Chapter 7: Regional Strategies for NCD Prevention and Control

Key messages

- Regional strategies could enhance NCD prevention, especially for tobacco and food.
- Three main situations lend themselves to regional cooperation: when there are positive or negative externalities, there are economies of scale and scope, and the production (or prevention) of a good is only possible if all countries participate.
- Potential areas for regional collaboration include tobacco control (including harmonizing tobacco taxes and strengthening anti-smuggling measures); standardizing and mandating food labeling; purchasing essential medications for treatment of NCDs; and developing a shared evidence base for intervention, training, and surveillance.
- Institutions to lead and manage supranational coordination need to be identified.

Introduction

The NCD burden, using any of the comparable measures available, is highly variable across South Asia (as noted in Chapter 1). However, by contrast, NCD risk factors are similar, especially for tobacco—which has the best data, and to a more limited degree with available data, for diet and alcohol use. Thus, NCD prevention may benefit from harmonizing health policies and strategies at a regional level for tobacco control and healthy dietary practices.

The centerpiece of tobacco control efforts include policies that restrict advertising to adults and marketing to children, and that increase tax rates of cigarettes and tobacco products to reduce consumption, especially among the poor, who tend to use more tobacco than the rich (Ross and Chaloupka 2006). The tobacco industry tends to target its marketing efforts at countries with fewer restrictions, where tobacco is taxed less and is easier to buy. Media advertising for tobacco products in countries with fewer restrictions can therefore penetrate into countries with more restrictive policies. Also, low cigarette prices increase the risk of smuggling back into countries with restrictive policies, higher taxes, and higher tobacco prices.

Thus, harmonization of tobacco policy is not only important—its absence may cause harm. One response at a global level was the FCTC (Box 4.1 above), which has been adopted by all countries in South Asia. However, implementation worldwide has been slow or stalled because of several complexities, including weak international collaboration.

Food-exporting countries’ policies can heavily influence health dietary practices through the quality of food consumed in food-importing countries. For both tobacco use and food consumption, the poor are the most susceptible to domestic and international policies because they have higher smoking rates and make food purchases based on cost, not quality.

Several other situations may benefit from international collaboration. For example, smaller countries may not—alone—be able to carry out important activities efficiently, including training health professionals; purchasing, manufacturing, and regulating drugs; and conducting research. (Chapter 5
showed common county-level gaps in human resource supply and skills for NCDs, medication availability and affordability, an evidence base for interventions, and surveillance systems.)

In addition, some countries may be reluctant to undertake certain initiatives because they are concerned that they will lead to increased levels of smuggling across international borders, lowering tax revenues. This is especially true for tobacco and alcohol, but also applies to pharmaceuticals and other health products where a secondary market for drugs exists (if one country, for example, negotiates a better price than another).

Examples where regional approaches have been employed include those for HIV/AIDS in Africa, Central Asia, and the Caribbean (World Bank 2008b; Godinho et al. 2005). With commonalities among countries, these two reports describe how a regional approach has focused on developing national policies, using evidence-based interventions, prioritizing strategies, targeting multisector and civil society responses, enhancing capacity for monitoring and evaluation, and harmonizing donor collaboration.

Guiding Principles for Regional Collaboration

Policy makers use the concept of public goods to define the role of government and international agencies in policy implementation. But as globalization gathers pace, goods—as well as diseases—cannot be kept within national borders.

Experiences inside and outside public health can provide guidance on where collaboration may have advantages. For example, the International Task Force on Global Public Goods, convened by European governments, defined global public goods as “issues that are broadly conceived as important to the international community, that for the most part cannot or will not be adequately addressed by individual countries acting alone and that are defined through a broad international consensus or a legitimate process of decision-making” (International Task Force 2006).

A similar approach could be taken for nonpublic goods as well. The International Task Force also calls for the intervention of global institutions, such as the United Nations and the World Bank (International Task Force 2006). The report stops short of recommending how these global institutions could establish mechanisms to finance and provide those global goods.

