HIV in Senegal: Historical, Political, and Cultural Dynamics
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Abstract:

Data suggests that the human immunodeficiency virus (HIV) emerged in Sub-Saharan Africa in the late 1970s; by the early 1980s, HIV stretched from the West African coast to the Indian Ocean. Today, Sub-Saharan Africa—home to only 10% of the world’s population—accounts for 67% of all people living with HIV. Among such dismal numbers, Senegal stands apart as a success story, boasting a seropositive rate that has not exceeded 1.5% among the general population since the first recognized case of HIV was detected in 1986.

This paper will examine the possible factors that have lead to Senegal’s low and stable HIV/AIDS rate within the population at large: a preexisting framework of STD education, testing, and treatment in urban areas; early and wide-spread screening for HIV in blood used in transfusions; promotion of condom use and provisions for reliable and affordable condoms; sex education at an early age within the school system; and social cohesion around strong religious values (which has resulted in considerable control of sexuality). There remain hurdles concerning HIV/AIDS in Senegal—including strong social stigmas surrounding certain sexual practices (e.g., same-sex relations and prostitution)—which will also be treated.

Brief overall history:

Acquired immune deficiency syndrome (AIDS) first appeared among homosexual male populations in the United States in 1981. By 1983, scientists had established that
the human immunodeficiency virus (HIV) caused AIDS.¹ By the mid-1980s it became clear that, though largely unnoticed, this deadly virus had already touched most of the world. At the onset, what was to become the HIV/AIDS pandemic comprised many smaller and isolated epidemics, each with its own distinct geographical parameters and affected segment of the population.² Epidemiological data suggest that the extensive spread of HIV in Sub-Saharan Africa began in the 1970s. By the mid-80s, this became the area in Africa most dramatically affected by the virus, with a band of infection stretching from the northwest coast to the Indian Ocean. In 2007, over 68% of the world’s thirty-three million people living with HIV/AIDS were found in Sub-Saharan Africa.³

Though the epidemic has ravaged much of the continent, Senegal is seen as a successful model of government response in African, boasting HIV seropositive rates that have not exceeded 1.5% in the general population.⁴ Existing social values and norms and the early implementation of a cohesive government policy have contributed to the country's success. The Senegalese model is not without flaws; there are many hurdles to overcome. For example, the social stigma attached to certain sexual practices, namely men having sex with men and prostitution, have left these two groups exposed to rates as

³ Press release by UNAIDS, Global HIV prevalence has leveled off; AIDS is among the leading causes of death globally and remains the primary cause of death in Africa, November 20 2007.
high as 20% by some estimates.\textsuperscript{5} \textsuperscript{6} For seropositive rates to remain low or decline in the general population as well as within these high-risk demographics, greater discussion concerning policy aimed at these groups must be discussed.

**Epidemiological Characteristics:**

The first suspected cases of HIV in Senegal were diagnosed between 1984 and 1985 and were later confirmed as the less pervasive HIV-2; the first cases of HIV-1, the form identified earlier in the West, were not diagnosed until 1986.\textsuperscript{7} Since the virus first appeared, Senegal has successfully kept seropositive rates within the general population between 0.5% and 1.5%. Consistent with the rest of Africa, heterosexual contact was and continues to be, the main means of transmission of HIV/AIDS in Senegal.\textsuperscript{8}

Immigration into Senegal has impacted the concentration of infection by region. The regions of Ziguinchor and Kolda have been the most dramatically affected by the virus, showing seropositive rates of 2.2% and 2% respectively in 2005. These rates are much higher than those in other regions, such as the capital city of Dakar (0.6%) and the northern region of St. Louis (0.4%).\textsuperscript{9} The regions of Ziguinchor and Kolda are located on the Senegalese border with Guinea-Bissau and have experienced a major influx of immigration from other West African countries with higher HIV prevalence rates, such as

\textsuperscript{8} Lom, 24.
Cameroon, Côte d’Ivoire, and Guinea. The majority of these immigrants are transient males who come to the area looking for work and stay for short periods of time. Usually they come without wives or families and are therefore more likely to have a large number of casual sexual partners. They are not affected by traditional social controls and have less access to sexual health information due to language barriers and lower levels of community integration. This leads to a higher likelihood of unprotected sex between HIV positive immigrants and Senegalese woman, who in turn become infected. For this reason, HIV is not contained within immigrant communities. Seropositive rates may also be higher in the rural and highly religious region of Kolda due to a lower percentage of children in state-sponsored schools (31% of girls and 40% of boys) where sexual health education has been integrated into the curriculum; this will be discussed later.

