



650 MILLION REASONS

Achieving Universal Health Coverage
for Adolescent Sexual and Reproductive
Health in Asia and the Pacific

Acknowledgements

This review was commissioned by the UNFPA Asia and the Pacific Regional Office and developed under the direction of Sylvia Wong, with overall guidance by Dr. Aleksandar Sasha Bodiroza. The review was conducted by the Burnet Institute, Australia, led by Elissa Kennedy, with contributions from Thomas Stubbs, Lia Burns, Marie Habito and Stephen Bell. Secondary data analysis was conducted by Kate Francis, Chloe Hunter and Peter Azzopardi from the Murdoch Children's Research Institute, Australia.

The following UNFPA colleagues provided significant inputs and reviewed the report: Anthony Daly, Davide de Beni, Madusha Dissanayake, Jessica Gardner and Shanon McNab from the UNFPA Asia and the Pacific Regional Office, and numerous adolescent youth specialists in UNFPA country offices and the UNFPA Pacific Subregional Office.

This regional policy review was made possible with the generous support of the Gates Foundation through the Catalytic Leadership Investment grant.

Design and layout: Visual Traffic, Jafar Irshaidat

Editing: Gretchen Luchsinger

Published September 2026

All photographs courtesy of UNFPA Asia and the Pacific

Disclaimer: The material in this report was commissioned by the UNFPA Asia and the Pacific Regional Office. UNFPA accepts no responsibility for errors. The findings, interpretations and views expressed in this publication do not necessarily reflect the views of UNFPA. The designations in this work do not imply an opinion on the legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

Suggested citation: 650 Million Reasons: Achieving Universal Health Coverage for Adolescent Sexual and Reproductive Health in Asia and the Pacific. UNFPA Asia and the Pacific Regional Office, Bangkok, 2026



650 MILLION REASONS

**Achieving Universal Health
Coverage for Adolescent
Sexual and Reproductive
Health in Asia and the Pacific**

PREPARED FOR THE UNFPA ASIA AND THE PACIFIC REGIONAL OFFICE BY:

Burnet Institute

85 Commercial Rd,
Melbourne, Victoria,
Australia

+61 3 9282 2111

www.burnet.edu.au



Abbreviations & acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
DHS	Demographic and Health Survey
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
MICS	Multiple Indicator Cluster Survey
RMNCH	Reproductive, maternal, newborn and child health
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Contents

FOREWORD	3
EXECUTIVE SUMMARY	4
ADOLESCENTS: IN NEED OF UNIVERSAL COVERAGE BUT OFTEN LEFT BEHIND	7
AIMS AND OBJECTIVES	9
OVERVIEW OF ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN ASIA AND THE PACIFIC	11
SERVICE COVERAGE	14
KEY HEALTH OUTCOMES	17
ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND UNIVERSAL HEALTH COVERAGE	19
INCLUSION IN NATIONAL HEALTH POLICIES AND PLANS	19
INCLUSION IN NATIONAL ESSENTIAL HEALTH SERVICES PACKAGES	26
FINANCING AND FINANCIAL PROTECTION	32
LEGAL FRAMEWORKS TO ENABLE EQUITABLE ACCESS	39
EQUITABLE ACCESS TO QUALITY SERVICES	45
ACCOUNTABILITY	52
CONCLUSIONS AND RECOMMENDATIONS	56
REFERENCES	58
ANNEX	62



Foreword

The future prosperity of countries across Asia and the Pacific hinges on how well they meet the needs of their adolescents aged 10–19. Sexual and reproductive health (SRH) is unequivocally part of this vision. It equips adolescents to navigate the physical, developmental and socioemotional changes unique to this life stage, building a foundation for early adulthood and beyond. Investing in adolescents' health and well-being is both a moral imperative and a strategic policy goal. Without reaching it, government commitments to universal health coverage and to broader development progress will remain far out of reach.

This report explores the inclusion, coverage and equity of adolescent SRH within universal health coverage in the region. It provides an essential, unvarnished assessment of the current policy landscape, highlighting a deeply concerning truth: Despite many commitments, adolescents' SRH remains largely overlooked and underresourced. Millions of young people across our region have pressing SRH concerns but lack the services and information they need.

The core challenge before us is clear: We must comprehensively dismantle the multiple barriers to adolescent SRH. While supportive policies may exist on paper, they are frequently fragmented and weakened by contradictory legal frameworks. As a result, millions of adolescents are unable to access confidential, life-saving care. Financial obstacles and judgmental provider attitudes also push adolescents away, even when care is available in otherwise supportive policy environments.

The report confirms what has long been evident: Poor SRH among adolescents has generational consequences. High rates of early pregnancy and increased risks of childbirth complications lead to disrupted education and reduced opportunities for employment. Amid major demographic shifts in our region, more adolescents than ever will carry this burden into adulthood and old age, putting their own children and successive generations at risk of languishing.

The findings presented here are not an endpoint but a call to action. The universal health coverage agenda can no longer afford to leave adolescents behind. Policymakers and health leaders must embed explicit goals and actionable commitments for adolescent SRH within universal health coverage plans and strategies, supported by adequate and sustainable financing to ensure quality, accountability and equitable access.

The time for incremental adjustment has passed. Let this be the generation that transforms health systems across Asia and the Pacific so they are genuinely responsive to the rights and needs of adolescents. Their future, and ours, depends on it.

Dr. Aleksandar (Sasha) Bodiroza

Regional Director, a.i.

UNFPA Asia and the Pacific Regional Office

Executive summary

The Asia and the Pacific region is home to a vast and vital demographic: nearly 650 million adolescents aged 10–19, accounting for almost half of the world's total. This life stage represents a critical window for safeguarding SRH across the life course. Health systems that provide comprehensive and high-quality information, counselling and services during adolescence therefore play a key role in laying a strong foundation for their health and well-being and setting them up for success. Government commitments to universal health coverage and other national goals on maternal and child health, HIV and gender equality cannot be achieved without addressing adolescents' SRH needs.

A recent UNFPA review in the Asia and the Pacific reported that sexual activity commonly begins in adolescence. Around 1 in 6 girls and 1 in 10 boys aged 15–19 have had sex. A significant proportion have had sex by age 18; many report sex before marriage. Sexual behaviours posing risks for HIV and sexually transmitted infections (STIs) typically begin in adolescence, and over 3.7 million girls aged 15–19 give birth each year.¹

Despite the critical need among adolescents for SRH information and services, coverage remains inadequate. Less than a third of 15–19-year-olds have comprehensive and correct knowledge of HIV. In most countries, fewer than half of adolescent girls have their need for family planning satisfied by modern methods of contraception.

This regional report explores the inclusion, coverage and equity of adolescent SRH within universal health coverage in Asia and the Pacific. Through a literature review, policy and legislative mapping, and secondary analysis of national data from 30 countries, the study (i) examines the extent to which universal health coverage policies, strategies, and plans include adolescents aged 10–19 and their SRH needs; (ii) identifies financing and financial risk protection mechanisms for adolescent SRH; (iii) assesses the extent to which policy, legislative, and regulatory frameworks support adolescents' access to quality SRH services; (iv) identifies national mechanisms for accountability; and (v) describes the coverage and equity of key SRH services for adolescents.

KEY FINDINGS

Countries in Asia and the Pacific have made significant commitments to achieving universal health coverage. They have made some important progress on maternal and child health and HIV. However, they have not achieved universal coverage of adolescent SRH. Adolescents continue to experience high unmet needs for SRH care, information and education; low coverage of essential services; and a high burden of poor SRH outcomes.

Most countries have a supportive policy foundation for advancing universal health coverage for adolescent SRH. Almost all national health and SRH-related policies and plans identify adolescents as a priority and have defined national quality standards for adolescent health services that broadly include SRH. Policy objectives or strategies to improve the quality and accessibility of adolescent-responsive (or “friendly”) health services are in place in most countries. In countries with a national adolescent health or youth policy, SRH is a core component, particularly in relation to reducing adolescent fertility and preventing the transmission of HIV.

Yet key gaps and challenges remain:

Many existing policies are fragmented. They lack a comprehensive approach to adolescent SRH. Policies and strategies primarily emphasize improving SRH awareness and access to sexuality education and counselling, but not the full constellation of SRH services.

- Only around half of countries include specific objectives or actions within national adolescent health policies or strategies to provide universal access to SRH commodities (including contraceptives) and health services.
- Gaps persist in including some SRH services within national health strategies and/or essential health services packages, particularly in countries where abortion is legal (e.g., safe abortion and/or post-abortion care in line with national laws); access to HIV testing, treatment and support specifically for adolescents and young key populations; and gender-based violence.

1. UNFPA Asia and the Pacific Regional Office, *My Body Is My Body, My Life Is My Life: Sexual and Reproductive Health and Rights of Young People in Asia and the Pacific* (2021)

Most countries have complex, often contradictory laws and policies on adolescent SRH. These create significant barriers to achieving universal health coverage, putting millions of adolescents at risk of poor SRH.

- On average, there is a three-year difference between the age at which adolescents can legally consent to sex and the legal age of consent to healthcare.
- Only fifteen countries have clear provisions for adolescents under 18 to independently access HIV testing. Only nine provide clear guidance on adolescents accessing contraception without parental consent.
- Some 65 million adolescents live in countries with either a stated requirement for parental consent for access to contraception and/or with no policy support for adolescents to access confidential contraceptive services (this includes limiting access to married women only).
- Almost 166 million adolescents live in countries that criminalize consensual sex between same-sex partners. Such prohibitions represent significant barriers to unmarried young people accessing essential SRH services and care.

Financing for adolescent SRH remains very limited, with insufficient investments to implement current policies and programmes or scale up adolescent-responsive health services.

- Several countries have moved to provide free healthcare through tax-based, pre-paid or targeted financial protection schemes. Yet coverage among adolescents is low. There is insufficient evidence of how effectively these approaches

reach adolescents, including those who are out of school, living away from home, unemployed or migrants.

- More than half the region's adolescents, some 370 million, live in countries where the majority of health expenditure is out-of-pocket. A substantial proportion of girls reports financial barriers to healthcare.

Adolescents describe daunting obstacles to obtaining SRH care.

- Care is often poor quality due to the judgmental attitudes of providers, mistreatment, refusal of services without parental consent, and discrimination based on marital status, age, gender or sexual orientation.
- Several challenges to adolescent-responsive SRH services encompass inadequate provider training and support, infrastructure constraints and a lack of institutional backing.

Most countries have national indicators to track progress on adolescent SRH and promote accountability.

- Most commonly, indicators relate to adolescent fertility, demand for family planning and HIV knowledge.
- Few national or local level health facility mechanisms, however, support the meaningful partnership and engagement of adolescents in policymaking, planning, and the design and monitoring of SRH services and programmes.



Recommendations to accelerate progress towards universal health coverage for adolescent sexual and reproductive health.

1. Anchor adolescent SRH in universal health coverage frameworks

Include an explicit goal and action plan for adolescents and their SRH within universal health coverage policies, plans, and strategies. Clear goals and adolescent specific SRH indicators are essential to track progress, strengthen governance reform, and reinforce accountability. Improved data disaggregation is critical to ensure adolescents are visible in health systems planning and monitoring.

2. Increase and secure financing for adolescent SRH

Increase resources for adolescent SRH and ensure all adolescents are covered through mandatory, prepaid financing mechanisms. Sustainable financing is required to guarantee access to a comprehensive package of SRH services and commodities, reduce out of pocket costs, and prevent financial barriers from excluding adolescents from care.

3. Strengthen service delivery for quality and accessibility

Improving the quality, reach, and responsiveness of SRH services for adolescents requires a comprehensive and systems level approach. This requires the inclusion of an essential adolescent SRH package within universal health coverage benefit packages and health insurance schemes, covering contraception including emergency contraception, HIV testing and care, abortion in line with national law, maternal and newborn health, HPV, and gender based violence services. Equally critical is the training and supervision of health workers to ensure the provision of confidential, non judgmental, and stigma free care, aligned with quality and competency based standards.

