2006 Update

Senegal

EPIDEMIOLOGICAL FACT SHEETS
ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS

December 2006

World Health Organization

unicef

Joint United Nations Programme on HIV/AIDS
UNAIDS
UNHCR · UNICEF · WFP · UNDP · UNFPA
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HIV/AIDS estimates

The estimates and data provided in the following tables relate to 2005 unless stated otherwise. These estimates have been produced and compiled by UNAIDS/WHO. They have been shared with national AIDS programmes for review and comments, but are not necessarily the official estimates used by national governments. In order to calculate regional totals, older data or regional models were used to produce minimum estimates for these countries. The estimates are given in rounded numbers. However, unrounded numbers were used in the calculation of rates and regional totals, so there may be minor discrepancies between the regional/global totals and the sum of the country figures. The new estimates in this report are presented together with ranges, called 'plausibility bounds'. These bounds reflect the certainty associated with each of the estimates. The wider the bounds, the greater the uncertainty surrounding an estimate. The extent of uncertainty depends mainly on the type of epidemic, and the quality, coverage and consistency of a country's surveillance system. The general methodology and tools used to produce the country-specific estimates in the table have been described in a series of papers in Sexually Transmitted Infections 2006, 82 (Suppl x). The estimates produced by UNAIDS/WHO are based on methods and on parameters that are informed by advice given by the UNAIDS Reference Group on HIV/AIDS Estimates, Modelling and Projections.

Estimated number of adults and children living with HIV/AIDS, end of 2003 and 2005

These estimates include all people with HIV infection, whether or not they have developed symptoms of AIDS.

	2003	2005
Adults (15+) and children	57 000	61 000
Low estimate	28 000	29 000
High estimate	92 000	100 000
Adults (15+)	53 000	56 000
Low estimate	26 000	26 000
High estimate	85 000	92 000
Children (0-14)	4400	5000
Low estimate	1500	1700
High estimate	10 000	12 000
Adult rate (15-49) (%)	0.9	0.9
Low estimate	0.5	0.4
High estimate	1.5	1.5
Women (15+)	31 000	33 000
Low estimate	13 000	14 000
High estimate	55 000	58 000

Source: 2006 Report on the global AIDS epidemic

Estimates 2005	Men	Women
Prevalence among 15-24 year olds	0.2	0.6
Low estimate	0.1	0.2
High estimate	0.4	1.1

Source: 2006 Report on the global AIDS epidemic

HIV prevalence among young people

	2000	2001	2002	2003	2004	2005
Prevalence among 15-24 year olds						
Prevalence among 15-24 pregnant women				0.7	1.2	

Source: 2006 Report on the global AIDS epidemic

Estimated number of deaths due to AIDS

Estimated number of adults and children who died of AIDS:

	2003	2005
Adults and children	4000	5200
Low estimate	2000	2500
High estimate	6500	8600

Source: 2006 Report on the global AIDS epidemic

Estimated number of orphans due to AIDS

Nb: only for generalized epidemics

Estimated number of children who have lost their mother or father or both parents to AIDS and who were alive and under age 17 at the end of 2005:

Estimated number of orphans	2003	2005
Current living orphans	18 000	25 000
Low estimate	10 000	14 000
High estimate	28 000	39 000

Source: 2006 Report on the global AIDS epidemic

	2003	2005
Maternal orphans	11 000	17 000
Low estimate	6300	9000
High estimate	18 000	26 000
Paternal orphans	10 000	14 000
Low estimate	5500	7400
High estimate	15 000	21 000
Dual orphans	4400	6700
Low estimate	2400	3600
High estimate	6800	10 000

Source: 2006 Report on the global AIDS epidemic

	Year	Total
Education ratio		
External support for OVC		

Source:

The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance

Global surveillance of HIV/AIDS and sexually transmitted infections (STIs) is a joint effort of WHO and UNAIDS. The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, initiated in November 1996, is the coordination and implementation mechanism for UNAIDS and WHO to compile and improve the quality of data needed for informed decision-making and planning at national, regional and global levels. The primary objective of the working group is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STIs. For this purpose, the working group collaborates closely with WHO Regional Offices, national AIDS programmes and a number of national and international institutions. The goal of this collaboration is to compile the best information available and to improve the quality of data needed for informed decision-making and planning at national, regional, and global levels. The Epidemiological Fact Sheets are one of the products of this close collaboration across the globe.

