REGIONAL GUIDE
SEARO/WPRO REGION

AMWHO

2026 AMWHO INTERNATIONAL CONFERENCE

Global Child and Adolescent Health: Protecting the Next Generation in a Time of Crisis

Introduction

The South-East Asia Region (SEARO) of the World Health Organization (WHO) comprises almost 2 billion people—approximately 25% of the world's population.[1] The SEARO region comprises 10 Member States: Bangladesh, Bhutan, India, the Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste, and the Democratic People's Republic of Korea, with the Regional Office based in New Delhi, India.[2] Presently, the SEARO Region is advancing immunization programs, disaster risk reduction, and urgent refugee healthcare access.[3] By actively pursuing projects to reinforce health and well-being, invest in women, girls, and adolescents, realize access to technology and innovations, and raise capacity, knowledge management, and research, the SEARO region seeks to become a resilient and overall healthier region.

Founded in 1948, SEARO has seen numerous compositional changes since its formation, through the countries of Vietnam, Laos, Cambodia, Mongolia, Afghanistan, and, most recently, Indonesia, all exiting the organization.[4] This demonstrates a frustration in the governance of the region: country leaders may perceive the regional body as lacking coordination and guidance to support these countries' health systems adequately. Although Indonesia's exit as the previous second-largest member-state is a setback for SEARO, there are positive shifts in health conditions in countries such as India, which has a significant scale and variety of technological influence, and Thailand, which has advanced in innovative policy and diplomacy in healthcare.[4]

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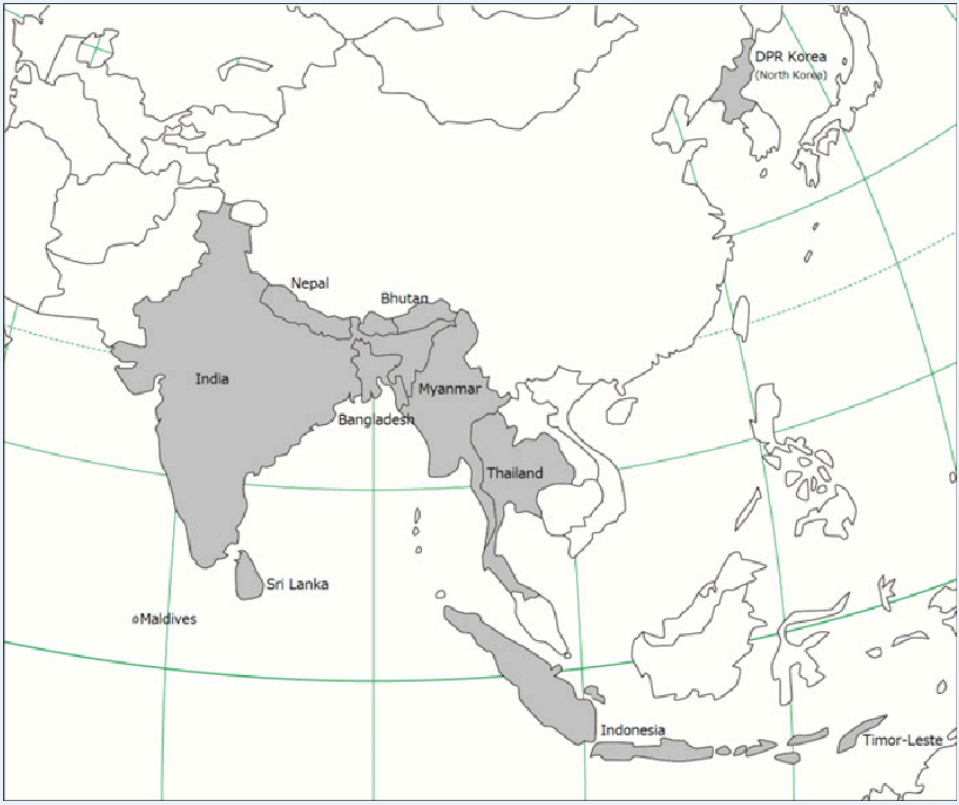

Figure 1. Map of the South East Asian Region (SEARO) of the WHO.[5]

But even as technology advances, SEARO faces numerous challenges in battling its persisting global health issues. In 2019, almost half the world's tuberculosis (TB) cases were in this region, along with the high prevalence of diabetes mellitus, stroke, and heart disease. The region also carries one of the highest maternal mortality ratios, with low usage of antenatal care in countries such as Bangladesh (47.01%).