Consistent with trends in the rest of Africa, women are more likely to be HIV positive than men in Senegal. In Sub-Saharan Africa, 75% of seropositive people are female. This number is somewhat lower in Senegal, where females constitute about 60% of the HIV positive population. There are multiple factors, both biological and social, that place women at greater risk than men. Women are biologically two to three times more likely than men to contract HIV in unprotected sexual encounters. Greater susceptibility of females is attributed to hormonal changes and vaginal microbial ecology.

11 Fanget, 6.
14 Lom, 24.
and physiology. These factors are exacerbated in young women due to the immaturity of the genitals and a lower level of sexual secretion than in more mature women.

Certain erotic sexual practices in Senegal also augment the biological vulnerability of woman. Substances such as baking soda, peppermint, and washing powder are often inserted into the vagina to increase male pleasure during intercourse. These substances are abrasive; they dry the vaginal walls and increase the likelihood of infection, both when a condom is used and when it is not.

A number of social factors in Africa, and Senegal more specifically, are attributed to the inequality of seropositive rates between men and women. The link has long been established between low levels of education and high rates of HIV/AIDS. Seventy-seven percent of Senegalese women are illiterate—compared to fifty-seven percent of Senegalese men. A lack of education perpetuates the spread of HIV in two ways. It impedes the struggle of women to reach economic independence, a factor associated with lower vulnerability to HIV, and denies them access to information concerning HIV/AIDS prevention.

Limited access to education, compared to men, is one factor that has created a feminization of poverty. Within this context of pauperism, women often forfeit the power to choose or negotiate the conditions of their sexual relationships. Economic distress forces many women into prostitution or other systems of sex in exchange for material goods or protection. In these unequal relationships, a woman is often unable to

15 Quinn, 1583.
16 Fanget, 8.
17 Fanget, 8.
18 Fanget, 9.
require condom use, even if she is aware that they are an effective means of protection against HIV transmission. Sex as an economic transactions inevitably leads to higher numbers of sexual partners, thereby increasing the risk of infection. This risk is augmented by the fact that uneducated women are less likely to have access to health information; they are not within the school system, where, in Senegal, much sexual health information is disseminated. Combined, these factors create an environment where one of the most inherently vulnerable populations is unaware of measures that can be taken to protect itself from the virus.

**Reasons Behind Low Seropositive Rates:**

Senegal may have had an “epidemiological advantage” over other African states from the onset. The first cases of HIV in Senegal were identified as a viral strand known as HIV-2, less virulent than the HIV-1 strand which had been previously isolated in Europe.\(^{20}\) The first confirmed cases of HIV-1 did not appear in Senegal until 1986.\(^{21}\) This may have played a role in slowing the spread of the virus throughout the country.

Though Senegal is constitutionally a secular state, 95% of the population is Muslim, and the religion exerts a powerful force on politics, society, and family dynamics.\(^{22}\) Certain characteristics of Islam have played a role in the containment of the spread of the virus. Islam encourages a social norm of male circumcision at birth.\(^{23}\) The World Health Organization has determined that circumcision reduces a male’s risk of

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\(^{21}\) Putzel, 172.

