Anthropology Now

ISSN: 1942-8200 (Print) 1949-2901 (Online) Journal homepage: https://www.tandfonline.com/loi/uann20

Where Have All the Children Gone? Against Children's Invisibility in the COVID-19 Pandemic

Julie Spray & Jean Hunleth

To cite this article: Julie Spray & Jean Hunleth (2020) Where Have All the Children Gone? Against Children's Invisibility in the COVID-19 Pandemic, Anthropology Now, 12:2, 39-52, DOI: 10.1080/19428200.2020.1824856

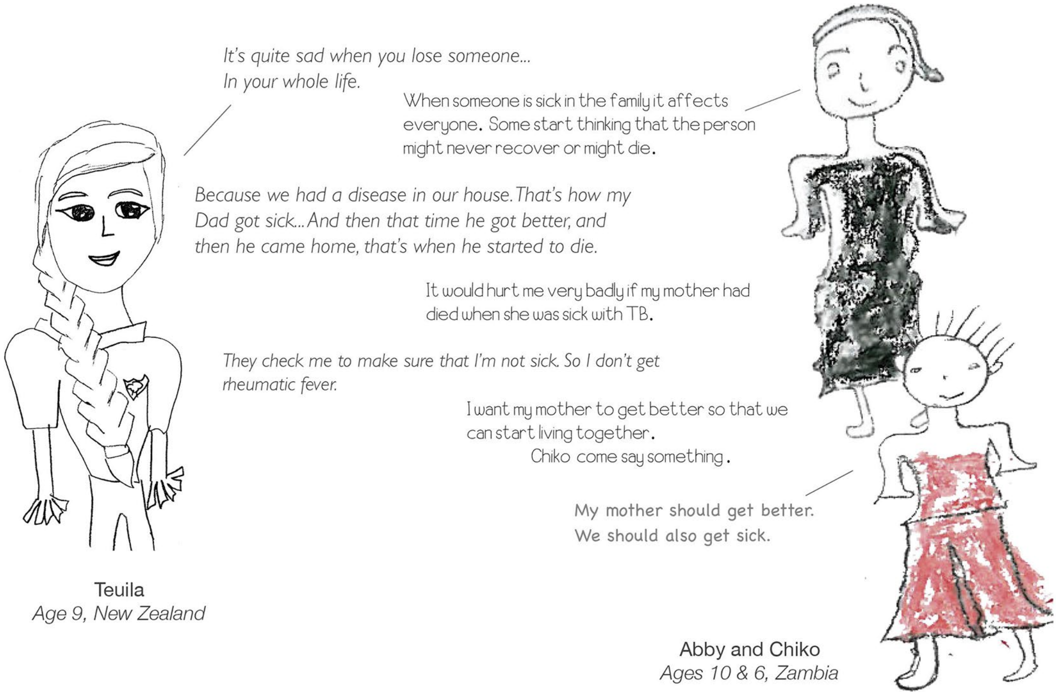
To link to this article: https://doi.org/10.1080/19428200.2020.1824856

an anthropology of the
COVID-19 pandemic

Where Have All the Children Gone? Against Children's Invisibility in the COVID-19 Pandemic

Julie Spray and Jean Hunleth

Teuila, a Tongan migrant living in New Zealand, and sisters Abby and Chiko, who live in Zambia, have never met each other in real life. But their stories, narrated to Julie and Jean, respectively, speak to each other across time and space. They represent global experiences of childhood, and the commonalities of family illness for children that transcend national borders, cultures, local illness experiences and the particularities of disease. Teuila speaks to Abby of the respiratory illness that killed her father in their damp, overcrowded Auckland home and the "sore throat" swabbing she seeks from the school nurse as part of a national rheumatic fever (RF) prevention programme. Abby reflects to Teuila the threat of losing a parent, whether to death or separation as part of protocols to prevent tuberculosis (TB) transmission from parent to child. "We should also get sick," adds Chiko, because in wishing to contract TB themselves, the sisters envisioned their reunification with their mother, and their relocation within the interdependent webs of care that represent their social life and their security.