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As a response to COVID-19, countries such as Pakistan and Afghanistan faced high costs in importing vaccines, along with supply chain and cross-border disruptions intensifying this difficulty. Approximately 20% of SEARO's population consists of adolescents, who suffer from countless public health issues: suicide, mental health issues, road injury, and maternal mortality.[6] Additionally, adolescents in this region face limited access to sexual and reproductive health (SRH) services and high rates of adolescent pregnancy, with South-East Asia having one of the highest adolescent birth rates globally.[7] SRH services are essential for adolescent health and well-being, and include access to sanitary products and contraceptives.

The Western Pacific Region (WPRO) of the WHO is composed of 38 member states and areas, and is home to almost 2.2 billion people.[8] This region contains approximately 26% of the world's population. The WPRO region's focus for the 2025-2029 period is to maintain progress on achieving the UN's sustainable development goals via working with families and communities.

Since it was established in 1949, the WPRO has played a large role in disease elimination efforts across the region, particularly with measles and polio elimination and substantial malaria reduction.[9] The great diversity of economic development in the region presents some challenges regarding governance.

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Data Source: WHO | Map Production: WHO WPRO DSI | Map Date: 18 June 2025 | © WHO 2025, All rights reserved.

World Health Organization
Western Pacific Region

Figure 2. Map of the WHO Western Pacific Region (WPRO).

High-income countries such as Japan and Australia have significantly greater health system capacity than lower-income countries in the region. Some of the most pressing issues facing the region now include health financing, antimicrobial resistance, and newborn mortality.[10] Newborn mortality in the region remains high, with 100,585 newborns dying in 2022.[11]

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For adolescents in the WPRO region, mental health is a key concern, with approximately 25% of global suicides in 2019 occurring in the region. Although WPRO has made many efforts to advance mental health services and strategies, suicide rates remain high, especially among Pacific Island countries (PICs).[7]

Similar to the SEARO region, another major issue in lower-income WPRO nations is access to SRH services, and high adolescent birth rates in countries such as Papua New Guinea, Fiji, and other Pacific islands. Lack of access to contraceptives, education surrounding sexual and reproductive health, stigma surrounding sexual assault, rape, pregnancy, and menstruation all dramatically affect the health outcomes for adolescents, and can contribute to mental health and physical health issues.[12]

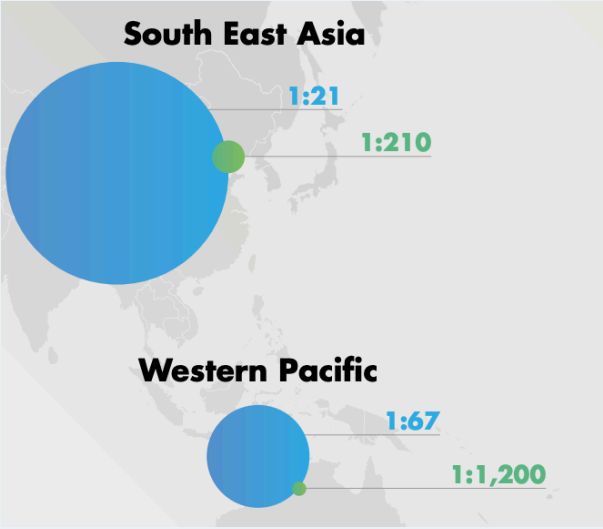

Figure 3. Inequitable risks of maternal and child death across regions. The size of each bubble corresponds to the risk in each region that (blue) a child will die before the age of five and (green) a 15-year-old girl will eventually die from a maternal cause over her lifetime.13