Guiding principles developed by the World Bank (Development Committee 2007) established the following criteria where global collaboration should be considered: (i) there should be an emergent consensus in the international community that global action is required; (ii) there should be an institutional gap that international agencies could help fill to encourage global action; (iii) international agencies should have the requisite capabilities and resources to be effective; and (iv) global action by international agencies could catalyze other resources. Governments in South Asia could use these principles to decide what activities they want to pursue regionally. Some of the very practical factors (such as which international agency is willing to take the lead in developing an agenda) may direct the focus on and resolution of a specific issues. Assuming that there is consensus, capacity, resources, and feasibility (see Common Challenges for Tackling NCDs in Chapter 5), three types of situation can justify a regional approach. The first is when positive or negative externalities may occur. Examples of the former are knowledge management for addressing NCDs that leads to better prevention and control policy resulting in lower NCDs burdens; the latter might include smuggling and inconsistent tobacco taxation

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among countries with common borders such that exposure to tobacco increases secondary to the tax policy.

The second is when there are economies of scale and scope in working regionally. For example, this may occur when the marginal cost of supplying the good to multiple countries in the region is negligible. Group purchasing is an especially relevant issue for small countries, which do not have the purchasing power of larger nations. Also, in South Asia, a few countries (mainly Bangladesh and India where the pharmaceutical industry is rapidly developing) may be well positioned to supply the good and could do it more efficiently through regional agreements.

The third type of situation is when the production (or prevention) of a good is more effective if all countries participate, including collective bargaining for group purchase of drugs, food labeling, tobacco labeling, comparative effectiveness studies, and research. An example is food labeling and regulated contents of processed foods where it may be less costly for industry to have a uniform approach to the entire region than to label and process a product differently for each country (Roos et al. 2002).

Using the above guiding principles, the following potential areas for collaboration within the region are outlined. Some of these regional strategies are specific to NCD risk factors; others are broader and affect the health system as a whole, yet are critical to strengthening the overall NCD response. A rationale for each strategy is also presented.

Strategies for NCD Risk Factors

Expand and Harmonize Tobacco Advertising Bans to Reduce Demand

Tobacco is a major NCD risk factor common to the region. Most countries' tobacco policies have advertising bans for national TV, radio, magazines, and newspapers, although most of these bans do not extend to international media (Table 7.1). Only half have policies for warning labels on tobacco packaging. These inconsistent policies take away from their potential impact, and synergies among them may be lost. This also can lead to big countries, India for example, which can dominate regional culture and politics resulting in large influences, good or bad, in smaller countries that share common borders. Thus, harmonizing and expanding ban policies would fill country level gaps in policies and address inconsistencies across the region.

The rationale for a regional strategy and collaboration is that collective bargaining with media for advertising and industry for tobacco labeling would give smaller countries greater leverage. In addition, wider bans would have the positive externality of limiting second-hand smoke exposure in public spaces.
Table 7.1 Tobacco prevention and control policies in South Asia

<table>
<thead>
<tr>
<th>Category</th>
<th>Indicator</th>
<th>AFG</th>
<th>BGD</th>
<th>BTN</th>
<th>IND</th>
<th>MDV</th>
<th>NPL</th>
<th>PAK</th>
<th>LKA</th>
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</tr>
<tr>
<td></td>
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<td>Yes</td>
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<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Local magazines and papers</td>
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<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>International magazines and papers</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Public smoking ban</td>
<td>Government facility</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Public transport</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Package labeling</td>
<td>Warning on package</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

*Source: WHO 2008b.*

**Increase and Harmonize Tobacco Taxation to Reduce Consumption**

The most cost-effective policy tool for tobacco control is taxation of tobacco products. It has been highly effective in reducing prevalence of smoking in both developed and developing countries (World Bank 2006), and FCTC signatories are committed to levy excise taxes on tobacco products. Studies have estimated that for every 10 percent increase in the price of tobacco, consumption of tobacco products can be expected to decrease by 2.7 percent in Bangladesh, 8.8 percent in Nepal, and 5.3 percent in Sri Lanka (Adeyi et al. 2007) and by 4–9 percent in India, depending on the type of tobacco product (John 2008b). While raising tobacco taxes may increase government revenues and may reduce the number of smokers, it can also prompt smokers to switch to cheaper products, such as *bidis*, a much less expensive—but equally harmful—form of smoked tobacco, and it can provide an incentive for smuggling if the price of cigarettes is lower in neighboring countries.