Teuila
Age 9, New Zealand

Abby and Chiko
Ages 10 & 6, Zambia

Anthropology Now, 12:39–52, 2020 • Copyright © 2020 Taylor & Francis Group, LLC
ISSN: 1942-8200 print / 1949-2901 online • https://doi.org/10.1080/19428200.2020.1824856

The problem here is that Abby's, Chiko's and Teuila's experiences with TB and RF programming have been invisible to the adults who design and fund the health programmes that shaped their lives. And we see this troubling trend in public health and policy approaches to COVID-19. We write this piece to work against children's invisibility in the time of COVID-19, taking lessons from Teuila, Abby and Chiko and from what we learn by placing them in conversation here. Through this conversation and the drawings that the girls produced, we experiment with a form of co-writing and co-construction of children's narratives and images. Through using children's modes of expression, play and creativity, we show what children can tell us when we're willing to listen. We also reveal the pathways for including children's perspectives into efforts to create better possible futures during and in the aftermath of global crises.

Our studies on TB in Lusaka, Zambia, and RF in Auckland, New Zealand, provide an apt starting point given the similarities between the COVID-19 pandemic and TB and RF. Abby and Chiko were living through a TB epidemic that affected their low-income, high-density residential area especially hard and is still ongoing as concerns shift to the COVID-19. The girls participated in Jean's Children as Caregivers study in 2007 and 2008 when their mother was experiencing some of the worst symptoms and social effects of TB. She was coughing, frail and unable to do basic day-to-day tasks on her own, and she, along with her children, had been kicked out of her home by a husband who did not want a sick wife. Abby and Chiko's mother was taking TB medications and for two months was separated from her daughters to prevent the spread of the infection to the girls and because their extended family did not have the caregiving capacity or space to accommodate mother and daughters together. Teuila spoke to Julie in 2015 in the South Auckland school where Julie conducted fieldwork after Teuila's father had died from pneumonia. Along with other children in her school, Teuila engaged with a government intervention to reduce RF deaths through school-based strep throat testing and treatment. Although pneumonia and RF are distinct diseases, a 9-year-old's experience of losing her father from one becomes inextricably linked with the other.

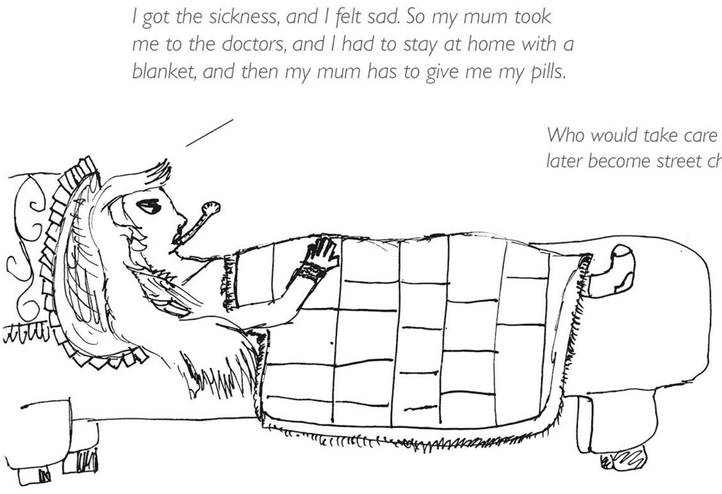
The COVID-19 pandemic is, of course, different from the TB and RF epidemics, both biologically and in the scale and widespread social disruption it has caused. But what we have learned from our work with children such as Teuila, Abby and Chiko is that political and policy responses to disease that fail to account for children's experiences fail to care for children. They reinforce the power structures of age, and they compound existing inequities for both children and adults. In Jean's work on TB, she has shown that entire policies get written without regard for how children respond to disease. Julie has shown this is the case *even when* children are the targeted group. Considering children's actions and experiences is imperative for creating sensible and effective policies on TB and RF that benefit not only children but everyone. The COVID-19 pandemic, and its scale, makes it exceptionally clear to us that we need a future where children's experiences and responses to disease are taken seriously.

