HIV Leadership through Accountability

Situation Analysis

Senegal

2011

Compiled by

The WORLD AIDS CAMPAIGN

For

The Leadership through Accountability Programme

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	**Antiretroviral Therapy**
CSO	Civil Society Organisation
CBO	Community Based Organisation
DFID	Department for International Development
GBV	Gender based violence
GNP+	Global Network of People living with HIV
HIV	Human Immunodeficiency Virus
IDU	Intravenous drug user
LGBT	Lesbian Gay Bisexual and Transgender
LTA	Leadership through Accountability programme
MARP	Most at risk population
MSM	Men who have sex with men
NCPI	National Composite Policy Index
NGO	Non Governmental Organisation
NSP	National Strategic Plan
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
UA	Universal Access
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

Report

Country Context

Senegal is a semi-arid country located on the westernmost point of Africa, with an estimated population of 12.5 million people. Predominantly rural and with limited natural resources, the country earns foreign exchange from fish, phosphates, peanuts, tourism, and services. Its economy is highly vulnerable to variations in rainfall and changes in world commodity prices. Senegal depends heavily on foreign assistance, which in 2007 represented about 23% of overall government spending--including both current expenditures and capital investments--or African Financial Community franc (CFA) 315 billion (U.S. $630 million)[1]. The 2009 estimate of the Gross Domestic Products (GDP) was estimated at US$ 13, 865 billion, GDP per capita was US$ 1, 031 and the public debt was estimated to be 32% of the GDP in the same year[2].

The fishing sector is Senegal's export leader. In 2007, fishery products contributed 22% of Senegal's export earnings and employed about 15% of the population. Receipts from tourism, the second major foreign exchange earner, contributes between 4.6%-6.8% of GDP annually. Agriculture employs about 70% of the economically active populace. Mining, especially of phosphates, employs about 33,000 people and provides about 15% of export value[3].

Growth rates over the last decade have hovered at around 5%, which was largely consumed by high population growth and has led to few effects in poverty reduction. The national poverty line is determined by the cost of basic food needs plus essential non-food items. In 2005, the proportion of the population below this threshold was 50.8%, down from 68% in 1994. The target for the MDGs purposes is 34% by 2015[4]. Furthermore, large regional differences exist in the incidence of poverty, as well as differences between rural and urban areas of the country[5].

Education is compulsory at the primary level but only 62% of primary-school age children were enrolled in schools in 1999, and the pupil-teacher ratio at primary level was 51 to 1. The projected adult illiteracy was 62.7% in 2000, and it was constituted as follows: 52% males and 72.4% females[6]. The Ministry of Labor has indicated that the public school system cannot cope with the number of children that must enrol each year. As a resul, many school-age children seek education through informal means such as apprenticeships without monetary wage[7]. Furthermore, there are few or no middle schools in the rural areas and that forces learners to either quit school or travel long distances to continue their education[8].

Senegal is a multilingual country. French is the official language and several of the Senegalese languages have the status of "national languages": These include Balanta-Ganja;Hassaniyya; Jola-Fonyi; Mandinka;

[1] http://www.state.gov/r/pa/ei/bgn/2862.htm

[2] http://www.gfmag.com/gdp-data-country-reports/185-senegal-gdp-country-report.html#axzz1Y0wmtd8a

[3] http://www.state.gov/r/pa/ei/bgn/2862.htm

[4] http://uk.oneworld.net/guides/senegal/poverty?gclid=CIaExJbV56oCFcQLtAodyxCw7A

[5] http://unicefglobalstudy.blogspot.com/2011/02/multidimensional-poverty-in-senegal.html

[6] http://www.nationsencyclopedia.com/Africa/Senegal-EDUCATION.html

[7] http://en.wikipedia.org/wiki/Education_in_Senegal

[8] http://www.aed.org/News/Stories/middle-schools-senegal.cfm

Mandjak; Mankanya; Noon(Serer-Noon); Pulaar; Seereer-Siin; Soninke; and Wolof. In terms of usage, Wolof is the lingua franca and the most widely spoken language in Senegal, as a first or second language. With regards to Religions, Muslim constitutes 95% of the population, Christian 4%, traditional religion 1%.

