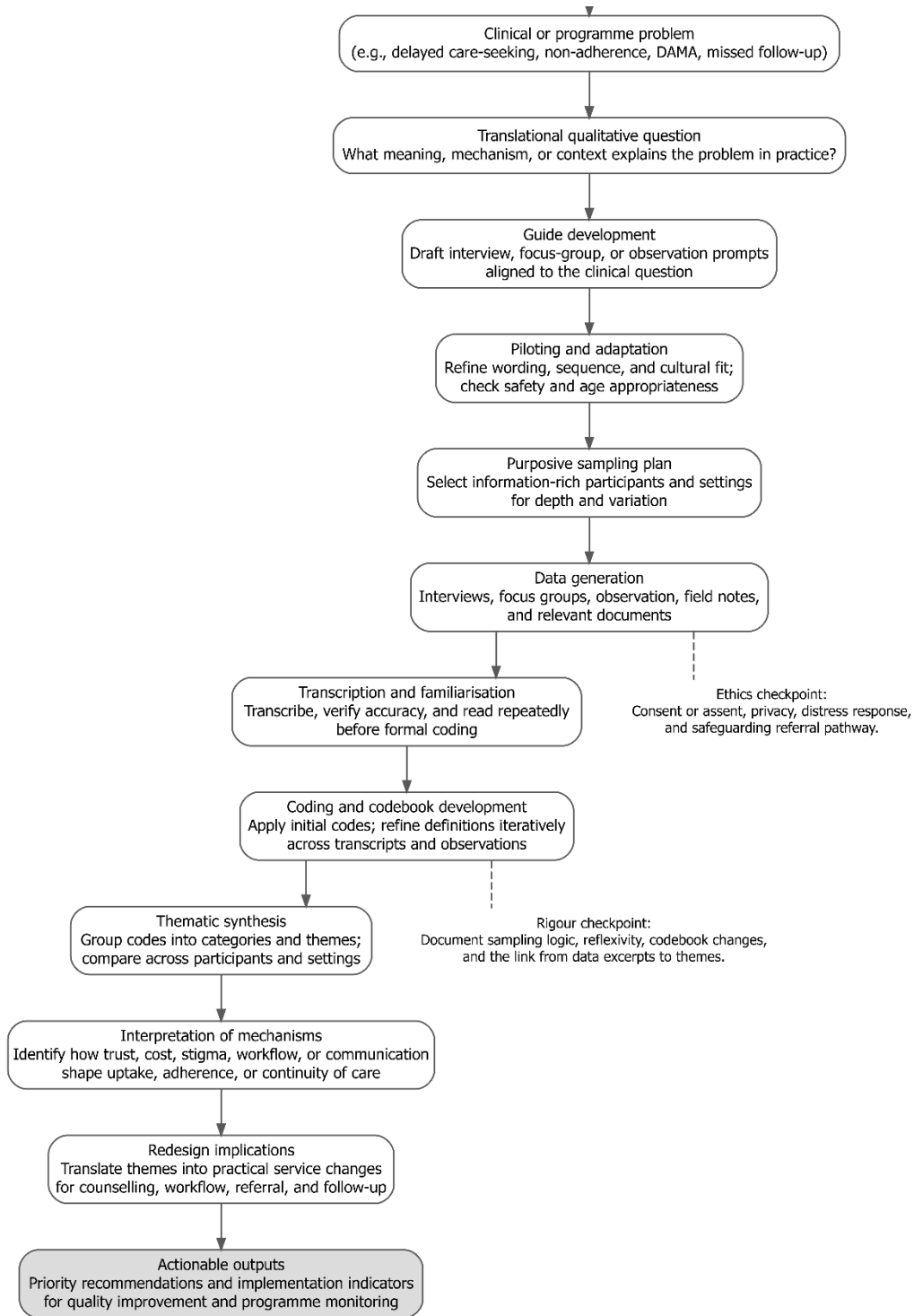


Figure 3: From clinical problem to actionable qualitative themes: guide development, data generation, coding, thematic synthesis, and redesign implications.