Subtheme 1: Vaccine Uptake and Infectious Disease Management

The SEARO and WPRO regions have faced challenges in vaccination uptake and infectious disease management. The SEARO region has faced external factors to health: political conflict, climate change, economic crises, and refugee migration all contribute to decreased vaccination coverage and accessibility for youth in rural locations. In 2023, around 3.4 million children in SEARO countries did not receive all vaccines, and 2.7 million received none.[14] COVID-19 and its effects, furthermore, worsened other conditions for these youth: learning losses led to a decreased salary outlook of 2.4% annually for many developing Asian countries, and child marriage applications almost doubled in Indonesia and other countries in the two regions.[15] Similarly, countries such as Cambodia, Mongolia, the Philippines, and Vietnam report more than 2,000 measles cases each in early 2025, signaling a sharp decrease in measles vaccinations being provided to children.[16]

Both regions have been making efforts to mitigate concerns for youth vaccination accessibility. Countries such as Indonesia are now conducting school-based vaccinations and have developed new electronic registries, reaching 16 million with measles and rubella vaccines as of 2022. A zero-dose agenda, co-spearheaded by the WHO with a focus on integrating immunization platforms with newborn, child, and adolescent care, has become a top regional priority, as per the Regional Vaccination Implementation Plan 2022-2026.[17]

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Typhoid, a disease with 60,000 annual deaths heavily skewed towards youth in the 5-19 year bracket, is now being mitigated using the highly efficacious Typhoid conjugate vaccine in countries such as Nepal.[17] Multifaceted courses of action are in their early stages to repair the damage that COVID-19 has caused.

Ultimately, most countries have recovered from the COVID gap, but many countries in the SEARO and WPRO regions require significant coverage levels or recovery. Case studies of Myanmar-Thailand immunizations and India's battles with the tuberculosis crisis demonstrate these sustained gaps in medication accessibility, in addition to their corresponding setbacks in youth healthcare, education, and wellbeing.

CASE STUDY 1: VACCINATION GAPS AMONG YOUTH ALONG THE MYANMAR-THAILAND BORDER

Polio, a viral illness that mainly affects nerves in the spinal cord and brain stem, was one of the most feared diseases of the 20th century. Vaccines began to be developed in the mid-20th century, and by 2003, polio remained endemic in only 6 countries, and by 2006, only 4. However, Polio outbreaks continue to circulate to this day in unvaccinated communities, and a new issue, vaccine-derived poliovirus (VDPV), is a new threat to communities. This form of polio occurs when the live, weakened virus found in the oral polio vaccine circulates for a long time in an under- or unimmunized population.[18]

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The prolonged circulation of the virus allows it to genetically change into a more dangerous form, becoming more contagious and leading to outbreaks. In 2023, 85% of children affected by polio lived in fragile and conflict-affected areas.[19] Regions affected by instability and population displacement, like Myanmar, remain vulnerable to VPDV and wild poliovirus.

Myanmar has faced recurrent disruptions in routine immunization programs for children as a result of decades of political instability and civil conflict following the military coup of 2021. Currently, Myanmar's military government controls only 21% of the nation's territory, and ethnic armies and rebel forces hold 42%.[20] The conflict in Myanmar has displaced over three million civilians and resulted in more than seventy-five thousand total deaths.[21] Much of this displacement has resulted in Burmese refugees in Thailand, with Thailand now hosting over 80,000 refugees from Myanmar.[22] These conditions of uncertainty have resulted in disruptions of public health delivery, especially routine childhood immunization programs that are essential to healthy childhood development and reducing the circulation of disease among the whole population.

In 2019, Myanmar experienced a VPDV outbreak[23], which triggered supplementary polio immunization with the Oral Polio Vaccine for all children under 5 in high-risk zones. This highlighted the risks of prolonged circulation of weakened vaccine strains in under-immunized populations.

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However, the border between Myanmar and Thailand has become a vulnerable vaccination area for children and adolescents. While Thailand maintains a strong healthcare system, education and school-administered vaccination programs are critical to maintaining population immunity and health. Migrant children and adolescents along the border, and out-of-school youth are routinely missed and fall behind on their vaccinations due to legal, economic, and language barriers.

Efforts need to be made to identify immunization gaps for polio and other viruses along the border areas among migrant children and adolescents, to improve documentation of vaccines, and to continue international dialogue to improve the health conditions of people living along the border.[24] Without targeted endeavors to ensure full coverage of vaccinations for children and youth in the Myanmar-Thailand border area, VPDV will continue to circulate and infect vulnerable populations, compromising the health and development of children and undermining regional polio eradication efforts.