Resisting Children's Invisibility

Abby spoke these words through Jean's recorder to an imagined teacher, impressing her younger sister Chiko with her boldness. The story she wanted to tell, Abby continued, was one in which her mother came home to live with and be cared for by Abby. Not the story authored by clinic workers and family members, or by a global TB treatment industry that has ignored children's roles in the TB epidemic.

After Teuila's father died from pneumonia, her story did get told by the New Zealand media, but the images that circulated nationally did not resemble Teuila's illustrations of her life. Teuila's drawing shows her experience of strep throat, but through her embroidered quilts and decorated bedstead she emphasises the care she received from her family. "And sock," she made sure Julie saw. The sock was an important detail. Teuila likely did not have her own bed, and in her retelling of what happened when she was sick she describes lying on the couch. But in her drawing she is princess-like—important to the family who cared for her enough to make sure she was warm, right to the tip of her toes.

Children have their own stories. They tell those stories from their own perspectives, distinctly positioned in social organization, space, time and body. Abby's stories come from witnessing her mother's life. When a girl, her mother cared for parents, who died slow, ugly deaths once separated from TB and HIV; she missed out on the education and job needed to support herself once separated from an abusive husband. Teuila's stories come from her perspective as the big sister in a large



Tongan family, as the younger classmate stronger in the language of drawing than English and from a life in which socioeconomic disadvantage is less recognizable than the love and care of close relationships. These are not perspectives that adults, from their adult social position and adult bodies, can assume.

Yet children know that adults are usually the ones to author their stories. Abby and Teuila both wrote or drew stories that countered national and international narratives about their lives. They positioned themselves as caring *for* themselves and others and also being cared for *by* others. They told stories in response to the stories that adults were telling about them, and they offered needed correctives to those stories. The story that Abby heard often about her life came from social messaging on billboards and wall fences, from politicians and nongovernmental organizations on the radio or television and in the songs children sang in school programming to combat HIV stigma. This story was that without a mother, she would end up as an orphan, unable to go to school, abused by relatives and living on the street. She repeated a common refrain among children in Zambia about the trajectory of a child whose parents become ill: that death is imminent, leaving a child an orphan who then becomes a street child. Thinking to her own future, she imagined and resisted the life scripted for her. While the media focused on her damp and leaky home, Teuila showed us the importance of a sock. Abby's and Teuila's words and drawings, in conversation, remind us that it is mostly adults now authoring children's stories in the time of COVID-19.

So how are adults representing children in public health and media approaches to COVID-19? On the whole, we see few children's stories. Instead, we see a large-scale *invisibilising* of children. We see children's *dis*-appearance, first in how they are ignored or minimized: in the way that COVID-19 projects proposed and funded at our own university focus on people "above the age of 18" or how leaders forget that children exist. This ignoring reflects the political status of children. In the United States, the relationship between the state and children is mediated by parental rights, with the assumption that children are the sole responsibility of individual caregivers, not society. Consequently, public policy around COVID-19 has tended to delegate all consideration of children beyond medical advice to parents, with little support.

Meanwhile, when a handful of national leaders held COVID-19 press conferences for children, coverage went viral. These were unusual exceptions to an unspoken rule. Even then, that coverage focused disproportionately on the fates of the tooth fairy or Easter bunny, diminishing children's worries as cute but dismissible and ignoring children's less dismissible concerns about family members taking ill, unemployment, schooling or social precarity. As the well-established field of childhood studies has taught us, these representations come, in part, from social constructions of children as innocent, incompetent and in need of adult protection. We don't *want* to hear children's real stories, because their reality does not match what we think childhoods *should* be.

This is a second way that adults make children's stories invisible: by controlling their authorship. We see adults attempting to closely control how children perceive their reality: see the proliferation of opinion pieces advising parents on how to talk to children about COVID-19 (which often end up as "what to tell children"). We are not speaking against such advice pieces, which have their place. But we would point out that children do not live in worlds isolated from illness and illness messaging, no matter how much the adults ignore them, attempt to control the messaging or silence themselves and others in children's presence.