These efforts should be reinforced through the integration of national quality standards on adolescent health within existing public health facilities, alongside the development and evaluation of innovative service delivery models such as school based, digital, and self care approaches.

4. Review legal and regulatory barriers

Review, as appropriate and in accordance with national laws and relevant international commitments, legal, regulatory and policy barriers that may impede adolescents' equitable access to appropriate SRH information and services, taking into account adolescents' evolving capacities, the rights, duties and responsibilities of parents and legal guardians, and the principles of non-discrimination, privacy and confidentiality.

5. Clarify consent and rights to access SRH services

Provide clear national guidance on adolescents' access to appropriate SRH information and services, confidentiality and consent, taking account of their evolving capacities and the rights, duties and responsibilities of parents and other persons legally responsible for adolescents, consistent with national law and applicable international commitments.

6. Strengthen health literacy, demand, and community support

Expand approaches that improve adolescents' health literacy, demand for services, and enabling community environments. Comprehensive sexuality education, digital platforms, accessible counselling, and targeted strategies to address community level barriers are key to supporting informed decision making and timely care seeking.

7. Engage adolescents as partners and decision makers

Meaningfully engage adolescents as expert decision makers in the design, monitoring, and evaluation of SRH services and programmes. Adolescent participation improves relevance, quality, and accountability of services, ensuring programmes respond to lived realities rather than assumptions.

Adolescents: In need of universal coverage but often left behind

Universal health coverage is a core component of the 2030 Agenda for Sustainable Development, committing governments to ensure that “all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It includes the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course.”¹

Since the adoption of the 2030 Agenda and its global Sustainable Development Goals (SDGs) in 2015, many countries in Asia and the Pacific have made significant commitments to, and some progress towards, universal health coverage, including for reproductive, maternal, newborn and child health (RMNCH).² The regional universal health coverage index for Asia increased from 64 in 2015 to 68 in 2021. It declined over the same period in Oceania (73 to 72), however, with considerable disparities among countries in this region (Table 1).³

“The onset of puberty brings a heightened need for such services to support a healthy transition to adulthood. For many young people, adolescence marks the onset of sexual activity, within or outside marriage.”

All adolescents require equitable access to quality and comprehensive SRH information, education and counselling. The onset of puberty brings a heightened need for such services to support a healthy transition to adulthood. For many young people, adolescence marks the onset of sexual activity, within or outside marriage.⁴ This requires responsive health services, provided through universal health coverage, that support adolescents in having safe sexual relationships and preventing or managing risks such as unintended pregnancy, STIs, HIV and gender-based violence.

Failing to meet this need has significant health consequences. In Asia and the Pacific, pregnancy and childbirth complications remain a leading cause of death among girls and a contributor to poor

perinatal health outcomes. Moreover, some of the fastest-growing HIV outbreaks in the region are now among adolescents.⁵⁻⁷

Poor SRH during adolescence has broader health and socioeconomic impacts, contributing to poor mental health, lower educational attainment, limited economic opportunities and gender inequality, all of which extend into adulthood and the next generation.⁸ Costs to national economies are high. In the Philippines, annual economic losses due to adolescent pregnancy are estimated to be over \$500 million, equivalent to 1 per cent of gross domestic product.⁹

Despite its critical importance, adolescent SRH has largely been missing in universal health coverage in Asia and the Pacific. A 2019 UNFPA-commissioned review found that many national insurance schemes did not cover SRH services for adolescents. In most countries with data, health insurance covered fewer than 20 per cent of adolescents.⁴

The World Health Organization (WHO) has called for greater attention to adolescents within universal health coverage and recommended key actions for governments to address their specific health needs (Box 1).¹⁰ Accelerating progress in Asia and the Pacific requires examining the current state of universal health coverage to identify gaps in adolescent SRH care as well as opportunities to close them. This will help to avoid a situation where large numbers of adolescents are chronically left behind.

“Poor SRH during adolescence has broader health and socioeconomic impacts, contributing to poor mental health, lower educational attainment, limited economic opportunities and gender inequality, all of which extend into adulthood and the next generation.”

Table 1.
Universal health coverage index

Country	Service coverage index	Subindex (RMNCH)	Overall progress towards universal health coverage
Afghanistan	41	47	Stagnating 
Bangladesh	52	59	Stagnating 
Bhutan	60	83	Improving 
Cambodia	58	74	Stagnating 
China	81	92	On track or achieved 
Fiji	58	79	Decreasing 
India	63	68	Improving 
Indonesia	55	78	Stagnating 
Kiribati	48	71	Stagnating 
Lao People's Democratic Republic	52	60	Stagnating 
Malaysia	76	83	Improving 
Maldives	61	66	Decreasing 
Marshall Islands	59	73	Decreasing 
Micronesia	48	72	Stagnating 
Mongolia	65	82	Decreasing 
Myanmar	52	56	Decreasing 
Naoero	60	66	Stagnating 
Nepal	54	78	Improving 
Pakistan	45	63	Stagnating 
PNG	30	47	Decreasing 
Philippines	58	66	Stagnating 
Samoa	55	64	Stagnating 
Solomon Islands	47	70	Stagnating 
Sri Lanka	67	76	Improving 
Thailand	82	89	On track or achieved 
Timor-Leste	52	70	Stagnating 
Tonga	57	77	Stagnating 
Tuvalu	52	65	Stagnating 
Vanuatu	47	61	Stagnating 
Viet Nam	68	80	Stagnating 

Box 1.

World Health Organization recommendations to provide universal health coverage for adolescents

Strengthen service delivery

- Prioritize adolescents in universal health coverage benefit packages
- Invest in the education of health workers
- Implement supportive legal frameworks
- Develop and implement national quality standards
- Co-deliver or bundle health services
- Engage beyond the health sector

Enhance financing

- Acknowledge the economic benefits of investment in adolescents
- Assess the impact of out-of-pocket payments
- Cover all adolescents with mandatory, prepaid, pooled funding
- Increase spending on adolescent health
- Include adolescents in universal health coverage investment plans
- Design financing and service delivery to leave no one behind

Improve governance

- Engage adolescents
- Monitor adolescent health and service coverage, quality and spending
- Report on adolescent health indicators
- Drive evidence-based programming, policy and resource allocation
- Strengthen research and policy capacity

Source: World Health Organization, 2019. *Adolescent Health: The Missing Population in Universal Health Coverage* (Geneva)

AIMS AND OBJECTIVES

This report explores the inclusion, coverage and equity of adolescent SRH within universal health coverage in Asia and the Pacific. It aims to achieve the following objectives:

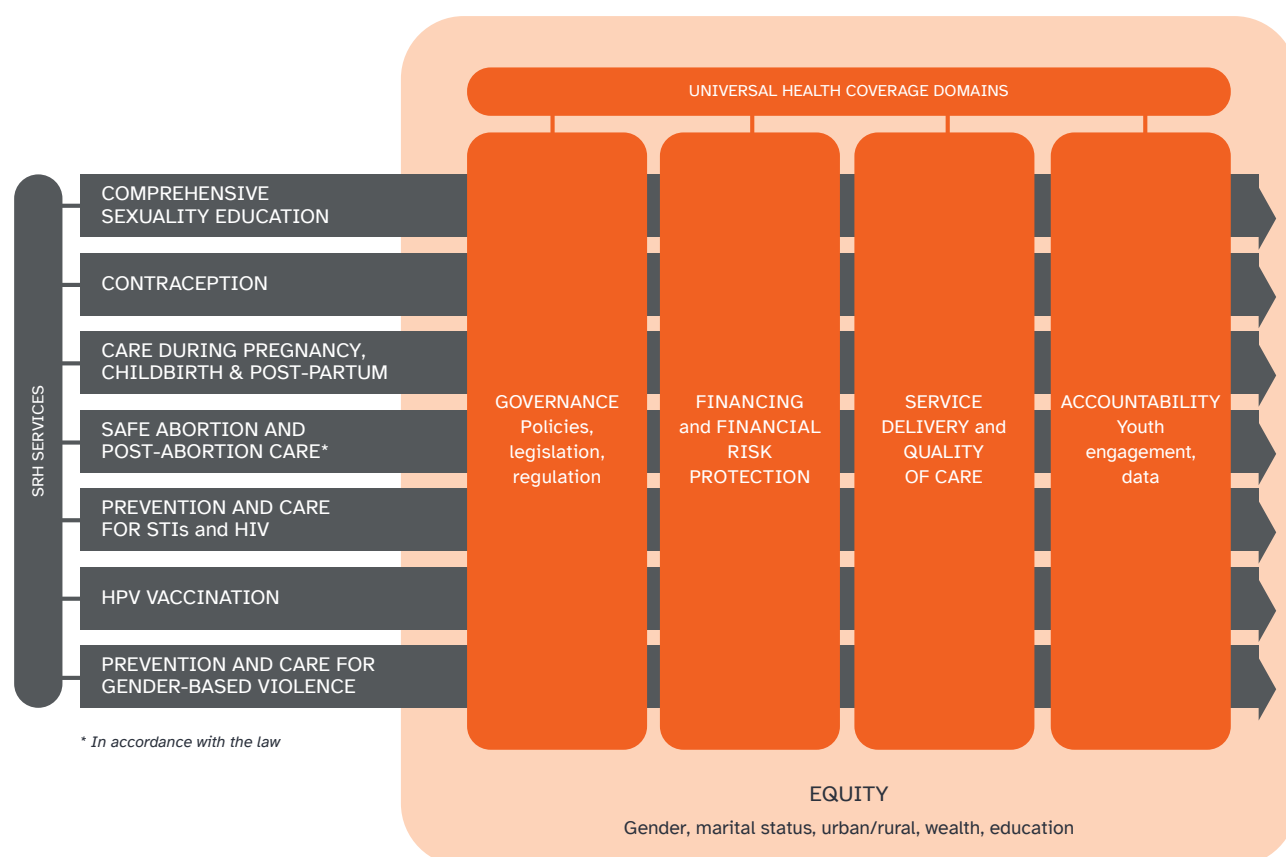
1. Examine the extent to which policies, strategies and plans for universal health coverage include adolescents aged 10–19 years and their SRH needs
2. Identify financing and financial risk protection mechanisms for adolescent SRH
3. Assess the extent to which policy, legislative and regulatory frameworks support adolescents' access to quality SRH services
4. Identify national mechanisms for accountability
5. Describe the coverage and equity of key SRH services for adolescents

CONCEPTUAL FRAMEWORK

The report draws on WHO guidance and recommendations on universal health coverage for adolescents, universal health coverage frameworks, and global frameworks on core components of essential SRH care, information and education.^{4,10,11} The conceptual framework for the report focuses on SRH services most relevant to adolescents as well as^{4,11} health system domains required to achieve universal health coverage for this age group. Equity is a cross-cutting concern (Figure 1).

Figure 1.

Core adolescent SRH services and universal health coverage domains



While there is no universal definition of essential SRH services, several frameworks and guidelines have identified core components. They include the Programme of Action of the 1994 International Conference on Population and Development (ICPD),¹² the WHO Reproductive Health Strategy,¹³ the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights,¹⁴ UNFPA's *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*¹⁵ and the WHO Universal Health Coverage Compendium of Health Interventions.¹⁶

Core SRH services include: antenatal, labour, childbirth and postnatal care; contraception and family planning; management of infertility; sexual health promotion and care; comprehensive sexuality education; safe abortion and post-abortion care in line with national law; prevention and care for female genital mutilation and intimate partner and sexual violence; and the prevention, diagnosis and management of HIV, STIs and reproductive cancers (cervical, breast, uterine, ovarian and prostate). This report focuses on services most relevant to adolescents aged 10–19, as elaborated in Figure 1.^{4,11}

The report defines adolescents as people aged 10–19, consistent with definitions by the United Nations. Some indicators and data are only reported for 15–24-year-olds.