Translating Qualitative Findings into Child Health Improvement

The translational value of qualitative inquiry becomes most useful when themes are presented as leverage points for change. In paediatric practice, qualitative findings help explain why a technically sound intervention fails, why a service remains underused, or why families disengage after discharge. By identifying mechanisms such as distrust, hidden costs, communication failure, stigma, or workflow bottlenecks, qualitative inquiry supports redesign that is clinically relevant and contextually workable.⁴⁻⁶

Translation should be organised across levels. At the micro level, qualitative findings improve counselling, shared decision-making, and support for adherence. At the meso level, they inform clinic flow, discharge routines, referral loops, team communication, and provider training.

At the macro level, they clarify trust, legitimacy, and communication ecology, helping programme teams choose credible messengers, improve rollout sequencing, and align implementation with lived realities. Figure 4 summarises the micro-, meso-, and macro-level pathways through which qualitative findings are translated into improvements in child health services. At the same time, Table Via and Table VIb show how specific qualitative themes can be converted into practical redesign actions and measurable implementation indicators.

Clinical and Programmatic Use-Cases

Use-cases make the translational role of qualitative inquiry concrete. Each vignette should follow the same template: presenting the problem, what routine quantitative data show, what qualitative inquiry reveals, the likely mechanism, and the redesign implication. Figure 5 (Panels A–D) presents four structured explanatory vignettes that illustrate how common paediatric and programme problems can be translated from

quantitative patterns into qualitative mechanisms, service redesign implications, and feasible qualitative study designs.

Recurrent readmissions are often counted accurately but explained poorly. Interviews with caregivers and staff, plus discharge observation, can reveal how transport costs, competing household demands, unclear danger-sign counselling, and fear of judgement weaken the discharge plan. The redesign implication is simpler discharge communication, better follow-up contact, and earlier social support triage.

Adolescent non-adherence is usually documented as missed doses or appointments, but qualitative inquiry often shows the role of identity, stigma, privacy, school schedules, and communication tone. Services may fail not because counselling is absent, but because it is not adolescent-friendly. The redesign implication is to improve privacy, timing, communication style, and continuity with trusted providers.

Discharge against medical advice should be viewed as a process rather than a single event. Pathway interviews often reveal uncertainty about costs, family pressure, low trust, and communication breakdowns before discharge. This reframes DAMA as a modifiable systems problem and supports earlier interventions such as staged communication, social work review, and structured shared decision-making.

Community resistance to a new paediatric service is often labelled as a lack of awareness. Yet, qualitative work usually reveals a trust ecology shaped by rumours, prior institutional experiences, perceived hidden costs, and messenger credibility. The redesign implications are co-designed communication, visible accountability, and the deliberate engagement of trusted local channels.