As well as the messages Abby heard about TB in Zambia, Teuila in New Zealand heard RF campaigns aimed at parents that showed what can happen to children whose strep throats go untreated. In both countries, children repeated slogans from TB, HIV and RF campaigns like mantras: "If you don't take your TB medicine, you will die"; "My brother almost died. Sore throats can kill." In pandemics and outbreaks, illness and illness messaging is everywhere. As Jean walked down the street with her 4-year-old near her St. Louis home, they saw messages in the masks people wore, the signs in yards and the chalk on sidewalks. Jean and her son felt these messages in their bodies as they tensed up and tightened their grips on each other's hands when someone came too close. What happens when the story we try to create for children conflicts with their realities?

Finally, we see children's invisibility in the absence of attention to the full spectrum of their needs. Children are undoubtedly experiencing terrible hardships, particularly those already marginalised through racism, colonialism and economic disadvantage. Kids across the United States and elsewhere are now experiencing in-person classrooms, online learning or some shifting combination of both, and all of these permutations carry unique challenges for young people. There are children and young people who are living in unsafe situations or with family violence without school as their usual escape and support system. They are experiencing prolonged disconnection from the in-person peer interaction and physical intimacies critical for social and emotional development.

And there are young people who are taking photographs of maskless peers in crowded school hallways, experiencing fears, insecurities and anxieties about the health and security of themselves and their families. Children of essential workers may have been left without caregivers or had to physically distance from parents. Children's caregivers may have died. Young people are graduating into a world with no jobs, or had to forfeit college to contribute to their families, or where the money earmarked for college tuition may now be needed to replace parental income. Where are their stories?

Instead, public health and news media have been largely preoccupied with debating and evaluating a much narrower version of risk: Can children catch COVID-19? Can they be severely affected? Can they spread it? As children's apparent near-immunity in the early months of the pandemic subverted the narrative of vulnerable children and protective adults, we immediately saw children reconstructed as risks, as threats to adults through their potential as asymptomatic carriers of disease. As a body of scholarly literature in youth studies can attest, adult fixation on the risky child trope is common; as those holding power over the reproduction of society, if young people are not under adult control, they pose a threat to the social order. In the following months, debates about children's risk flipped once again with the identification of a rare paediatric inflammatory syndrome associated with COVID-19. While these are important considerations, particularly for determining schooling and childcare strategies, they reduce childhood well-being to just physical health and render children as merely risky bodies, not human agents who actively contend with a multiplicity of challenges. As we see in our research, this is the calculus that leaves children out of TB and RF programming, to the detriment of both children *and* the interventions.

What are we missing when we invisibilize an entire social group? As has been widely noted, COVID-19 has exposed the impracticability and unsustainability of children's position in society. Parents have struggled with the impossible demands of being simultaneous caregiver, essential worker, wage earner, teacher and psychologist. Teachers are now struggling with the impossibilities of physical distancing.

Our fieldwork experiences with children were of constant physicality, bodily intimacy and closeness. The children Jean worked with repeated a refrain of "wanting to be closer" to family members who were sick, going to great lengths to retain proximity or get back to family when they were separated. The schoolchildren Julie worked with sat with their thighs snug against hers, hugged her, held her hand. They combed their teacher's hair, interlinked their limbs, tangled their bodies in soccer games. What does it mean to enforce physical distancing at school when children's well-being, development and modes of expression are all about proximity? Meanwhile, children may be doing many things that we don't expect because we don't think of them as fully human yet. Children may be picking up messages we didn't expect them to hear because we segregate them from public life and think that because we don't recognise them, they can't see us. Children may be contributing their care and labour invisibly. This is because we think of them only as passive recipients of care and because of assumptions that children do not work, only play.