The report covers 30 low- and middle-income countries in Asia and the Pacific: Afghanistan, Bangladesh, Bhutan, Cambodia, China, Fiji, India, Indonesia, Kiribati, Lao People's Democratic Republic, Malaysia, Maldives, Marshall Islands (Republic of the), Micronesia, Mongolia, Myanmar, Naoero, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Solomon Islands, Sri Lanka, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu and Viet Nam. Definitions of low- and middle-income countries are based on World Bank calculations,¹⁷ using gross national income per capita.

A THREE-PRONGED APPROACH

The report builds on three major components:

1. Scoping review of peer-reviewed and grey literature published within the last five years to synthesize evidence on the approaches, access and coverage, quality (including experiences of care) and equity of SRH for adolescents in Asia and the Pacific
2. Mapping of national policies and legislation in 30 countries against the WHO framework and recommendations on universal health coverage for adolescents
3. Secondary analysis of national data for 30 countries to quantify current SRH needs and coverage of services/interventions against key SRH indicators

The annex provides additional details.

LIMITATIONS

This review was desk-based. It only includes documents available electronically. Where English versions were not available, Google Translate was used and further inputs sought from UNFPA country offices to provide information or validate findings. A number of government policy documents and unpublished project reports and case studies have likely not been identified.

Analysis of national SRH data was limited to those publicly available in electronic databases and published reports. Limited data were reported by age for some indicators (for example, out-of-pocket expenditure). The lack of data disaggregated by both age and other characteristics (marital status, location, wealth, education) limited analysis of equitable coverage and outcomes for adolescents.

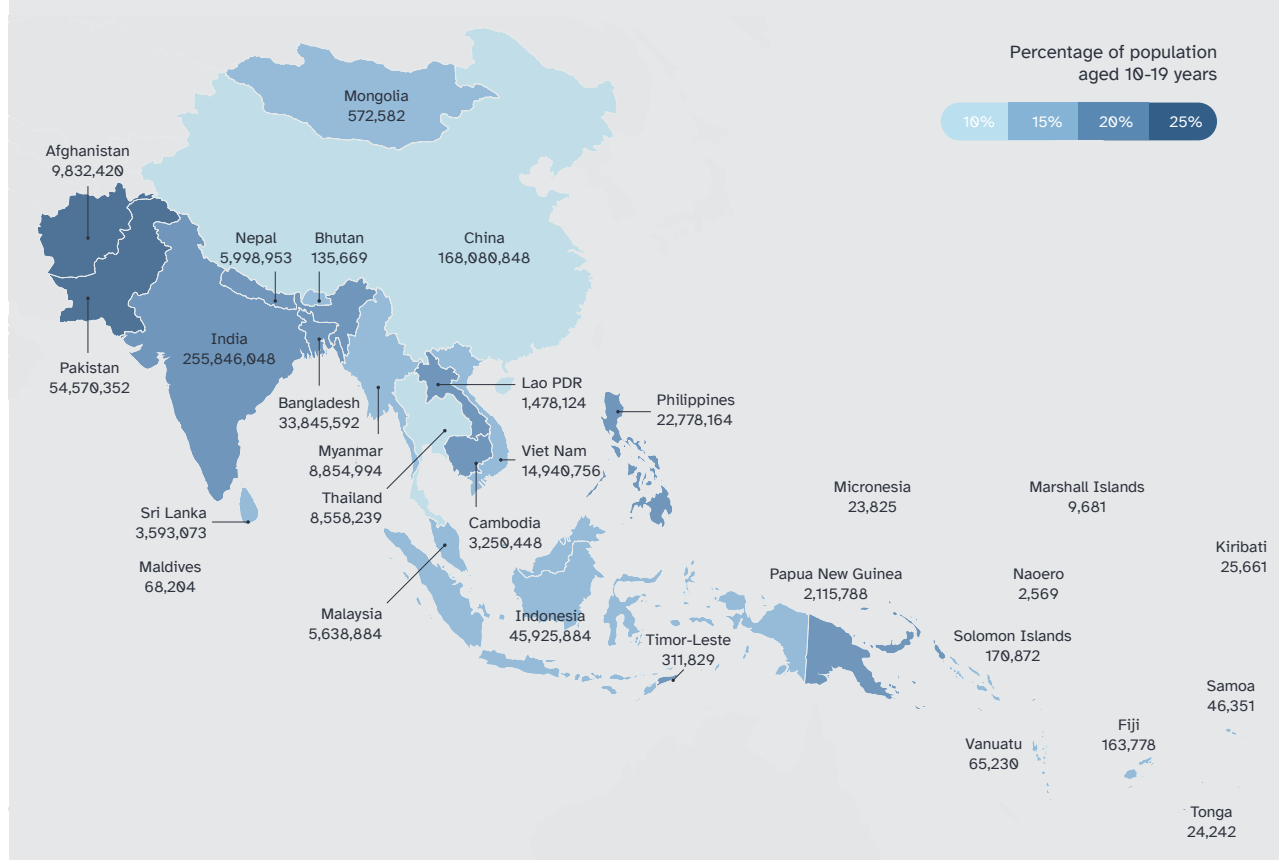
Overview of adolescent sexual and reproductive health in Asia and the Pacific

CURRENT NEEDS OF ADOLESCENTS

The 30 low- and middle-income countries considered in this report have nearly 650 million adolescents. Almost 1 in 6 people in Asia and the Pacific is aged 10–19 (Figure 2).

Figure 2.

Number and proportion (percentage) of the total population aged 10–19



Source: United Nations Department of Economic and Social Affairs, Population Division, [World Population Prospects 2022](#).

Sex during adolescence is common in the region: **1 in 6 girls and 1 in 10 boys aged 15–19 report having had sexual intercourse.¹⁸ A significant proportion of young people have had sex by age 18** (Table 2). In some countries, the onset of sexual activity coincides with marriage,

particularly for girls. Sexual activity among unmarried young people is also common, however, most notably in Pacific island countries, where almost a quarter of never-married girls and around half of never-married boys report having had sex.

Table 2.

Adolescent sexual activity, marriage, intimate partner violence and HIV prevalence

Country	Adolescents aged 15-19 who have ever had sex (percentage)		Young people who had first sex by age 18 (percentage)		Never-married young people aged 15-24 who have ever had sex (percentage)		Adolescents aged 15-19 who are currently married or in union (percentage)		Ever-partnered girls aged 15-19 who have experienced intimate partner violence in the previous 12 months (percentage)	Number of adolescents aged 10-19 living with HIV (number)
	Female	Male	Female	Male	Female	Male	Female	Male		Total
Afghanistan	17	3	31	6	-	-	17	3	23	500
Bangladesh	38	-	55	-	-	-	38	-	29	500
Bhutan	-	-	-	-	-	-	-	-	10	-
Cambodia	12	6	17	5	0	8	11	2	8	3,400
China	-	-	-	-	-	-	-	-	11	-
Fiji	13	22	-	-	-	41	4	0	32	100
India	15	8	21	5	3	12	13	2	19	-
Indonesia	11	-	16	-	2	-	9	-	14	15,000
Kiribati	19	54	-	-	14	64	11	5	31	-
Lao People's Democratic Republic	30	22	-	-	17	37	27	10	11	1,000
Malaysia	-	-	-	-	-	-	-	-	-	500
Maldives	8	6	6	18	6	17	4	0	9	-
Marshall Islands	-	-	-	-	-	-	-	-	25	-
Micronesia	-	-	-	-	-	-	-	-	28	-
Mongolia	14	35	-	-	26	43	4	2	9	-
Myanmar	14	8	14	6	0	7	13	5	15	11,000
Naoero	-	-	-	-	-	-	-	-	26	-
Nepal	22	19	34	17	2	25	21	5	14	1,100
Pakistan	14	3	17	4	-	-	14	3	17	5,100
Papua New Guinea	25	26	34	33	21	40	4	1	35	3,000
Philippines	10	-	14	-	-	-	6	-	16	11,000
Samoa	17	38	-	-	21	52	8	2	26	-
Solomon Islands	44	44	50	54	-	-	11	2	34	-
Sri Lanka	-	-	10	-	-	-	-	-	6	-
Thailand	-	-	-	-	-	-	8	3	13	7,000
Timor-Leste	9	12	16	15	2	21	8	1	27	-
Tonga	11	13	-	-	7	22	3	2	25	-
Tuvalu	20	54	-	-	29	-	9	3	26	-
Vanuatu	22	41	-	-	28	55	8	1	35	-
Viet Nam	10	6	-	-	5	19	7	1	12	5,100

Source: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), 2014–2023; UNAIDS 2025 update (available at <https://aidsinfo.unaids.org/>) and data available at <https://data.unicef.org/>; intimate partner violence data are modelled estimates from WHO based on prevalence data collected between 2000–2018 (<https://vaw-data.srhr.org/>).

Data indicates that adolescents have very high demand for SRH services to prevent, identify and manage needs related to pregnancy, STIs and HIV, and gender-based violence. **Between 6 and 35 per cent of ever-partnered girls aged 15–19 have experienced intimate partner violence** (physical and/or sexual violence by a current or former partner) in the previous 12 months (Table 2). **HIV prevalence is increasing among adolescents in some settings** even as it remains low among the general adolescent population.¹⁸

Up to 79 per cent of married adolescent girls in the region have a demand for contraception (Table 3). Data on unmarried sexually active girls are scarce. Where they are available, they indicate that unmarried sexually active girls not only have a very high demand for services to prevent pregnancy but often substantially higher needs than their married peers. Childbearing during adolescence is common in many countries, underscoring the need for responsive maternal and newborn healthcare for pregnant girls and young mothers. In 2019, an estimated **3.7 million births occurred among girls aged 15–19 years** in the region. Around 1 in 10 young women has a live birth by age 18.

Table 3. Demand for contraception and the prevalence of adolescent childbearing (percentage)

Country	Currently married girls aged 15–19 with a demand for family planning	Unmarried sexually active girls aged 15–19 with a demand for family planning	Women aged 20–24 years who had a live birth by age 18
Afghanistan	-	-	16
Bangladesh	-	-	25
Bhutan	-	-	-
Cambodia	60	-	7
China	-	-	-
Fiji	61	-	3
India	49	71	8
Indonesia	54	-	6
Kiribati	46	-	7
Lao People's Democratic Republic	50	88	18
Malaysia	-	-	-
Maldives	49	-	0
Marshall Islands	-	-	-
Micronesia	-	-	-
Mongolia	68	94	4
Myanmar	73	-	5
Naoero	-	-	-
Nepal	59	-	15
Pakistan	-	-	7
Papua New Guinea	51	82	17
Philippines	75	94	6
Samoa	59	-	7
Solomon Islands	56	97	14
Sri Lanka	-	-	3
Thailand	79	-	6
Timor-Leste	37	-	7
Tonga	-	-	3
Tuvalu	-	-	4
Vanuatu	65	-	10
Viet Nam	59	-	8

Source: DHS, MICS and other household surveys, 2014–2023.



SERVICE COVERAGE

In most countries, **fewer than a third of 15–19-year-olds have comprehensive and correct knowledge of HIV**, a proxy measure of effective coverage of sexuality education (Table 4). Coverage of sexual health and HIV services varies considerably. Coverage of HIV prevention interventions and testing remains very low in many countries, particularly among young people in key populations.¹⁸ Outside Cambodia, Nepal and Viet Nam, **fewer than two thirds of adolescents living with HIV receive antiretroviral therapy (ART)**.

In most countries, **less than half of adolescent girls have their need for family planning satisfied by modern methods of contraception**. Despite a significant scale-up in some settings, HPV vaccination remains far from universal in half the countries with data.

“Data indicates that adolescents have very high demand for SRH services to prevent, identify and manage needs related to pregnancy, sexually transmitted infections and HIV, and gender-based violence.”

Table 4.

