



# ASEAN Socio-Cultural Community POLICY BRIEF

ASCC Research and Development Platform | Policy Brief #5 | 2024

## EXECUTIVE SUMMARY

- In the past decade, ASEAN Member States (AMS) have seen troubling increases in avoidable deaths attributed to noncommunicable diseases (NCDs).
- Following the ASEAN Post-2015 Health Development Agenda 2021-2025, ASEAN efforts to promote a healthy lifestyle include NCD prevention programs, tobacco control, reducing harmful alcohol usage, prevention of injuries, and promotion of mental health, healthy ageing, and healthy diets.
- Policy gap analysis indicates that a 'hit-and-run' intervention and rolling out regulation without an integrated multi-sectoral actionable framework are no longer enough to address these risks to health. Therefore, each AMS needs to strive toward designing a Healthy City that prioritizes health aspects in the development framework and includes integration of health promotion into the national health strategic plan.

## POLICY RECOMMENDATIONS

- Develop and strengthen sustainable funding mechanisms for healthy lifestyle promotion and NCD controls at national and regional levels
- Strengthen the capacity of health systems and healthcare personnel, especially in primary healthcare facilities.
- Build community-based behavioral changes initiatives to endorse ownership of health in communities.
- Enhance the NCD surveillance system and services, and evaluate the current surveillance mechanisms, especially at the regional level.

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## Promoting a Healthy Lifestyle in ASEAN

*Resilience Development Initiative and Aly Diana*

### Introduction

Strategic and collaborative actions at the regional level are imperative to maintain and fortify the region's quality of health. Southeast Asia is facing a triple burden of diseases which are the rise of communicable diseases (CDs), noncommunicable diseases (NCDs), and the health impacts of climate change (Castillo-Carandang et al. 2020, pp.803-819). Demographic transition into an ageing population in some ASEAN Member States (AMS) further compromised the Association of Southeast Asian Nations (ASEAN) community's health quality. The rapid economic growth and urbanization in the ASEAN region also contribute to the proliferation of lifestyle-related NCDs risk factors, such as tobacco and alcohol use, physical inactivity, and unhealthy diet. The latter triggers the increase of overnutrition on top of undernutrition and micronutrient deficiency.

### ***The rising burden of noncommunicable diseases***

The impact of the COVID-19 pandemic and restrictive access to health facilities hamper efforts to manage

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NCDs (WHO 2020) and disturb healthcare delivery services for NCDs' treatment. The burden of NCDs in ASEAN is intensified by: (i) the surging of tobacco and alcohol use, especially among the younger generation, caused by the absence of relevant policies and appropriate marketing and consumption restriction; (ii) the substantial numbers of injury-related deaths and disability, particularly mortality rates caused by road traffic injuries (RTIs) and occupational-related injuries; and (iii) the rising concern over mental health and malnutrition issues.

**Promoting a healthy lifestyle for a healthy ASEAN Community**

A robust framework accommodating the region's diverse conditions is necessary to address the increasing health risks. As various sectors heavily influence NCDs initiatives (see Figure 1), the

framework requires a holistic and multi-sectoral approach. This approach will place a vital role in individuals and communities, empowering them to take action on their health and create a sustainable health security system. These empowering actions are the essence of Health Promotion. Promoting a healthy lifestyle will encourage engagement in health programs and individual health ownership, reducing modifiable behavioral risks. ASEAN's strategies to achieve the ASEAN Community's health potential through healthy lifestyle promotion throughout life and strengthening the cost-effective multi-sectoral intervention for prevention and control of NCDs align with efforts to control mentioned health risks. Therefore, this policy brief aims to discuss the progress of the ASEAN Member States in promoting a healthy lifestyle and recommend policy actions tailored to ASEAN and its Member States.