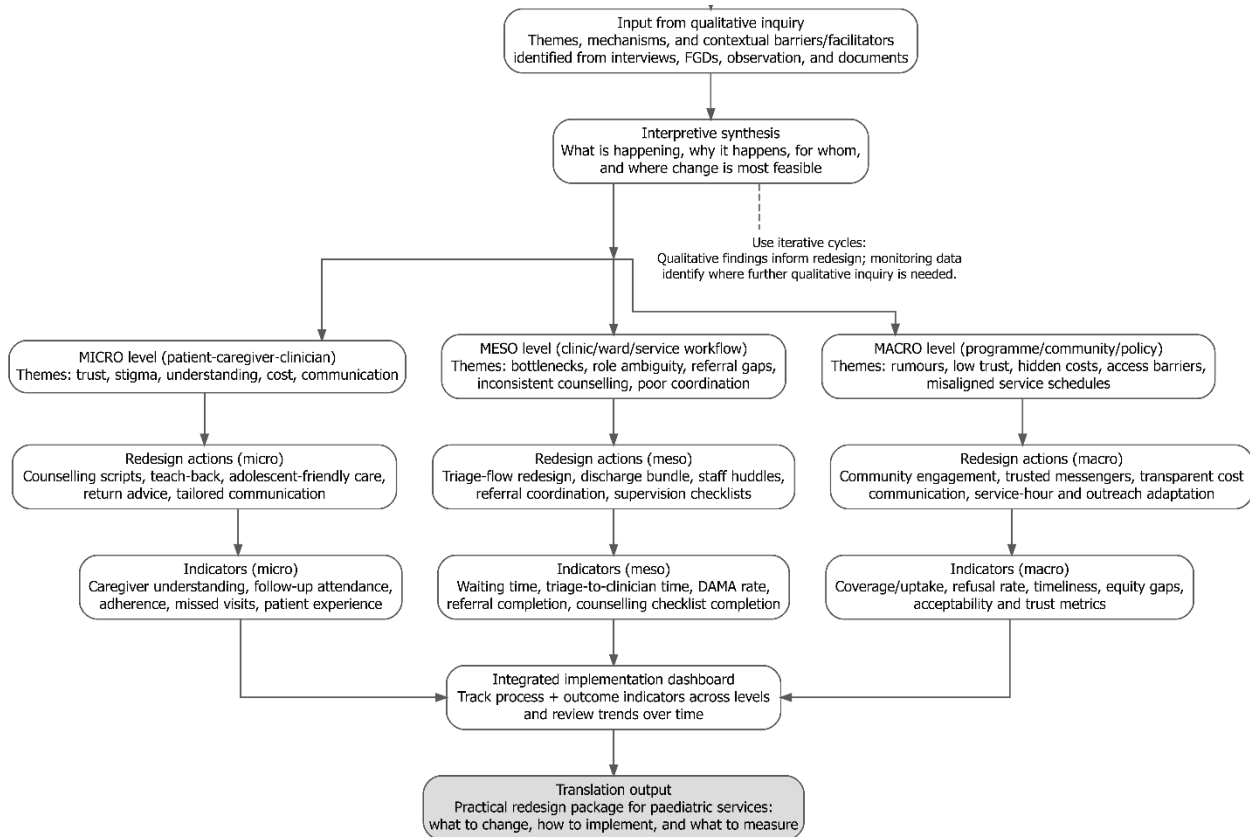


Figure 4: Micro-meso-macro translation pathway from qualitative inquiry to paediatric service redesign and measurable indicators.

Practical Roadmap for Paediatricians and Trainees

A practical roadmap helps clinicians and trainees convert recurring service problems into rigorous qualitative studies. Start with a specific failure point (for example, repeated readmissions, poor follow-up attendance, adolescent disengagement, or DAMA), then reframe it as a qualitative question about meaning, process, or context. Choose one method and do it well, usually interviews or focused observation for trainee-led work, then recruit purposively for information-rich variation.

Plan rigour and ethics before fieldwork begins, including interviewer preparation, consent and assent, privacy, safeguarding, reflexivity, and an audit trail. Analyse transparently from codes to themes to actionable recommendations using a codebook and analytic memos. Finally, test a

service change and evaluate whether it improves uptake, experience, or outcomes. Figure 6 provides a practical, stepwise roadmap for paediatricians and trainees, illustrating how to move from a recurring clinical or programme problem to a focused qualitative study, rigorous analysis, and implementable service-improvement action.

Conclusion and Recommendations

Qualitative inquiry is a core method, not an optional add-on, in paediatric translational work. It reveals whether evidence can be accepted, trusted, and enacted in real homes, clinics, and communities. Many child health service failures persist not because of a lack of evidence, but because services are rarely designed around the social, cultural, and institutional realities that shape care decisions.

Beyond the Stethoscope: Humanising Child Health Through Qualitative Inquiry (A Translational Method Review)