\(^{22}\) Creevey, 151.

acquiring HIV through heterosexual contact by 48-60%\textsuperscript{24}. Evidence suggests that circumcision also decreases a man’s chances of contracting other sexually transmitted infections (STI) including syphilis and gonorrhea as well as reduces the risk of transmitting chlamydia to a female partner.\textsuperscript{25} Individuals who have contracted another STI are more susceptible to HIV infection.\textsuperscript{26} Coupled with the epidemiological differences between HIV-1 and HIV-2 and the greater prevalence of the latter, it is possible that HIV did not have the same facility to spread in Senegal compared to other states where circumcision was not widely practiced and/or where the HIV-1 was the more prominent strand of the virus.

The Koran forbids intoxication by drugs or alcohol and extramarital sexual encounters. These behavioral constraints have been linked to a decrease in unprotected sexual encounters that often occur during intoxication and an overall reduction in the number of sexual partners.\textsuperscript{27} In Senegal, these two values seem to be widely respected. In the Dakar, men were three to four times less likely to report having casual sexual partners than men of the same socio-economic background in the capital cities of Guinea-Bissau and Côte d’Ivoire, Senegal's non-Muslim neighbors.\textsuperscript{28}

The political history of Senegal has played a positive role in the fight against HIV. In 1960, Senegal gained independence after 300 years of French colonial rule.\textsuperscript{29}

\textsuperscript{25} “Male Circumcision: global trends and determinants of prevalence, safety, and acceptability,” 24.
\textsuperscript{27} Gilbert, 400.
\textsuperscript{29} Andrew Clark, “Imperialism, Independence, and Islam in Senegal and Mali,” *Africa*
The transition from colonialism to independence was marked by relative peace, which has remained a constant through the last fifty years of Senegal’s existence. In conflict-ridden regions of Africa, soldiers are frequently seen as vectors for the spread of the virus through increased violence against woman, trading sex for survival, and rampant casual sex with multiple partners. Additionally, the movement of infantry spreads the virus from community to community.\textsuperscript{30} Because of this lack of roving bands of soldiers, the political peace and stability that Senegal enjoys has been linked to low levels of HIV in the country.

**Reasons behind low seropositive rates: political**

Along with the relative peace and stability of the government, the concentration of political power in Senegal's executive branch allowed for expedient government action at the first emergence of the virus. President Abdou Diouf, was able to quickly and authoritatively implement public health policy with little hindrance from other branches of the government, and in this context of a *de facto* one-party state, any dissenters to Diouf’s response were quickly quelled.

Though a number of pre-existing social elements have been influential, it is the actions taken by the central state that have been crucial in limiting the spread of HIV in Senegal. In contrast to other African states, the Senegalese government took direct action as soon as the virus emerged in the population. Stigmatization and blaming of black Africans by colonial rulers perpetuated segregation and discrimination of blacks, evident during the bubonic plague epidemic that hit Cape Town and Port Elizabeth at the turn of the twentieth century. This has caused many African leaders to view the emergence of

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\textsuperscript{30} Putzel, 172.
HIV/AIDS as a tool of the West to further vilify Black Africa as disease ridden, immoral, and sub-human. The politics surrounding colonial treatment of past epidemics have left a lasting impact on public health policy in much of Africa, as seen in South Africa’s position on HIV/AIDS under President Thabo Mbeki, which has been marked, until recently, by the immobilization of the government in policy development and a refusal to accept the epidemiological realities of the virus.

As it concerns public health and infectious disease, Senegal’s colonial experience is not unique. During the colonial era, Senegal experienced outbreaks of yellow fever, bubonic plague, influenza, and STIs; the policies implemented by the French in response to these epidemics followed the same patterns of racial politics characterized by the relationship between the conqueror and the conquered: demonization and segregation of the black African communities. The most striking example of these policies is the creation of the Médina housing band around Dakar, which was created in response to the 1914 bubonic plague outbreak. Exploiting the epidemic, the French colonizers forced black Senegalese to live within this community—characterized by sub-standard housing and public infrastructure—in an effort to tighten their control over African property in Dakar.