Tax policies vary widely across countries, and across different tobacco products within the same country. The excise tax combined with all other taxes ranges from nearly 75 percent in Sri Lanka for a 20 piece pack of the most sold brand of cigarettes to under 10 percent in Afghanistan (Figure 7.1). In addition, tax on *bidis* is only a fraction of that on cigarettes.
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Figure 7.1 Share of total and excise taxes in the price of 20 piece pack of the most sold brand of cigarettes (top) and for the most sold brand of *bidis* (bottom), South Asia, 2008

Source: WHO 2008b.

To reduce consumption, the tax level should increase the actual retail price. This is an area where the tobacco industry can reduce profit margins to maintain consumption rates by keeping prices low. For the most sold brand, an almost 10-fold variation in price is found between countries (Figure 7.2).

Figure 7.2 Price of the most sold and cheapest brand of cigarettes (top) and most sold 20 pack of *bidis* (bottom), (US$), 2008

Source: WHO 2008b.
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The rationale for regional harmonization of tax policy is the potential for negative externalities associated with increased consumption due to access to cheaper tobacco products in neighboring countries and the increased risk of smuggling that such large cost variations create.

**Harmonize Tobacco Taxes and Strengthen Anti-Smuggling Measures**

Recognizing that smuggling can undermine FCTC implementation, in March, 2010, an FCTC working group (which includes South Asian countries) developed a draft protocol to control illicit tobacco trade (Intergovernmental Negotiating Body 2009). Areas the protocol covers are its relationship to other international agreements, such as the UN Convention against Transnational and Organized Crime, the development of an international tracking and tracing system, and requirements for wholesale customer identification and verification. This protocol is expected to aid the implementation of the FCTC and is currently under consideration by the FCTC’s Conference of Parties.

While many countries struggle to control tobacco smuggling, others are more successful. The experience in Spain, for example, demonstrates the effectiveness of focusing on the supply chain. From 1996 through 2000, Spain increased its resources dedicated to track cigarette smuggling from €4 million to €44 million. Through systematic detection of traffic routes and seizure of containers, fines and penalties on smugglers, as well as strong law enforcement mechanisms, Spain reduced the market share of smuggled cigarettes from 16 percent to 2 percent, and boosted tax revenues from tobacco products from €2,300 million to €5,200 million—a significant return on investment (Joossens and Raw 2008).

Europe and South America present good examples of regional cooperation on tobacco control. The European Commission (EC), based on the Racketeer Influenced and Corrupt Organization Legislation, filed a suit against the tobacco companies in a U.S. court after European courts had found the tobacco industry liable for indirectly participating in smuggling across Europe. Tobacco companies immediately attempted to settle out of court. They had been negotiating, country by country, a memorandum of understanding that was unenforceable and non-binding, while offering to donate funds for health and other social programs, as they had previously done with several other countries (BAT 2009; Gilmore et al. 2006; Samet et al. 2006). The EC, acting as a regional entity, negotiated a more stringent agreement on behalf of all its member countries, and dropped the suit only after the tobacco industry accepted it. This agreement, which includes tracking mechanisms financed by tobacco companies, has served as a model for other regions.

In 2003, several countries in South America began harmonizing tobacco product taxes to reduce susceptibility to illicit trade. This move also made them less vulnerable to ad hoc agreements with the tobacco industry (Iglesias and Nicolau 2006). These same South American countries also created a common database of the various types of warnings on cigarette packages to support the implementation of the FCTC at country level (Mercosur 2003).

The rationale for a regional approach to taxation and smuggling is that, unchecked, smuggling will undermine advertising and tax policies designed to reduce consumption.