CASE STUDY 2: INDIA'S BATTLES WITH GLOBAL TUBERCULOSIS

India has been progressing in tuberculosis (TB) improvement over the last few years, but has moved further from its goal of reducing TB cases by 90% by 2025, now appearing unachievable to doctors and activists.

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India carries more than 25% of the world's TB cases and 17% of deaths from the disease as of 2023; 80% of the country's TB cases are from those of the lowest income quintile. Additionally, the country has the greatest number of people with drug-resistant TB, with 119,000 cases reported in 2021.[26] TB heavily affects India's youth population: 38% of victims fall between the ages of 18 and 29.[25] In addition, 40% of adolescents between the ages of 15 and 19 were found to have sustained stunted growth, and were found to often attack the youth in poverty, urban residences, and chronic undernutrition. 38.2% of youth who had some exposure to the disease were also found to have lasting effects on growth and health.[26] There are a greater number of variable effects of TB on these youth. In Southeast Delhi, it was found that patients attending Directly Observed Treatment Short-course (DOTS) Centers for medical assistance, specifically young adults, faced more stigma and discrimination in their workplaces, while lower socioeconomic classes found this negative treatment from their family and friends.[27]

Government conditions only bolster this crisis. The BPal treatment for TB had a 90% cure rate as per a clinical trial; regardless of subsequent approval in 2020 by India's drug regulator, the health ministry was much slower in approving the treatment, even unresponsive to the WHO's request to shift to BPal in 2023.[27]

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Undernourishment is also one of the largest risk factors for TB infections, and the RATIONS study published in 2021 found that TB incidence could be cut in almost 50% if food baskets are provided in addition to TB medications.

Although India's government responded by providing some food support to TB patients, it has not focused on or expanded that initiative since 2018. However, Indian youth are playing a unique role in advocating for TB support where the government is lacking. YOUNITE Global, a youth-led platform focused on empowering young people to advocate for TB elimination, holds consistent awareness events with the goal of a TB-free India.[27] The "Take Charge Against TB" program, taking place across 3 major Indian cities in 2025, enlisted youth volunteers in improving healthcare professional training for TB supportive treatments and reaching more than 16 million people.[25] However, more of a focus needs to be dedicated to supporting communities that are struggling with access to treatments and solutions, especially for youth across income gaps.

CASE STUDY 3: URBAN-RURAL INEQUITIES IN CHILDHOOD IMMUNIZATION IN CHINA

China, a member of the WPRO region of the WHO, comprises over a billion people, with an upper-middle-income level.[28] As the nation has developed into a global power, it has experienced an unmatched amount of internal migration compared to other nations.

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In 2020, nearly 376 million people lived someplace other than their household registration area.[29] Most of these internal migrants are comprised of individuals and families moving from China's rural interior to coastal areas, where state reforms since 1979 have expanded manufacturing, and more current economic policies have boosted domestic demand for labor in these coastal areas.[29] Furthermore, between 2008 and 2018, the population living in urban areas in China increased from 624 million to 831 million.[30] In 1978, China established the National Immunization program, which enabled all Chinese children to receive a total of 14 free vaccines. Although this program remarkably increased vaccination rates across the nation, important vaccines like the pneumococcal conjugate vaccine, rotavirus, and HPV vaccines are not included, resulting in out-of-pocket costs for families.[31]

Disparities exist between children in urban and rural areas in terms of vaccination rates, particularly with these important vaccinations not included in China's NIP. Rural areas, inhibited by economic development and vaccine awareness, have low non-NIP vaccination rates, more medical expenses, and a social burden.[31] In addition, China's child mortality rate is significantly higher in rural areas than urban ones, with the urban-rural ratios for the infant mortality rate and the under-five mortality rate reaching 1:1.94 and 1:2.29.[31]

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These inequalities in vaccination coverage can lead to outbreaks of vaccine-preventable disease within rural areas themselves, and throughout the entire nation. In Shanghai, children whose families migrated from rural areas, roughly 40% of the city's total population, are half as likely as urban children to have received the first dose of the measles vaccine by 9 months of age, and 42% less likely to receive the second measles dose by 24 months.[32]