Though sharing a common colonial history, the way in which Senegal's particular North/South relationship has affected HIV/AIDS policy contrasts sharply with the rest of Africa. In 1983, Professor of Microbiology Souleyman Mboup of the University of Dakar Hospital Le Dantec, along with other university researchers, became interested in

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31 Echenberg, 92.
32 Echenberg, 90.
33 Echenberg, 92.
the virus that had been recently identified in the United States—HIV/AIDS. Working
hand in hand with academics from abroad, Mboup and his researchers began to study
within Senegal and between 1984 and 1985 they identified a viral strand of HIV
characteristically different from that isolated in the West, later to become known as HIV-
2. Professors Mboup’s breakthrough in the new field of HIV/AIDS research caught the
eye of the international medical community and quickly garnered Mboup’s team respect
and recognition; foreign experts began migrating to Senegal to work under the direction
of the professor.35

In 1986, the first six cases of HIV-1 were diagnosed in Senegal, and Mboup
leveraged his fame and notoriety to lobby Senegalese President Abdou Diouf to mount a
campaign to the stem the spread of the virus.36 The issue of HIV was framed differently
than in other African countries; the positive international attention won through
successful intervention was seen as outweighing the negative stigmatization associated
with accepting the realities of the virus’s presence. President Diouf came to view a
proactive government response to HIV/AIDS prevention—including increased support
for further research—as a means of gaining Senegal soft power in the international
community. In this sense, a vigorous campaign against the virus became a way to
leverage a small, poor country with a legacy of dependences into a position of respect.
As a result, not only did Senegal respond at the first signs of the virus, that response was
based on sound medical research and advise.

It was within this context that the Senegalese government took its first steps in

34 Charles Becker, “Law, Ethics, and AIDS in Sub-Saharan Africa: Senegal as a Case
Study,” In The HIV/AIDS Epidemic in Sub-Saharan Africa in a Historical Perspective, ed.
35 Putzel, 175.
36 Putzel, 176.
the fight against a disease that, if left unchecked, could have devoured the population. The National AIDS Prevention Committee, or the NAPC—created in 1986, just months after the first confirmed cases of HIV-1—took a multi-faceted approach to AIDS.\textsuperscript{37} Mandatory testing for HIV in all blood banks was added to the already strict policies concerning transfusions. Working closely with the World Health Organization Global Programme on AIDS, the NAPC created a national sentinel network to monitor HIV infection with posts located in Dakar, Kaolack, Zinguinchor, and St. Louis; 74\% of the urban population of Senegal lives in one of these four centers.\textsuperscript{38} Surveillance concentrated on populations of pregnant women, female sex workers, and men with symptoms of STIs, which allowed Senegal to accurately measure the percentage of the population infected with HIV. The government then mounted educational campaigns to disseminate information regarding prevention.

In the prevention of HIV/AIDS, access to information is considered a human right in Senegal. Since 1992, the Ministry of Education has integrated sex and HIV education into the school system for all children twelve years and older.\textsuperscript{39} The Senegalese government has channeled much of its resources into the educational system, including 33\% of the total budget with mixed results.\textsuperscript{40} According to The Human Development Index, only 42\% of Senegalese children of secondary and tertiary age are enrolled in school; however, this number does not account for children in rural areas who are more likely to attend Koranic schools. Among school age children living in urban areas, where HIV is more rampant, school attendance is relatively high; 76\% of the children in Dakar

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\item \textsuperscript{37} Meda, 1398.
\item \textsuperscript{38} Meda, 1399.
\item \textsuperscript{39} Meda, 1402.
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are currently attending classes. To ensure the accuracy of HIV prevention information, teachers are trained and standardized educational materials are circulated. The distribution of educational materials is not concentrated in Dakar; by 1997, 130,000 school manuals had been distributed to both public and private schools throughout the country. In these manuals, condom usage was underlined as effective protection against the virus. The Senegalese government also ensures that condoms are widely available and affordable to the general population.

Education campaigns have not been relegated to the academy. A multitude of non-governmental organizations (NGOs), working in conjunction with the government, has made a concerted effort to launch education programs within community organizations, cultural associations, sporting groups, etc. Programs have also been designed to target high risk groups not included in the academic framework, such as sex workers and men who have sex with men—though all programs that target the latter are implemented covertly due to factors that will be discussed in more detail later.