So where do we find children's stories, and how do we listen to them? If children's stories do not come in adult form, this does not make them less than. In New Zealand, high school student Aigagalefili Fepulea'i-Tapua'i Instagrammed her cry for equity in response to COVID-19, writing in a viral post, "like any kid wants to write essays when they have to deal with being beat up … if education is key, why do our locks keep changing?"[1] Teuila expressed herself most confidently through drawing. Through this mode of expression she also memorialized her father, whom, she explained to Julie, is—present tense—an artist who taught her to draw. Chiko annotated her big sister Abby's stories, but in doing so she tells one of her own as someone who, at 6, knew it was transgressive for children to contest the stories adults write. Authoring children's stories means shifting from an adult-centric focus on verbal articulation and relearning the languages of childhood, the technologies of youth, to translate children's perspectives for adults who don't know how to hear, without colonizing them with adult agendas. This is our responsibility.

What Do Children Do in a Pandemic?

Teuila and Abby are saying that children are enmeshed in networks of care. They are dependent on parental care in worlds that are hostile toward children's needs, but their adult kin also get sick. They ensure their survival, and the survival of their parents, through care that flows both ways. And these relations of care shape the health of everyone.

Every person in this world,
one way or another gets sick.
No one is as strong as metal
and doesn't get sick.
We all get sick.

Sometimes I help my mum,
and do something for her.

Whenever I'm sick.
I get a scarf to put it around my neck. Get two
clotheses, put it on. Get one jacket, put it on.
And get a long pants, and go with it to school.
Whenever I'm sick.

The global TB protocols ignored Abby's efforts to care for her mother, and her strong belief that she was the person who cared enough to give good care to her mother. Global and national TB programming does not ignore care or social support. Yet those considered "TB treatment supporters" or caregivers are always adults. Likewise, RF programming in New Zealand gave little consideration to children, even as children were the target of interventions. When children had sore throats, their parents were expected to take them to the doctor to get their throats swabbed. Health promotion aimed to educate parents and compel them to take action. In both cases, and now with COVID-19, policymakers have black-boxed the part where children experience these protocols in their bodies and relationships—the part where children *do* things that have bodily, relational and social effects.

Yet while children *do things*, they are not super-agents. Their agency is shaped by the opportunities and constraints of their worlds, which are often not of children's own making. So Teuila wraps up in two sets of "clotheses" when she's sick, but she is still going to school. In the classroom, she shows Julie how she has an extra T-shirt concealed under her uniform polo. She wears this T-shirt because she sometimes comes to school cold, but she doesn't have a school uniform jacket or jersey, and the school policy will not allow children to wear nonuniform clothes.

Relatives still cleave Abby from her mother on the advice of clinic workers, severing their mutual care and limiting Abby to imagined forms.[2] How, then, do we challenge children's invisibility while holding that children are not super-agents and without placing undue responsibility on them to maintain their health and that of others? In our respective writings about children in Zambia and New Zealand, we advance the concepts of interdependence and coproduction to position children as actors in global health interventions, in their families and communities and in producing their own health.

Interdependence under Covid-19

Abby drew for Jean what it was like to care for her mother. She made her food and fanned her when she slept. Not pictured, Abby also monitored her mother's daily TB medications, without which Abby said "you die." She worried when her mother was too weak to walk to the clinic to submit sputum for a test needed to see if the medicine was working. She eventually offered to take the test for her mother. She did these things with love, something she had in abundance for her mother and that she felt others might not. And her mother also loved her. She depicted the reciprocal love and work above, saying my mother "helps me wash the clothes" when she feels up to it. *Feelings* of care, Abby told Jean, affect the way people care—and if they remember to give care at all. *She* could not forget her mother's medicine and other needs because she cared, and because she had so much at stake. Abby made clear that her long-term well-being depended on her mother's recovery from TB. And she was determined to ensure her mother's survival.