National HIV context

The HIV/AIDS prevalence in Senegal is estimated at 0.7%. The epidemic is stable in the general population, however, HIV has disproportionately affected the most-at-risk populations; which include the very poor, sex workers, migrant labourers, men who have sex with men (MSM). The HIV prevalence is around 19.4% on sex workers and 21.5% on MSM. There are large disparities between men and women with prevalence rates of 0.4% and 0.9% respectively. Regional disparities are also found with the Kolda (2%) and Ziguinnchor (2.2%) regions in the south having the highest rates of infection.[9]

According to the 2008 UNGASS report approximately two women are HIV positive for every one man who is infected or, 63% of people living with HIV/AIDS are women, and there are high rates of new infections among women in long term, stable heterosexual relationships. Women between the ages of 25 to 29 have the highest prevalence (1.5%).

Migrants who travel to other countries face a greater risk of HIV infection than less mobile populations in Senegal. One study conducted in 11 villages around Matam, found that 27% of returned male international labour migrants were infected with HIV/AIDS; compared with less than 1% of nonmigrant males[10].

Children in Senegal are affected by the epidemic by contracting HIV from their mothers and by losing a parent to AIDS. In 2007, there were 8, 400 children under 18 who had been orphaned by AIDS and 3, 100 children under 15 living with HIV[11].

Although condom use among sex workers and the general population has, according to UNAIDS, been three times higher than it was a decade ago; there are factors that pose a threat to the continued success against the virus, these are: movement of migrant workers, early sex debut, and the high prevalence among sex workers and MSM. In 2002, 88% of MSM in Dakar reported having had vaginal sex and therefore, privide the bridge of transmission to the general population.

HIV and AIDS Estimates

Total Population	2010	12.5 million[12]
Life expectancy at birth	2010:	57 years (male), 61 years (female)[13]
Under-5 mortality rate	2008	85/1,000 live births, or approx. 1 in 12 children die before their fifth birthday[14]
Estimated population living with HIV/AIDS	2009[15]	59 000 [50 000- 69 000]
Adults 15+ living with HIV/AIDS	2009	54 000 [46 000 -63 000]
Women 15+	2009	32 000 [27 000- 38 000]
Number of new infections adults 15-49	2009	48 000 [3 100- 6 300]

[9] http://www.aidsalliance.org/linkingorganisationdetails.aspx?id=4

[10] http://www.prb.org/Articles/2003/MigrationandHIVinNorthernSenegal.aspx

[11] http://www.usaid.gov/our_work/global_health/aids/Countries/africa/senegal.pdf

[12] US Census Bureau, International Data Base 2010
[13] US Census Bureau, International Data Base 2010
[14] WHO World Malaria Report 2009
[15] All 2009 statistics taken from UNAIDS Global Report 2010

Number of new infections	2009	6 000 [4 100- 7 900]
Adult new infections 15-49 (%)	2009	0.10 [0.10- 0.11]
Number of AIDS related deaths	2009	1 800 [1 500-2 300]
Orphans	2009	19 000 [15 000-25 000]
Adult prevalence (%)	2009	0.9 [0.7-1.0]
Young women 15-24 (%)	2009	0.7 [0.5-1.0]
Young men 15-24 (%)	2009	0.3 [0.2-0.4]

Treatment

In 2006 more than 4400 people, or almost half of all people in need, were receiving lifesaving antiretroviral treatment (ART) in Senegal, nearly three times the number in June 2004, when only 1 600 people were on treatment. As of February 2007, there were approximately 5,900 people on ARV treatment in Senegal, the majority of whom were in Dakar (in 2011, nearly two-thirds of the people receiving treatment in Senegal were living in Dakar). Progress in treatment scale-up has been achieved despite challenges posed by a centralized public health infrastructure and weak procurement and supply management systems. Senegal has decentralized and expanded its HIV treatment programme, increasing the number of physicians qualified to dispense antiretroviral medicines from 12 in 2001 to 95 in 2005 and the number of antiretroviral treatment sites from 6 to 32 in the past two years. Large disparities still exists in Senegal's health coverage, with 70% of doctors, and 80% of pharmacists and dentists living in the capital city[16]. However, Prevention of mother-to-child transmission services (PMTCT), which in 2004 were available only in the capital Dakar, are now available in all 11 regions of the country[17].