Coverage of services for HIV, HPV and pregnancy prevention (percentage)

Country	Adolescents aged 15–19 with comprehensive correct knowledge about HIV/AIDS		Adolescents aged 10–19 living with HIV receiving ART	Girls who have received the first dose of HPV vaccination by age 15	Married and sexually active unmarried girls aged 15–19 who have their demand for family planning satisfied by modern methods of contraception
Afghanistan	1	4	10	-	21
Bangladesh	11	-	50	15	72
Bhutan	-	-	-	93	-
Cambodia	-	-	75	-	53
China	-	-	59	-	-
Fiji	26	27	47	64	14
India	18	26	-	-	47
Indonesia	12	-	18	5	79
Kiribati	32	19	-	55	28
Lao People's Democratic Republic	18	21	48	95	-
Malaysia	-	-	53	77	-
Maldives	27	21	-	90	6
Marshall Islands	-	-	-	71	-
Micronesia	-	-	-	60	-
Mongolia	14	17	-	-	-
Myanmar	13	14	56	-	73
Naoero	-	-	-	-	-
Nepal	18	24	89	-	25
Pakistan	1	0	14	-	23
Papua New Guinea	21	21	51	-	31
Philippines	16	-	16	14	46
Samoa	4	6	-	87	8
Solomon Islands	25	31	-	51	13
Sri Lanka	16	-	-	95	-
Thailand	52	54	59	61	-
Timor-Leste	6	13	-	-	21
Tonga	4	8	-	39	-
Tuvalu	9	24	-	-	-
Vanuatu	8	18	-	-	28
Viet Nam	37	47	88	-	-

Source: DHS and MICS, 2014–2023; WHO/UNICEF Joint Reporting Form on Immunization 2023; Global AIDS Monitoring and UNAIDS 2025, data available at <https://data.unicef.org/>.

Coverage of maternal and newborn care is generally higher than other SRH services but varies substantially among countries (Table 5). Skilled and facility-based care for births is nearly universal for adolescents in most countries. Coverage of antenatal and postnatal care is lower, despite higher risks of poor maternal and perinatal health outcomes among adolescents.

Coverage remains low across the continuum of maternal and newborn care in Afghanistan, Bangladesh, Lao People's Democratic Republic, Myanmar, Papua New Guinea and Timor-Leste, all of which have high rates of adolescent childbearing and maternal mortality.

Table 5.

Share of births to women below age 20 receiving antenatal, birth and postnatal care (percentage)

	4+ Antenatal care visits	Skilled birth assistance	Birth in a health facility	Postnatal care within two days for mother	Postnatal care within two days for newborn
Afghanistan	18	55	53	37	10
Bangladesh	36	71	65	56	56
Cambodia	82	98	97	82	77
Fiji	79	100	100	96	100
India	58	91	91	78	80
Indonesia	83	88	73	77	68
Kiribati	66	96	96	85	92
Lao PDR	52	56	57	1	2
Maldives	83	100	96	90	92
Mongolia	90	100	100	6	5
Myanmar	43	61	38	67	34
Nepal	75	80	80	65	67
Pakistan	44	73	70	53	58
Papua New Guinea	49	63	63	47	47
Philippines	76	89	87	68	72
Samoa	70	89	95	75	78
Solomon Islands		89	87	68	72
Sri Lanka		99	100	100	
Thailand	81	100	99		
Timor-Leste	73	59	46	31	26
Tonga	90	100	99	85	100
Vanuatu	75	92	92	89	95
Viet Nam	73	90	91		82

Source: DHS and MICS, 2014-2023.



KEY HEALTH OUTCOMES

Low coverage of SRH information and services contributes to a high burden of poor SRH among adolescents. **In 2021, 10–19-year-olds lost 3.5 million years of healthy life to maternal disabilities, HIV and STIs.**¹⁹ High unmet needs for contraception led to a significant number of unintended pregnancies among adolescents, and an estimated 3.6 million unsafe abortions among girls and women aged 15–24 each year.¹⁸ Maternal mortality remains high in several countries (Table 6), with an estimated 6,178 maternal deaths among 10–19-year-olds in 2021.¹⁹ Despite some progress, maternal mortality remains a leading cause of death among adolescent girls.

In 2021, over 2,000 HIV-related deaths occurred among adolescents in the 30 countries.¹⁹ The burden of poor health due to HIV has increased among adolescents in the last two decades in most countries,²⁰ suggesting critical gaps in services for prevention, treatment and care.

Table 6.

Key sexual and reproductive health outcomes for adolescents

Country	Births to women below age 20 that were mistimed or unwanted (percentage)	Maternal mortality among girls aged 15–19 (ratio of deaths per 100,000 live births)	New HIV infections among adolescents aged 10–19 (number)	Deaths due to HIV/AIDS among people aged 10–19 (ratio per 100,000)
Afghanistan	5	321	100	0.03
Bangladesh	15	95	100	0.02
Bhutan	-	406	-	0.11
Cambodia	18	48	500	1.28
China	-	25	-	0.12
Fiji	-	105	100	0.47
India	8	456	-	0.36
Indonesia	12	166	3,600	0.15
Kiribati	-	226	-	0.45
Lao People's Democratic Republic	-	83	200	0.30
Malaysia	-	98	100	0.72
Maldives	44	248	-	0.27
Marshall Islands	-	57	-	0.42
Micronesia	-	83	-	0.45
Mongolia	-	27	-	0.02
Myanmar	5	187	2,100	1.11
Naoero	-	91	-	0.26
Nepal	25	152	100	0.09
Pakistan	5	284	-	0.21
Papua New Guinea	30	297	1,000	1.20
Philippines	45	52	4,800	1.09
Samoa	-	33	-	0.45
Solomon Islands	33	288	-	0.47
Sri Lanka	-	54	-	0.13
Thailand	-	20	1,200	2.37
Timor-Leste	7	232	-	1.40
Tonga	-	168	-	0.12
Tuvalu	-	114	-	0.27
Vanuatu	-	62	-	0.45
Viet Nam	-	110	1,000	0.49

Source: DHS, 2015–2022; estimated maternal mortality ratio, Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2023 (available at <https://vizhub.healthdata.org/>); Global AIDS Monitoring and UNAIDS 2025, data available at <https://data.unicef.org/>.

Adolescent sexual and reproductive health and universal health coverage

Adolescents are a crucial population group in universal health coverage, with significant implications for health systems and service delivery. They require services that respond to their stage of physical, emotional, cognitive and social development.^{21,22}

Achieving universal health coverage for adolescents requires:

- Specifically addressing them in national policies, plans and strategies
- Including adolescents and their priority SRH needs in essential healthcare packages and financial protection mechanisms
- Establishing an enabling policy, legislative and regulatory environment for equitable access to quality SRH services

Inclusion in national health policies and plans

Key findings

All countries include adolescent SRH within at least one national policy, plan or strategy.

National policies mostly focus on the prevention of adolescent pregnancy, HIV and STIs through SRH education, information, awareness-raising and counselling.

About half of countries have specific national objectives or actions to provide adolescents with universal access to SRH commodities and health services, including contraception.

A few countries have specific actions for adolescents and young members of key populations related to safe abortion and/or post-abortion care in accordance with the law, or access to HIV testing, treatment and support.

All countries have a youth policy and/or national adolescent health plan or policy that includes SRH (Table 7). These focus on improving awareness, promoting healthy sexual behaviours and counselling. All countries, except Afghanistan, have a policy, objective or other measure to provide adolescents with life skills education, and/or improved communication, awareness and counselling on SRH.

However, existing policies and plans for adolescents and youth do not necessarily provide clear strategies on universal access to SRH services and commodities, including contraception. Many countries have a policy objective or general strategy to improve “youth-friendly” health services. Yet few policies specifically elaborate which SRH services and commodities would be included. While most policies highlight the need to address adolescent pregnancy, just over half of countries (18) include specific actions to provide or improve access to

contraception. Eleven outline specific actions to support pregnant or adolescent mothers. For example, the Youth and Adolescent Development Strategy 2021–2030 in Lao People’s Democratic Republic has a specific strategic directive to enhance contraceptive access through information and free supplies in health facilities.

Bangladesh, India, Sri Lanka and Thailand have national guidelines on providing adolescent SRH services, including contraception. India also details actions to support pregnant adolescents and safe abortion in line with national law. Across these contexts, the focus of HIV-related services is on prevention through life skills or sexuality education, and to some extent on improving access to testing and treatment. Less attention goes to the specific needs of young key populations.



Table 7. Inclusion of specific sexual and reproductive health domains in national adolescent health and/or youth policies, plans or strategies

Country	Sexuality education/ comprehensive sexuality education	Family planning	Maternal health	Safe abortion/ post-abortion care (in accordance with the law)	HIV/ STIs	HPV	Gender- based violence
Afghanistan*							
Bangladesh							
Bhutan							
Cambodia							
China							
Fiji							
India							
Indonesia							
Kiribati							
Lao People's Democratic Republic							
Malaysia							
Maldives							
Marshall Islands							
Micronesia							
Mongolia							
Myanmar							
Naoero							
Nepal							
Pakistan							
Papua New Guinea							
Philippines				 for PAC**			
Samoa							
Solomon Islands							
Sri Lanka							
Thailand			-	-		-	
Timor-Leste							
Tonga							
Tuvalu							
Vanuatu							
Viet Nam							

Note: "Yes" indicates a specific objective or action for adolescents; "Partial" refers to SRH needs highlighted but with no specific objective, strategy or action; "No" denotes no prioritization, actions or objectives.

* The 2016–2021 RMNCAH strategy is under review and policy responses here and in subsequent tables reflect the new national health strategy that has been recently endorsed.

** In accordance with the law.

Yes 
No 
Partial 



ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut



3 tablets containing
Norgestrel 0.02 mg and
Ethinylloestradiol 0.02 mg
per tablet. For oral use only.
Do not use if you are pregnant
or breastfeeding. Consult your
doctor.

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut



3 tablets containing
Norgestrel 0.02 mg and
Ethinylloestradiol 0.02 mg
per tablet. For oral use only.
Do not use if you are pregnant
or breastfeeding. Consult your
doctor.

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut



ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut



1 tablet contains
Levonorgestrel 0.02 mg
and Ethinylloestradiol 0.02 mg
per tablet. For oral use only.
Do not use if you are pregnant
or breastfeeding. Consult your
doctor.

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

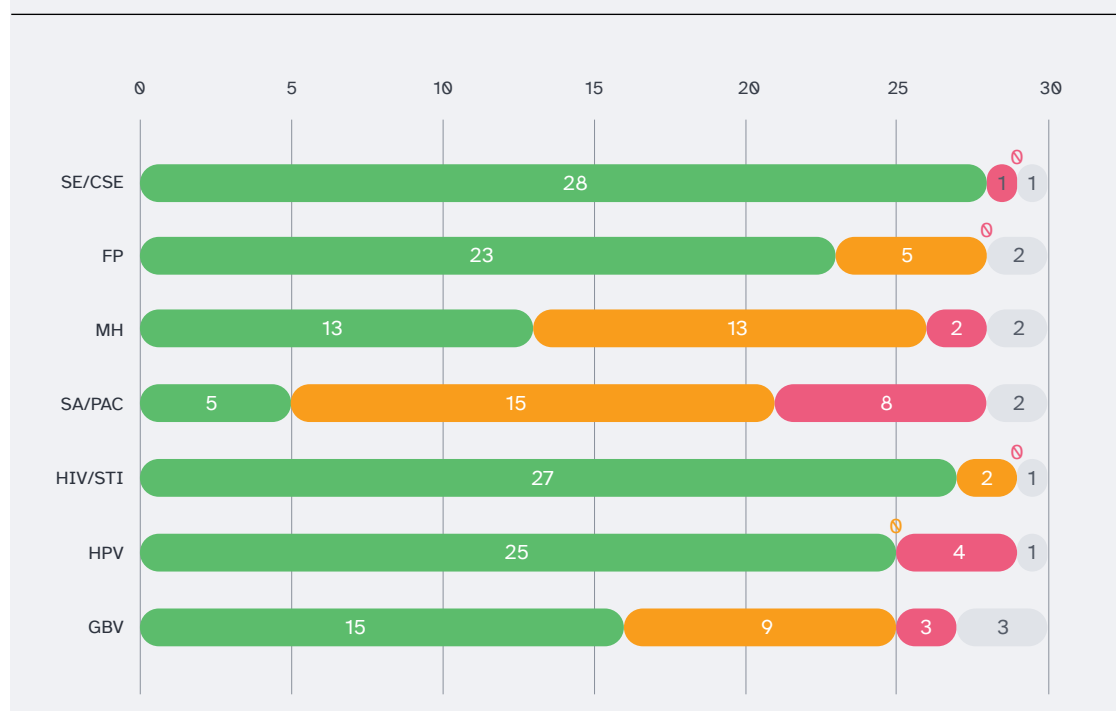
ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

ORAL CONTRACEPTIVES
(Family Planning Pills) 3 x 35 tabs Microlut

Almost all countries have national SRH-related policies, plans or strategies that specifically include adolescents or youth (Figure 3, Table 8). Strategies and plans related to HIV and STIs, reproductive health or family planning (with a focus on preventing adolescent

pregnancy), and, to some extent, gender-based violence identify adolescents as a priority population. This emphasis, however, is not always matched with specific objectives or actions to address their unique health needs or barriers to health services.