Within this framework, the Fact Sheets collate the most recent country specific data on HIV/AIDS prevalence and incidence, together with information on behaviour (e.g.; casual sex and condom use) which can spur or stem the transmission of HIV.

Not unexpectedly, information on all of the agreed upon indicators was not available for many countries in 2005. However these updated Fact Sheets do contain a wealth of information which allows identification of strengths in currently existing programmes and comparisons between countries and regions. The fact Sheets may also be instrumental in identifying potential partners when planning and implementing surveillance systems.

The Fact Sheets can be only as good as information made available to the UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance. Therefore, the Working Group would like to encourage all programme managers as well as national and international experts to communicate additional information to them whenever such information becomes available. The Working Group also welcomes any suggestions for additional indicators or information proven to be useful in national or international decision-making and planning.

Assessment of the epidemiological situation 2006

HIV-1 and HIV-2 surveillance information on antenatal clinic women is available from Senegal since the mid-1980s. In Dakar, the capital, HIV-1 prevalence among antenatal clinic women was 1 percent or less for all years up to 1998. Median HIV prevalence rose gradually from 0.5% in 1998, 0.8% in 2000 to 1.9% in 2003. The prevalence in previous years had also been low. Median HIV prevalnce among pregnant women aged 15-24 years, the prevalence in 2000 was 0.8% and in 2003 it was 1.2%.

Although, HIV-1 prevalence has remained very low among antenatal clinic women in Dakar, prevalence among sex workers has increased gradually from less than 1 percent in 1986 to 14 percent in 2002. HIV-1 prevalence among sex workers outside of Dakar, in Kaolack and Ziguinchor, continues to increase, from 0 percent in 1986 to over 20 percent in 2002.

Since 1989, HIV-1 prevalence among male STI clinic patients in Dakar increased from 1 percent to nearly 5 percent in 1993. In 2002, 4 percent of male STI clinic patients tested positive for HIV-1 or HIV-1+2.

Basic indicators

For consistency reasons the data in the table below are taken form official UN publications.

DEMOGRAPHIC DATA	YEAR	ESTIMATE	SOURCE
Total population (thousands)	2005	11 658	UN Population Division
Population aged 15-49 (thousands)	2005	5568	UN Population Division
Female population aged 15-24 (thousands)	2005	1102	UN Population Division
Annual population growth rate (%)	1995-2004	2.2	UN Population Division
% of population in urban areas	2005	51	UN Population Division
Crude birth rate (births per 1000 pop.)	2005	36.2	UN Population Division
Crude death rate (deaths per 1000 pop.)	2005	11.2	UN Population Division
Maternal mortality rate (per 100 000 live births)	2000	690	World Health Report 2006, WHO
Life expectancy at birth (years)	2004	55	World Health Report 2006, WHO
Total fertility rate (per woman)	2004	4.9	World Health Report 2006, WHO
Infant mortality rate (per 1000 live births)	2004	78	UNICEF / WHO
Under 5 mortality rate (per 1000 live births)	2004	137	World Health Report 2006, WHO

SOCIO-ECONOMIC DATA	YEAR	ESTIMATE	SOURCE
Gross national income, ppp, per capita (Int.$)	2004	1720	World Bank
Per capita total expenditure on health (Int.$)	2003	58	WHO
UN Human Development Index (ranking)	2005	157	UNDP Human Development Report 2005
General government expenditure on health as % of total expenditure on health	2003	41.8	WHO
Adult literacy rate (%)	2000-2004	39.3	UNESCO
Male literacy rate (%)	2000-2004	51.1	UNESCO
Female literacy rate (%)	2000-2004	29.2	UNESCO
Net primary school enrolment ratio, male (%)	1998-2004	71	World Bank
Net primary school enrolment ratio, female (%)	1998-2004	66	World Bank
Human Poverty Index (ranking)	2005	87	UNDP Human Development Report 2005

	2001	2002	2003	2004	2005
National funds spent by governments on HIV/AIDS from domestic sources (US$)			5 943 445	11 921 236	

Source: UNGASS CR and SIDALAC

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HIV prevalence in different populations

