4.2 Communicable and noncommunicable diseases

Information and analysis

- Most PRSPs identify the “key diseases” in their country. In a few cases this is backed up with statistical evidence, but in most cases not.

- Certain countries outline very detailed disease control plans, based on rigorous analysis. For example, Mozambique includes a geographic breakdown of HIV prevalence with a correspondingly-targeted HIV/AIDS-control programme.

- In most countries, the diseases identified will also be those which disproportionately affect the poor, however even in the countries with the most detailed plans is there no detailed examination of this fact – for example a breakdown of disease burden by income quintile – nor a detailed discussion of which diseases are most likely to affect the poorest groups.

- Similarly, there is little analysis of the impoverishing effects of diseases.

Strategy and monitoring

- In most cases there is consistency between analysis and strategy, with a few notable exceptions (for example, in one country ARI is identified as the major cause of mortality, but there is no strategy to deal with it).

- All 10 of the PRSPs examined mention communicable disease control, and eight of these include some kind of monitorable indicator in their strategies.

- Eight out of 10 of the full-PRSPs address HIV/AIDS in their strategy; five of these include indicators to measure progress.

- However in only three cases for HIV/AIDS and two for communicable diseases are strategies targeted at poor and vulnerable groups,\(^1\) or poor and vulnerable regions. In Burkina Faso, the groups most vulnerable to HIV/AIDS are named (military, truck drivers, sex workers), and in Mozambique the specific areas where HIV/AIDS programmes need to be strengthened are named. In Mozambique, priority districts for malaria are also identified. But these are the only countries to be so specific. In other cases, the targeting is much broader, e.g. “strengthening equipment in outlying health facilities” or “enhancing ability to diagnose and treat opportunistic infections suffered by HIV/AIDS patients in peripheral health facilities”.

- Strategies to address noncommunicable diseases, and in particular smoking, represent one of the most significant gaps in PRSPs. Only one country, Albania, includes a strategy on smoking, and only Honduras mentions the rising noncommunicable disease burden.

- Links between communicable and noncommunicable diseases, and the Millennium Development Goals (MDGs) are weak – only two of the 10 full PRSPs reviewed

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\(^1\) In the case of HIV/AIDS, in particular, vulnerable groups are not necessarily the poorest.
linked with the Goal on HIV/AIDS, and only one linked with other targets relevant to communicable diseases.²

Summary points
1. In most cases there appears to be consistency between the information provided and the strategies outlined. Most, though not all, PRSPs identify those diseases which are major causes of morbidity and mortality in their country, and then outline strategies to address these diseases.

2. It is possible to infer that in many cases the strategy outlined will have an impact on the poor, as the diseases addressed are those affecting poor people. However, there is no specific discussion of the need for pro-poor targeting, i.e. how to adapt general strategies to meet the needs of the poorest groups.

3. Strategies to address noncommunicable diseases are missing from most PRSPs.

² All targets related to communicable diseases are found under goal 6 of the MDGs: “Combat HIV/AIDS, malaria and diseases”.