Figure 3. Number of countries that include adolescents in national policies, plans or strategies related to SRH



Note: "Yes" indicates a specific objective or action for adolescents; "Partial" refers to actions or objectives included but not specific to adolescents; "No" denotes no actions or objectives.

SE/CSE - Sexual education / comprehensive sexual education
 FP - Family planning
 MH - Maternal health
 SA/PAC - Safe abortion / post-abortion care
 HIV/STI - Human immunodeficiency virus / sexually transmitted infection
 HPV - Human papillomavirus
 GBV - Gender-based violence

Yes ■
 Partial ■
 No ■
 NA ■

Inclusion in national health policies and plans

Like adolescent-specific policies, general SRH policies and plans primarily focus on preventing adolescent pregnancy, STIs and HIV by increasing information, awareness and counselling. Just over half explicitly mention contraceptive services for adolescents within national family planning or reproductive health strategies. Lao People's Democratic Republic, Micronesia, Nepal, Papua New Guinea, the Philippines, Thailand and Vanuatu include specific targets or indicators for contraceptive prevalence among 15–19-year-olds and/or actions or objectives to improve access to contraception for them. Some countries, including Bhutan, Myanmar, Papua New Guinea and the Philippines, provide specific guidance on contraceptive choices for adolescents within national family planning service standards.

Many countries identify pregnant adolescents as a priority within maternal and newborn health strategies. Some include objectives to better measure or

understand barriers to accessing maternal healthcare among adolescents. Only a few detail specific actions to improve access to or the quality of care for pregnant adolescents. Just five countries (Fiji, India, Myanmar, the Philippines and Thailand) include specific actions for adolescents related to legal abortion, primarily for improving access to post-abortion care.

Within HIV and STI strategies, most policies prioritize prevention for adolescents by improving education and awareness. Young key populations are often missing in these efforts, however. Few examples exist of specific actions or objectives to improve the coverage of other preventive interventions, testing or care within strategies targeting adult key populations. Similarly, strategies on gender-based violence commonly identify adolescent girls as being at risk, yet offer little in terms of actions to prevent or respond to violence against them.



Table 8.

Inclusion of adolescents in national SRH policies, plans or strategies

Country	Overall	Sexuality education/ comprehensive sexuality education	Family planning	Maternal health	Safe abortion/ post-abortion care	HIV/STIs	HPV	Gender- based violence
Afghanistan								
Bangladesh								
Bhutan								
Cambodia								
China								
Fiji								
India								
Indonesia								
Kiribati								
Lao People's Democratic Republic								
Malaysia								
Maldives								
Marshall Islands								
Micronesia								
Mongolia	-	-	-	-	-	-	-	-
Myanmar								
Naoero^								
Nepal								
Pakistan								
Papua New Guinea								
Philippines								
Samoa								
Solomon Islands								
Sri Lanka								
Thailand								-
Timor-Leste								
Tonga								
Tuvalu^								
Vanuatu								
Viet Nam			-	-	-			-

Note: “Yes” indicates a specific objective or action for adolescents; “partial” refers to actions or objectives included but not specific to adolescents; “no” denotes no actions or objectives. In Naoero and Tuvalu, SRH is integrated into the national health strategy.

Yes 
 No 
 Partial 

Inclusion in national essential health services packages

Key findings

Countries include contraception, maternal and newborn health services, and HIV and STI-related services relevant to adolescents in national essential services packages and/or medicines lists.

Only a few countries include services related to legal abortion or post-abortion care, HPV or gender-based violence.



Inclusion in national essential health services packages

All countries with an available document detailing a ***national essential health services package and/or essential medicines list include some SRH services relevant to adolescents*** (Figure 4 and Table 9). Almost all include contraceptive care, maternal and newborn care and HIV/STIs services. Eleven countries provide 6 to 10 methods of contraception, including short- and longer-acting modern methods, supporting contraceptive choice; 15 have registered emergency contraception (Table 10). Only Samoa, Sri Lanka and Vanuatu include emergency contraception in the national essential services package or medicines list.

The inclusion of other key SRH services for adolescents varies. Only 5 countries include abortion services in line with national law or post-abortion care; 7 HPV vaccination and 12 services for gender-based violence. Only Sri Lanka integrates comprehensive adolescent SRH services in an essential health services package at the national level.

Figure 4. Number of countries that include SRH services and/or commodities within a national essential services package or medicines list



SE/CSE - Sexual education / comprehensive sexual education
 FP - Family planning
 MH - Maternal health
 SA/PAC - Safe abortion / post-abortion care in accordance with the law
 HIV/STI - Human immunodeficiency virus / sexually transmitted infection
 HPV - Human papillomavirus
 GBV - Gender-based violence

Yes ■
 No ■
 NA ■

Table 9. Inclusion of adolescent-relevant SRH services in a national essential health services package and/or medicines list

Country	Sexuality education/ comprehensive sexuality education	Family planning	Maternal health	Safe abortion/ post-abortion care	HIV/STIs	HPV	Gender-based violence
Afghanistan		1-5 methods					
Bangladesh		6-10 methods					
Bhutan		1-5 methods					
Cambodia		6-10 methods					
China	-	None/NA	-	-	-	-	-
Fiji		6-10 methods					
India		1-5 methods					
Indonesia	-	1-5 methods	-	-	-	-	-
Kiribati		6-10 methods					
Lao People's Democratic Republic		6-10 methods					
Malaysia	-	1-5 methods	-	-	-	-	-
Maldives		1-5 methods					
Marshall Islands							
Micronesia							
Mongolia		1-5 methods					
Myanmar		6-10 methods					
Naoero	-	1-5 methods	-	-	-	-	-
Nepal	-	6-10 methods	-	-	-	-	-
Pakistan		6-10 methods					
Papua New Guinea							
Philippines		1-5 methods					
Samoa		1-5 methods					
Solomon Islands		1-5 methods					
Sri Lanka		6-10 methods					
Thailand	-	1-5 methods	-	-	-	-	-
Timor-Leste							
Tonga		1-5 methods					
Tuvalu		6-10 methods					
Vanuatu		6-10 methods					
Viet Nam	-	None/NA	-	-	-	-	-

Note: Additional data on contraceptives came from the [Contraception Policy Atlas 2023](#).

Yes 

No 





Table 10.
Access to emergency contraception

Country	Registered	Available over the counter or without a prescription
Afghanistan		
Bangladesh		
Bhutan		
Cambodia		
China		
Fiji	-	-
India		
Indonesia		
Kiribati		
Lao People's Democratic Republic		
Malaysia		
Maldives	but imported	
Marshall Islands	-	-
Micronesia		
Mongolia		
Myanmar		
Naoero	-	-
Nepal		
Pakistan		
Papua New Guinea	but imported	
Philippines		
Samoa		
Solomon Islands		
Sri Lanka		
Thailand		
Timor-Leste	-	
Tonga		
Tuvalu		
Vanuatu	but imported	
Viet Nam		

Source: [Contraception Policy Atlas 2023](#).

Yes

No

NA

Financing and financial protection

Key findings

More than 370 million adolescents live in countries where the majority of health expenditure is out-of-pocket.

While almost all national SRH, RMNCH and HIV policies identify adolescents as a priority group, none include a specific budget allocation for adolescent SRH.

Governments have committed to providing free SRH services for adolescents at the point-of-care. Yet financial barriers remain a major contributor to limited care-seeking behaviour and unmet need for health services.

Despite progress in providing free healthcare through tax-based, pre-paid or targeted financial protection schemes, coverage among adolescents remains low in many countries.

There is little evidence on the extent to which financial protection approaches effectively reach adolescents, especially those who are unmarried, out of school, living away from home, unemployed or migrants.

A critical gap persists in data and research examining the effectiveness of existing financial protection approaches for adolescents.



Government financing and budget allocations

While almost all national HIV, SRH and RMNCH policies identify adolescents as a priority, none include specific budget allocations for adolescent SRH. Only eight countries provide data or documents detailing budget allocations or government expenditure on reproductive health for the total population. Among these countries, the proportion of current health expenditure allocated to reproductive health varies significantly, from 0.1 per cent in Afghanistan to 13.9 per cent in Bhutan (Table 11).

Most countries report a regular budget allocation for general adolescent health programmes, except Afghanistan, Cambodia and Pakistan. No data are available on total expenditure on adolescent health or expenditure specifically on adolescent SRH.

Financial protection

Most countries have a national law guaranteeing universal access to primary healthcare (Table 12). Around half report having fee exemptions for adolescents at the point-of-care as part of general public outpatient care. Approximately half of countries report that three key SRH services – contraception, maternal health and HIV/STI care – are provided free of charge to adolescents at public health facilities. In the remaining countries, free access to these SRH services is partial, limited to specific population groups, such as poorer households or married women. And yet, a significant proportion of adolescent girls report a problem in accessing care for financial reasons. Where data is available, that proportion can be upwards to 65 per cent.

Table 11.

Government expenditure on reproductive health and adolescent health

Country	Government expenditure on reproductive health as a percentage of current health expenditure	Regular government budget allocation to support the national adolescent health/well-being programme
Afghanistan	0.1	No
Bangladesh	-	Yes
Bhutan	13.9	Yes
Cambodia	2.8	No
China	-	Yes
Fiji	-	-
India	-	Yes
Indonesia	-	Yes
Kiribati	-	-
Lao People's Democratic Republic	3.8	-
Malaysia	-	Yes
Maldives	-	Yes
Marshall Islands	-	-
Micronesia	-	-
Mongolia	-	Yes
Myanmar	2.9	Yes
Naoero	-	-
Nepal	3.6	Yes
Pakistan	-	No
Papua New Guinea	-	Yes
Philippines	-	Yes
Samoa	7.2	-
Solomon Islands	-	Yes
Sri Lanka	6.6	Yes
Thailand	-	Yes
Timor-Leste	-	Yes
Tonga	-	-
Tuvalu	-	-
Vanuatu	-	Yes
Viet Nam	-	Yes

Source: [WHO Global Health Expenditure Database](#); [WHO Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy Survey, 2023](#).

Table 12.
Financial protection for adolescents

Country	Adolescents covered by any health insurance (percentage)		National law guarantees universal access to primary healthcare	Fee exemptions for adolescents at the point-of-care in public sector services*						Adolescent girls who report a problem accessing healthcare for financial reasons (percentage)
	Females	Males		Outpatient care	Family planning	Maternal health	HIV	STIs	HPV	
Afghanistan	0	0								65
Bangladesh	0	-								43
Bhutan	-	-								-
Cambodia	11	4	-							51
China	-	-								-
Fiji	5	2	-	-	-	-	-	-	-	-
India	26	27								26
Indonesia	56	-								20
Kiribati	-	-	-	-	-	-	-	-	-	-
Lao People's Democratic Republic	9	8								-
Malaysia	-	-			-		-	-		-
Maldives	4	2								26
Marshall Islands	-	-	-	-		-				-
Micronesia	-	-	-	-		-				-
Mongolia										-
Myanmar	0	1								30
Naoero	-	-	-	-	-	-	-	-	-	-
Nepal	9	8								30
Pakistan	0	0								37
Papua New Guinea	2	1								65
Philippines	64							-		45
Samoa	1	0	-							-
Solomon Islands	1	3								53
Sri Lanka	-	-								-
Thailand	98	99								-
Timor-Leste	-	-								37
Tonga	79	81	-	-	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-	-	-	-	-
Vanuatu	1	0								-
Viet Nam	89	87								-

Source: DHS, MICS and other household surveys, 2014–2023; WHO Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy Survey, 2018–2019 and 2023.
Note: * Partial indicates services are provided free of charge for certain population groups.