To combat the vaccination gap, China established a four-tier immunization program management system at all levels of government. These later expanded to the county, township, and village levels, establishing access to vaccinations regardless of location. By the end of 2024, China had engaged more than 456,000 professionals in vaccination services, and in 2025, created at least one vaccination unit in every township and subdistrict.[33] Yet, the coverage areas of rural vaccination stations must still be adjusted so that nearby county hospitals can take some of the burden. To decrease the gap in vaccination coverage between children across these areas, policy support and economic assistance for rural-non-NIP vaccination must be considered, including important childhood vaccines, such as those for the rotavirus, pneumonia, and Hib.[34] It is important to acknowledge these vaccines are costly, and there is no currently efficient way to ensure access in rural areas.[31] It may be beneficial to gradually incorporate non-NIP vaccines into the NIP while prioritizing the high-risk population.[34]

Subtheme 2: Sexual and Reproductive Health

Sexual and reproductive health is a prevalent concern that many SEARO and WPRO countries are presently grappling with, especially with 60% of the world's youth being contained in the Asian and Pacific regions. A major concern in these locations is child marriage. Across the WPRO region, about 19 million girls and 4 million boys aged 15-19 are in unions.[35] Although this number has been cut down by 50% over the last 20 years in South Asia, 1 in 8 young women in South Asia and 1 in 14 in Southeast Asia have begun pregnancy by the age of 18.[35] In the Pacific, maternal health disorders are the leading cause of death among young girls. In addition to these cases, education on these topics is highly limited, with very few young adults learning consistent Sexual and Reproductive Health (SRH) knowledge in academic settings.

Progress is beginning its introduction in both regions; contraception and gender-based violence resource accessibility are increasing. However, struggles continue to persist, with National Human Rights Institutions (NHRIs) struggling to integrate SRH reporting into their systems, and the continuation of underfunded healthcare resources, and a lack of political urgency to address these issues.[36]

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CASE STUDY 1: ADOLESCENT PREGNANCIES IN THE PHILIPPINES

A member of the WPRO region, the Philippines is an archipelago nation in Southeast Asia, comprised of over 7000 islands.[37] In 2019, the National Economic and Developmental Authority of the Philippines declared that teenage pregnancy was a "national and social emergency."[38] Since then, although there have been many efforts to curb the rate of adolescent pregnancy and improve access to sexual education resources and contraceptives, the adolescent birth rate continues to be among the highest in the region.

The adolescent birth rate (ABR) in the Philippines ranges from 3.5% to 17.9% across the nation[39], and the number of girls giving birth aged 10-14 rose from 2,113 to 3,433 between 2020 and 2023.[40] Out of live births within the 15-19 age group for young mothers, only 3% were fathered by men of the same age group.[41] This troubling data suggests that a majority of teenage pregnancies in the Philippines may be a result of coercion and unequal power relations between the mother and father.

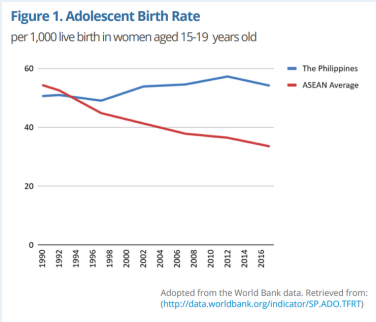

Figure 4. Adolescent birth rate in the Philippines compared with the association of south east asian nations (ASEAN) per 1000 women from 1990-2016.[41]

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Adolescent pregnancy brings a variety of health and social risks to young mothers. In the Philippines, adolescent mothers are more likely to be exposed to domestic violence, which has the potential to contribute to health complications for the fetus and both mental and physical health complications for the mother. The health risks of youth pregnancy for young mothers include a higher risk of eclampsia, puerperal endometritis, systemic infections, low birth weight, preterm birth, and severe neonatal conditions for the child.[38]

Furthermore, young mothers' lives are dramatically changed by pregnancy and childbirth. Not only do they face health risks, but young mothers face decreased rates of educational attainment and employability, making adolescent birth a major economic issue for the Philippines as well. According to a 2020 UNFPA policy brief, “the non-completion of secondary education impacts employment opportunities, and total earnings in families”, and the net estimated effect of adolescent birth is an annual loss of 33 billion pesos, or about 600 million USD.[41]