This section contains information about HIV prevalence in different populations. The data reported in the tables below are mainly based on the HIV database maintained by the United States Bureau of the Census where data from different sources, including national reports, scientific publications and international conferences are compiled. To provide a simple overview of the current situation and trends over time, summary data are given by population group, geographical area (Major Urban Areas versus Outside Major Urban Areas), and year of survey. Studies conducted in the same year are aggregated and the median prevalence rates (in percentages) are given for each of the categories. The maximum and minimum prevalence rates observed, as well as the total number of surveys/sentinel sites, are provided with the median, to give an overview of the diversity of HIV-prevalence results in a given population within the country. Data by sentinel site or specific study from which the medians were calculated are printed at the end of this fact sheet. The differentiation between the two geographical areas Major Urban Areas and Outside Major Urban Areas is not based on strict criteria, such as the number of inhabitants. For most countries, Major Urban Areas were considered to be the capital city and - where applicable - other metropolitan areas with similar socio-economic patterns. The term Outside Major Urban Areas considers that most sentinel sites are not located in strictly rural areas, even if they are located in somewhat rural districts.

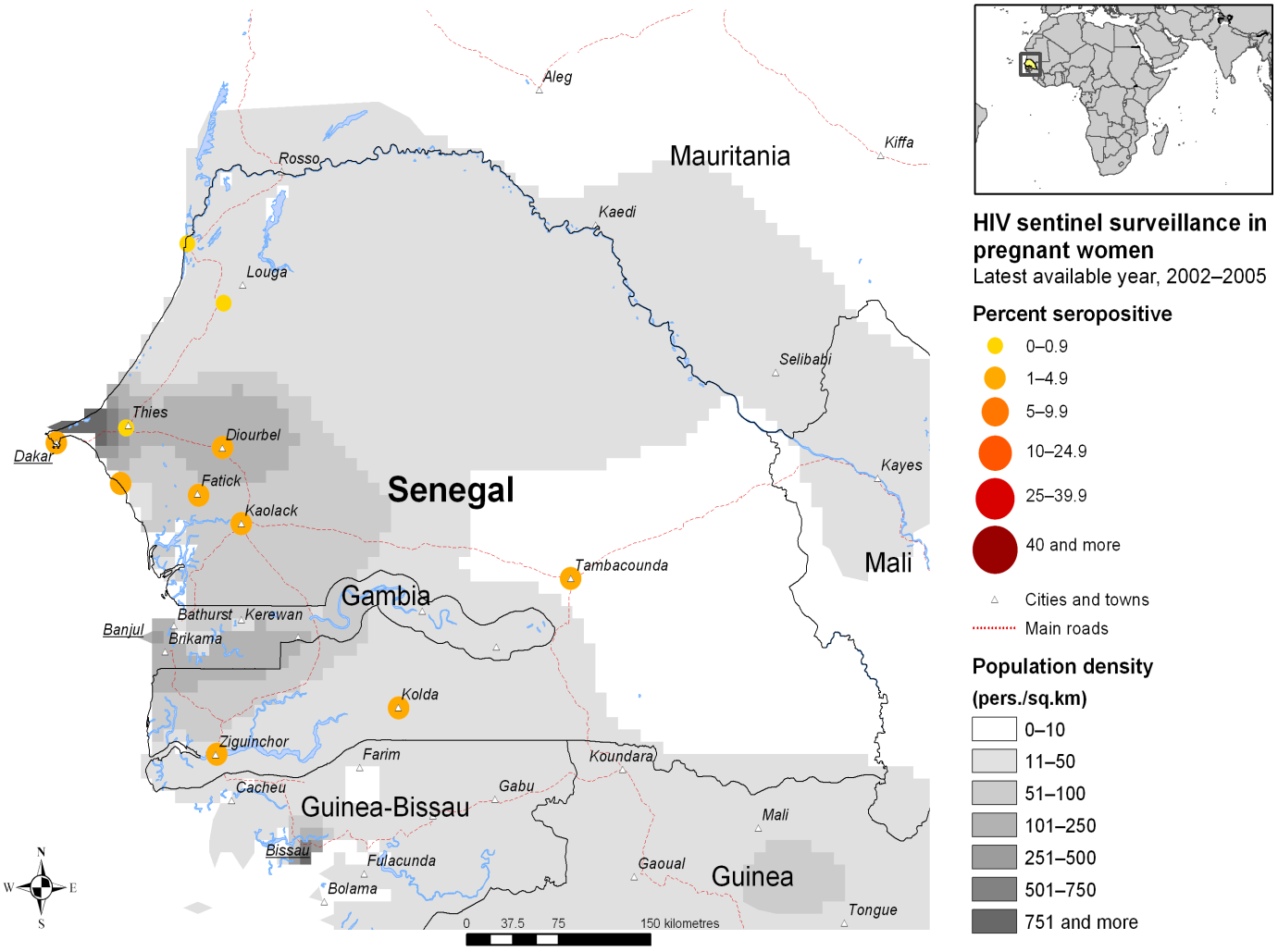
HIV sentinel surveillance prevalence

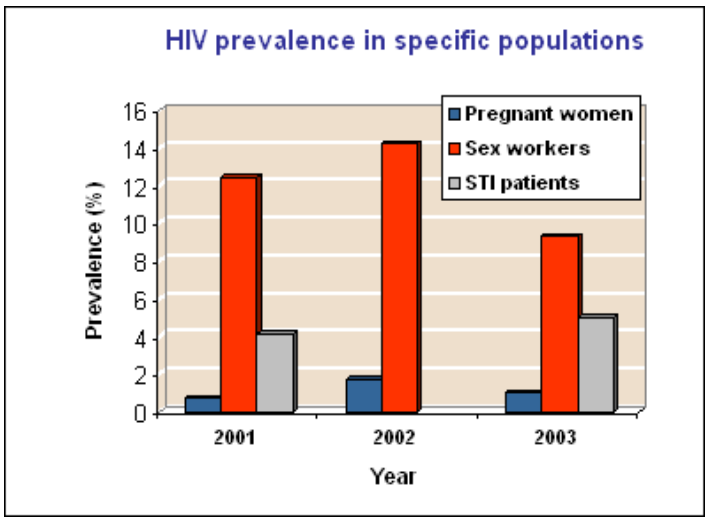
Group	Area		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Pregnant women	Major urban areas	N-Sites	1	1	1	1	3	3	3	2	1	1	1	1	3	3		