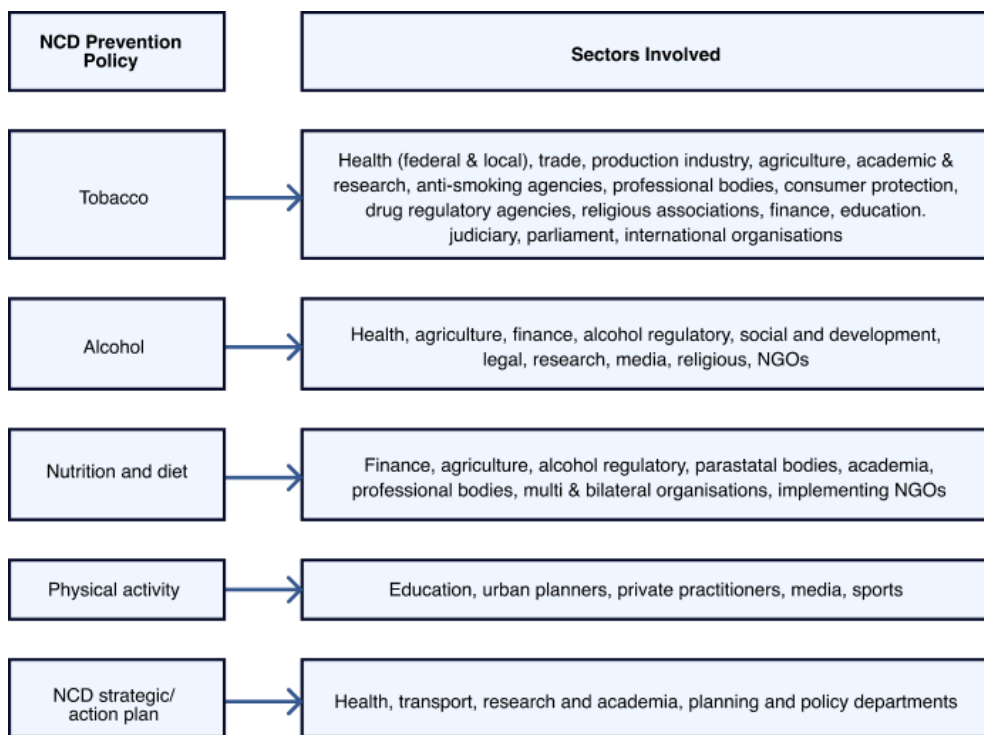


Figure 1. Multi-sectoral action in NCDs prevention policy development

Source: Juma et al. 2018, p.19

## Prevention & Control of Noncommunicable Diseases

In AMS, NCDs are the leading cause of mortality. Cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases account for more than 80% of NCD-related early deaths (WHO 2021). Many young individuals in poor and middle-income nations die early due to NCDs, resulting in lost productivity and social and economic implications. Furthermore, mental illnesses are usually connected to NCDs, as mental illness and NCDs share many related risk factors and influence each other concerning disease progression and severity of health, social, and economic consequences (Gray and Klein 2022, p.5).

NCDs account for 44% of AMS's total disability-adjusted life years (DALYs) (Dhillon et al. 2012, p.849). In 2019, Indonesia had the highest number of DALYs, with 27,651,438 cases, and deaths from NCDs, with 912,683 deaths. With about one million fatalities, cardiovascular diseases are the leading cause of death in AMS, accounting for 48.5% (Institute for Health Metrics and Evaluation 2019).

Various programs or regulations are in place to address NCDs worldwide and within each AMS. The following are some of the programs: (i) Brunei Darussalam National Multisectoral Action Plan for the Prevention and Control of NCDs (BruMAP-NCD, 2013-2018 and 2021-2025); (ii) National Strategic Plan for Noncommunicable Disease Medium Term Strategic Plan to Further Strengthen the NCD Prevention and Control Program in Malaysia 2016-2025; (iii) Roadmap for Addressing the First 1,000 days, Infant and Young Child Feeding (IYCF) and the cost of not breastfeeding in Southeast Asia - Alive & Thrive; (iv) ASEAN Leaders' Declaration on the Reformulation and Production of Healthier Food and Beverage Options; and (v) Joint Statement of the 14th ASEAN Health Ministers Meeting.

