beneficiaries applied for credit which they used to set up income-generating projects within their local communities. Zambia has supported agricultural micro-finance schemes. A scheme initiated in 2003 has provided credit to some 120,000 refugees and locals, allowing for a 25% increase in the amount of land cultivated per family. By investing their loans and through their own hard work, the community – refugees and locals – now produce enough food for domestic consumption plus a surplus which they market. Not only has the community become self-reliant but it also earns three times more money than before the initiative.

In Mexico refugee children had their own primary schools in the settlements. Integration was not fostered through joint schooling although older refugee children could attend local high schools. In Uganda, the Jesuit Refugee Service is responsible for running schools in refugee settlements to which local children also have access. Integration is facilitated as refugee children come into contact with local children and locals have improved access to educational services. In Zambia, refugee children have unrestricted access not only to primary schools but also – a rare thing in refugee situations – to secondary and tertiary education. Under the Zambia Initiative, UNHCR and bilateral donors provided significant financial support to the education sector, enhancing access to education services from which both local and refugee communities benefited.

### Participatory approach

A key element of programmes to promote local integration in the three countries has been provision of space for refugees to articulate their needs. In Mexico, refugees chose community representatives who liaised with the government, UNHCR and donors. They facilitated their own return to Guatemala through negotiating the demilitarisation of several conflict zones. Uganda’s Local Governments Act encouraged participatory decision-making and led to the establishment of Refugee Welfare Councils to identify and respond to development needs of refugees. In Zambia the participatory approach was taken a step further with the creation of 22 Local Development Committees – with elected refugee and community members – to identify, implement and manage community development projects.

### Conclusion

Repatriation is generally regarded as the preferred solution for refugee populations but other viable options need to be considered when repatriation is impossible. Local integration is one such option. It allows those refugees who cannot or do not wish to repatriate the possibility to enjoy the freedoms and livelihood they would have in their home countries. While there have been implementation problems, the governments of Mexico, Uganda and Zambia should be commended for their efforts to protect and assist refugees by all-inclusive assistance programmes and their commitment to including refugees in national development strategies.

Ana Low worked in 2005 as an intern with UNHCR’s Reintegration and Local Settlement Section. Email: analow83@hotmail.com

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Promoting the female condom to refugees

UNHCR and its partners have been providing male condoms since the late 1990s. However, uptake remains alarmingly low. Will the agency be more successful in promoting the female condom, a female-initiated barrier method of contraception and disease prevention?

The public health rationale for condom use in the refugee setting is compelling, as refugees are particularly vulnerable to HIV and sexually transmitted infections (STIs). Social dislocation, economic deprivation, increased sexual violence, lack of access to medical services, increased transactional sex and increased contact with potentially infected populations put refugees, especially women, at heightened risk.

The female condom is a loose-fitting polyurethane sheath. It has an inner ring, which is inserted into the vagina and keeps the condom in place, and an outer ring, which remains on the outside of the body. Inserting the device correctly takes some practice. The female condom is currently the only available form of woman-initiated protection against HIV. Produced in the UK, it is about ten times more expensive than the male condom. It is marketed for single-use only, but the World Health Organisation has outlined a cleaning procedure for re-use (up to five times) for cases where resources are limited and no other alternatives for sexual protection are available.

In order to promote the female condom more successfully, experiences were reviewed in thirteen country programmes, and interviews and workshops were conducted with refugees and NGO staff in Kakuma refugee camp, Kenya.

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by Jacqueline Papo
The main outlets for condom provision are through STI and family planning clinics, peer educators and community health workers, and condom dispensers. Many additional potential outlets for condom provision remain unutilised. These include: Prevention of Mother-to-Child Transmission services; support programmes for vulnerable women, the mentally impaired, orphans and vulnerable children, and commercial sex workers; home-based care and supplementary feeding programmes for HIV/AIDS patients; traditional birth attendants and healers; drug shops; links to women’s sanitary pad distribution; and dispensers sited in bars, clubs, beauty salons, schools, vocational centres, youth centres, food distribution centres and public latrines.

Uptake obstacles

Most NGO staff and refugees have never seen a female condom. In Kakuma initial reactions varied from enthusiasm, surprise and awe, to scepticism and fear. There is still much distrust and stigma associated with condoms. Stories of women dying because of male condoms lodged inside their vaginas, of men piercing the tip of condoms, of condoms breaking and of Western plots to lace condoms with HIV are common.

There are wide gaps in basic knowledge on HIV/AIDS transmission ("if a man eats a lion with HIV, will he get HIV?"); adolescent development ("how will a young woman’s body develop if she doesn’t come in contact with men’s protein in semen?"); and reproductive anatomy ("won’t the female condom disappear inside the woman’s body?").

Unequal gender dynamics and traditional cultural practices prevent many women from introducing the female condom into their relationships. Many women expressed fear and discomfort at the idea of having to insert it. Previous experience with inserotive devices such as tampons, diaphragms or cervical caps is limited and self-touching of genitalia is taboo in many cultures.

It is important to:
- make female condoms available through health-related, as well as non-health-related outlets
- develop posters, diagrams and pamphlets tailored to differing levels of literacy and ethnic/cultural backgrounds
- include men in all awareness-raising initiatives as they often remain the final decision-makers in the bedroom
- help women develop condom negotiation skills, for both casual and steady relationships
- encourage women to exchange tips on female condom use and break taboos associated with sex through group discussions
- promote the female condom not just for high-risk groups but for all sexually active men and women who want a method of dual protection, against HIV/STIs as well as unwanted pregnancy
- use peer educators and community health workers to access hard-to-reach groups
- train all health providers, peer educators, social workers and workshop leaders on the female condom to ensure they fully understand it and incorporate it in their activities
- consult key community members, especially when courting controversy by introducing condoms in non-health-related fora
- strengthen funding and co-ordination of condom provision efforts to ensure adequate supplies and avoid re-use of female condoms
- extend activities to include NGO staff as well as host communities
- share experiences among field staff to develop good practice which can also be used to inform the provision of future other female-controlled technologies, such as microbicides.¹

Jacqueline Papo, a former UNHCR Research Intern, is a doctoral student at the Department of Public Health, University of Oxford. Email: jacqueline.papo@stx.ox.ac.uk

To obtain a copy of UNHCR’s Female Condom Strategy, email hivaid@unhcr.org


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¹ www.global-campaign.org/about_microbicides.htm