**Standardize and Mandate Food Labeling Policy to Improve Knowledge and Awareness of Food Composition**

Food-importing countries—especially the smaller ones—have little control over the exporting countries’ food quality and can suffer some adverse consequences. Food labeling is becoming more common, and accurate information is a first step to increase awareness of the nutritional components and calorie

http://www.who.int/fctc/inb/en/
content for consumers. As most of these food labels are established for larger countries, the smaller countries need to accept that it is not economically viable for their industry to label food.

Trans fats are an example where labeling may assist health promotion efforts to improve the quality of dietary fats. Multinational food companies have created products that have advantages for them but are harmful to the population. While each country could tackle these issues alone, it is likely to be more effective for countries in South Asia to work together to develop strategies with multinational food companies to eliminate trans fats, and reduce unsaturated fats and salt in their products. However, the first step is awareness of the trans fat content.

Food labeling can also assist national efforts to reduce obesity, a growing problem in South Asia among adults and, in some cases, children, through increasing awareness of calorie content. A major challenge for this effort is that significant chronic energy deficit and underweight persist at the same time. Many of the initiatives to tackle obesity will require consideration of sociocultural contexts specific to each country while addressing nutritional content of foods and the importance of increasing the level of exercise. In addition, food labeling will complement awareness campaigns for healthy foods.

The rationale for a regional strategy and collaboration for food labeling is that it provides both a much stronger negotiating position for countries vis-à-vis the food industry, as well as economies of scale (in that that similar labels can be used for several countries).

**Strategies to Improve Health Systems**

**Collaborate on Group Purchasing of Essential Medications to Increase their Access and Affordability**

Because medications play a key role in achieving improved clinical outcomes among people with NCDs, assuring that patients have access to the appropriate medication is important. However, the context in South Asia makes this goal hard to achieve. All countries in the region spend a considerable proportion of total health expenditures on drugs, and much of this is paid by patients themselves, including the poor. This is largely due to the unavailability of essential drugs in the public sector because of inadequate public purchasing practices, and large mark-ups in the private sector (Cameron et al. 2009), and public policies that may not provide drugs.

Most of the countries in the region lack the expertise and facilities to produce a wide range of pharmaceuticals. As a result, essential drugs for NCDs are likely to be imported. India, however, has an extensive drug manufacturing program that caters both to internal and external markets, the latter mainly within South Asia. Bangladesh also has an extensive manufacturing industry for some medications, but nearly all are consumed domestically. Quality control and good manufacturing practices for medications are both issues that challenge these two markets.

While the market place is likely to develop drugs that respond to demand from people who can pay for them, many institutions and individuals cannot afford to. Country collaboration (to gain better bargaining power and affordability to drugs for NCDs) is likely to help provide real gains on this preventable burden.

Most countries in South Asia have developed essential drug lists to determine what drugs governments should purchase. Yet if countries were able to decide on a common essential drug list and to have a commonly agreed-on set of regulations, their procurement units could negotiate with drug companies collectively instead of individually, strengthening their bargaining position and securing lower prices. Countries should therefore compare their lists and rationalize them, to eliminate country differences.
International cooperation may well result in lower prices in those South Asian countries where they are high. In Bangladesh, Nepal, and Pakistan, for example, drugs provided by public facilities are free of charge, but when a list of 32 essential medicines for chronic conditions was examined, less than 8 percent were actually available in the public sector. Therefore, patients have to buy drugs in private outlets where only 30 percent of the lowest-price generics are available (Mendis et al. 2007). When compared with international reference prices the lowest price generics are 2.05, 1.64 and 1.14 times more expensive in Nepal, Pakistan, and Bangladesh respectively; whereas in Sri Lanka the prices of the lowest-price generic and the most commonly sold generics are equivalent to the international reference price.