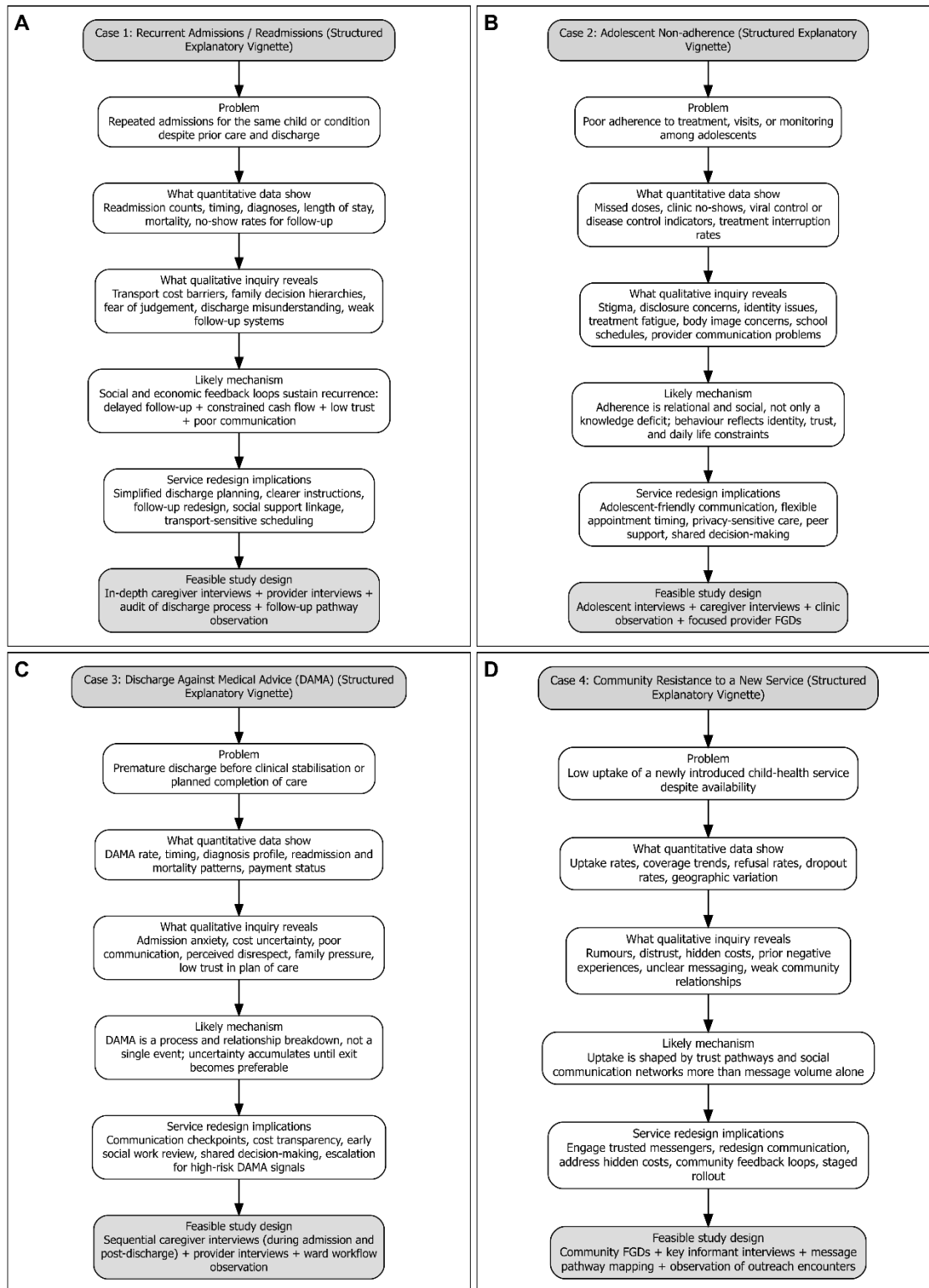


Figure 5: Structured explanatory vignettes linking common service problems to qualitative mechanisms and redesign actions (Panels A-D: readmissions, adolescent non-adherence, DAMA, community resistance).

