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Medical Anthropology and Pediatric Healthcare in the Age of COVID-19

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Medical anthropology has a broad and far-reaching research agenda, seeking to illustrate the inequities of the world and their impacts on health. Paediatric health and well-being are a rich part of the discipline's body of research. When it comes to integrating into US healthcare systems and impacting clinical outcomes, anthropologists are tertiary figures with little ability to shape medical policy and practice, particularly for paediatric populations. The rise of COVID-19 as a principal health concern has made the absence of practicing medical anthropologists in paediatric clinical settings more concerning than ever.

We have seen COVID-19 bring the Social Determinants of Health (SDoH), violence (both domestic and community), and health implications of the defunded educational systems to the forefront of biomedical paediatric concerns. These are tried and true areas of research for medical anthropologists. Healthcare systems across the country, however, are struggling with how to engage patients and shape policies that address these concerns. As a practicing medical anthropologist serving as paediatric clinical coordinator for a Managed Care Organization (MCO) in an integrated healthcare delivery and financing system (*i.e.*, a healthcare system which operates hospitals, primary care practices, and health insurance), I have seen the difference we can make when we demand a seat at the table.

A key example of this impact is in the current state of paediatric immunization rates (Santoli *et al*. 2020). We have seen a consistent decrease in rates during COVID-19, ranging from key early childhood immunizations such as the Rotavirus vaccine, which cannot be caught-up later, to other multidose immunizations like Measles, Mumps, and Rubella (MMR), which are crucial for herd immunity. Healthcare systems lean on approaches such as call campaigns to members about why immunizations are important and pressuring paediatricians to do more outreach for the sake of immunization quality metrics, even during times of hardship and fear like the COVID-19 pandemic. By failing to ask patients about their personal well-being during COVID-19 or their experiences with their providers, healthcare systems may make people feel more isolated and less considered, further complicating the decision to seek care. These impersonal approaches, falling into the standard top-down methods of healthcare, ignore the plethora of opportunities to connect with patients and families through qualitative questioning about fears during COVID-19.

Pushing back on these approaches, in May of 2020, I designed a training for telephonic outreach staff around anxiety, fear, and identifying needs during COVID-19. By walking members through their health concerns à la Spradley's Mini-Tour questions (Spradley 1979), we have seen higher engagement from families of children due for preventative care visits. This model looks to ask a parent or guardian to describe a specific topic area in their lives and how they experience that topic. In this case, families were asked, "what are your concerns around COVID-19 and accessing care?" After talking through the answer(s) to this question, call representatives can then connect the parent or guardian directly to their paediatrician to

have a shared and supportive conversation around COVID-19 concerns. We noticed that parents and guardians who had been part of conversations where ethnographic interviewing skills were used had begun expressing an increased comfort level in articulating their concerns, seeming more confident in asking questions of their providers, and showing better adherence to preventative care services including childhood immunizations. By using an anthropological lens in the healthcare setting, making and keeping a preventative care appointment became more accessible for these families.

We have a unique skillset as medical anthropologists, with an opportunity to connect high-level policies, clinical interventions, and personal experiences. The consistent reinforcement of top-down policy in US healthcare has few tangible, positive impacts for individuals and misses the opportunity to identify their complex needs. Children always feel the acute failures of this system, particularly during COVID-19. With a medical anthropological perspective in the conversation, we have been able to open our processes to include conversations between patients and providers around concerns, fears, and tactics. The person-centered nature of medical anthropology positions us to offers unique insights not found in other medical fields. We have, and should continue to, offer our insights and skills as consultants for all forms of health delivery systems. COVID-19 has made it clear, though, that medical anthropologists must step into more practicing healthcare roles to impact practice and policy and to improve paediatric health and well-being.

References

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