This was a heavy weight to carry. No one around her seemed to recognize this interdependence except for Abby, Chiko and their mother, who, as Abby complained,

was just "being told" what to do by other people—clinic workers and family members. Abby noted often that her mother's physical proximity and survival kept Abby from becoming an "orphan," a child who is overworked, abused and left to fend independently in the households of relatives or on the streets of Lusaka. Her mother cared enough to ensure that she stayed in school and had everything she needed for the future, making the family's enforced separation of mother and daughter especially troubling to Abby. These two themes—caring for her mother and receiving care in return—were woven together. Spotlighting the interdependence of these relationships draws attention to the ways in which care flows between adults and children, healthy and sick.[3]

In global TB control efforts and their local implementations, the problem is often framed as an adult one in which adults get sick with active TB disease and other adults support them, or not, within macrolevel processes that promote medication above other social, economic and political change. If children come up at all, the problem is their proximity to sick adults because of transmission risks and the possibility of harm to the child, the person who is sick and the household because of a child knowing about the disease. The child could lose hope, cause the sick person to lose hope or stigmatize an entire household if she revealed the disease haphazardly as children are believed to do. From a child-centered perspective, this means that an entire group of people (children) are being ignored or seen as victims or perpetrators. Interdependence offers a corrective to a more adult-centric view of children as un-agentive and of care as flowing unidirectionally from active adult to receptive child.

COVID-19 makes evident how interconnected and interdependent people are. The dependencies between people—particularly in the absence of structural or systemic support—have become the subject of many articles on the pandemic. Almost absent, however, are discussions of the interdependencies between children and adults. We suggest that a view of these interdependencies offers insight into many of the topics that are at the forefront of the news.

Here are just a few examples. Much has been said about how to talk to children about the pandemic, but little advice is offered on how to listen to children. Seeing and supporting even very young children's care given through a drawing, a glance, a fantasy, a house chore offers an opportunity for communication and connection. And, as Jean's work on TB has shown, not telling does not mean that children lack knowledge or that what is directly told *to* children is the extent of their knowledge. Further, little is written about children's care work in the pandemic. Two questions need to be addressed: How are children supporting households and sick persons or younger siblings when schools are closed or when guardians are essential workers? How about when hired care workers are not allowed in the home or in close proximity to persons who need care?

Coproducing health with COVID-19

Teuila told Julie that she came to the school clinic about every two weeks to be swabbed for streptococcus A, even when she didn't feel a sore throat, "because I have to take care of myself … so [I] don't get rheumatic fever." She thought she might be sick, she said, because sometimes her sister was sick, or her mum and dad—or rather, just her mum. Teuila some-

Sometimes I help my mum, and…
do something for her.
Whenever I'm sick.

I get a scarf to put it around my neck. Get two
clotheses, put it on. Get one jacket, put it on.
And get a long pants, and go with it to school.
Whenever I'm sick.

times caught herself talking about her father as though he were still there. "And that's why I come here every day, to make sure that they don't sick at me. Like, make sure that they don't get germs at me?" Teuila was acutely conscious of how disease spreads. Her stories are laden with references to drinking contaminated water and sharing germs through cups and bottles for drinking. If she came to the clinic, the "science people" could check her to make sure she wasn't sick with the germs, like those that killed her father.

The problem with children presenting *too* often to be swabbed, from an intervention perspective, is that the tests are expensive. Clinic staff worried that the children they saw on a weekly basis were wasting resources. The problem from a child-centred perspective is that children are inequitably burdened with the responsibility of monitoring their health, undue anxiety about their well-being and fear they might die. It is possible that both outcomes could have been avoided by a policy that recognised children's agency and their humanity. Children do not have health handed to them. They *coproduce* their health, and *what they do* matters and must be taken into account.[4]

Teuila is the person who did or did not identify and disclose a sore throat. *Teuila* elected to engage with the clinic, and those practices partially determined whether her throat was swabbed, her strep throat treated and her risk of RF mitigated. But what children do is also contingent on their social circumstances. While adults can often conclude that if they don't understand children's behaviour it means children are irrational or ignorant, Teuila's practices are even more understandable when we take into account her family circumstances. The boys in the campaign poster, she told Julie, were her cousins, although she didn't know them well. "What are you worried about?" Julie asked her, and she responded, pointing at the boy with the scar in the picture, "I worry about that I might get one of those … my, what my cousin's got?" Children's practices are rational, once we understand their contexts.