However, studies have shown that there are still significant challenges in combating NCDs in AMS, including high mortality rates, the lack of access to NCDs medications, insufficient clinical and public health practice, and the high prevalence of NCDs risk factors.

ASEAN can implement several strategic actions to tackle those issues. The measures include improving NCDs management strategies, expanding medications availability, ensuring Universal Health Coverage (UHC) achievement, enhancing health professionals' roles, and utilizing evidence-based technologies to improve NCDs monitoring.

## Reduction of Tobacco Consumption and Harmful Use of Alcohol

### *Reduction of tobacco consumption*

In the 20 years since 2000, the prevalence of tobacco users in ASEAN has declined, albeit remains within the bounds of dangers. The emergence of Electronic Nicotine Delivery Systems (ENDS) usage amongst users ages 13-15 exacerbated the situation, according to the WHO and Global Youth Tobacco's data stated in the ASEAN Socio-Cultural Community's (ASCC) Trend Report on Strengthening Promotion of Healthy Lifestyle for A Healthier ASEAN Community.

In ASEAN, the progress made against nicotine use has been decent. However, several components of the framework, particularly the rate of taxes, the availability of cessation or rehabilitation in quitting tobacco consumption programs, the coverage of smoking bans, the lack of anti-tobacco campaigns, the lenient restrictions on tobacco advertising, and the relatively affordable and accessible of nicotine use, are still subjects to improvement. Therefore,



to fill the void of each AMS's national nicotine regulatory framework, recommended actions may include: (i) expanding the coverage of smoking bans to include communal spaces and recreational spaces; (ii) strengthening the programs and services to accommodate smokers' rehabilitation and; (iii) calling for greater policy compliance in ASEAN through systematic monitoring on compliance to retailers and established companies and funding for agencies to help enforce compliance on tobacco control (CDC 2014, p.26); (iv) curbing access and affordability to any tobacco and ENDS products; and (v) pushing for comprehensive frameworks to prevent the proliferation and elevation of tobacco and ENDS users, especially for those aged 13+ in ASEAN as mentioned in ASCC's Trend Report on Strengthening Promotion of Healthy Lifestyle for A Healthier ASEAN Community (2022).

ASEAN countries have made progress in the actions mentioned in the framework. Thailand and Singapore have successfully increased the rate of smoking ban coverage, with both countries showing good scores in monitoring, smoking bans, and providing cessation programs for smokers. Tobacco-related advertisements are well-regulated among all ASEAN countries, excluding Indonesia, which scored adequately. Taxation is a work in progress, but several countries have committed to increasing taxes. Thailand has been especially committed to improving the tobacco tax by 8.6% in three years (WHO 2017a; WHO 2021a, WHO 2021b).

### ***Alcohol consumption reduction***

Throughout the past two decades, the ASEAN region has been experiencing an inclining percentage of adult alcohol consumption, followed by the youth.

The lack of national action plans for alcohol consumption reduction efforts in both adults and

youth, the lack of policy interventions for the sales of alcoholic beverages, leniency on the maximum legal Blood Alcohol Concentration (BAC) while driving, warning labels, advertising, product placement, and sponsorship; absence of community support; and the non-existent national monitoring systems for many of AMS have become significant policy gaps hampering the alcohol reduction efforts in ASEAN. As for the implementation gap, there is a considerable lack of enforcement in points of sale, advertising, promotion, sponsorship, product placement, and minimum age. With that said, AMS must: (i) reduce the affordability of alcoholic beverages; (ii) enforce alcohol-related laws and policies, such as blood alcohol limits, points of sales, minimum age, and promotion; (iii) provide brief interventions for persons with hazardous and harmful alcohol use; and (vi) serve the consumer with information about the risk related to harmful use of alcohol through label and media campaign; (v) restrict or ban promotions of alcoholic beverages in connection with sponsorships and activities targeting young people; and (vi) push for comprehensive frameworks to prevent the proliferation of alcohol consumption in ASEAN. In the region, countries have shown significant effort in addressing the misuse of alcohol. The Philippines, Singapore, Viet Nam, and Indonesia have established a national policy addressing the usage of alcohol. The tax surrounding alcoholic beverages is well covered and documented across the ASEAN states. Excluding Cambodia, all ASEAN states have set a national legal age for the sales of alcoholic beverages, with Indonesia, Lao PDR, and Malaysia increasing the legal age. In general, the region is moving towards having a unified age of between 18-21 for the sale of alcoholic beverages. All ASEAN member states, excluding Indonesia, have a maximum legal blood alcohol concentration to reduce drunk driving. Except for the Philippines and Singapore, the rest of ASEAN have set partial to full regulations concerning alcohol advertisement.