Yes

No

Partial

Financing mechanisms to provide free or universal healthcare vary substantially.

Some countries, such as Sri Lanka and Thailand, provide free healthcare for all residents through government schemes or tax-funded public health systems. Other countries, such as India, Indonesia, Lao People's Democratic Republic, the Philippines and Viet Nam, have national or government-run health or social insurance schemes. These operate through mandatory pre-paid or voluntary contributions from employers and employees, with additional government subsidies.²³ Such schemes reduce user fees through low co-payments or free services for a defined package of health services, usually aligned with the national essential health services package. While these schemes do not specifically target 10–19-year-olds, adolescents are generally covered through family, employer or school-based insurance schemes.^{24,25}

Some financial protection mechanisms target disadvantaged households and/or specific SRH services (such as maternal and newborn health) to address health inequities. Examples include the Health Equity Fund in Cambodia, which provides free healthcare to eligible households,²⁶ and Janani Suraksha Yojana and Janani-Shishu Suraksha Karyakram in India, which offer cash assistance and free maternal healthcare to pregnant women.

Other strategies with potential include using vouchers for adolescents to obtain subsidized or free SRH services; these may be linked to interventions to improve the quality of adolescent health services.²⁷ Voucher schemes for reproductive health exist in Bangladesh,²⁹ Cambodia³⁰ and Pakistan.²⁸ But they are generally not adolescent-specific and typically target married women.

While not directly aimed at adolescents, national insurance and other financial protection mechanisms do include some SRH services that are a priority for them. There is little evidence, however, on whether adolescents can access these approaches, or if they reduce financial barriers or increase health service use.

National household surveys indicate that the proportion of adolescents covered by any health insurance varies greatly

(Table 14), from 0 per cent in Afghanistan, Bangladesh and Pakistan to nearly full coverage in Thailand (98 per cent for females, 99 per cent for males), Viet Nam (89 per cent for females, 87 per cent for males) and Tonga (79 per cent for females, 81 per cent for males).

There is a critical lack of evidence on the effectiveness of existing financial protection approaches that target adolescents and unmarried young people.

Some studies have noted barriers to adolescents independently accessing health benefits through household schemes. For example, Indonesia launched a universal healthcare system called Jaminan Kesehatan Nasional in 2014, requiring all residents to register for it. The scheme covers basic, advanced and hospital healthcare, including many services related to SRH and maternal health. Adolescents are covered under a “family card” or through an employer. However, stakeholders reported that adolescents were among the least covered by insurance, however, particularly those who are out of school, homeless or separated from their family.

Some SRH services (such as contraceptive implants and injectables) are not fully covered.³¹ Similarly, in Cambodia, a study found that it was unclear if adolescents

covered by the Health Equity Card could negotiate access to care independently of their parents or guardians.³²

Older adolescents, and those who are unemployed, out of school, marginalized or from low-income households, are more likely to face financial barriers to accessing health services. They may be excluded from national financing mechanisms altogether.^{24,33}

Adolescents who are migrants or displaced, particularly undocumented migrants, may also be left out of national health insurance or entitlements to access free healthcare.³⁴ Smaller studies suggest that financial barriers significantly contribute to unmet needs and forgone care in the region. Adolescents commonly report out-of-pocket expenses as an obstacle, particularly those who are financially dependent on their parents or household.³⁵⁻³⁷

Even where services are provided free of charge, adolescents report that costs of transport, informal fees or commodities are barriers to seeking SRH services.

In some settings, adolescents, unaware that services are free, have avoided seeking care because they assumed they would pay for it.³⁸⁻⁴¹ Some evidence suggests that adolescents may prefer to seek SRH services from private service providers, due to more flexible opening hours, improved privacy and perceptions of higher quality. Fees for private services may be more expensive, however. Not all adolescents can afford them.³²

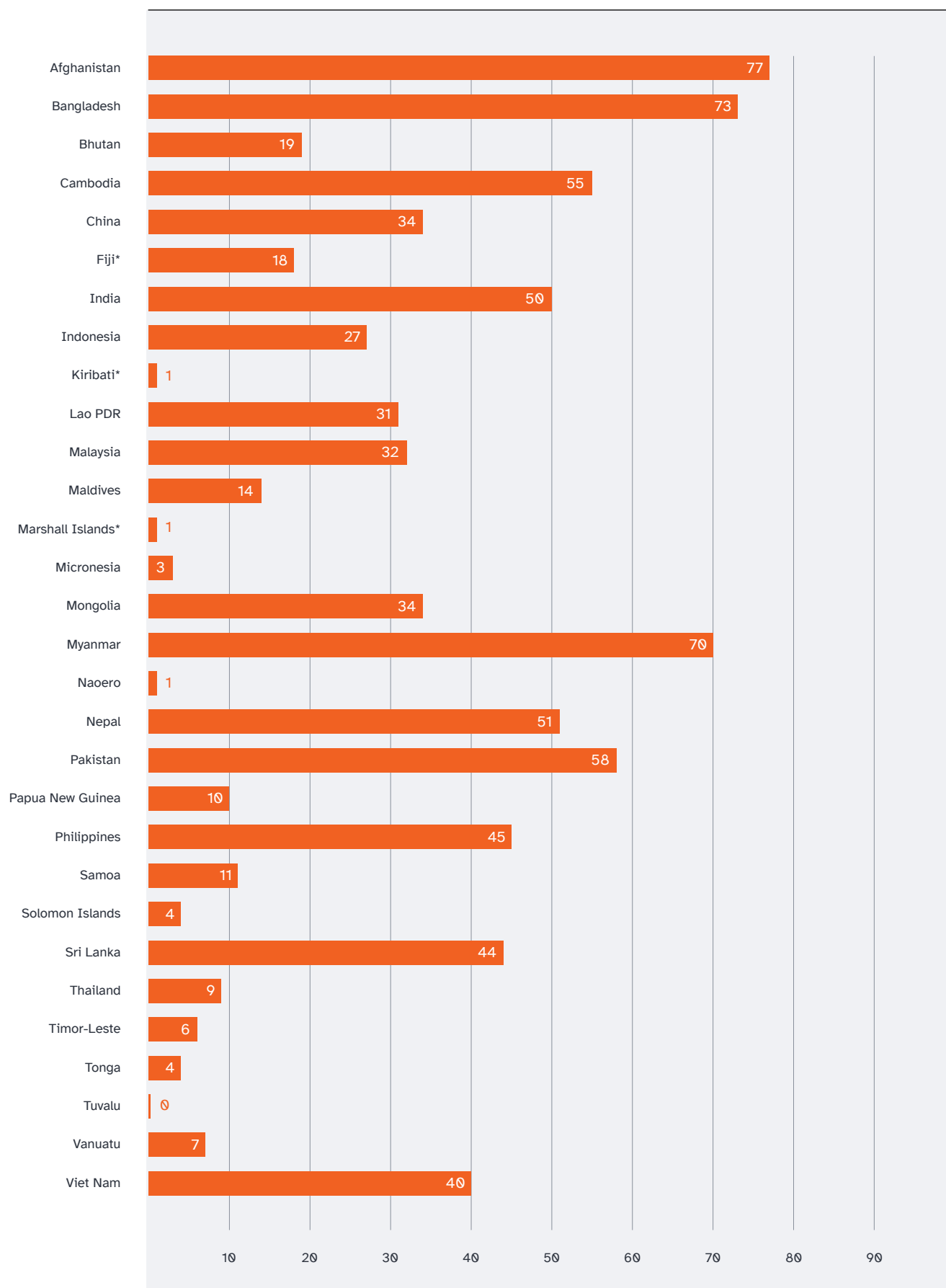
In some countries, such as Vanuatu, national SRH or adolescent health policies specify that adolescents should

not be denied health services, including contraception, if they are unable to pay. It is unclear how extensively health services implement this policy, however.

Despite government commitments to provide free SRH services for adolescents at the point-of-care, a substantial proportion of adolescent girls reports financial barriers to access

(Table 12). More than 370 million adolescents live in countries where the majority of health expenditure is out-of-pocket. Out-of-pocket expenditure accounts for more than a third of total current health expenditure in 12 countries (Figure 5).

Figure 5. Out-of-pocket expenditure as a percentage of current health expenditure



Source : WHO Global Health Observatory, 2021 estimates available from <https://www.who.int/data/gho/>.

Legal frameworks to enable equitable access

Key findings

Despite broadly supportive legal and regulatory frameworks aimed at full and equal access to SRH services, most countries have complex, fragmented and often contradictory laws and policies that create significant barriers for adolescents.

Legal barriers may prevent adolescents from accessing SRH services without parental consent or limit access to services based on marital status. Criminalization of adolescent sexual behaviour, sexuality and some specific SRH services are also significant obstacles in some countries.

Across the region, 65 million adolescents live in countries where parental consent is required for access to contraception; 304 million live in countries where sex before 18 or non-marital sex is criminalized.



The legal age of consent to sex and the legal age of majority at which a young person is assumed to have the capacity to access healthcare independently are important determinants of access to SRH services.

The Convention on the Rights of the Child recognizes the evolving capacity and maturity of adolescents and their agency with respect to their sexual lives.⁴² While legislation on the age of consent to sex is designed to protect children from sexual abuse and exploitation, it should also respect the capacity of adolescents of similar ages to consent to non-exploitative sexual activity.⁴³

Many of the countries reviewed have a legal age of consent to sex that broadly reflects this guidance, including exemptions for adolescents who are close in age (Table 13). Nearly a quarter of the countries have a high legal age of consent to sex (18 years) and/or consent to sex is only legal after marriage (particularly for girls), without exemptions for consensual sex between adolescents who are close in age.

Most of the countries display disparities between the legal age of consent to sex and the legal age of majority. On average, there is a three-year difference between the age at which adolescents can legally consent to sex and the legal age of consent to health care. Barring clear provisions to allow young people under the age of majority to consent to SRH-related services, these disparities can present a significant barrier to adolescents seeking confidential SRH care. They may contribute to a high unmet need for counselling and services to prevent unintended pregnancy, STIs and HIV.

Guidance is mixed on the age at which adolescents can access specific SRH services without requiring consent from a parent or guardian. Some 65 million adolescents under age 18 live in countries with either a stated requirement for parental consent for access to contraception under the age of majority or no broad policy support for adolescents to access confidential contraceptive services. Only eight countries specifically allow access to contraception under age 18.

Roughly half of the countries have provisions for adolescents under age 18 to access HIV testing independently from parents or guardians. While many countries affirm adolescents' right to privacy and confidentiality, health providers often lack guidance on providing confidential services to minors with sufficient capacity for consent.

“Many adolescents live in places where certain aspects of adolescent sexual behavior or some SRH services are illegal.”

Almost 304 million adolescents under age 18 live in settings where sex before age 18 or non-marital sex is criminalized. Such statutes contradict broader support for adolescents to access services to prevent pregnancy and/or provisions for HIV testing before age 18.

Many adolescents live in places where certain aspects of adolescent sexual behavior or some SRH services are illegal. In some countries, consensual sex between same-sex partners, irrespective of age, is criminalized or illegal. This legal environment makes it difficult for adolescents to seek health

services that protect them from discrimination, HIV and STIs. Furthermore, only four countries in the region (India, Marshall Islands, Micronesia, and Mongolia) offer legal protection against discrimination in healthcare based on sexual orientation, with similar protections existing in some areas of the Philippines. Moreover, non-marital sex is criminalized in countries where 62 million adolescents reside, creating significant obstacles for unmarried young people seeking essential information, services and care.