Senegal established the first VCT site in 2001 and an additional 15 sites by the end of 2006. All these sites were based in NGOs or private sector structures, and half of them integrated VCT into existing health service; either in 'Alliance Nationale Contre le SIDA' (National Alliance against AIDS) or youth Reproductive Health (RH) services[18]. Recognising that the demand for VCT could not be satisfied through these limited number of structures, the Ministry of Health (MOH) decided to integrate VCT into all the health centres across the country. The MOH started its VCT scale-up in 2006.

In 1998, when Senegal became the first sub-Saharan African country to establish an ARV program, fees for treatment were based on a sliding scale based on economic and social criteria. The fees were eventually eliminated in 2003; Senegal is now one of few African countries that provide free ARV treatment. Although this free treatment is supposed to be available to any resident living with HIV/AIDS who meets the clinical criteria (based on a CD4 count test), not all those in need receive it. In addition, other costs associated with treatment—for example, costs of transportation, diagnostic tests, treatment for opportunistic infections, and nutritional and other needs—all create barriers to treatment access. Because the health care sector lacks capacity, only about one-half of the patients on ARV treatment are regularly monitored to ensure patient compliance and efficacy of treatment.

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[16] http://en.wikipedia.org/wiki/Health_in_Senegal

[17] http://www.who.int/hiv/mediacentre/news58/en/index.html

[18] http://www.fhi.org/NR/rdonlyres/eoacw2migmfqthcs7ntydgvpdhlvxfgdwt6ehx2judx4x6fbppxlmtram3xpg67zdh4f6ahbsx527k/IMPACTFinalReportSenegalHV.pdf

The government exercises tight control over the procurement and distribution of ARVs, however, system inefficiencies have led to drug shortages. The strict regulations regarding ARV delivery also hinder rural residents from accessing treatment. Until recently, only doctors could prescribe ARVs, and many rural clinics were staffed only with nurses. There are now a few national NGOs that are approved to dispense ARVs, but these are primarily based in Dakar and other major cities, which does not improve accessibility in rural areas. The low number of ARV provision sites is a serious barrier to treatment scale-up and it advocates that treatment be decentralized more effectively.

ARVs are not available in paediatric forms, a situation that presents a significant challenge in providing treatment to children. As is the case in many developing countries, in Senegal paediatric ARVs are more expensive than adult ARVs, difficult to procure, and subject to frequent drug shortages. The problem of effective treatment is exacerbated by the unreliable estimate of the number of children who are in need of treatment. Children are not widely tested[19].

National Response

The Government of Senegal responded rapidly to HIV/AIDS, establishing in 1986 the *Programme National de Lutte Contre le SIDA* (National Program for the Fight against AIDS), which in 2002 was renamed the *Conseil National de Lutte Contre le SIDA* (National Council for the Fight against AIDS). The national program undertook significant measures to prevent HIV/AIDS transmission, including condom promotion, sentinel surveillance, confidential counselling and testing, education of sex workers, and integration of HIV into sex education. The current national strategic plan, *Le Plan Stratégique de Lutte contre le Sida (PSLS) 2007–2011*, was built on the 2002–2006 PSLS and continues successful HIV prevention programs.

The 2007–2011 Strategic Plan continues to prioritize these action areas to maintain Senegal's low HIV prevalence. HIV/AIDS prevention is part of the strategic aims of all of Senegal's various development planning programs, including the Poverty Reduction Strategic Papers for 2002–2015 and the Education and Training Development Program for 2000–2010.

The condom promotion includes a dissemination of millions of condoms through social marketing programs to the general populations and free distribution to high-risk populations such as commercial sex workers, health care patients with sexually transmitted infections, youth, and the military have made condoms widely available[20].

Senegal's strategy emphasizes a multisectoral approach that includes the participation of government ministries, the private sector, and religious and other civil society organizations, as well as PLWHA. The National AIDS Council (NAC) and the International HIV/AIDS Alliance have shown great commitment and there is high level of political will. The national network of people living with HIV (RNP+) are engaged with NAC, AfriCASO and other civil society organisations in dialogues on access to treatment, prevention, support and care. Priority action areas included prevention, blood safety, sexually transmitted infections, mother-to-child transmission, and social mobilization. However, efforts to engage and work with key populations, in particular sex workers and men who have sex with men, are inadequate.