On the other hand, government efforts in making producers warn their consumers about potential health hazards have been poor, with the Malaysian government being an exception. Community action faces the opposite trend, where most ASEAN countries possess either a monitoring system or a community action mechanism to combat alcohol consumption. For example, Thailand's Non-Alcohol 2020 Buddhist Lent, endorsed by the Thai Health Promotion Foundation to urge drinkers' healthy lifestyle commitment, and the Office of the Basic Education Commission's project, involving youth to write letters urging parents to quit drinking.

## Prevention of Injuries

Southeast Asia accounts for many global injuries-related deaths and disabilities. One of the reasons for the high number of injuries-related deaths in ASEAN countries is Road Traffic Injuries (RTIs). In 2019, ASEAN's average mortality rate caused by RTIs was 17.6 per 100,000 population (WHO 2021c). The number was higher compared to 2015. In 2019, Viet Nam, Thailand, and Malaysia had the highest mortality rates due to road traffic injury, accounting for 48% of the ASEAN mortality rate (ibid.). Road trauma is generally higher in low and middle-income countries (LCIMs), especially in countries experiencing rapid economic growth due to the increase in 2- and 3- wheeled vehicles. The increasing number of 2- and 3- wheeled vehicles is a growing concern in AMS, as 70% of road accidents in Thailand, Cambodia, and Lao PDR involve these vehicles (Kitamura et al. 2018, p.167). However, the regulatory framework for managing those vehicles remains underdeveloped.

The existing situation in ASEAN portrays the gaps in regulations addressing changes in road safety issues. An integrated approach incorporating road safety into the city development framework is pivotal. AMS have undertaken multi-sectoral

collaboration to implement this approach, such as Indonesia's Transit-Oriented Development and Singapore's Walk-Cycle-Ride strategy. These strategies ensure multi-sectoral collaboration for integration in public transportation and cycling and walking pathways as part of city development.

ASEAN and its member states' efforts for road safety align with the Five Pillars of Road Safety proposed in The Decade of Action for Road Safety 2011-2020. These include implementation of the ASEAN Regional Road Safety Strategy 2016-2025; optimization of Multi-sector Road Safety Special Working Groups (MRSSWG) and Malaysia Institute of Road Safety Research (MIROS) as the ASEAN Regional Road Safety Center; policy to enforce multimodal transportation; community-based program to develop road strategy in Malaysia; and actions to raise road safety awareness in children through Helmet for Kids Programs in Viet Nam.

However, analysis has shown gaps in existing initiatives to address the rise of road trauma. The limitation includes the leniency of private vehicle ownership, underdeveloped mass transportation options, inadequate policies to separate and protect vulnerable road users (VRUs) such as pedestrian, bicyclist, and motorcyclist, ineffective road safety awareness campaigns in high-risk groups, and insufficient post-crash responses.

In that regard, future action to reduce RTIs in ASEAN should use the Safe System approach stated in the Global Plan for Decade of Action for Road Safety 2021-2030. These actions may include: (i) multimodal transportation agenda, which can be implemented through the revitalization of existing public transport and strengthening regulation on tax or cost of private vehicles; (ii) VRUs specific policy to increase the walkability of the urban cities; and (iii) enhancing post-crash response through public participation and health facilities

improvement.