		Minimum	1.1	0.3	0	0	0	0.3	0	0.1	0.5	0.9	1.5	0.6	0.4	0.7		
		Median	1.1	0.3	0	0	0	1	0.3	0.3	0.5	0.9	1.5	0.6	0.8	1.7		
		Maximum	1.1	0.3	0	0	0.8	1.7	0.6	0.4	0.5	0.9	1.5	0.6	1.1	2		
	Outside major urban areas	N-Sites	3	3	3	2	2	1	2	2	5	5	5	3	8	9		
		Minimum	0	0	0	0.4	0	0	0.1	0.7	0.2	0.2	0	0.2	0.3	0.5		
		Median	0.2	0	0	0.6	0.3	0	0.1	0.7	0.5	0.7	0.5	0.6	1.2	1.6		
		Maximum	0.4	0	0.1	0.8	0.6	0	0.1	0.8	0.7	1.1	0.9	1.2	2.1	2.6		
Sex workers	Major urban areas	N-Sites	1	1	1	1	3	2	1	3	3	1	2	2	3			
		Minimum	4.5	4.4	5.3	9	4	7.1	6.7	7.3	6.1	13.7	13	8.9	4.5			
		Median	4.5	4.4	5.3	9	10.1	11.4	6.7	7.6	7	13.7	13.8	11.3	9.7			
		Maximum	4.5	4.4	5.3	9	11.2	15.7	6.7	12.9	13.3	13.7	14.5	13.8	14.2			
	Outside major urban areas	N-Sites	3	3	2	2	2	2	2	2	2	2	1	1	2			
		Minimum	0.5	0	1.9	8	8.5	6.7	13.4	14.2	17.1	10.3	17.2	22.8	20.8			
		Median	2.7	1.4	5	8.8	8.8	7.8	13.7	15.2	19.5	12.6	17.2	22.8	21.8			
		Maximum	4.7	11.5	8.1	9.5	9.2	8.8	14	16.2	21.9	14.9	17.2	22.8	22.7			
Injecting drug users																		
STI patients	Major urban areas	N-Sites	1	1	1	1	2	2	3	2	3	1	1	1				
		Minimum	1.1	1.6	2.3	4.5	2.2	3.1	1.4	0	0	3.5	4.3	4.1				
		Median	1.1	1.6	2.3	4.5	3.5	4	4.9	1.6	3	3.5	4.3	4.1				
		Maximum	1.1	1.6	2.3	4.5	4.9	4.8	6.2	3.3	4	3.5	4.3	4.1				
	Outside major urban areas	N-Sites	3	3	3	2	2											
		Minimum	0	0	0	1.1	2.2											
		Median	0	0	1	2	2.6											
		Maximum	2.5	2.6	2.8	2.9	3											
Men having sex with men																		
Tuberculosis patients	Major urban areas	N-Sites	1	1	1	1	3	2	2	3	3	2			3			
		Minimum	3.5	3.7	5	6	5	5.9	5	7	3.1	9			2.3			
		Median	3.5	3.7	5	6	7.2	7.2	6.2	10.1	4.9	9			9.7			
		Maximum	3.5	3.7	5	6	14.3	8.5	7.4	10.9	9.6	9.1			9.9			