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[19] **HIV/AIDS Policy in Senegal 2007**

[20] http://en.wikipedia.org/wiki/HIV/AIDS_in_Senegal

Another private sector initiative in the fight against HIV/AIDS was the development, by YouthNet, of a media-based HIV education and stigma reduction campaign focusing on youth. The campaign sprung from the global HIV prevention campaign by Music Television (MTV) called 'Staying Alive'[21]. While the MTV version of 'Staying Alive' globally reached audiences primarily through the television, the Senegal project emphasised local programming over the radio. During the six months campaign, from September 2002 to February 2003, more than 30 radio stations broadcasted on HIV/AIDS issues several times a week; including interviews with young people.

Senegalese officials have joined other African leaders to affirm their commitment to the fight against HIV/AIDS in the international arena, participating in both the special summit in Abuja on HIV/AIDS and TB in April 2001 and in the United Nations General Assembly Special Session on HIV/AIDS in June 2001.
In keeping with the United Nations Millennium Development Goals, the Senegalese government has pledged to fight against poverty, hunger, and illiteracy and also to halt and reverse the spread of epidemics such as HIV/AIDS by 2015.

Religious and community leaders are actively involved in HIV prevention. Muslim and Christian religious leaders have been at the forefront of the national response, preaching about HIV in mosques and incorporating HIV education into religious teaching programs (the sexuality education is done in religious institutions and not in schools). Both Muslim and Christian organizations provide care and psychosocial services and promote tolerance. Furthermore, an estimated 95% of the population is Muslim.

Critical Issues and Major Challenges

Despite Senegal's contained HIV/AIDS epidemic, the national response has not sufficiently targeted high-risk populations, such as men who have sex with men, unregistered sex workers, partners of sex workers, migrant workers, orphans and other vulnerable children, and rural populations. Because a low prevalence rate may be perceived as an indicator of successful HIV control, the government has found it more politically palatable to emphasize the low overall HIV-prevalence rate than to draw attention to the relatively high prevalence among certain groups.

Due to the lack of disaggregated data from the ARV provision sites, it is difficult to determine whether marginalized, high-risk populations, such as sex workers and men who have sex with men, have equal access to treatment. Because these groups are not effectively receiving testing, counselling, or other HIV services, it is likely that they also have difficulty accessing treatment.

The financial burden of HIV care presents another barrier to access. HIV and CD4 count tests, ARV treatment, and treatment for TB are free, but the diagnostic tests and treatment for other opportunistic infections require fees. Another challenge is sustainable funding, much of the organisations depend heavily on the Global Fund and therefore there is need to expand funding options to include domestic funding sources. A large number of the organisations have also lost funding and others will lose funding after June 2011 and this will potentially reverse the gains achieved thus far. The challenge raised by civil society organisations is the perception that there is low HIV prevalence in the West Africa region. This is translating to limited financial support and limited international exposure of some of the challenges.

In addition, Senegal has yet to adopt a legal framework that protects the rights and dignity of people living with HIV/AIDS. There have been numerous consultative meetings, and a draft law on HIV/AIDS was finalized in mid-2006, but it has not been adopted by parliament. Despite the advocacy efforts of civil society

[21] http://www.fhi.org/en/Youth/YouthNet/CountryPrograms/Senegal.htm

organizations to push forward the law, there is a lack of collective urgency. However, in 2010, an HIV Law that was aimed at protecting PLWHIV was enacted and it contains a clause that criminalises the voluntary transmission of HIV. This is a challenge because government has been unwilling to review the issue. Society for Women and AIDS in Africa (SWAA) has deliberated with their legal experts and they feel that it may be difficult to enforce the clause because the accuser has to bring evidence to show wilful transmission.

In the meantime, stigma and discrimination create serious obstacles to implementing programs to control HIV/AIDS. Because people living with HIV/AIDS have no legal recourse against stigma and discrimination, there are no formal complaints on record, despite reports of many incidents in communities, hospitals, and workplaces.

Stigma and discrimination are prevalent in all levels of society; including communities, social and professional circles, and they continue to pose a challenge to universal access. Men who accompany their wives to health centres are stigmatised and most PLWHA are still unable to disclose their positive status to their families, and there is a stigmatisation of widowed women within their family home. The belief is widely held that HIV/AIDS is associated with promiscuity and is a divine punishment. This strong perception contributes to the difficulties that people living with HIV/AIDS have in revealing their HIV status. Women are economically and socially marginalised and this affects their ability to access information and to utilise health services, for an example, SWAA noted that pregnant women had to get permission from their husbands or husbands' family or from a father to visit health care centres. In some cases, women who have been widowed by HIV have had to re-marry for strategic reasons, that is, to support themselves and their children. Furthermore, cultural prescriptions prevent women from talking about their pregnancy and hence they do not visit health services early; despite being encouraged to visit these before the end of the first 14 weeks of pregnancy.