So how might we think about children as coproducers of health in the age of COVID-19? Children's perceptions and practices are relevant at multiple junctures. Children will play a role in their own exposure, especially at school. Teachers can encourage physical distancing, masks and handwashing, but children have their own social lives and produce their own cultural meanings. Children in peer cultures will decide whether these are resisted or appropriated into new games and social ways of being. How that will happen will depend on many things, including how children are presented with information about the associated inflammatory syndrome.

Children also have a major role in symptom perception and disclosure or concealment. Much like the sore throat swabbing for RF prevention, children's symptoms are not always detectable by anyone besides themselves, and even then, children may not have learned to distinguish "symptoms" from other unpleasant sensations of the body. Caregivers and children will need to work together to identify when children are sick. Children also contribute to their own self-care if and when they are ill; while caregivers may make decisions about when to see a doctor or whether to administer drugs, children can rest or play, drink or abstain, take medication or share pills with siblings.

How might children shape health during COVID-19?

The care provided by children such as Abby, Chiko and Teuila was not only symbolic. When they took on housework, fetched tea, made meals, helped with toileting or delivered medication, they also materially shaped the health of their family members. They allowed others to conserve energy, ensured adequate nutrition and hygiene and facilitated adherence. When we think about children as coproducers within webs of interdependencies, we are saying that children, as both receivers and givers of care, also coproduce the health of family members, friends, neighbours and teachers. Children may be the most invisible medical labour force of all, but they *are* essential workers.

Through their self-care practices, too, children are not only coproducing their health. They are also working on and through their interdependent relationships. Children can care for others *by* caring for themselves, Teuila tells us. She helped her mother by taking care of herself when she was sick, by layering up with extra "clotheses" and going to school. Another child at Teuila's school, Mila, told Julie about how she came to the clinic to be swabbed so that her ill mother would not worry about her. By protecting their own health, children eased the mental load of their caregivers, supporting their caregiver's well-being. They also work toward maintaining the health of others to ensure their social survival. As Abby told Jean one day, she had cooked, cleaned and taken care of her mother's and her siblings' needs. "If my mother died when she was sick with TB, who would take care of me? I always pray to God to let my mother take care of me at least up to a stage where I can take care of myself and do the same for my sister and my brother."

Children's practices are empathetic and make sense in their contexts, but may not always align with adult health goals. Teuila told Julie about how she would only take the an-

I'm cooking nshima and relish for mom. Mom is sleeping and she is sweating so she told me to fan her with a t-shirt.

Mom is now eating what I cooked for her..

I give them a tea, give them a biscuit, and- and also… turn off the TV or turn to another channel. And… make, and make them stand up and go to the toilet.

I have to help myself and help my family too, because if my mum helps me, then I'll help her? And together, we are family. We have to work as a team.

tibiotics for her strep throat every second day, so that her brother and sister could have a turn on the alternates. In doing so, she cared for her siblings as well as protected herself from their germs, and she shaped both her own health status and theirs, though not in the way that health professionals may have anticipated or desired. Abby and Chiko tried to stay near their mother with TB, because to them the benefits their care provided to their mother outweighed the risks of contracting TB.

These dynamics are also at play during COVID-19, even if we're still reckoning with their nature. Children will care for siblings so that parents can work to pay health care bills. Children will watch ill parents and alert others to symptoms or declining health status. Children, if sick or exposed, will elect whether to participate in physical distancing. This is a way to think of children, not as carriers or victims, risks or responsible, but as family members who, like any other family member, feel motivated to care for and protect their loved ones just as much as they need closeness. This is why it is critical for policymakers to understand the dimensions of children's needs and motivations in context and to address these needs as part of a holistic intervention. Children matter, and they can shape the health of others in meaningful ways.