Group	Area		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Tuberculosis patients	Outside major urban areas	N-Sites	2	2	3	2	1		1	2	1	1	1		1			
		Minimum	1.4	1.7	0	0.5	4.5		5.9	0	7.8	9.2	6.4		13.3			
		Median	1.8	1.9	1.1	2.2	4.5		5.9	1.2	7.8	9.2	6.4		13.3			
		Maximum	2.1	2.1	3	3.9	4.5		5.9	2.3	7.8	9.2	6.4		13.3			

Maps & charts

Mapping the geographical distribution of HIV prevalence among different population groups may assist in interpreting both the national coverage of the HIV surveillance system as well in explaining differences in levels of prevalence. The UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance, in collaboration with the WHO Public Health Mapping and GIS Team, Communicable Diseases, is producing maps showing the location and HIV prevalence in relation to population density, major urban areas and communication routes. For generalized epidemics, these maps show the location of prevalence of antenatal surveillance sites. Trends in antenatal sentinel surveillance for higher prevalence countries, or in prevalence among selected populations for countries with concentrated epidemics, are a new addition. These are presented for those countries where sufficient data exist.





Reported HIV/AIDS cases

Reported AIDS cases

Following WHO and UNAIDS recommendations, AIDS case reporting is carried out in most countries. Data from individual AIDS cases are aggregated at the national level and sent to WHO. However, case reports come from surveillance systems of varying quality. Reporting rates vary substantially from country to country and low reporting rates are common in developing countries due to weaknesses in the health care and epidemiological systems. In addition, countries use different AIDS case definitions. A main disadvantage of AIDS case reporting is that it only provides information on transmission patterns and levels of infection approximately 5-10 years in the past, limiting its usefulness for monitoring recent HIV infections. Despite these caveats, AIDS case reporting remains an important advocacy tool and is useful in estimating the burden of HIV-related morbidity as well as for short-term planning of health care services. AIDS case reports also provide information on the demographic and geographic characteristics of the affected population and on the relative importance of the various exposure risks. In some situations, AIDS reports can be used to estimate earlier HIV infection patterns using back-calculation. AIDS case reports and AIDS deaths have been dramatically reduced in industrialized countries with the introduction of Anti-Retroviral Therapy (ART).

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
Males																	
Females																	
Total																	

Reported HIV cases

A case of HIV infection is defined as an individual with HIV infection irrespective of clinical stage (including severe or stage 4 clinical disease) confirmed by laboratory criteria according to country definitions and requirements.

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Total
Males											
Females											
Total											

Source:

Note: In some instances, the number in the total column is not the sum of the individual years due to differing reporting, estimation processes or available data.

Sexually transmitted infections (STIs)

The predominant mode of transmission of both HIV and other STIs is sexual intercourse. Measures for preventing sexual transmission of HIV and STIs are the same, as are the target audiences for interventions. In addition, strong evidence supports several biological mechanisms through which STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility. Thus, detection and treatment of individuals with STIs is an important part of an HIV control strategy. In summary, if the incidence/prevalence of STIs is high in a country, then there is the possibility of high rates of sexual transmission of HIV. Monitoring trends in STIs provides valuable insight into the likelihood of the importance of sexual transmission of HIV within a country, and is part of second generation surveillance. These trends also assist in assessing the impact of behavioural interventions, such as delaying sexual debut, reducing the number of sex partners and promoting condom use. Clinical services offering STI care are an important access point for people at high risk for both STIs and HIV. Identifying people with STIs allows for not only the benefit of treating the STI, but for prevention education, HIV testing, identifying HIV-infected persons in need of care, and partner notification for STIs or HIV infection. Consequently, monitoring different components of STI prevention and control can also provide information on HIV prevention and control activities within a country.

