

Editorial

The first paper in this issue directs attention to decisions that often precede a clinical consultation: how families recognise illness, explain its causes, choose treatment, and decide when professional care is necessary. In *Perceptions, Health-Seeking Behavior and Traditional Treatment of Common Childhood Illnesses in Yemen: A Qualitative Study*, Fauzia Faraj Bamatraf examines these decisions among caregivers in Al-Mukalla. Her findings deserve particular attention because they identify opportunities for family physicians to address delays in care through better communication, safer home management, and closer engagement with the people who influence a child's treatment.

Conducted between January and May 2025, the study involved three focus groups with 21 caregivers of children under five, together with interviews with five traditional healers and observations of treatment practices. Participants were purposively selected, and caregivers had previous experience using traditional medicine or home remedies. This approach provides insight into how these participants understood childhood illness and acted on that understanding. It does not estimate the prevalence of traditional medicine use across Yemen or establish the effects of particular practices on mortality. Its contribution is to explain decisions that routine service statistics cannot adequately describe.

A central finding is that caregivers' explanations of illness shaped which treatments they considered appropriate. Participants sometimes understood diarrhoea, vomiting, or other symptoms as part of teething and normal development. Other explanations included accidental falls, the evil eye, or the perceived unsuitability of breast milk. Biomedical explanations, including poor hygiene and contaminated food, existed alongside these beliefs. Some caregivers regarded particular conditions as illnesses for which medical treatment would be ineffective and traditional treatment

necessary. Under these circumstances, knowing where a clinic is located does not necessarily lead a family to seek care there.

This distinction has practical importance. Health education that merely advises families to consult a doctor may leave the underlying reason for delay untouched. If a caregiver believes an illness cannot respond to medical treatment, repeating instructions without discussing that belief is unlikely to resolve the disagreement. Bamatraf's findings support a more attentive consultation in which clinicians ask what the family thinks has caused the illness, which treatments have already been tried, and what changes would prompt them to seek further help. Such questions make the family's reasoning available for discussion and allow advice to address the actual concern.

The study also shows that treatment decisions were shared within families and communities. Mothers consulted grandmothers, mothers-in-law, friends, and neighbours. Traditional healers offered familiar explanations and treatments that participants described as accessible and affordable. These accounts suggest that educational programmes should include influential family members and community figures. Advice given to one caregiver may have limited effect if other decision-makers continue to recommend a different course of action. Family medicine is well placed to recognise these relationships and incorporate them into counselling.

Care is needed, however, to avoid explaining delayed treatment solely through culture. Participants also described financial constraints and the convenience of home remedies. One account linked hospital attendance to the availability of money, with family-provided remedies used in the meantime. The appropriate response therefore extends beyond correcting misconceptions. Community education should be accompanied by practical attention to the cost of care, availability of treatment, and the ability to reach a functioning service. Families need recommendations they can follow.

Several reported practices warrant direct clinical attention. Caregivers described withholding breastfeeding during diarrhoeal illness, using leftover or shared medicines, and administering antibiotics without a clearly identified prescription. Only a few mentioned oral rehydration solution. These findings identify specific subjects for counselling: maintaining feeding, demonstrating the correct preparation and use of oral rehydration solution, and reviewing all medicines and remedies given to a child. WHO guidance supports oral rehydration and continued nutrient-rich feeding, including breast milk, during diarrhoeal illness. WHO, *Diarrhoeal disease*

The reported use of honey from birth also requires an explicit safety message. Honey should not be given to infants younger than 12 months because of the risk of infant botulism. Its traditional reputation or use in other clinical contexts does not establish its safety when fed to an infant. This is precisely the kind of specific, actionable information that should accompany respectful discussion of home remedies. CDC, *Foods and drinks to avoid or limit*.

The observations of cauterisation are especially concerning. They document the application of heated instruments to children's skin as treatment for symptoms including persistent diarrhoea, vomiting, cough, and fever. These observations bring a concrete child-safety concern into view. Respect for a family's beliefs must be accompanied by clear advice against harmful procedures and timely assessment of the underlying illness. Equally, the acceptance of a treatment by caregivers cannot establish its effectiveness or safety. The study records beliefs and experiences; these should not be interpreted as clinical validation of the remedies described.

Bamatraf recommends engagement with traditional healers because of their influence within the community. This proposal merits careful development around a defined purpose: recognising concerning symptoms, discouraging harmful practices, and

facilitating prompt referral. Such engagement should have explicit safety standards and should be evaluated. It must not imply professional endorsement of untested treatments. A useful programme would examine whether referrals occur earlier, whether families can act on them, and whether harmful practices become less frequent.

The paper also provides a basis for further research. Broader community studies could assess how frequently the reported beliefs and practices occur, including among families who do not use traditional medicine. Prospective work could examine the sequence and timing of treatment decisions. Educational interventions should be judged by changes in care-seeking and child safety, alongside knowledge. The value of this qualitative study lies in making those next questions more precise and locally relevant.

Khawla Faraaq Alzaitoni's review, Neutropenia in Infants, addresses a different diagnostic challenge. It describes conditions ranging from transient or self-limited neutropenia to serious inherited disorders. The practical emphasis is on interpreting laboratory findings together with age, clinical presentation, infection history, and changes over time. The review supports a proportionate approach that identifies infants needing specialist assessment while avoiding the assumption that every low neutrophil count carries the same implications. The other papers in this issue address related responsibilities in education, health-system organisation, and clinical interpretation. In *Invisible Curriculum*, Unmeasured Outcomes, Hakan Yaman and Aylin Yaman examine gaps between competency frameworks, assessment, accreditation, and feedback in family medicine training. Their conceptual analysis has a direct educational connection to Bamatraf's study: understanding a caregiver's explanation, discussing uncertainty, and negotiating a safe plan are abilities that require deliberate teaching and observation. A curriculum may name communication and community orientation as compe-

tencies without adequately establishing how trainees demonstrate them in practice.

Hakan Yaman's *Health System Expansion Without Proportional Health Gains?* examines the relationship between healthcare utilisation and outcomes in Türkiye. The paper raises questions about whether increasing service volume is accompanied by sufficient attention to appropriateness, continuity, and coordination. Its descriptive, aggregate analysis cannot establish that particular consultations or interventions were unnecessary. Nevertheless, it encourages scrutiny of what service activity achieves. Alongside the Yemeni study, it shows why both delayed access to needed care and potentially low-value utilisation require attention to the decisions and circumstances surrounding each encounter.

In *Cognitive Testing: Bedside Screening Tools and Formal Neuropsychological Assessment*, A. Abyad reviews the complementary roles of brief screening and detailed assessment. A central clinical message is that a score requires interpretation within the patient's history, functional abilities, language, education, and cultural context. Screening can identify the need for further evaluation, but it cannot supply every element of a diagnosis. This concern with interpretation is relevant across family medicine: measurement becomes useful when clinicians understand what it means for the individual patient.

The Letter to the Editor, *Data rich, meaning poor*, similarly argues for preserving the interpretation of patients' experiences within increasingly measurement-focused care.

Bamatraf's paper gives this issue its most immediate community-based priority. For practices caring for young children, its findings support a concrete change: make the family's understanding of illness, prior treatments, and ability to obtain further care a routine part of assessment. A safe plan should explain what to do at home, what to avoid, and when and where to seek help. The next step is

to test whether this approach enables children to receive appropriate treatment sooner.

Warm regards,
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