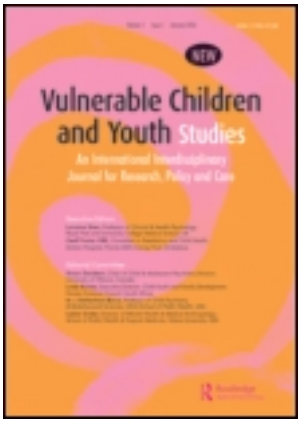

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AIDS orphan tourism: A threat to young children in residential care

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AIDS orphan tourism: A threat to young children in residential care

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The dominant global perception that sub-Saharan Africa is experiencing an "AIDS orphan crisis", coupled with growing trends in international voluntourism, has fostered a potentially high-risk situation for already vulnerable young children in the region. This article reviews the current discourse on what is being called a crisis of care for children, as well as literature on out-of-home/family care and its adverse impacts on child development. We also describe an emerging "AIDS orphan tourism", and show how short-term attachments formed between children in group residential care and volunteers may worsen known impacts of institutional care. This article advocates against the exploitation of especially vulnerable young children in sub-Saharan Africa for commercial gain by tour operators in the current growth of "AIDS orphan tourism". We instead propose that young people who wish to volunteer their time and talents to assist children less fortunate than themselves be properly informed about children's development and attachments to others, as well of the vulnerabilities and rights of young children, especially those outside of family care.

Keywords: orphan; AIDS; orphanage; tourism; attachment

Introduction

Globally circulated, the poignant spectre of "AIDS orphans" and "children left behind" portrays children as abandoned, innately vulnerable and in need of care. Such images, presented by the international media, NGOs and now tourism operators, conjure up a desire among those primarily in the Western world to take direct action in the care of such children. At the interface of global discourse and Western sentimentality lies the growing phenomenon of "AIDS orphan tourism", by which individuals travel to residential care facilities, volunteering for generally short periods of time as caregivers. As we discuss in this article, such actions are often based on confounded understandings of the prevalence of orphaned and abandoned children, the everyday realities of children and families affected by the HIV/AIDS epidemic and the particular vulnerabilities of children in residential care facilities. The aim of this article is to build the connection between this sometimes-misleading discourse on "children and HIV/AIDS" in sub-Saharan Africa, the expansion of out-of-home residential care (such as orphanages and children's homes) and parallel developments in the volunteer tourism industry, burgeoning with opportunities for foreign tourists to provide care for "AIDS orphans" as part of philanthropic travel. In building these connections, we also bring

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together literature on the developmental impacts of group residential care on young children and the potential for additional harm created by volunteer tourism.

This article introduces what has been called "myth-making" in the discourse surrounding children and care in the context of the HIV/AIDS epidemic in the region. It then highlights the context of residential care and the particular vulnerabilities faced by children who grow up in such settings. In so doing, it provides an overview of theory and evidence that relate to the development of children's attachments to adults, including in residential care, allowing for an informed understanding of the ways in which children may be affected by care provided by volunteer tourists. Lastly, it highlights the growing trend of *voluntourism* in sub-Saharan Africa and the issue of "AIDS orphan tourism", a term we utilize to refer to short-stay programs that entail providing immediate and direct care to vulnerable, young children, identified by tourism operators as "AIDS orphans",

Throughout this article, we utilize the term *caregiver* to refer to the individual or individuals who have primary responsibility for a child and who provide care in their parenting role. The term *residential care* is utilized to define "a group living arrangement for children in which care is provided by remunerated adults who would not be regarded as traditional carers within the wider society". Although there is immense diversity in the situations encompassed by the term residential care, this definition implies an organized and deliberate structure to the living arrangements for children and describes a professional (rather than parental) relationship between adults and children (International Save the Children Alliance, 2003, p. 1). Residential care does not always entail traditional, large-scale orphanages, but also encompasses smaller-scale "children's homes" and "places of safety" (Meintjes, 2007). However, all are encompassed in the definition.

Ultimately, we argue that for policymakers, child advocates and potential volunteers, the growing trend of "AIDS orphan tourism" must be approached with caution, and the protection of already vulnerable young children is prioritized above other concerns. For researchers in particular, we highlight this growing trend as an area requiring further research, and for policymakers, an area in need of immediate action.