STI syndromatic reporting

Genital discharge

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											

Source:

Genital ulcers

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											
Females											
Total											

Source:

STI etiological reporting

Chlamidya

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											
Females											
Total											

Source:

Gonorrhoea

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											
Females											
Total											

Source:

Syphilis

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											
Females											
Total											

Source:

Herpes simplex

Reported cases	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Males											
Females											
Total											

Source:

Syphilis prevalence, women

Percent of blood samples taken from pregnant women aged 15-49 that test positive for syphilis - positive reaginic and treponema test-during routine screening at selected antenatal clinics.

Syphilis prevalence, ANC women

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Total											

Prevalence of curable STIs among specific populations

Prevalence of curable STIs among female sex workers

	Year	Area	Rate	Range
Chlamydia				
	1997-1999	Urban	28.5	

Source: Sturm-Ramirez K. Molecular epidemiology of genital Chlamydia trachomatis infection in high-risk women in Senegal, West Africa. J Clin Microbiol 2000; 28 (1): 138–145.

	Year	Area	Rate	Range
Gonorrhoea				
	1997-1999	Urban	6.7	

Source: Sturm-Ramirez K. Molecular epidemiology of genital Chlamydia trachomatis infection in high-risk women in Senegal, West Africa. J Clin Microbiol 2000; 28 (1): 138–145.

	Year	Area	Rate	Range
Syphilis				
	1997-1999	Not specified	20	20-26
	2000-2001	Not specified	3.8	0-16.3

Source: 1) Comite National de Lutte Contre le SIDA, FHI, USAID. Bulletin epidémiologique N° 8, Décembre 2000. 2) Sturm-Ramirez K. Molecular epidemiology of genital Chlamydia trachomatis infection in high-risk women in Senegal, West Africa. J Clin Microbiol 2000; 28 (1): 138–145.

	Year	Area	Rate	Range
Trichomoniasis				
	1997-1999	Urban	12.6	

Source: Sturm-Ramirez K. Molecular epidemiology of genital Chlamydia trachomatis infection in high-risk women in Senegal, West Africa. J Clin Microbiol 2000; 28 (1): 138–145.

Prevalence of curable STIs among other specific populations

Specific populations according to the epidemic pattern of the country

	Year	Area	Rate	Range
Chlamydia				
Source:				

	Year	Area	Rate	Range
Gonorrhoea				
Source:				

	Year	Area	Rate	Range
Syphilis				
Source:				

	Year	Area	Rate	Range
Trichomoniasis				
Source:				

Health service and care indicators

HIV prevention strategies depend on the twin efforts of care and support for those living with HIV or AIDS, and targeted prevention for all people at risk or vulnerable to the infection. It is difficult to capture such a large range of activities with one or just a few indicators. However, a set of well-established health care indicators may help to identify general strengths and weaknesses of health systems. Specific indicators, such as access to testing and blood screening for HIV, help to measure the capacity of health services to respond to HIV/AIDS - related issues.

Access to health care			
Indicators	Year	Estimate	Source
% of population with access to health services - total			
% of population with access to health services - urban			
% of population with access to health services - rural			
Contraceptive prevalence rate (%)	1999	10.5	UNPOP
Percentage of contraceptive users using condoms			
% of births attended by skilled health personnel	2000	58	UNICEF
% of 1-yr-old children fully immunized - DPT	2004	87	WHO/UNICEF
% of 1-yr-old children fully immunized - Measles	2004	57	WHO/UNICEF
% of ANC clinics where HIV testing is available			

Estimated number of adults (15+) in need of treatment

Total number of adults needing antiretroviral therapy

	2003	2005
Both sexes	8600	10 000
Low estimate	4600	5300
High estimate	13 000	16 000

Source: WHO and UNAIDS, March 2006

Estimated number of people receiving antiretroviral therapy

Total number of people receiving antiretroviral therapy at end of each year

	2003	2005
Males		
Females		
Both sexes	1500	4000

Source: Based on the most recent calculated ART need estimates by WHO and UNAIDS, as of March 2006.