## **Promotion of Occupational Health, Mental Health, Healthy and Active Ageing, and Good Nutrition and Healthy Diet**

### ***Promotion of occupational safety and health***

Occupational safety and health (OSH) has become critical for workforce movement among ASEAN countries and is a vital component of decent work. The data on work-related injuries in Malaysia, the Philippines, Singapore, and Thailand recorded 2,391 fatal occupational injuries and 342,650 nonfatal occupational injuries from 2016 to 2020 (ILOSTAT 2020). WHO and ILO study (2021) also concludes that people working 55 or more hours per week have a higher risk of stroke and ischemic heart disease than those working 35-40 hours a week. Regionally, in 2016, 35.83% and 22.52% of the total number of attributable deaths were caused by stroke and ischaemic heart disease due to long working hours. These numbers increased over the period 2000 to 2016.

AMS and ASEAN have shown their efforts in promoting OSH through policies, programs, laws, regulations, and statements. Most AMS have policies and programs related to OSH, including national profiles, master plans, national strategies, and national programs. AMS also have primary laws as a critical legal instrument supporting the policies and programs. These primary laws aim to protect the workers' health and safety from workplace health and safety hazards and provide guidance and management on occupational health and safety to minimize their exposure to hazards and accidents. OSH is also regulated under AMS's national legislation, which includes regulating protection against hazards and protection in economic activity sectors and national frameworks. Additionally, AMS also have specific authorities and bodies which are responsible for OSH monitoring

and regulation.

ASEAN has established ASEAN Occupational Safety and Health Network (OSHNET) and has developed the ASEAN OSHNET Work Plan for 2016-2020 and 2021-2025. To further signify the commitment of ASEAN to promote closer public-private partnerships in improving OSH in the region, ASEAN also awarded companies with excellent occupational safety and health, which has been conducted since 2016.

However, several challenges in promoting OSH must be tackled, including the increasing number of attributable deaths and DALYs due to exposure to long working hours and limited access to appropriate safety and health training, information, and tools, especially for informal workers. There is a need to take decisive action in implementing working hours and overtime conditions and improving the workplace health system. Collaboration with local workplaces and communities/associations are also options to improve the working condition of informal workers.

### ***Promotion of mental health***

Depression will be the primary cause of the global disease burden by 2030. Mental diseases account for 13% of the worldwide disease burden (Tanyaluk and Sutteera 2020). In 2017, 792 million people suffered mental health issues (ibid.). Moreover, mental well-being has also become a concern recently, especially due to the COVID-19 pandemic. The pandemic's social and economic disruption has increased risk factors contributing to mental disorders (Minas 2021, p.37). Most AMS, however, do not prioritize mental health programs and policies. About 10% of the adult population in AMS have suffered a mental or behavioral problem. In Southeast Asia's low and medium-income countries (LMICs), mental health treatments are insufficient. Depression, anxiety, somatoform

disorders, and alcohol and drug abuse are common mental health problems. The average suicide death rate in AMS is 5.37 per 100,000 population (WHO 2016 and 2019). The most significant proportion of psychiatrists is in Singapore, whereas Thailand has the highest proportion of nurses working in the mental health sector. In Cambodia, Indonesia, Malaysia, Myanmar, the Philippines, Thailand, and Viet Nam, just 1.5 psychiatrists per 100,000 persons are recorded (ibid.). Mental health facilities are unfortunately assigned to their secondary healthcare provider in Myanmar, Cambodia, and Indonesia.

However, ASEAN serves as both a market and a developer for mental health applications. Ooca (Thailand), Naluri (Malaysia), Riliv (Indonesia), Mosia (Viet Nam), MindFi (Singapore), and Arooga Health (Philippines) are some of the region's most popular applications right now (AASYP 2021). In addition, ASEAN also issued several commitments on mental health, including the 2013 Policy Brief on Mental Health in ASEAN, ASEAN Plus Three Leaders' Statement on Cooperation on Mental Health amongst Adolescents and Young Children, and the 2021 Mental Health in a Post-pandemic ASEAN, all of which highlight previous work on the subject.