The HIV/AIDS epidemic, "orphans" and the "crisis of care"

Research and reports concerning the HIV/AIDS epidemic and children in sub-Saharan Africa almost always begin with a reference to rapidly increasing numbers of "orphans", a term synonymous with vulnerability, abandonment and a need for adult action (Anderson & Heston, 2006; Beegle, De Weerdt, & Dercon, 2005; Bicego, Rutstein, & Johnson, 2003; Black, 2008; Booysen & Arntz, 2002; Cichello, 2003; Crampin et al., 2003; Deininger et al., 2003; Foster, 2000; Kamali et al., 1996; Lewis, 2006; Monasch & Boerma, 1994). Often reiterated are statistics of the 22 million people in sub-Saharan Africa living with HIV, the 12 million children orphaned by the epidemic and numbers expected to rise for at least the next decade (UNAIDS, 2008; UNICEF, 2004). These figures have created a sense of urgency in responding to the "crisis of AIDS orphans" and placed the issue at the centre of policy and programming debates, as well as prominence within the media and academic research. Indeed, the statistics do not merely depict the current state of the epidemic, but represent a "call to action" by governments, international bilateral and non-governmental organizations, as well as the international media, and tourism operators. However, both the prevalence of children without care and the nature of care in sub-Saharan Africa are often misunderstood and misreported by the international media (*The New York Times*, 2003; *The Toronto Star*, 2008).

First, the very definition of "AIDS orphan" is confusing: children who have lost either *one or* both biological parents (UNAIDS/UNICEF/USAID, 2004). The prevalence of orphaning has been used to depict the stage of the epidemic, beginning with infections and proceeding to illness and adult mortality. However, "AIDS orphaning", in this sense, is a technical demographic and epidemiological term not commensurate with common-sense definitions of an "orphaned" child. For example, although there are approximately 12 million children in sub-Saharan Africa categorized as orphans, only 2.4 million children are estimated to have lost *both* parents as a result of AIDS. Contrary to everyday understandings, more than 80% of children defined as orphans have a surviving parent (Richter, 2008; UNAIDS/UNICEF/USAID, 2004). This fact has not been well-communicated, and many donors and programming agencies in the global North proceed from the assumption that children defined as "AIDS orphans" have lost both of their parents, have been abandoned by their families and are in need of replacement care.

AIDS orphans "left behind" are perceived as children without parents or close family, and deprived of "love, attention and affection" as well as the "interpersonal and environmental stimulation" necessary for their development (UNICEF, 2004, p. 9). In such scenarios, the capacity of the extended family safety net is seen to be in a continual state of deterioration due to increasing levels of prime-age adult mortality (Deininger et al., 2003; Foster, 2000; Guest, 2003; UNAIDS/UNICEF/USAID, 2004; UNICEF, 2005). Children are thus seen to be increasingly left without care as traditional systems "overstretch" and "erode" (Aspaas, 1999; Ayieko, 2000; Foster, 2000; George et al., 2003; Guest, 2003; Kaleeba, 2004; Oleke, 2006; UNICEF, 2004). Non-traditional family forms, such as child-headed households, female-headed households, grandparent-headed families and apparent rising numbers of delinquent, street children are regarded as manifestations of impending breakdown (Adebe & Aase, 2007). In these scenarios, household dissolution is inevitable and cataclysmic (Hosegood, 2009). Despite recent critiques about the definition of "child-headed households" and whether they are without adult support (MacLellan, 2005; Payne, 2008), such households are highlighted as "an easily observable indicator of children who are not receiving traditional extended family care" (Foster, 2000, p. 60) with the plight of these households "particularly desperate . . . in many cases these orphans are isolated completely from their extended family" (Booysen & Arntz, 2002, p. 172). Indeed, although children living alone face unique challenges and increased vulnerability, necessitating interventions and support, there are misconceptions about their prevalence and nature. Across sub-Saharan Africa, only very small numbers of orphaned children find themselves living without any resident adult caregiver (Floyd, Crampin, Glynn, & Madise, 2007). In South Africa, less than 1% (0.6%) of children have been estimated from national surveys to be living on their own (Hosegood, 2009; Meintjies & Giese, 2006; Richter & Desmond, 2008). Furthermore, although such households may emerge following the death of adult members of a household, and must be regarded as special cases in need of support, these households tend to be transitional, with adults soon moving in to care for children, or children moving to join other households (Ford & Hosegood, 2005; Hosegood & Timaeus, 2005).