Over the past 20 years, both developed and developing countries have attempted various models to improve drug availability and reduce their price. There are several examples of aggregated pooled procurements at state, country, and intercountry levels that have led to lower prices and improved quality control (Huff-Rousselle and Burnett 1996; Murakami et al. 2001; WHO 2007). In some instances, pooled procurement is used with subsidies that both encourage participation of private pharmacies and improve access for the poor—a potential approach that could be adopted regionally instead of just one country at a time.

Some European and Latin American countries use reference pricing, where the insurance plan or government takes as a reference for reimbursement the lowest priced generic (Schneeweiss 2007). Adopting the same system would give countries in South Asia greater bargaining power with drug companies. Another approach is comparative effectiveness (discussed in the next section).

All South Asian countries have some type of regulation of pharmaceuticals, although the resources and level of regulation vary extensively. While a country like India could undertake reforms on its own, and some Indian states have already done so, the situation is more difficult for smaller countries that do not have adequate regulatory infrastructure. Regional support to evaluate options according to the needs of each country could make it possible to establish common systems that may include quality control, purchasing support, and monitoring drug availability. WHO has already developed a methodology for putting in place regulations and monitoring the availability and prices of drugs, but it needs to be carried out by countries (Cameron et al. 2009; Niens and Brouwer 2009).

Thus, the rationale for increasing access and affordability of essential medications is that the negotiating power of procurement units would increase (especially in smaller countries), and bulk purchasing would reduce costs and help assure adequate supplies. This approach would be most feasible for neighboring countries with similar health systems and good cross-border collaboration. However, the transaction costs may be significant,\(^{29}\) and would need to be weighed against the benefits.

**Establish a Regional Health Technology Assessment Institution to Improve the Comparative Effectiveness of Interventions for NCDs and other Conditions**

Although accurate data are scant, Chapter 2 showed that significant resources are spent on NCDs in South Asia. Thus, assuring that these resources have the best chance of achieving the desired outcomes is a high priority. The fast-growing global knowledge base for NCDs is an important asset to help countries channel resources where they will have the largest impact but is not currently be used much by countries. However, there are major challenges in tapping this base.

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\(^{29}\) These include the costs of additional people, additional warehouse space and equipment to handle larger volumes, and transport costs. These are real incremental costs that need to be financed before the volume of drugs can be scaled up. While these costs may not be known, they may be significant.
First, the volume of new research makes it difficult for any single entity to keep track of it all. It is not possible for institutions—and certainly not for individuals—to keep abreast of the nearly 100,000 new papers published in the health sciences literature every year (NLM 2009). The technical solution has been the emergence of specialized entities that conduct systematic literature reviews. Some of these entities are academic centers and government agencies that either contract out or directly conduct these reviews; others are self-standing not-for-profit organizations, such as the Cochrane Collaboration, probably the best-known of these entities.

Second, many research studies use different approaches and methods, leaving the advantage of one treatment relative to another unclear. In an attempt to tackle this challenge, comparative effectiveness assessments of interventions and treatments examine the efficiency (the outcome yielded from the inputs) by examining two or more treatment options and deciding which has (i) the greatest efficacy (the outcome in a carefully controlled study setting), (ii) the greatest effectiveness (the outcome in a typical clinic or community setting), and (iii) the greatest cost-effectiveness (the cost per outcome achieved). Countries may use different assessment methods and acceptability thresholds that are not necessarily standard and would fit other countries objectives.

Comparative effectiveness is also used to improve allocative efficiency (targeting resources where they will be the most effective and likely have the largest impact). Many countries have a legacy of heavy investment in hospitals and much less investment in ambulatory services where highly cost-effective interventions can be delivered (Chapter 2). This is true in some South Asian countries.

Third, the cost, especially the fixed cost, of establishing an institution to rate comparative effectiveness can be high. Also the number of drugs, devices, and procedures that need evaluation is huge. All this suggests there is an advantage in having a regional body rather than national institutions. South Asia has several different models to choose from. The United Kingdom has one of the oldest and most respected bodies, the National Institute for Clinical Effectiveness. For policy decisions and resource allocation, it relies on synthesis and critical appraisal of available evidence, including cost-effectiveness, to develop practice guidelines that provide technical support to the country’s publicly funded National Health Service. It develops guidelines with professional organizations, but not with private industry. The government also funds audits of the implementation of guidelines and information gathering of emerging clinical innovations.