Among the challenges facing young women in the Philippines, barriers to accessing medical services and contraception exist. The legal age for sexual consent in the Philippines is younger than the age necessary to access contraceptives, abortions, and other medical services. In 2022, the Philippines raised the age of sexual consent from 12 to 16.[42]

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However, strict age conditions in the Philippines bar children under the age of 18 from accessing contraceptives.[43]

In 2023, an Adolescent Pregnancy Prevention Bill was passed in the Filipino House of Representatives to increase access to sexual and reproductive health services for adolescents, including contraception.[44] However, in the face of the election, supporters of the bill withdrew, and since then, the bill has faced many challenges and opposition, and a substitute version of the bill was re-filed in January 2025.[45] However, amidst controversy within Filipino politics regarding the bill, it is recommended that a standardized curriculum be created for all school levels focused on education regarding sexuality, maternity, and resources for students. Improved access to contraceptives is also essential for preventing adolescent pregnancy and the transmission of sexually transmitted diseases. Additionally, measures must be taken to reduce stigma and discrimination surrounding teen pregnancy, sexual assault, and rape to encourage a supportive environment for young women and young mothers.[38]

CASE STUDY 2: "PERIOD POVERTY", SCHOOL ABSENTEEISM AND MENSTRUAL HEALTH INEQUITIES IN SRI LANKA

A member of SEARO in the WHO, Sri Lanka is an island nation in the Indian Ocean, and has an approximate population of 22 million people.[46]

Subtheme 2: Sexual and Reproductive Health

In 2019, Sri Lanka faced its worst economic crisis, with unprecedented and catastrophic market crashes. India provided a relief package of about $4 billion, and from 2019-2024, the country's economy rebounded.[47] In 2024, the economy outperformed the IMF projection of 4.5% growth, marking an end to the crisis.[47] However, the crisis resulted in hyperinflation, exhaustion of foreign reserves, and limited accessibility to medical supplies and increased pricing of basic commodities. One of the major effects of this crisis was an increase in period poverty.[48] Period poverty refers to the inability to afford or access menstrual care products. A 52% tax on imported menstrual hygiene products during the crisis severely limited access to them, and even after the tax was revised to 43%, it still dramatically impacted the number of women able to purchase such products regularly.[48] The use of cloth pads instead of disposable ones has become the most common practice in Sri Lanka. These pads can be unsafe and can cause burning, discomfort, and difficulty walking.

Period poverty has many negative consequences for menstruating individuals. Aside from discomfort and inconvenience, period poverty deeply impacts education. An estimated 50% of students did not attend school during menstruation from 2019-2024.[48] This is due to beliefs around menstruation and to avoid embarrassment and humiliation at school.

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A 2015 analysis found that 60% of teachers surveyed thought blood to be impure, 80% thought bathing during menstruation should be avoided, and 40% thought that vaginal insertion of tampons had harmful side effects.[49] Furthermore, 66% of girls were found to be unaware of menstruation until menarche.[50] These staggering statistics paint a grave picture of the state of menstrual awareness and health in Sri Lanka. This issue is not isolated to Sri Lanka and extends to many other south asian countries such as India, Bangladesh, and Pakistan. In the WPRO region, period poverty significantly impacts Papua New Guinea, Samoa, and Fiji.

In the midst of daily life, schools remain a focal point for delivering essential education and services. For young menstruating individuals, schools can be a point to both receive menstrual products and education surrounding sexual and reproductive health. Taxes on sanitary products must be reduced, and affordability increased; the rate of school absenteeism in relation to menstruation must be reduced, and the stigma surrounding menstruation must be reduced.[49]

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CASE STUDY 3: CHILD MARRIAGE RATES IN BANGLADESH

Bangladesh, a member of SEARO as a country in South Asia bordering India and Myanmar, is one of the most densely populated countries in the world.[51] It also has one of the highest rates of child marriage, with 2011 data showing that 66% of women aged 20-24 got married before 18, the legal age for marriage.[52] About 33% of women in this group were married before the age of 15.[52] This high rate of child marriage is also discrepant by physical region. Child brides in Bangladesh are more likely to come from rural areas and reside in poorer households, and are less likely to have received a secondary education. Married girls are also found to be four times more likely out of school compared to unmarried girls, and nearly half of child brides were found to have a child before age 18, 80% giving birth before the age of 20.[52]

Although child marriage is less common today compared to previous generations, there has been an observed difference based on wealth and income groups. Wealthier communities have a sharper decline in child marriage rates compared to those who are low-income.[53] The World Inequality Report for 2026 finds that the top 10% of Bengali earners receive about 41% of national income; conversely, the bottom 50% receive only 19%.