Senegal enjoyed the added advantage over other African countries of a framework for STI testing and treatment predating the emergence of HIV. Prostitution, which is prevalent in Senegal, thanks to the shipping traffic through its commercial ports, has been regulated since French colonial times, and its legalization was codified after independence in 1969. Prostitutes, who must be over the age of twenty-one, are obliged to register with the state and receive a permit before practicing their trade; they must also

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42 Meda, 1402.
undergo monthly STI screening. After the creation of the NAPC, HIV testing became mandatory as well. If test returns positive, the woman’s card is suspended until she is STI free. In theory, the return of an HIV positive test should disqualify a woman from prostitution for life; however, recently, some HIV positive women have been allowed to keep their cards—since it requires them to continue coming to the clinic to receive medical care and counseling, thereby increasing the health officials' ability to monitor their care and encourage them to make wise health choices in the future.  

Obviously, the Senegalese system of legalized prostitution and registration is not perfect. There is little in the way of institutional mechanisms to require that all prostitutes register or complete their monthly exams, and many sex workers are allowed to keep their permits even after testing positive for HIV with no legal obligation to inform clients of their status. However, the government's policy of prostitute registration and education has helped. A recent study in Dakar found that, among prostitutes, 96% could articulate the three main prevention mechanisms.  

It should also be noted that all of the women who participated cited the availability of free condoms at the health clinic as a dominant factor in their choice them with their clients. Sex-workers may continue to be one of the demographics most vulnerable to HIV, but the Senegalese government’s pragmatic approach to combat HIV within this community has, at the very least, provided a means of monitoring the spread of the virus and may have stemmed a full-blown epidemic within this high-risk group.

Unlike some other African countries, such as South Africa under President Mbeki, Senegal has not only accepted the use of antiretroviral (ARV) drugs by HIV

44  Homaifar. 123.
45  Homaifar. 118.
positive patients, it has embraced their use. In 1998, *L’Initiative Sénégalaise d’Accès aux ARV*, or Senegalese Initiative for ARV Access, made Senegal the first African country to subsidize the treatment, and by 2003, the country began offering citizens free access to ARVs. Though ARVs do not slow the spread of the virus directly, the acceptance of financial responsibility for treating seropositive positive patients underlines the government’s commitment to fight against HIV/AIDS.

Even with the availability of free ARVs, room for policy improvements still exist. As of December 2004, only 2,700 people were receiving subsidized ARVs, leaving an estimated 12,000 people in need of treatment. Though both the preliminary HIV testing and the ARV drugs are offered free of charge, the laboratory tests required before treatment can begin are not covered by public funds. These tests, which can include blood workups and x-rays, are very costly, and many patients are unable to take advantage of the government program. Senegal is an extremely poor country, with an average per capita income under $600; the majority of the funding for this and other programs comes from NGOs and multi or bi-lateral aid agencies, like USAID, which has donated over $25 million dollars to the Senegalese HIV/AIDS program since 1987.

Senegal is a religious country. As mentioned earlier, Islam in many ways has created an environment conducive to controlling the spread of HIV. With 95% of the population identifying as Muslim and vast networks of mosques exerting social control throughout the country, the Senegalese government understands the effectiveness of Islam as a vehicle to disperse information concerning HIV/AIDS. The relationship that

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has developed between the government’s AIDS program and Islam can be viewed as positive as a whole. In 1988, just two years after the creation of the NAPC, the largest Muslim NGO in Senegal, Jamra, signed an agreement with the government highlighting the Muslim response to the growing world epidemic.\(^{49}\) This signaled the beginning of what would become years of conversation between Jamra staff, health officials, and imams that has resulted in a slow change in the perception of many of these religious leaders that HIV/AIDS was a scourge of the degenerate.