In Germany, where there are multiple payers, the German Institute for Quality and Efficiency in Healthcare (IQWiG), a not-for-profit nongovernmental entity, collates and presents a structured assessment of comparative clinical effectiveness of different medical interventions to inform negotiations between insurers and professionals. This entity has an advisory capacity only; final decisions are made by the Joint Federal Committee, which is made up of health care providers and insurance funds.

There are also models from low- and middle-income countries that may be more relevant to countries in South Asia, and the most relevant is perhaps Brazil. Brazil has entered into an agreement with the United Kingdom to use guidelines from the National Institute for Clinical Effectiveness as a starting point. The Ministry of Science in Brazil then reviews the guidelines and proposes adaptations to the Brazilian context; Brazilian economists conduct cost analyses based on the costs in Brazil; the final presentation is then made to the decision maker, the MOH. The information presented to the minister of health includes these recommendations, physicians’ requests, and opinions of hospital managers and patient advocacy groups. Once included in the benefits package, the drug or device is fully funded and available throughout the system.
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The rationale for regional collaboration to establish a comparative effective institution is that such a body is unsustainable in terms of resources or expertise for a single country, yet the outputs will provide critical guidance on policy development for prevention and treatment at the country level.

**Use Regional Education and Training Capacity to Complement the National Needs for Human Resources in order to Improve both Staffing and Skill Levels**

Health professionals play a vital role in the prevention and, especially, treatment of people with NCDs, yet most countries in South Asia are significantly short of health professionals. The larger countries are investing in additional training, and the smaller ones heavily depend on them for training their own nationals. There is considerable migration across regional countries among health professionals in addition to out-migration to more prosperous countries beyond the region. Thus several aspects involving labor, training, and migration of health professionals could be addressed from a regional perspective. A better understanding of the country-level dynamics of HRH within and outside the region would lend insight to where efforts might be strategically placed to address shortages and needed skills.

For small countries, cross-national training of health professionals would offer benefits, including lower costs and a higher-quality education in settings with greater clinical expertise and a population with an adequate case load for training.

One possibility is to have the initial years of training carried out in one country and then have formal clinical rotations to other countries. In the United States, for example, an HRH training program has all the initial training for physicians and nurses from rural western states in Washington state, which has a large urban center; then the clinical rotations are to the trainees’ home states. These rural states do not have the funds or the population to support a medical or nursing school, but they help support the medical school in Washington state and, in return, are allowed to admit their students to Washington state medical school for basic training and then continue the clinical training in their home state.

This is a model that could benefit the smaller countries in the region, and has multiple advantages. It allows more training of health professionals from smaller countries; it does not require larger countries to fill gaps smaller countries health professionals needs; and means that people in smaller countries can be treated by people from their own country.

The rationale for adopting a regional approach for the HRH gaps that most countries are facing stems from the economies of scale achievable.

**Establish a Regional Network of Surveillance and Burden Assessment to Improve National Capacity through Knowledge Sharing and Experience Exchange**

Surveillance—a challenge across the region—is critical not only for policy formation but for the development of efficient programs that will reach the target population. This is a country-level activity and countries have made much progress recently with technical support from WHO and financing support from development partners. However, international cooperation—in creating information systems both to identify the prevalence and economic burden of NCDs and to determine how the care for NCDs is being financed and delivered—would provide momentum and be of great benefit for planning and potentially jumpstarting efforts in the area of surveillance.

Most regional countries already use international data-collection forms for surveillance efforts. It will be important for countries to review the information that is being collected and look for gaps in it. Most countries still rely on Global Burden of Disease study estimates. That methodology seldom has country-specific data, leaving most estimates based on regional numbers, especially for the smaller countries. To the extent that countries need to collect data that are unique to their own country for policy
formulation, using common data instruments may have the advantage that it allows for intercountry comparisons, at least for elements of comparative interest.