In contrast to prominent "AIDS orphan" and "crisis" discourse, a number of researchers have noted that the capacities and strengths of informal, traditional family systems can and still do support a large number of orphans, despite the burden imposed by the HIV/AIDS epidemic. This view critically challenges predictions of social breakdown and holds that traditional arrangements of care are flexible and resilient, offering a range of possibilities for care (Adato et al., 2005; Adebe & Aase, 2007; Bray, 2003; Chirwa, 2002; Floyd et al., 2007; Madhaven, 2004; Meintjies & Giese, 2006; Norman, 2006; Richter & Desmond, 2008;

Anderson & Heston, 2006; Wittenberg & Collinson). Indeed, in contrast to prevailing rhetoric, studies show that most orphans – upwards of 90% – continue to live with their families, with most single orphans continuing to live with their surviving parent (Ainsworth & Filmer, 2002; Heymann, Earle, Rajamaran, Miller, & Bogen, 2007; Subbarao, 2001; UNICEF, 2004). These arrangements are governed by "intergenerational contracts" in which reciprocity and redistribution are vital to shaping the nature and degree to which extended family members make commitments towards each other (Adebe & Aase, 2007). In part, this is because the very notion of family in sub-Saharan Africa includes extended networks of kin, increasing the human, if not economic, capacity of such networks to care for children, including orphans (Amoateng & Richter, 2003; Chirwa, 2002). Thus, while the number of children who have lost one or both parents, in particular to AIDS, is increasing in sub-Saharan Africa (Richter, 2008), the actual number of children who are completely dislocated or without family care remains very small (Richter & Desmond, 2008).

Furthermore, numerous studies have shown that nearly every factor identified as critical to increasing childhood vulnerability in the context of HIV/AIDS-affected families involves financial strain (Adato et al., 2005; Anderson & Heston; 2006; Booysen & Arntz, 2002; Chazan, 2008; DeSilva et al., 2008; Heymann et al., 2007; Howard et al., 2006; Norman, 2006; Nyambedha et al., 2003; Oleke, 2006; Rugalema, 1998; Schenk, 2008). Economic constraints are often responsible for the barriers to the effective integration of orphans into households, the discrimination or neglect of children orphaned by AIDS, conflicts related to property, inadequate food and clothing and disruption of the schooling of orphans (Anderson & Heston, 2006; Ansell & Young, 2004; Bond, 2006; Oleke et al., 2006). In sub-Saharan Africa, the epidemic exacerbates the poverty of already vulnerable families, with those who already face chronic unemployment and loss of livelihoods being the most at-risk for long-term and severe vulnerability (Cornia & Zagonari, 2007). In this context, poverty has the potential to destabilize the care of children due to increasing costs associated with additional dependency, as well as providing for ailing adults (Richter, 2008).

Mindful of the vulnerabilities faced by families, there is international agreement that residential care is a matter of absolute last resort when all avenues for appropriate family care have been exhausted (OAU, 1999; UNICEF, 1990; 2007). Residential care should only be seen as a viable option when families and communities – supported by government and civil society – are unable to protect children from vulnerability; when early prevention strategies have failed; and when transitional care structures cannot return children to a safe and enriching, non-residential family care environment. However, despite national and international policy, misconceptions surrounding the "AIDS orphan crisis" have led to the assumption that large numbers of children are without family care, fuelling the funding and establishment of residential care homes. In sub-Saharan Africa, very little research has been conducted on the prevalence of residential care settings. There is widespread deficiency in government registration and an overwhelming dearth of information on the nature of homes across the region (Abdulla, Nott, & Hoddinott, 2007; Meintjes et al., 2007). Despite such constraints and a lack of current available research, Foster (2004) found that in six southern African countries there was a 35% increase in residential care institutions between 1999 and 2003.