Almost 130 million adolescents live in countries where abortion is highly restricted by law or prohibited entirely. Only six countries have legislation supporting access to abortion on request. Four of these require parental consent for adolescents under 18. Gestational age limits apply in most countries where abortion is available on request or on broad social grounds – usually within 12 weeks. These limits may disproportionately impact adolescent girls, who are more likely to seek abortion late due to late recognition of pregnancy or sociocultural or other barriers to seeking care.⁴⁵



Legal frameworks to enable equitable access

Table 13.

Legal age of consent to sex and medical care (years)

Country	Legal age of consent to sex		Age a young person can consent to healthcare without requiring the consent of a parent/guardian		
	Female	Male	Legal age of majority	Contraception	HIV testing
Afghanistan	After marriage	After marriage	18	No specific provision permitting access (focus is married couples)	16
Bangladesh	14	Not specified	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Bhutan	18	18	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Cambodia	15	15	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	Under 18 if in the young person's best interests
China	14	14	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	18
Fiji	16	16	18	18	Under 18 if a mature minor
India	18	18	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	18
Indonesia	18*	18	21	Restricted to married couples	18
Kiribati	15	15	21	No specific provision	No specific provision for those under 18
Lao People's Democratic Republic	15	15	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	14
Malaysia	16 (after marriage)	16	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Maldives	After marriage	After marriage	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Marshall Islands	16 or 13 if partners are close in age	16 or 14 if partners are close in age	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	14
Micronesia	16	16	18	Some provision for mature minors	14 (Pohnpei)
Mongolia	16	16	18	No restriction based on age (based on health worker assessment of maturity)	18
Myanmar	16	16	18	Policy support for provision to adolescents from age 15, but no explicit guidance regarding requirements for parental consent	Flexible depending on maturity, social situation, risk

Country	Legal age of consent to sex (years)		Age a young person can consent to health care without requiring a parent/guardian consent (years)		
	Female	Male	Legal age of majority	Contraception	HIV testing
Naoero	16 or 13 if partners are close in age	16 or 13 if partners are close in age	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Nepal	18	18	18	Adolescents aged 10-19 have the right to access contraception without parental consent	16
Pakistan	16 (after marriage)	16	18	No specific provision permitting access (focus is married couples)	No specific provision for those under 18
Papua New Guinea	16	16	18	16	12
Philippines	16	16	18	18	15 (under 15 if at high risk)
Samoa	16	16	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	Under 18 if young person is living independently from guardians
Solomon Islands	15	15	18	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 18
Sri Lanka	16	16	18	Under 18 if the young person is likely to engage in sex with risks to their physical or mental health if services are not provided	16 or younger if a mature minor
Thailand	15	15	21	10	Under 18 if a mature minor
Timor-Leste	16 or 14 if "not taken advantage of"	16 or 14 if "not taken advantage of"	17	No specific provision, focus is on married couples	No specific provision for those under 17
Tonga	15	15	21	Broad policy support for services to prevent adolescent pregnancy, but no specific guidance on age of consent for contraception	No specific provision for those under 21
Tuvalu	15	15	18	No specific provision	No specific provision for those under 18
Vanuatu	15	15	18	No legal requirement for parental consent	Under 18 if a mature minor
Viet Nam	16 or 13 if partners are close in age	16 or 13 if partners are close in age	18	Law supports access to contraception for 10-19 year-olds	16

Source: UNFPA Young People and the Law 2020 Update;⁴⁴ Age Of Consent; review of national policies and legislation from government websites.

Note: * Indonesia's Child Protection Law stipulates age 18 but the Penal Code is age 15 for girls. In Aceh Province, Muslims can only consent to sex after marriage.

Adolescents' equitable access to quality services

Key findings

Most countries have national standards of quality healthcare for adolescents that include some SRH services. Only two countries (Samoa and Solomon Islands) clearly address all key domains of SRH in national standards.

The implementation of national standards remains uneven, often resulting in poor-quality SRH services for adolescents and contributing to high unmet needs.

Insufficient financial and human resources, poor infrastructure for private and confidential services, and limited adolescent-specific data have hampered the integration of adolescent SRH into public health facilities.

Adolescents report substantial barriers to accessing SRH services, including community stigma, judgmental healthcare provider attitudes, inaccessible health facilities and fears about lack of confidentiality. Unmarried adolescents and other socially marginalized young people face particularly acute concerns.



Adolescents' equitable
access to quality
services

National service quality standards for adolescent healthcare

Nearly all countries have established national service quality standards for adolescent healthcare or have regional guidance defining quality standards. Around half have a national policy or guideline outlining the competencies required for health workers providing adolescent health services; 16 countries report supporting the continuous professional education and training of health care workers on adolescent health (Table 14).

Most countries have included SRH services in national service quality standards for adolescent health (Table 15), particularly in relation to sexuality education, contraception and HIV/STIs. Some also have standards on the care of pregnant adolescents; only a few have standards on services for adolescents to prevent or respond to gender-based violence. Eleven countries have standards on abortion, generally limited to post-abortion care. Six explicitly refer to HPV.

Table 14.

National service quality standards for adolescent health

Country	National service quality standards for adolescent health	National policy/ guidelines that specify the competencies of health workers in adolescent health	Continuous professional education system in place for primary care health workers to receive training on adolescent health
Afghanistan			
Bangladesh			
Bhutan			
Cambodia			
China			
Fiji	Regional only		
India			
Indonesia			
Kiribati	Regional only		
Lao People's Democratic Republic			
Malaysia			
Maldives			
Marshall Islands	Regional only		
Micronesia			
Mongolia			
Myanmar			
Naoero			
Nepal			
Pakistan			
Papua New Guinea			
Philippines			
Samoa			
Solomon Islands			
Sri Lanka			
Thailand			
Timor-Leste			
Tonga	Regional only		
Tuvalu	Regional only		
Vanuatu			
Viet Nam			

Source: WHO [Adolescent Country Profiles](#) (data from 2018);
WHO [SRMNAH Policy Profile Country Surveys 2023](#).

Yes No No standards 

Adolescents' equitable access to quality services

Table 15. Inclusion of SRH in national service quality standards for adolescent health

Country	SRH broadly included	Sexuality education/comprehensive sexuality education	Family planning	Maternal health	Safe abortion/post-abortion care	HIV/STIs	HPV	Gender-based violence
Afghanistan								
Bangladesh								
Bhutan								
Cambodia								
China								
Fiji*								
India								
Indonesia								
Kiribati*								
Lao People's Democratic Republic								
Malaysia								
Maldives								
Marshall Islands*								
Micronesia								
Mongolia								
Myanmar								
Naoero								
Nepal								
Pakistan								
Papua New Guinea								
Philippines								
Samoa								
Solomon Islands								
Sri Lanka								
Thailand								
Timor-Leste								
Tonga*								
Tuvalu*								
Vanuatu								
Viet Nam	No standards							

Note: * Regional standards/guidance only.

Yes 
No 
N/A 

Integration of adolescent-responsive services into the existing health system

Several countries have introduced adolescent-responsive health services through public health systems. Yet very few evaluations have assessed their effectiveness in increasing the coverage of SRH services or improving health outcomes for adolescents. In India, the Government launched the Rashtriya Kishor Swasthya Karyakram scheme in 2014 to strengthen adolescent health outcomes through health promotion and services.⁴⁶⁻⁴⁹ Also known as the National Adolescent Health Programme, it established adolescent-friendly health clinics in primary health centres, offering preventative, promotive and curative services for a comprehensive range of health needs, including SRH.^{47,48,50,51}

Reviews of national initiatives in India and Nepal have indicated that improving health workforce training, providing clear implementation guidance and operational support, and investing in formative research to enhance service design and delivery can improve the quality and uptake of healthcare by adolescents. Sustained support, ongoing monitoring and supervision and community engagement are required to maintain access and quality.^{52,53} Smaller-scale or pilot projects, typically led by non-governmental organizations, that have focused on health workforce training, facilities with greater privacy and community mobilization to address sociocultural barriers have reported improvements in service use by adolescents.^{54,55}

Some studies have indicated that despite national policies and programmes to improve adolescent SRH services, usage and quality remain limited.^{50,51,56-59} Multiple challenges comprise:^{41,49,50,60-65}

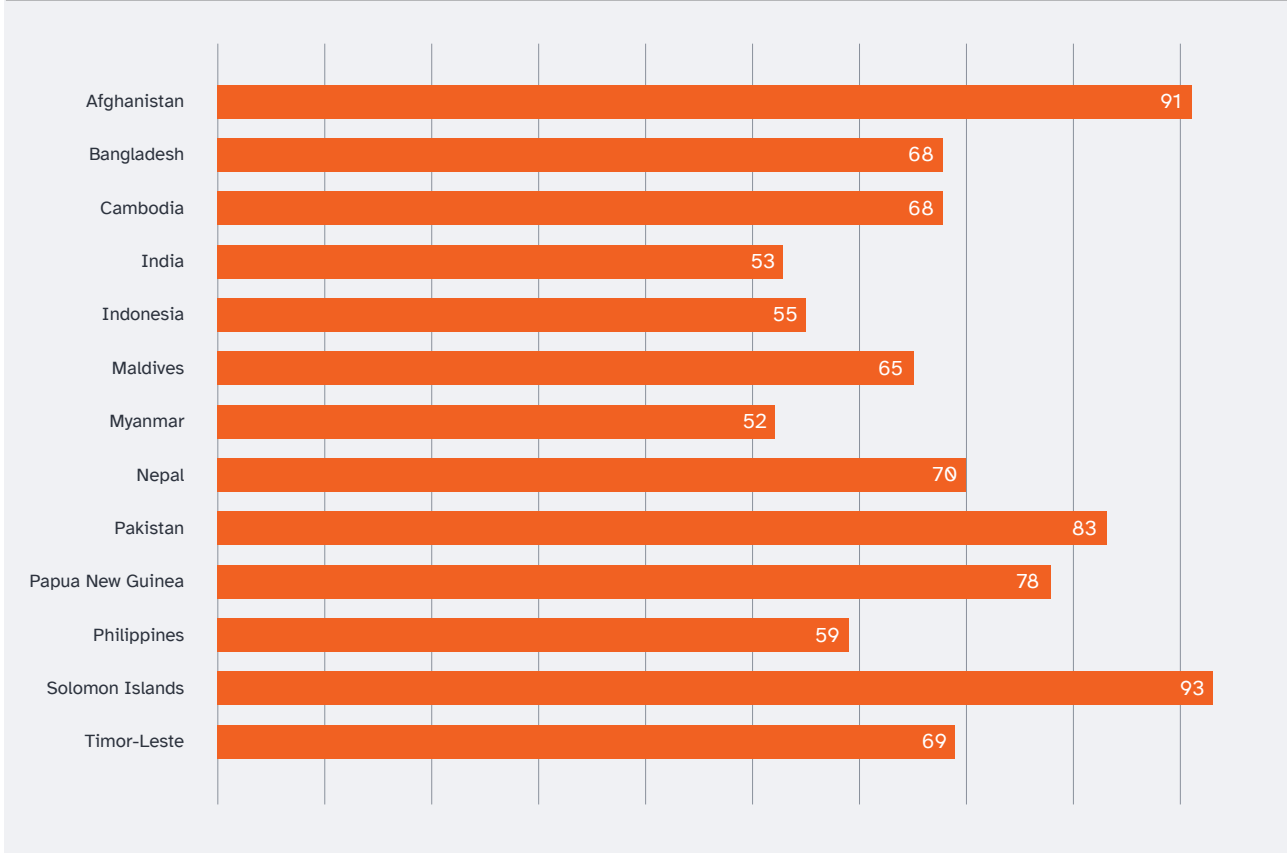
- Lack of government and institutional support (including national prioritization at the district and facility management levels)
- Inadequate budgets and insufficient resources to implement national strategies and programmes
- Insufficient training and support for primary-level health providers, and high workloads that limit capacities to provide services to adolescents
- Lack of adolescent-specific job aids, signs and health promotion materials
- Poor facility infrastructure, including a lack of private waiting areas and consultation rooms
- Limited integration of age-disaggregated or adolescent SRH indicators in health information systems to support service delivery and quality assurance
- Shortages of commodities, such as condoms and contraceptives

Adolescents' equitable access
to and experiences of services

Even where there are supportive policy and legal frameworks for adolescent SRH services, many young people report substantial barriers affecting access to information, prevention and care (Figure 6). The most commonly reported barriers by adolescent girls include not wanting to

attend a clinic alone, high costs, distance and transport difficulties, and a lack of female providers. In many settings, the requirement for permission from a guardian or partner to use services is a significant barrier.