The rationale for a regional approach for establishing a surveillance network includes economies of scale from implementing similar surveys across the region, and the collective bargaining of governments with the institutions that will conduct the surveys and studies.

**Regional Institutional Capacity and Past Collaboration**

Efforts have already been targeted toward a number of the above strategies. For example, WHO is leading efforts in tobacco, surveillance, health policy development, creating an evidence base for intervention, and NCD training. Much progress has been made. The goal of this chapter has been to highlight the common issues where justification for a regional strategy is strong and build on what has been done.

A critical element for a regional policy or activity to get off the ground, as noted in *Guiding Principles For Regional Collaboration*, is having institutions that can lead and manage supranational coordination. Some South Asian institutions that could play this role are shown in Table 7.2. The organization and structure of regional programs can take several forms, which the countries need to decide on, keeping in mind the roles and responsibilities of the regional coordinating institution. In the most successful regional programs, the coordinating institution has the financial and political capacity to facilitate participation of all members, to monitor progress toward goals, and to manage conflicts. Using an evidence-based approach, initial regional programs should start with a stakeholder analysis, in order to analyze the strengths and weaknesses of different organizational options and to formulate the first topics to address.
Table 7.2 Some regional institutions important for policy development, implementation, and technical assistance

<table>
<thead>
<tr>
<th>Category</th>
<th>Institution</th>
<th>Location</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>WHO United Nations Agencies</td>
<td>Global, regional, country</td>
<td>Policy development, technical assistance, leadership, convening, training</td>
</tr>
<tr>
<td></td>
<td>WHO Collaborating Centers</td>
<td>Regional, country</td>
<td>Technical assistance, subject expertise</td>
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<td></td>
<td>Centers of Excellence supported by UnitedHealth/National Institutes of Health (United States)</td>
<td>International and regional, located in Bangladesh (one), and two in India (Bangalore, Delhi) and linked with U.S. and U.K. academic institutions</td>
<td>Translation research, surveillance, burden studies, and training</td>
</tr>
<tr>
<td></td>
<td>South Asia Network for Chronic Disease</td>
<td>India</td>
<td>Research on causes, prevention, and management of chronic diseases</td>
</tr>
<tr>
<td></td>
<td>Public Health Foundation of India</td>
<td>India</td>
<td>Policy development, broad research capacity, convening capacity, leadership</td>
</tr>
<tr>
<td></td>
<td>International Centre for Diarrhoeal Diseases, Bangladesh</td>
<td>Bangladesh</td>
<td>Research on mortality, systematic reviews</td>
</tr>
<tr>
<td></td>
<td>Global Alliance for Chronic Diseases</td>
<td>Australia, Canada, China, India, United Kingdom, and United States</td>
<td>Funding of global research for chronic diseases</td>
</tr>
<tr>
<td>Non-health</td>
<td>South Asian Association for Regional Cooperation</td>
<td>Regional centers in South Asia (except Afghanistan)</td>
<td>Economic and social development</td>
</tr>
</tbody>
</table>

Source: Authors.

Conclusions

The key areas identified for regional collaboration have a clear rationale and deserve careful consideration. A consensus among countries that action is needed is the first step. An example of progress can be found with tobacco. All South Asia countries have signed the FCTC and most already have some taxation policy in place. Moving toward harmonization of tobacco taxation in the region will remain a challenging task, although it can use the existing base of advertising bans and tax policy, to build on. In other areas less progress has been made, and leadership, commitment, and resources from countries and development partners will be needed.

Varying difficulties in implementing these policies and actions are likely. Developing most policies and strategies will entail engaging stakeholders outside the health sector (such as the finance ministry for tobacco tax policy, the education ministry for HRH training and skill building), and in many cases stakeholders from outside government (such as the food industry for labeling food products). Other actions, such as health technology assessment and surveillance, come mostly from within the health sector but will need to engage both public and private sectors and health professionals from many disciplines.