Toward Possible Futures

Anthropologists have long known that moments of crisis reveal us to ourselves. But crises also offer opportunities for change, for reexamining the architecture of our societies and transforming the systems, structures and assumptions that create suffering with new values and new ways of thinking. As we listen to Teuila, Abby and Chiko, we hear in this moment a way to reenvision children's roles in health, toward a future where policies and practices see and include children. We see in the scale and visibility of COVID-19 an opportunity for visibilizing children so that the same tropes about childhood do not get reproduced with every crisis. For one thing is certain: The threat of COVID-19 may wane through vaccination and other measures, but this is not the last time we will face a global pandemic, and health crises will always be present. How do we want to see and hear children next time?

Through their stories, Teuila and Abby also tell us about the future childhoods this pandemic is making. COVID-19 will have lasting effects on children, shaping the childhoods of those who aren't yet born and stratified by existing socioeconomic differences. The social life of disease lingers; we see this in the way that orphanhood discourses shaped Zambian children's experiences of TB long after it became inappropriate to call children orphans to their faces. And disease becomes embodied in deeply habituated, largely unconscious ways; for Auckland children, common complaints of sore throat reflected the way their attention was repeatedly drawn to their throat and associated with death. During COVID-19, we see new social and bodily practices become routine: handwashing, mask-wearing, physical distance, new childcare arrangements, new ways of being together when apart. We see some children gaining time with parents at home. We see some children losing access to education, and some losing grandparents. How will we keep cognizant of the changing social category of childhood, as well as these new ways of learning to be human?

Teuila, Abby and Chiko tell us that the way is to listen to children, to acknowledge their perspectives and to address the needs they share with us. And so they will have the final say here, through Abby's words and Teuila's drawing:

“Don't under-rate me because I am young.”

Notes

1. https://www.instagram.com/p/CAUvntwnQ3H/?utm_source=ig, Posted May 18 2020.
2. Jean Hunleth, “Zambian Children's Imaginal Caring: On Fantasy, Play, and Anticipation in an Epidemic,” *Cultural Anthropology* 34, no. 2 (May 2019): 155–86. https://doi.org/10.14506/ca34.2.01.
3. Jean Hunleth, *Children as Caregivers: The Global Fight Against Tuberculosis and HIV in Zambia* (New Brunswick, NJ: Rutgers University Press, 2017).
4. Julie Spray, *The Children in Child Health: Negotiating Young Lives and Health in New Zealand* (New Brunswick, NJ: Rutgers University Press, 2020). https://doi.org/10.2307/j.ctvvh85fc.

ORCID

Julie Spray http://orcid.org/0000-0001-7382-8704
Jean Hunleth http://orcid.org/0000-0003-4516-4407

Julie Spray is a postdoctoral research associate in the Division of Public Health Sciences at Washington University in St. Louis, Missouri. A medical and childhood anthropologist, she argues through her work for greater inclusion of children's perspectives in health policy and of children as participants in their health care. Her recently published book, *The Children in Child Health: Negotiating Young Lives and Health in New Zealand* (Rutgers University Press, 2020), features children's experiences of a rheumatic fever epidemic against a backdrop of colonization, poverty and social marginalization. She has also written about children's perspectives on the pandemic for the popular New Zealand news site *The Spinoff*. She can be found on Twitter @JulieSeraSpray. Jean Hunleth is her favorite coproducer and American.

Jean Hunleth is Assistant Professor of Surgery and Anthropology in the Division of Public Health Sciences at Washington University in St. Louis, Missouri. Her work with children living through epidemics has appeared in her award-winning book *Children as Caregivers: The Global Fight Against Tuberculosis and HIV in Zambia* (Rutgers University Press, 2017) and, most recently, in “Zambian Children's Imaginal Caring: On Fantasy, Play, and Anticipation in an Epidemic,” published open access in *Cultural Anthropology* (2019). She recently discussed children's carework in the context of COVID-19 on *Anthropod*, the podcast of the Society for Cultural Anthropology. She is currently studying family caregiving for children in Zambia's only pediatric hospital in the time of COVID-19. She can be found on Twitter @jhunleth.