In terms of a large-scale response to the "crisis of care", residential care has a number of disadvantages. It has been shown to be at least 10 times and up to 100 times more costly than family care (Desmond, Gow, Loening-Voysey, Wilson, & Stirling, 2002). The establishment and maintenance of such facilities may divert external support from families

who, with help, could care for vulnerable children at home. As illustrated in the highly publicized case of David Banda, the Malawian boy adopted by Madonna in 2006, destitute families sometimes place children in orphanages in the hope that their child will receive food and be educated (Williamson, 2003). If directed at families, this additional financial support would enable destitute parents to better feed, clothe, educate and care for their children at home (Adato et al., 2005; Richter, 2008).

Beyond the large-scale and unsustainable costs associated with residential care facilities, there are serious problems about the nature of care received by children residing in institutional care and the long-term implications in terms of childhood development.

Residential care and disrupted relationships

As residential care increases for the permanent placement of "AIDS orphans", it is important to briefly review the implications for young children, often of a long-term nature. Within the psychosocial literature, there is agreement that long-term institutional care adversely affects young children in a number of ways, even upon follow-up into adulthood (Frank, Klass, Earls, & Eisenberg, 1996; Rutter, Quinton, & Hill, 1990; Viner & Taylor, 2005). The most agreed upon explanation for these effects concerns the dependency of children's development on stable and secure attachments to one or more adults (Richter, 2004). There is strong evidence to support the fact that human infants are born biologically prepared to form attachments to their caregivers and that the neurophysiological templates for human development are dependent on such attachments (Shonkoff & Phillips, 2000). Stable, strong and affectionate attachments enable infants to develop a sense of security that supports their exploration of the world and encourages them to seek out new learning and relationships (Ainsworth, 1989).

In terms of knowledge about the implications of child development in residential care settings, René Spitz (1945) was one of the first clinical theorists to describe the emotional development of infants in the first year of life and the emergence of what he called *anaclitic depression* in infants separated from their primary caregivers. He identified a high level of mortality of infants in institutional care, despite the availability of food, comfort and medicine. Working from the foundations laid by Spitz and others, John Bowlby's work on maternal deprivation emphasized the critical importance of interpersonal relationships for young children. Bowlby (1952) asserted that the formation of an ongoing, warm relationship was as crucial to a child's survival and healthy development as the provision of food, child care, stimulation and guidance. The innate ability to develop these attachments is universal in children, but the patterns of attachment depend on the relationship that each child develops with caregivers over time (Morrison & Mishna, 2006; Rutter, 1995). Throughout the first year of life, infants gradually build up expectations of regularities in their relationships and in the routines of their daily lives. These relationship expectations – that one is loved and cared for, that one is not ignored and roughly handled, that one's care is predictable – amalgamate into mental templates of interpersonal expectations that guide social cognitions and behaviours as an adult (Ainsworth, 1989; Waters & Cummings, 2000). Patterns of attachment during infancy predict not only exploration, learning, social adjustment, emotional regulation and stress tolerance, but also the nature of future adult relationships, and later parenting behaviour (Goldberg, 1988; Rholes & Simpson, 2006).

Given that human infants are "designed" to maintain stable contact with secure attachment figures, there is perhaps no greater threat to their developmental integrity than disruption of the "parent (caregiver)–child" relationship. Repeated early experiences of

frustration in their need for stable and consistent soothing and attention, including separations, result in infants and young children developing insecure or disorganized attachments. Such experiences may negatively influence a child's sense of self, emotional functioning and social behaviour. Separations caused by hospitalization, assignment into foster care or entry into an orphanage cause dramatic disruptions in attachment relationships (Bowlby, 1982). Once in institutional care, the routines, staff turnover and large child–caregiver ratios cause frequent disruptions in attachments (Dozier & Bick, 2007). There is consistent evidence that for children who are institutionalized at a young age, a variety of emotional, social, behavioural and educational problems develop and persist over time (Berrick, Barth, Needall, & Jonson-Reid, 1997; Rutter, 2002). Recent studies of adoptees from Eastern Europe to the United States and Canada suggest that development deficits and delays tend to be irreversible. One hypothesis is that experience deprived of stable attachments irrevocably alters children's brain circuitry (Nelson, 2007), and this manifests in a wide range of deviant psychological and social traits (Chisholm, 1998).