Coverage	2003	2005
Both sexes	15%	35%

Source: WHO and UNAIDS, March 2006

Comments: See also the paediatrics estimates section on the next page, as the ART need among children should also be taken into account for estimating ART coverage.

Services providing antiretroviral therapy

Reported number of sites that are providing antiretroviral therapy

	2003	2005
Public		
Private		
Total		32

Source: (total 2005) Annex 3: Progress on Global Access to HIV Antiretroviral Therapy, A Report on "3 by 5" and Beyond. Geneva, WHO and UNAIDS, March 2006.

Comments:

Paediatrics estimates, 2005

	Total	Source
Children living with HIV		
Low estimate		
High estimate		
Children in need of ART	1800	
Low estimate	600	
High estimate	3500	*WHO and UNAIDS, March 2006*
Children receiving ART		
Children in need of cotrimoxazole	8900	
Low estimate	3100	
High estimate	18 000	*WHO and UNAIDS, March 2006*
Children receiving cotrimoxazole		

Comments:

Coverage of HIV testing and counselling

Number of public, private and NGO sites providing testing and counselling services.

	Year	Area	Total number of sites
Public sector			
Private sector			
NGOs			
Total			

Source:

Number of people counselled and tested over time

Number of people who have been tested and counselled in the country.

	2003	2004	2005
Males			
Females			
Both sexes			

Source:

Knowledge and behaviour

In most countries the HIV epidemic is driven by behaviours (e.g.: multiple sexual partners, injecting drug use) that expose individuals to the risk of infection. Information on knowledge and on the level and intensity of risk behaviour related to HIV/AIDS is essential in identifying populations most at risk for HIV infection and in better understanding the dynamics of the epidemic. It is also critical information in assessing changes over time as a result of prevention efforts. One of the main goals of the 2nd generation HIV surveillance systems is the promotion of a standard set of indicators defined in the National Guide (Source: National AIDS Programmes, A Guide to Monitoring and Evaluation, UNAIDS/00.17) and regular behavioural surveys in order to monitor trends in behaviours and to target interventions. The indicators on knowledge and misconceptions are an important prerequisite for prevention programmes to focus on increasing people's knowledge about sexual transmission, and, to overcome the misconceptions that act as a disincentive to behaviour change. Indicators on sexual behaviour and the promotion of safer sexual behaviour are at the core of AIDS programmes, particulary with young people who are not yet sexually active or are embarking on their sexual lives, and who are more amenable to behavioural change than adults. Finally, higher risk male-male sex reports on unprotected anal intercourse, the highest risk behaviour for HIV among men who have sex with men.

Knowledge of HIV prevention methods

Prevention indicator: Percentage of young people 15-24 who both correctly identify two ways of preventing the sexual transmission of HIV and who reject three misconceptions about HIV transmission.

	Total	Urban	Rural	Year
Males				
Females	13			2000

Source: MICS

Reported condom use at last higher risk sex (young people 15-24)

Prevention indicator: Proportion of young people reporting the use of a condom during sex with a non-regular partner.

	Total	Urban	Rural	Year
Males				
Females				

Source:

Age-mixing in sexual partnerships among young women

The proportion of young women who have sex in the last 12 months with a partner who is 10 or more years older than themselves.

	Total	Urban	Rural	Year
Females				

Source:

Reported non regular sexual partnerships

Prevention indicator: Proportion of young people 15-24 having at least one sex partner other than a regular partner in the last 12 months.

Year	Males	Females

Source:

Ever used a condom

Percentage of people who ever used a condom.

	Age	Total	Urban	Rural	Year
Males					
Females					

Source:

Adolescent pregnancy

Percentage of teenagers 15-19 who are mothers or pregnant with their first child.

	Year	Percentage

Source:

Age at first sexual experience

Percentage of 15-19 year olds who have had sex before age 15.

	Year	Males	Females

Source:

Prevention indicators

Prevention of mother-to-child transmission (PMTCT) nationwide

Infection of HIV from an HIV-positive mother to her child during pregnancy, labour, delivery of breastfeeding is called mother-to-child transmission (MTCT). An estimated 530 000 (410 000 - 660 000) children were newly infected in 2006, mainly through mother-to-child transmission. The vast majority of these infections are preventable, yet coverage levels are remarkably low in most resource-limited countries.