Civil Society Organisations (CSOs) find it hard to work with government because they operate in an environment in which they have to conceal their identities lest they become stigmatised and discriminated against. They are not strengthened enough to be vocal and to play the watchdog role, they are virtually unable to form and develop working relationships with each other. UNAIDS also noted that there was a general lack of organisational capacity within the CSOs in terms of advocacy, campaign and lobbying.

Health Financing

The estimated budget for the 2007–2011 National Strategic Plan is approximately $105 million. As of March 2007, Global Fund Round 6 and the FHI had committed about $30 million to the plan. Government contributions will likely have to increase to fill the funding gap, particularly in light of the soon-to-be-discontinued financial support from the World Bank. There is a limit to sources of funding the response to HIV/AIDS in Senegal, especially within the country; the bulk of donor funds come from the Global Fund.

The government's health-sector budget allocation has increased steadily in recent years, from 23 billion CFA (Communauté Financière Africaine) francs in 2000 to nearly 44 billion CFA francs in 2005 (approximately $46 million to $88 million at about 500 CFA francs to 1 U.S. dollar). The government's expenditure on health care as a percentage of total gross domestic products (GDP) is still only 2.1 percent.

Activists acknowledge that Senegal cannot afford to finance an effective and comprehensive HIV/AIDS response without donor support. They do believe, however, that donor funding can be more strategically utilized to ensure sustainability.

High-risk Populations and Vulnerable Populations

HIV is largely concentrated among high-risk groups in Senegal, the very population that the government's prevention programs neglect. A few NGOs have recently started interventions specifically for marginalized groups at high risk of HIV infection, such as men who have sex with men, unregistered sex workers, and orphans and vulnerable children, but current efforts are not sufficient to fill the gap.

Women are disproportionately at risk of HIV infection—the prevalence rate is 0.9 percent among women and 0.4 percent among men. Prevention interventions have not adapted to respond to this fact effectively. An increase in the number of HIV infections among women means mother-to-child transmission is also on the rise. The current approach to mother-to-child transmission is highly medicalized, however, it does not address issues such as psychosocial support for women and the various social and familial implications.

Non-discrimination laws

Non-discrimination laws or regulations, which specify protections for most-at-risk populations or other vulnerable subpopulations?

By law sex workers are required to register and to have quarterly checkups and the government has, successfully provided HIV care to legal sex workers, linking prevention efforts, such as education and testing, with existing services for STIs. Sex work is therefore legal but regulated by the state. Since 1978, the Division for HIV/AIDS and STI Control of the Ministry of Health has provided STI diagnoses and treatment to registered sex workers with some success. Government efforts entirely neglect unregistered sex workers, who make up approximately 80 percent of all sex workers. These sex workers are often arrested and harassed by law enforcement agents, which makes them reluctant to seek prevention, care, and support services.

Laws that present obstacles to effective HIV Management

Laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Lesbian, gay, bisexual, and transgender (LGBT) persons in Senegal face legal challenges not experienced by non-LGBT residents. Senegal specifically outlaw same-sex sexual acts, and has prosecuted men accused of homosexuality in the past. Homosexuals also face routine discrimination in the society.

Article 319, paragraph 3 of the Senegal Penal Code bans homosexual conduct and according to the 2007 Pew Global Attitudes Project, a strong 96% of Senegal residents said that homosexuality should be *rejected* by society, making it one of the highest rejections of homosexuality in the 44 countries surveyed

In 2008 and 2009, two high profile cases of prosecution of Gay men brought national and international focus on LGBT rights in Senegal. In 2008, Dakar's Icone magazine reported on a "Gay Marriage" which had taken place in a private home. It had earlier published an "exposé" on the existence of homosexuality in Senegal, and the photos led to the arrest of five men who appeared in them. The men were later released without charge,

In December 2008 nine men were arrested in a private flat in Dakar, allegedly after a police received an anonymous tip. Five were tried, convicted, and sentenced to eight year prison terms in January 2008 for "indecent conduct and unnatural acts". This was the longest sentence in Senegalese history for

homosexuality, as the judge added an additional three years for "being members of a criminal group" to the maximum five year sentence for homosexual behavior. All were released after their convictions were overturned on appeal in April 2009, but had been forced to be held in special quarters due to threats from other inmates.