Although the evidence against institutional care for young children clearly exists, in times of both real and perceived crises, this knowledge has been put aside, and institutions have gone from being a "last resort" to an acceptable (and sometimes favoured) option for the care of children (International Social Service & UNICEF, 2004). Although there is very little literature on the effects of institutionalization in the context of AIDS in sub-Saharan Africa, the global consensus is based on invariable human psychological needs and experience, and it is clear that there are significant adverse effects of such care placements on the short- and long-term development of children. However, it is on this landscape of child vulnerability that global tourists are encouraged to take part in the short-term care of young, vulnerable children through "AIDS orphan tourism".

Volunteering and "AIDS orphan tourism"

In this article, we utilize the term "AIDS orphan tourism" to describe a form of volunteer tourism characterized by short-term travel to facilities to engage in everyday caregiving for "AIDS orphans". This emerging phenomenon is linked to global changes in tourism more generally and fostered by the "AIDS orphan" discourse outlined earlier. Meintjies and Giese (2006, p. 425) have argued that the image of the "AIDS orphan" is replicated and disseminated "because it has economic valence" and that "orphanhood is a globally circulated commodity". In the case of rising trends in volunteer tourism, the commodification of "AIDS orphans" is particularly salient and requires further analysis and discussion.

Volunteer tourism operators frequently advertise the enormous "needs" of both the institution and the children who reside there, and short-term volunteers are encouraged to "make intimate connections" with "previously neglected, abused and abandoned" young children and to take part in their daily caregiving activities (Amanzi Travel; I-to-I Meaningful Travel[1]; Volunteer Adventures). As Squire (1994) describes, landscapes become tourist places through the meanings ascribed to them by visitors and tourist operators. In this case, southern Africa is represented as a place of deprived institutions caring for orphans, in which volunteers are critical to the sustainability of operations, and therefore the very well-being of young, desperate children. This particular type of tourism has emerged at a time when alternative tourism in general is thriving. In recent decades, the tourism industry has grown and diversified to encompass a wide array of travel activities, with alternative, philanthropic and volunteer tourism leading the way. Today, growing numbers of tourists demand "authentic" travel experiences, reflecting both an inertia with mass tourism and an increasing desire for more interactive, meaningful and individualized

experiences (Lyons & Wearing, 2008; McIntosh & Zahra, 2007). In this article, we coin the term "AIDS orphan tourism" to discuss one aspect of this global industry as it occurs in sub-Saharan Africa and the potential consequences of a lack of regulation, knowledge and advocacy on behalf of children living in residential care settings.

In general, the flow of volunteer tourists tends to be from the global North to the global South, with all age groups participating. Volunteer tourism is a mushrooming industry and searches for such holidays online and in bookshops unearth a staggering array of options. *Voluntourism* has become a buzzword with travel providers. Travellers can add between a week and a month to their pleasure itineraries to work on projects such as building schools and conservation projects. A recent poll by travel magazine *Conde Nast Traveller* found that 20% of respondents had already taken a "volunteer vacation" and 62% were likely to make volunteering part of future trips. In some cases, corporations and governments are making such tourism a part of their policies on charity work and development. For example, the Department for International Development (DfID) in the United Kingdom provides £34.58 million to four of the largest UK volunteer sending agencies (Tourism Concern Annual Report, 2007).