Prevention mother-to-child transmission

	Total	Year	Comment
Antenatal care coverage (%), 1997--2005*	79	2005	
Number of pregnant women counselled on PMTCT services	16 114	2005	
Estimated number of HIV-infected pregnant women	4600	2005	
Number of HIV-infected pregnant women who received ARVs for PMTCT	57	2005	
% of HIV-infected pregnant women who received ARVs for PMTCT	1	2005	

* Data refer to the most recent year available during the period specified.

Source: UNAIDS/Unicef/WHO. Children and AIDS; A stocktaking report, Actions and progress during the first year of "Unite for Children, Unite against AIDS". New York, 2007.

Prevention indicators among injecting drugs users

Availability of harm reduction services	Number of centers	Number of people attending services	Estimation of coverage	Year
Needle exchange programs				
Opiod substitute therapy				

Source:

	Estimated number of IDUs aged 15-65	IDU prevalence(%)	Year
Needle exchange programs			

Source:

Screening of blood transfusions nationwide

Blood safety programs aim to ensure that the majority of blood units are screened for HIV and other infectious agents. This indicator gives an idea of the overall percentage of blood units that have been screened to high enough standards that they can confidently be declared free of HIV.

	Percentage
Percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines.	

Sources

Data presented in this Epidemiological Fact Sheet come from several sources, including global, regional and country reports, published documents and articles, posters and presentations at international conferences, and estimates produced by UNAIDS, WHO and other United Nations agencies. This section contains a list of the more relevant sources used for the preparation of the Fact Sheet. Where available, it also lists selected national Web sites where additional information on HIV/AIDS and STI are presented and regularly updated. However, UNAIDS and WHO do not warrant that the information in these sites is complete and correct and shall not be liable whatsoever for any damages incurred as a result of their use.

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Websites

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Annex: HIV surveillance prevalence by site

Group	Area		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Pregnant women	Major urban areas	Dakar	1.1	0.3	0	0	0	0.3	0.3	0.4				0.6	1.1	1.7		
		M'Bour					0.8	1.7	0.6						0.8	2		
		Thies					0	1	0	0.1	0.5	0.9	1.5		0.4	0.7		
	Outside major urban areas	Casamance																
		Diourbel													1.5	1		
		Fatick									0.4	0.4	0		1.4	1.2		
		Kaolack	0.4	0	0	0.8	0		0.1	0.7	0.7	0.7	0.5	0.6	1.1	2		
		Kolda													2.1	2.8		
		Louga									0.5	0.7	0.7		1	0.8		
		Saint-Louis	0	0	0						0.2	0.2	0	0.2	0.3	0.5		
		Tambacounda													0.8	2.6		
		Ziguinchor	0.2	0	0.1	0.4	0.6	0	0.1	0.8	0.6	1.1	0.9	1.2	1.2	2.3		
Sex workers	Major urban areas	Dakar	4.5	4.4	5.3	9	10.1			12.9	6.1	13.7	13	13.8	14.2			
		M'Bour					11.2	15.7	6.7	7.6	7		14.5	8.9	4.5			
		Thies					4	7.1		7.3	13.3				9.7			
	Outside major urban areas	Casamance																
		Kaolack	4.7	11.5	8.1	8	8.5	8.8	13.4	14.2	17.1			22.8	22.7			
		Saint-Louis	2.7	0								14.9						
		Ziguinchor	0.5	1.4	1.9	9.5	9.2	6.7	14	16.2	21.9	10.3	17.2		20.8			
STI patients	Major urban areas	Dakar	1.1	1.6	2.3	4.5	2.2	3.1	1.4	3.3	3	3.5	4.3	4.1				
		M'Bour							6.2		4							
		Thies					4.9	4.8	4.9	0	0							
	Outside major urban areas	Kaolack	2.5	2.6	2.8	2.9	3											
		Louga																
		Saint-Louis			0													
			0	0														
		Ziguinchor	0	0	1	1.1	2.2											
Tuberculosis patients	Major urban areas	Dakar	3.5	3.7	5	6	7.2	5.9	7.4	7	4.9	9.1			9.7			
		M'Bour					14.3	8.5	5	10.9	9.6				2.3			
		Thies					5			10.1	3.1	9			9.9			
	Outside major urban areas	Kaolack	1.4	2.1	3	3.9	4.5		5.9	2.3	7.8		6.4		13.3			
		Saint-Louis			0													
		Ziguinchor	2.1	1.7	1.1	0.5				0		9.2						