Even so, possible actions are needed to combat mental health problems in AMS, such as: (i) integrating mental health into chronic disease treatment in primary care settings; (ii) introducing mental health screening process in primary healthcare; (iii) promoting interprofessional collaboration for comprehensive mental health management; (iv) increasing the number of mental healthcare providers; (v) increasing access to mental health services; (vi) establishing public and private primary care networks in the community; (vii) using evidence-based and creative methods to improve treatment adherence; (viii) enhancing

clinical practice for better mental health management by reforming the health professions education (HPE) curriculum; and (ix) raising mental health awareness in schools, colleges, the workplace, and the community.

### ***Promotion of healthy and active ageing***

ASEAN's population is rapidly ageing, as proven by the shifting population structure between 2000 and 2018. In 2000, the highest share of the population was the youth aged 0-19 years old (40.8%), but the percentage dropped to 33.9% in 2018 (ASEAN 2020). Simultaneously, the total share of the productive working-age group (aged 15-59) and older people (aged 65 and over) increased to 61.8% and 7.5% in 2018 (ibid.). Singapore (7.2% to 13.7%) and Thailand (9.1% to 12%) experienced the most significant increase in the population aged 65 years and over from 2000 to 2019 (ibid.). Although the life expectancy in Southeast Asia has increased from 63 years in 2000 to 71 years in 2019, on average in 2019, the Healthy Life Expectancy (HALE) of the people is only up to 61 years (EU-ASEAN Business Council et al. 2021, p. 4). Older persons in the Southeast Asia Region spend up to 10 years with impairments, facing various health problems, including NCDs, mental health, dementia, injuries, and disabilities due to declining functional ability (Tiraphat et al. 2021, p.1).

Various programs and regulations have been enforced in AMS to promote and address healthy and active ageing, including national action plans and policies. These include improving and guaranteeing equitable access to quality and affordable healthcare goods and services for older persons, empowering older persons through more excellent social protection, and providing financial and healthcare assistance, among others. Additionally, ASEAN has recognized the need to address challenges in providing adequate care and

support to promote the well-being of older persons and established the ASEAN Strategic Framework on Social Welfare and Development (2011-2015). The framework also addresses income security for old age and active and healthy ageing.

However, it is vital to provide a supportive environment to promote healthy and active ageing further. ASEAN can implement several actions, including developing, encouraging, and implementing health promotion activities; encouraging and improving the employability of older persons; providing knowledge and skill sharing platforms; and creating an age-friendly built environment and system.

### ***Promotion of good nutrition and a healthy diet***

ASEAN faces the triple burden of malnutrition, including overnutrition, undernutrition, and micronutrient deficiencies. The prevalence of child stunting in Lao PDR, Cambodia, Indonesia, and the Philippines is over 30%, while Thailand and Viet Nam are experiencing notable reductions (World Bank 2019, p.13). For micronutrient deficiencies, approximately 36% of pregnant women in Southeast Asia suffer from anemia (Alis 2020, p.6). Simultaneously, overnutrition prevalence is growing alongside urbanization. Cambodia, Indonesia, and Lao PDR had the most rapid increases in almost three decades (WHO 2017b).

ASEAN executed diverse regulations to eradicate undernutrition and micronutrient deficiencies and stop the rise of overweight. Initiatives to address undernutrition and micronutrient deficiencies include: adopting the ASEAN Leaders' Declaration on Ending All Forms of Malnutrition; finalizing the ASEAN Strategic Framework and Action Plan on Nutrition 2018–2030; integrating exclusive breastfeeding programs into national regulation; developing and marketing fortified staple foods.

At the same time, the overweight prevalence control includes promoting dietary guidelines, implementing voluntary sweet or sugary beverage tax in several AMS, and enforcing food labelling systems.

However, a few programs are not optimized and sustainable due to the lack of resources; lack of monitoring, evaluation, and surveillance system to make effective and evidence-based initiatives; insufficient capacity of primary healthcare services; beliefs in the community; and the lack of food diversity caused by carb-heavy food production prioritization. Hence, future ASEAN initiatives must consider these barriers and prioritize developing multi-sectoral and community-based programs.