The purpose of this article is not to debate the merits of volunteer tourism as a general phenomenon. However, concerns about this form of volunteering have been raised in recent years by academics, activists as well as by volunteer organizations themselves. In regard to the nature of the work involved, voluntourism contributions tend to be brief and characterized as low skilled, precisely because of time constraints. In such scenarios, voluntourists may unwittingly displace or disrupt local work opportunities because individuals are willing to pay for the privilege to volunteer. Given the level of unemployment and poverty among young people in many parts of sub-Saharan Africa, such opportunities would arguably be better suited to local youth, many of whom would be grateful for regular meals, basic training and a testimonial to their work experience. Further, the coordination required is costly because of the large overheads required to host voluntourists. There are some concerns that tourists themselves may be exploited by local partners in developing countries. For example, a recent article in a South African newspaper[2] tells the story of three young foreign women who volunteered in children's organizations in Cape Town. After paying upwards of R34,000 (approximately $5000 at the time) for a six-month program, the company sent them a letter advising them to vacate their accommodation after only a few weeks, informing them that the program was being closed down. According to the article, this was not the first time complaints were levied against this particular organization and there is no indication that welfare or tourism authorities were able to offer much solace to these well-intentioned tourists. While some of the general issues of voluntourism are up for debate, we focus on the particular issues associated with "AIDS orphan tourism".

As has been previously discussed, the global discourse of "children and HIV/AIDS" has fostered the notion that there are countless children who have been abandoned and are living without family, kin or home in southern Africa (Meintjies & Giese, 2006). Residential care facilities have expanded, perversely driven by the availability of funds available for them (Firelight Foundation, 2005; UNICEF, 2004). Although we could find no research on the phenomenon of "AIDS orphan tourism", scans of the industry show that some residential care facilities have opened up to global volunteers for short periods of time for the express purpose of providing care, love and support to children living in a range of care facilities (small-scale children's homes, orphanages, etc.). In some of these situations, tourists have been encouraged to seek personal fulfilment through encounters with destitute and disadvantaged children. In others, the intermediary organization has linked affluent travellers with local organizations to do work of conscientizing and fund-raising.[3]

In a recent *Time magazine* article on the topic of volunteering with children in residential care settings, two opposing views were presented (2007). Tricia Barnett, director of Tourism Concern, an industry watchdog in the United Kingdom, stated that "If you're going to work with children in an orphanage, [how will they] understand what you're trying to do when you don't speak their language and you don't stay long enough to form a relationship? . . . what does it mean to the child?" However, Sally Brown, founder of Ambassadors for Children,[4] countered that "If a kid can be held for a couple of days, you're able to make a small difference". This article argues that programs which encourage or allow short-term tourists to take on primary caregiving roles for very young children are misguided for a number of reasons. Although there are a variety of issues related to the sustainability and appropriateness of funding such operations, the primary concern we have is with the emotional and psychological health of very young children. Young children who enter residential care, whether in large-scale orphanage settings or smaller-scale children's homes, are likely to have already experienced very difficult circumstances. In their current circumstances, they are likely to be one among many, clamouring for attention and affection from caregivers who are frequently poorly paid to do primarily domestic work (Meintjes et al., 2007). Enter the voluntourist in response to advertising, such as this excerpt from a large company marketing online:

> Working at a residential home for orphaned, neglected and abused children in XXXX,[5] this is a great chance to improve the lives of youngsters who haven't had the best start in life. You'll need to have a genuine love of children and a willingness to get involved in all aspects of their daily life, from playing games and organizing activities, to feeding and changing nappies. (I-to-I Meaningful Travel[1], 10 September 2007)

Many advertisements make it plain that volunteers will work with very young vulnerable children:

> The home provides full residential care for children between the ages of 0–5. The home aims to provide a healthy and nurturing environment for orphaned, neglected and abused children. The children have often had to deal with the stress of loss, abuse or neglect and so need lots of love and attention. (I-to-I Meaningful Travel[1], 10 September 2007)

Short-term volunteer tourists are encouraged to "make intimate connections" with previously neglected, abused and abandoned young children. However, shortly after such "connections" have been made, tourists leave; many undoubtedly feeling that they have made a positive contribution to the plight of very vulnerable children (Abdulla et al., 2007). Unfortunately, many of the children they leave behind experience another abandonment to the detriment of their short- and long-term emotional and social development. Inherently, the formation and dissolution of attachment bonds to successive volunteers is likely to be especially damaging to young children being cared for in such environments. The early adversity faced by young children with changing caregivers leaves them very vulnerable, putting them at greatly increased risk for developing disorganized attachments, thus affecting their socio-psychological development and long-term well-being.