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The income gap between the top and bottom halves of the population has decreased from 24 to 22 since 2014. Trends in female labor and average wealth have remained similar over the last few years.[53] Ultimately, it appears that these persistent trends align with child marriage: girls from the poorest 20% of families are twice as likely to experience child marriage as girls from families among the richest 20%.[52]

While income discrepancies correlate with high rates of child marriage, Bangladesh's cultural perspectives play a role in the situation: gender discrimination has often persisted in the country's history, and parents may see child marriage as a way to safeguard their daughters from experiencing societal issues.[53] The dowry practice, a historical cultural norm, often increased with the daughter's age, leading to financial pressure of pursuing earlier marriages. Some families interviewed by Human Rights Watch described how Bangladesh's high rate of natural disasters posed a threat to their survival and communities; coupled with fears of abduction, harassment, and threats towards women, child marriage seems most desirable to these families. Additionally, 70% of the parents believed that the marriage registrar, or *Kazi,* should take an active part against the practice of child marriage, insinuating an expectation that the country's systems do more to protect their daughters and their reproductive safety.[54]

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These high levels of child marriage often negatively impact the livelihood of these women. Further Human Rights Watch interviews of child brides find that, in addition to their earlier pregnancies, these women have no contraception, nor any background in managing a family.[53] 2018 data shows that children born to underage wives have a 13% greater chance of passing away from neonatal mortality, along with a higher prevalence of fever, diarrhea, cough, and other childhood illnesses. Alternatively, children born to wives married after 18 were approximately 21% less likely to pass away when under five.[55] Social and economic pressures prevent them from pursuing education if they choose to divorce their husbands. Pregnancy leads to early onset of health conditions, and high levels of domestic abuse and violence eventually lead to a lack of external support and resources.[53]

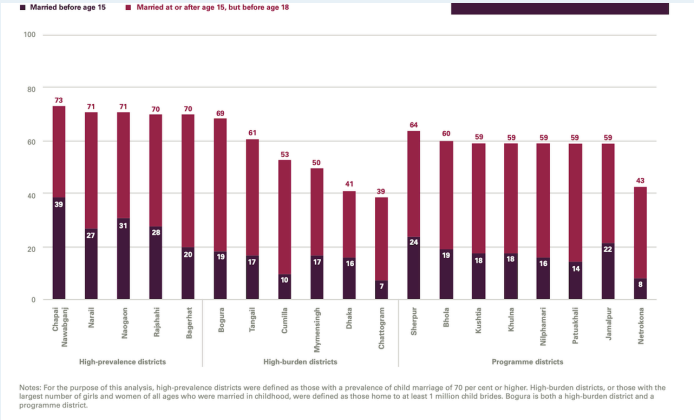

Figure 5. Percentage of women aged 20 to 24 years who were first married before ages 15 and 18 (2020 report).[52]

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Bangladesh has been taking measures to slow down this trend. Poverty has been reduced by about 30% in the last 30 years[56], and the UN has shared that they have gender parity in primary and secondary school enrollment. However, gender discrimination, social attitudes, and parental concerns have added to this persistence in child marriage in the country. There has been a lack of translation into adequate action, which is what is needed to decrease this persistent injustice to Bangladesh's young girls.

Conclusion

The health outcomes of youth in the SEARO and WPRO regions are shaped by inequitable access to vaccinations, sexual and reproductive health services, and resilient health systems. These intersecting structural factors must be addressed to support the health of these regions' youth and to protect the future of these nations. Addressing the challenges presented by political instability, economic inequality, and social stigma requires collaboration between authorities to create tailored and equity-centered policies that will prioritize the health of youths and establish the foundation of long-term population health and development.

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