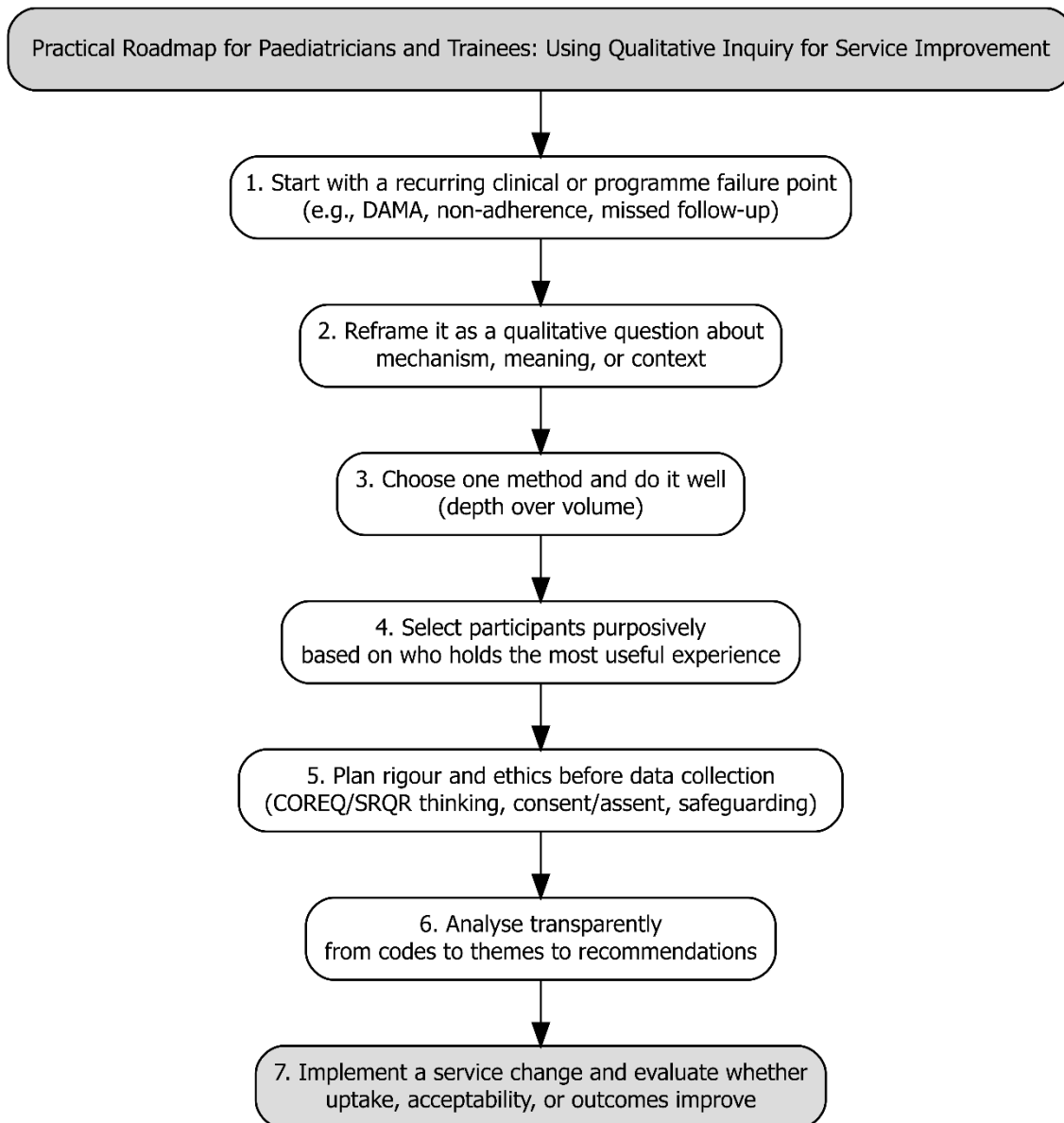


Figure 6: Practical roadmap for paediatricians and trainees: moving from a recurring clinical or programme problem to a focused qualitative study, rigorous analysis, and implementable service-improvement action.

Paediatric training programmes should embed formal teaching on qualitative methods within research and implementation curricula, with a practical focus on question formulation, purposive sampling, interviewing, observation, analysis, reflexivity, trustworthiness, and ethics. Paediatric journals and supervisors should normalise the use of explicit rigour markers in

qualitative reporting, including clear design statements, sampling logic, analytic procedures, reflexivity, and adherence to COREQ and SRQR. Ultimately, qualitative inquiry delivers the greatest value when its findings directly inform service redesign and small-cycle evaluation.

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