Press attention again focused on gay men in Senegal when local and international press reported the corpse of a man reputed to have been homosexual was twice disinterred from a cemetery in Thiès and dumped at his family's doorstep overnight[22].

Democratic Space

Senegal is a secular republic with a strong presidency, bi-cameral legislature, reasonably independent judiciary, and multiple political parties. Senegal is one of the few African states that have never experienced a coup d'état[23]. Making it one of the more stable countries in an unstable region. A model of religious and ethnic tolerance, it plays a key role in conflict resolution in West Africa and beyond[24].

Historically, Senegal has been one of the showcases for democracy and a market economy in West Africa. To the disappointment of many observers, the political culture in Senegal has deteriorated over the last two years. In 2007, after Wade's victory in the first round of the presidential elections for his second term, the opposition boycotted parliamentary elections. This decision by the opposition leadership has put key political forces outside democratic institutions. The souring of excessive centralization of power with the president, albeit in a democratic setting, increasingly became a problem with his, at times, erratic and often contested decisions.

The president is the chief of state and the Prime Minister is the head of government. The cabinet is made up of the council of Ministers appointed by the prime minister in consultation with the president. The country has a bicameral Parliament consisting of the Senate, reinstituted in 2007, (100 seats; 35 members indirectly elected and 65 members appointed by the president) and the National Assembly or Assemblee Nationale (150 seats; 90 members elected by direct popular vote and 60 elected by proportional representation from party lists to serve five-year terms). The legal system is based on French civil law system.

Relationship between the Government and Civil Society

There are more than 3,000 civil society organizations involved in the HIV/AIDS response, from community-based groups to national level NGOs. These groups have been integral to Senegal's success in controlling HIV/AIDS, by disseminating information on HIV/AIDS, offering psychosocial support to people living with HIV/AIDS, and advocating for an innovative and efficient national response.

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[22] Wikipedia

[23] Wikipedia

[24] http://www.usaid.gov/our_work/democracy_and_governance/regions/afr/senegal.html

In 2004, a group of five NGOs—known as l'Observatoire de la résponse au VIH/sida au Sénégal (Watchdog of the Response to HIV/AIDS in Senegal) or the Observatoire—drew attention to the weaknesses in the design and implementation of national HIV/AIDS policies.

Civil society organizations have been increasingly active in policy formulation in recent years. For example, national NGOs, community-based organizations, women's groups, and people living with HIV/AIDS are included in the CNLS, the national HIV/AIDS coordination body, and the Global Fund Country Coordinating Mechanism
Due to pressure from a broad group of civil society organizations, the Global Fund established a parallel civil-society funding mechanism in April 2006. Alliance Nationale Contre le SIDA (ANCS), a national NGO, is now one of the Global Fund's principal funding recipients. ANCS is responsible for outreach to marginalized groups, orphans and other vulnerable children, and people living with HIV/AIDS.

The government has also solicited civil society contributions for the development of the 2007–2011 National Strategic Plan, which provides the national framework for all programs and activities to control HIV/AIDS.

The new plan makes marginalized populations a higher priority. It also places greater emphasis on care and support activities for people living with HIV/AIDS and on programs that fight stigma and discrimination.

Community

Senegal National Network of People Living with HIV/AIDS
BP 142702 Colobane Dakar Senegal

Senegal National Network of People Living with HIV/AIDS,
54 rue Carnot, Dakar.

COSSEN (the national network of NGOs and CBOs responding to HIV)

RNP+ (the national network of PLWHA)

Enda Santé (mostly on key populations)

ANCS (GF Principal Recipient - also working on capacity development)

African Council of AIDS Services Organisations (AfriCASO)

AfriCASO is a grouping of non-governmental organisations that was established in 1991 and has since been structured into five networks, each corresponding to a sub-region.

UNAIDS

UNAIDS, the Joint United Nations Programme on HIV/AIDS, is an innovative partnership that leads and inspires the world in achieving universal access to HIV prevention, treatment, care and support.
Website: http://www.unaids.org

For more information, please consult:

HIV Leadership through Accountability Website
www.hivleadership.org

The World AIDS Campaign (WAC)
Tel: +31 20 616 9045
www.worldaidscampaign.org