Consistently observed characteristics of children in institutional care are indiscriminate friendliness and an excessive need for attention (Chisholm, 1998; Zeanah, Smyke, & Dumitrescu, 2002). Children tend to approach all adults with the same level of sociability and affection, often clinging to caregivers, even those encountered for the first time moments before. Children in more orthodox family environments of the same age tend to be wary towards newcomers and show differential affection and trust towards their intimate

caregivers. Institutionalized children will thus tend to manifest the same indiscriminate affectionate behaviour towards volunteers. After a few days or weeks, this attachment is broken when the volunteer leaves and a new attachment forms when the next volunteer arrives. Although there is little empirical evidence on children's reactions to very short-term, repeat attachments over time, evidence from a study of children in temporary or unstable foster care indicates that repeated disruptions in attachment are extremely disturbing for young children (McDonald, 1996).

Ultimately, children who have experienced early adversity require a non-threatening, stable world, not one where visitors awaken hopes that are dashed again after a few weeks. The Convention on the Rights of the Child (CRC), the African Charter on the Rights and Wellbeing of Children and the legislation protecting children in many countries place a special burden on those caring for children separated from their parents and families (Article 9). Of particular salience is Article 20 of the CRC which states that:

> 1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.

Voluntourism is potentially exploitative of children suffering adversity as a result of poverty and HIV/AIDS. Thus far, no formal regulations exist in any sub-Saharan African country to protect children from such practices. Nonetheless, opportunities for this form of voluntourism continue unabated. Available evidence suggests that itinerant caregivers are not in the best interests of the child and, without sufficient evidence of the extent, nature or dynamics of AIDS orphan tourism, those concerned for children's protection and rights should be deeply concerned.

Conclusion

As Adebe and Aase (2007) argue, contradictory notions of orphans have been constructed by donor and recipient organizations with the aim to induce an immediacy to act. The consequence is that stereotypical images which are not representative of the nuanced, everyday lives of the vast majority of children affected by HIV/AIDS are both constructed and reproduced. In such constructions, the child is disconnected from context, alone and with no available support mechanisms (Ruddick, 2003). It is this discourse that permeates the landscape of "children and HIV/AIDS" for the international media, NGOs and now tourism operators. Although the HIV/AIDS epidemic is clearly having a deleterious impact on families and children in sub-Saharan Africa, we are concerned about the ever-increasing number of residential facilities being established, a vast number of which remain unregistered and operate outside of the law (Abdulla et al., 2007). On this landscape, the growing international volunteer tourism industry is placing very young, vulnerable children at increased risk.

This article draws attention to the many young vulnerable children currently living in residential care in sub-Saharan Africa. Residential care as a viable, sustainable option to the challenges of caring for children in the context of the HIV/AIDS epidemic presents enormous challenges. Further, the consensus remains that such care often causes serious problems for the short- and long-term development of children. Repeated disruptions of attachment and abandonments in the form of "AIDS orphan tourism" exacerbate these risks. For these reasons, this article makes a number of points: the first is that every resource should be utilized to support families to enable them to provide high-quality care

for their children. Out-of-home residential care should not be an option when support can be given to families to take care of their children. Second, children out of parental care have a right to protection, including against experiences that are harmful for them. In particular, they have a right to be protected against repeated broken attachments as a result of rapid staff turnover in orphanages, exacerbated by care provided by short-term volunteers. Third, welfare authorities must act against voluntourism companies and residential homes that exploit misguided international sympathies to make profits from the conditions in which vulnerable young children are placed. Last, well-meaning young people should be made aware of the potential consequences of their own involvement in these care settings, be discouraged from taking part in such tourist expeditions and be given guidelines on how to manage relationships to minimize negative outcomes for young children.

Notes

1. I-to-I Meaningful Travel. Retrieved from http://www.i-to-t.com
2. *Sunday Tribune*, 21 October 2007.
3. See, for example, the Philanthropic Travel Foundation at http://www.philanthropictravel.org/.
4. Ambassadors for Children. Retrieved from http://www.ambassadorsforchildren.org/www2/.
5. Details have been omitted to protect individual facilities, children and youth volunteers.

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