This change in perception translated into action. In 1995, Jamra published *Le Guide Islam et Sida* (*The Islamic Guide to AIDS*), in both French and Arabic, which disseminated the basic facts about HIV/AIDS with a focus on how adherence to Islamic teachings could prevent the spread of the disease.\(^{50}\) The booklet advises against such practices as female genital mutilation, wife inheritance (a tradition within Muslim communities in Senegal where a man would marry the widow of his brother), premarital sex, and infidelity. The Catholic Church, which accounts for the other 5% of the Senegalese population, joined the campaign later. In 1991, a group of young Catholics began raising awareness of HIV/AIDS in school and from their efforts emerged the now prominent Catholic NGO Sida Services.\(^{51}\) Sida Services focuses on prevention, testing, counseling, and care of HIV positive patients. It began lobbying the Catholic hierarchy, in much the same manner as Jamra, to change the Church’s rhetoric concerning AIDS; their efforts yielded results, at least within Senegal. In 1996, Senegalese Catholic leaders agreed to attend a conference, “AIDS and Religion: the Responses of Christian

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\(^{50}\) Putzel, 178.  
\(^{51}\) Putzel, 178.
Churches,” which solidified the Church’s stance on AIDS. Much like the Muslim community, the Catholic Church in Senegal worked with the government on education rooted in Christian teaching and have helped with the care of HIV positive individuals. Support of condom usage proved an obstacle while working with religious leaders. Through much negotiation, a middle ground was reached where in the church would neither advocate the use of prophylactics nor oppose efforts by the government or the private sector to do so.\textsuperscript{52}

The work of the religious community culminated in November of 1997 with the First International Conference on AIDS and Religion, hosted in Dakar and sponsored by the Joint United Nations Programme on HIV/AIDS and the European Union.\textsuperscript{53} Additionally, a unified religious movement partnered officially with the Senegalese government in 1999 with the formation of \textit{L’Alliance des Religieux et Experts Medicaux Contre le Sida} (The Alliance of Religious and Medical Experts Against AIDS); composed of Jamra, Sida Services, The Association of Senegalese Imams, The National Counsel for the Fight Against AIDS, and the national organization born from the NAPC, this alliance is mandated with the implementation of HIV policy and organizes conferences and training sessions focused on AIDS prevention.\textsuperscript{54} Nowhere else in Africa has a scientifically sound message of HIV prevention been backed by such a concerted effort between the religious community and government. The prominence of Islam in Senegalese society, in conjunction with the its acceptance of scholarly advice and the close partnership between Church and State in disseminating information

\textsuperscript{52} Putzel, 178.
\textsuperscript{53} Sasyagues.
\textsuperscript{54} Sasyagues.
supports Senegal’s low seropositive rates.

**Hurdles to be Overcome:**

The religious community is still lacking in their message concerning condom use. Neither Islamic nor Catholic religious leaders in Senegal have come out *against* condoms. Muslim leaders have split with the global Islamic community and advocated for condom use within a marriage where one partner is seropositive; they, however, refuse to enter into dialogue concerning condom use in any other sexual situation.\(^{55}\) Healthcare personnel see this stance as an incomplete and inconsistent message of protection, though it is understood that such a position would be too radical for the Church to take at this time.

Though legalized prostitution has allowed for the systematic screening of sexually transmitted infections (STI), including HIV, and has made HIV treatment free and available, seropositive rates are still high within communities of sex-workers; by best estimate, 20% of Senegalese prostitutes are HIV positive.\(^{56}\) Some prostitutes choose not, or are unable, to register. Currently, the age at which a woman may register as a legal prostitute is twenty-one, but economic conditions force many women into the sex-market at a much younger age, as seen with the feminization of poverty. These women are not included under the umbrella of government policy and, hence, are not protected at the age when they are the most susceptible to infection for biological reasons. Until the challenges of women living in poverty are addressed, under-aged prostitution will continue. Though legal, prostitution is greatly stigmatized and many women choose not

\(^{55}\) Lom, 26.