Future initiatives for malnutrition may consider implementing a life-cycle approach, integrating horticultural into nutrition programs in rural areas, and strengthening fortified food consumption. Furthermore, regulating the distribution and marketing of unhealthy food and integrating nutrition education into the school's core subjects will also control the overweight prevalence and ensure healthy diets in youth. It is worth noting that creating sustainable food systems through environmentally-friendly agriculture and aquaculture practices is paramount in securing stocks of nutrient-rich foods to combat malnutrition (Tilman and Clark 2014).

### **Conclusion**

A healthy lifestyle is essential to achieving the ASEAN Community's health potential. ASEAN and AMS have made health headway in promoting a healthy lifestyle through diverse initiatives addressing tobacco and alcohol consumption, RTIs, OSH, mental health, healthy ageing, and malnutrition. However, enhancing swift and coordinated actions integrating healthy lifestyles in society is still

paramount to addressing the constant change of health risk factors affecting healthy lifestyles. As seen from experiences, 'hit-and-run' interventions and regulations without integrated multi-sectoral frameworks are no longer enough. Therefore, ASEAN needs to strive toward designing a Healthy City that prioritizes health aspects and includes integration of health promotion into the national strategic plan (i.e., Singapore's Healthy City). Initial efforts may consist of:

### 1. Develop a Sustainable Funding Mechanism

Sustainable funding is developing a robust mechanism to raise high revenues and spend them more efficiently and equitably. As stated in the discussion above, improvements to health systems and the development of new initiatives are paramount to enhancing healthy lifestyle promotion. These improvements will require support from robust funding. Hence, several actions can be implemented to accelerate funding in LMICs, such as: (i) conducting funding landscape analysis and scaling up joint funding mechanisms and multi-sectoral dialogue at regional and global levels; (ii) enhancing technical and policy support to identify significant sources of inefficiency and priorities to be addressed, and develop demands for donor support through clear health objectives; and (iii) mobilizing domestic resources through public-private partnership and enabling people and communities voice.

### 2. Strengthen the Capacity of Health Systems and Healthcare Personnel, especially in Primary Healthcare Facilities

and robust health systems are essential for healthy lifestyle integration into society. Thus, evaluating healthcare systems and HCP's capability is paramount in improving services and training

modules. The improvement will encompass NCD prevention, early detection mechanisms, and clinical or community-based rehabilitation services. Strengthening these efforts in primary healthcare facilities will also ensure broader coverage and impactful prevention of NCD. Initiatives to support these include: (i) conducting joint training and workshop with other regions or countries to enhance HCP's competence; (ii) facilitating effective multidisciplinary treatment through joint education and clinical decision support; and (iii) equipping primary healthcare facilities with standardized HCP, updated modules to train HCP, adequate equipment, and digital reporting system.

### 3. Build Community-based Behavioral Changes Initiatives

The above discussions have mentioned the vital role of intervention in community settings to promote behavior changes, such as nutrition and mental health interventions in school. Policy to strengthen community-based behavior change programs also promotes high engagement and ownership of health in communities, supporting the integration of new healthy behavior. The policies may include: (i) community mobilization through selecting and training community-based health workers in several rural areas; (ii) providing social protection through the availability of health insurance, conditional cash transfer, and incentives for community-based health workers or volunteers; and (iii) empowering community leaders to implement health programs.

### 4. Enhance Surveillance System, and Monitoring and Evaluation Mechanism

The availability of advanced and interconnected surveillance systems and monitoring and evaluation mechanisms are crucial for effective funding management and cost-effective program development. Several surveillance initiatives

to support healthy lifestyle promotion are: (i) collaboration with private sectors to integrate health applications involved in NCD control into the national health surveillance system; (ii) development of a harmonized Nutrition Surveillance System in ASEAN; (iii) traffic management surveillance

through advanced intelligent transportation system; (iv) regulate obligatory evaluation and reports of the occupational health system and status in workplaces across the country; and (v) development of a proper mental health surveillance system.

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