\(^{56}\) Homaifar, 118.
Men who have sex with men (MSM) are another segment of the population disproportionately affected by HIV/AIDS. Homosexual behavior, which is rejected by both culture and religion, is illegal in Senegal as in much of Africa, and, consequently, there exist no publicly implemented or supported programs to address the needs of this demographic. In fact, the Senegalese government has actively prosecuted NGOs for working with groups of MSM, inciting harsh criticism from the international community.

In mid-December 2008, nine men who worked with AIDES Senegal, an NGO that educates MSM about HIV and provides counseling, were arrested in Dakar for violating article 319.3 of Senegal’s penal code—the law that makes homosexual activity illegal. Police arrested the men at their home. Condoms and lubricants found at the site were used as evidence in their trials; the men were each sentenced to eight years in prison and a 500,000 CFA fine (about 1,000 USD) for their own personal sexual proclivities as well as their with AIDS Senegal. Since sentencing, both the European Union and the United Nations AIDS program have chastised the Senegalese government for its actions in this case.

As a consequence of harsh punitive measures and general cultural stigmatization, many MSM do not seek medical services due to fear of political and social persecution. This has led to elevated levels of STIs and HIV within homo/bisexual communities.

Though research is limited concerning the sexual health status of MSM in Senegal, an

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57 Homaifar, 130.
anthropological survey conducted in Dakar in 2000 found that almost half of those who responded had shown signs of an STI at some point in their life but had not sought the advise of a health care professional. This is not surprising when considering the social implications of being discovered as homosexual in Senegal; verbal and physical violence is widespread and ostracism from family, friends, and the community at large is commonplace.

The failures in education targeting the homo/bisexual community are present in much of the data concerning condom use. Research has found that while MSM are just as likely as the general population to know that HIV can be contracted through sexual intercourse, and cite condoms as a means of protecting oneself against the disease, MSM are less likely to practice safer sex. Possibly due to the deep-rooted mal vu of homosexual behavior in Senegal, most MSM also engage in sexual activity with woman in an effort to hide their sexual preference. If infected, these men could transmit the disease to their female partners creating a link between a discrete epidemic in an isolated demographic and the population at large. It is essential that the government jettison its misconception that HIV will remain an encapsulated epidemic within this demographic and allow for the sexual education of this group. Furthermore, laws that criminalize homosexual conduct between consenting adults are not in compliance with the International Convention on Civil and Political Right (ICCPR), which was ratified by Senegal without reservations in 1979. Continued prosecution of MSM and of the groups that work within this community, detriments progress in HIV/AIDS containment

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62 Tapsoba, 499.
63 “HIV and Men Who Have Sex with Men,” policy brief by UNAIDS, August 2006.
as well as violates Senegal’s treaty commitments.

It is the legality of prostitution that has allowed NGOs to work with this group to improve both prevention education and care of HIV positive individuals. Infection rates among prostitutes have the potential to decline. Conversely, the conversation concerning HIV/AIDS within the homosexual community is clandestine and groups that wish to work with them risk government prosecution, creating an environment in which HIV/AIDS rate are likely to increase.

**Conclusion**

In summation, Senegal can be viewed as a success story in the battle against HIV/AIDS. A number of preexisting social and political factors, coupled with epidemiological characteristics of the original virus, moderated the spread of the virus, and the government’s acceptance of sound scientific data and expedient implementation of a cohesive public health policy have been critical in sustaining seropositive rates that have not exceeded 1.5% in the general population. A subset of the population remains at great risk: prostitutes and MSM. Though civil society and the government are engaging the sex-workers community, MSM are not only stigmatized by society but also targeted by the government for prosecution, effectively squelching any efforts to disseminate information regarding prevention methods and care for the already infected. Even if Senegal were to ignore previous treaty commitments and continue to demonize this group, effectively ignoring the localized epidemic, the MSM community and the general population are inextricably linked through heterosexual networks and viral spread between the two occurs. The adoption of more progressive policy towards MSM would more closely align Senegal with the international community and would positively affect
seropositive rates in the state.

**Work Cited:**