Figure 6.
Girls aged 15–19 who report at least one problem accessing healthcare (percentage)



Source: DHS and MICS, 2014–2023.

Studies involving adolescents have detailed the barriers to SRH care, such as:

- Lack of awareness of SRH needs and services,^{40,41,64-66} including perceptions that services are only for married couples or women⁴⁸
- Requirements for the consent of a parent or guardian, particularly for services that are sensitive or stigmatized, such as contraception and abortion-related care⁶⁷⁻⁷⁰
- Long distances to access care, particularly in rural areas and settings with limited transport^{36,41,64,71,72}
- Inaccessible hours, such as clinics open only during school hours or services only offered for a limited time during the day^{40,49,67}
- Concerns about the lack of privacy and confidentiality^{39,58,65}
- Lack of parental and community support, including HPV vaccination^{73,74}
- Stigma associated with SRH and sexual behaviour that limits care-seeking for contraception, STI or HIV testing, abortion and pregnancy-related care^{35,58 75 76,77}

Several studies indicate that poor-quality care and mistreatment contribute to unmet SRH needs, particularly in public health services.^{36,78,79}

Judgmental attitudes among healthcare providers are commonly reported. These range from shaming or scolding adolescents for seeking care to refusing SRH services, such as contraception, particularly for unmarried girls.^{35,80}

Judgmental attitudes stem from stigmas or gendered or moral frameworks on adolescent and premarital sexual behaviour.^{41,64,65}

Very limited data capture equity in SRH coverage or outcomes for adolescents.

Available DHS data reveal that few countries report SRH indicators for both married and sexually active unmarried adolescents or disaggregate data by both age and other characteristics. The data that have been collected suggest that unmarried sexually active girls have significantly lower demand for family planning satisfied by modern methods of contraception compared with their married peers. Furthermore, girls from poorer households and rural locations generally have less access to contraception.

Published reviews have described substantial inequities in access to HIV and other SRH services for socially marginalized young people, including:^{18,81-84}

- Adolescents with diverse sexual orientations and/or gender identities/expressions
- Adolescent girls who engage in transactional sex
- Adolescents living with disability
- Refugee and migrant adolescents, who are often excluded from universal health coverage policies

Accountability

Key findings

All countries have national indicators to track progress on adolescent SRH and promote accountability. These indicators primarily focus on adolescent fertility, demand for family planning and HIV knowledge.

Few national or health facility mechanisms support adolescents' meaningful partnership and engagement in policymaking, planning, and the design and monitoring of SRH services and programmes.

All countries have incorporated at least one indicator of adolescent SRH into their national health policies, plans or strategies, usually in relation to adolescent fertility rates, contraceptive use and HIV knowledge (Table 16). Half report that they monitor the implementation of national quality standards for adolescent health. Only about a third of countries, however, have a national youth advisory group or other national mechanisms to support young people's engagement in policymaking, monitoring and evaluation. Among countries with national adolescent health service standards, only eight include specific guidance on feedback mechanisms for adolescent clients to provide inputs on services.

Table 16.
Accountability mechanisms for adolescent SRH

Country	National policies include indicators for adolescent SRH	Implementation of national adolescent health service quality standards monitored	National youth advisory group	Feedback mechanisms included in national adolescent health service quality standards
Afghanistan	NA	NA	NA	NA
Bangladesh	Yes	Yes	Yes	Yes
Bhutan	Yes	Yes	NA	Yes
Cambodia	Yes	Yes	NA	NA
China	Yes	Yes	NA	NA
Fiji	Yes	-	Yes	NA
India	Yes	Yes	Yes	Yes
Indonesia	Yes	Yes	NA	NA
Kiribati	Yes	-	Yes	NA
Lao People's Democratic Republic	Yes	Yes	Yes	NA
Malaysia	Yes	Yes	Yes	NA
Maldives	Yes	-	NA	Yes
Marshall Islands	Yes	-	NA	NA
Micronesia	Yes	-	NA	NA
Mongolia	Yes	-	NA	NA
Myanmar	Yes	Yes	NA	Yes
Naoero	Yes	-	No	No
Nepal	Yes	Yes	NA	No
Pakistan	Yes	-	Yes	NA
Papua New Guinea	Yes	NA	Yes	NA
Philippines	Yes	Yes	NA	Yes
Samoa	Yes	-	NA	Yes
Solomon Islands	Yes	-	Yes	NA
Sri Lanka	Yes	Yes	Yes	Yes
Thailand	Yes	Yes	NA	NA
Timor-Leste	Yes	-	Yes	No
Tonga	Yes	-	NA	NA
Tuvalu	Yes	-	NA	NA
Vanuatu	Yes	-	NA	NA
Viet Nam	Yes	-	NA	NA

Yes 
No 
NA 





Conclusions & Recommendations

Access to comprehensive, high-quality SRH information, counselling and services during adolescence lays the foundation for health and well-being throughout the course of life. It is essential for improving maternal and child health, reducing HIV and advancing gender equality. Yet many countries in the Asia Pacific region have not achieved universal health coverage for adolescents. Adolescents continue experiencing high unmet needs for care, information and education as well as low coverage of essential services. They shoulder a high burden of poor and preventable SRH outcomes as a result.

Most countries have a supportive policy foundation for advancing universal health coverage for adolescent SRH but have yet to provide full and equal access to services. Almost all national health and SRH-related policies and plans identify adolescents as a priority. There is a strong focus on reducing adolescent fertility and preventing HIV. Much of the emphasis is on improving adolescents' SRH knowledge, however. Less attention goes to specific strategies and actions to provide universal access to services such as contraception.

Almost all countries have defined national quality standards for adolescent health services; these broadly include SRH. Yet in many settings, an essential package of SRH services and commodities for adolescents is not clearly defined. Some SRH services (such as abortion-related care in line with national law, HPV vaccination, and services for sexual and gender-based violence) are not included in national essential health services packages. Most policies and guidelines primarily focus on older adolescents, with limited inclusion of 10–14-year-olds.

Despite broadly supportive legal and regulatory frameworks, **most countries have complex, fragmented and often contradictory laws and policies that create significant barriers to universal health coverage.** Little clear guidance or legislation exists to enable adolescents under the legal age of majority to access confidential healthcare without requiring the consent of a parent or guardian. On average, there is a three-year difference between the age at which adolescents can legally consent to sex and the legal age of consent to

healthcare. Around 65 million adolescents under age 18 live in countries with either a stated requirement for parental consent to access contraception and/or no broad policy support for adolescent access to confidential contraceptive services.

Data on government investment and resources for adolescent SRH are limited. Qualitative evidence indicates that investment in adolescent health is insufficient to implement current adolescent health policies and programmes or scale up adolescent-responsive health services. While several countries provide free healthcare through tax-based, pre-paid or targeted financial protection schemes, coverage among adolescents is low. It is not clear how effectively these approaches reach adolescents, including those who are unmarried, out of school, living away from their home, unemployed or migrants.

Many countries have made efforts to integrate adolescent-responsive SRH services into existing government health facilities. Yet **adolescents continue to report substantial barriers to access as well as poor-quality care.** They describe experiences with judgmental providers, mistreatment, refusal of services without parental consent, and discrimination based on marital status, age, gender or sexual orientation. Discriminatory social norms, inadequate provider training and support, infrastructure constraints, and insufficient resources lead to high unmet needs for SRH services in many settings.

Most countries have **national indicators to track progress on adolescent SRH and promote accountability.** These most commonly measure adolescent fertility, demand for family planning and HIV knowledge. National data on SRH coverage and outcomes for adolescents are more limited, however, particularly disaggregated by age, sex and marital status. Few national or health facility mechanisms support the meaningful engagement of adolescents in policymaking, planning, and the design and monitoring of SRH services and programmes.

Overall, a fragmented, often contradictory, policy environment imperils the SRH of hundreds of millions of adolescents, posing risks to them and the future of the region as they transition into adulthood.

Recommendations to Accelerate Progress towards Universal Health Coverage for Adolescent SRH

1. Include an explicit goal and action plan for adolescent SRH in government universal health coverage policies, plans and strategies.

Adopt specific indicators of adolescent SRH to track progress and improve the collection and reporting of SRH data on adolescents, including those who are unmarried. Prioritize advocacy for improved data disaggregation and indicator tracking to strengthen the governance reform and accountability agenda.

2. Increase government investment in adolescent SRH, and cover all adolescents with mandatory, prepaid funding for a comprehensive package of SRH services and commodities. Remove user and other out-of-pocket fees at the point-of-care for SRH services and commodities. Develop and evaluate financing mechanisms that specifically cover adolescents (including those who are unmarried or socially marginalized) and that reduce healthcare-related costs (such as transport).

3. Strengthen service delivery to improve the quality and accessibility of SRH care, information and education:

a. Define an essential, comprehensive SRH package of services specifically for adolescents. Incorporate this package within universal health coverage benefit packages and health insurance.

b. Improve training and supervision for health workers, with an emphasis on better understanding of adolescent development, respectful and non-judgmental care, and communication and counselling skills.

c. Strengthen the integration of national quality standards on adolescent health in existing public health facilities. Develop and evaluate new and innovative models of service delivery that respond to the needs of adolescents and overcome barriers to traditional models of care (for example, school-based SRH services, community and peer-based delivery, online and digital health, SRH self-care strategies, and over-the-counter or non-prescription access to commodities).

4. Review legal, regulatory and policy barriers that may impede adolescents' equitable access to appropriate SRH information and services. This can be done as appropriate and in accordance with national laws and relevant international commitments, taking into account adolescents' evolving capacities and the rights, duties and responsibilities of parents and legal guardians. Doing so will help uphold the principles of non-discrimination, privacy and confidentiality, supporting adolescents to achieve the highest attainable standard of health.

5. Provide clear and consistent guidance on consent for SRH services by adolescents and the right to access SRH services, aligned with the 2016 recommendations by the United Nations Committee on the Rights of the Child.⁴²

6. Strengthen approaches to improve adolescents' health literacy, demand for services and community support. Strengthen access to age-appropriate, evidence-based sexual and reproductive health information and education, including comprehensive sexuality education consistent with national policies and contexts, while engaging parents, families, communities and young people as appropriate.

7. Engage adolescents as expert decision makers in the design, monitoring and evaluation of SRH services and programmes. This includes establishing national mechanisms for their meaningful engagement in setting priorities and developing policies as well as health facility mechanisms to provide feedback and support quality assurance. Engage adolescents, including socially marginalized adolescents, in research to understand SRH and service delivery needs.

References

1. WHO (World Health Organization), 2021. [“What Is Universal Health Coverage?”](#)
2. Dhillon I, Jhalani M, Thamarangsi T, et al., 2023. “Advancing Universal Health Coverage in the WHO South-East Asia Region with a Focus on Human Resources for Health.” *Lancet Regional Health Southeast Asia* 18: 100313.
3. WHO (World Health Organization), 2021. *The Global Health Observatory: UHC Service Coverage Index*. Geneva.
4. UNFPA (United Nations Population Fund), 2021. *My Body Is My Body, My Life Is My Life: Sexual and Reproductive Health and Rights of Young People in Asia and the Pacific*. Bangkok.
5. Sully EA, Biddlecom A, Darroch JE, et al., 2020. *Adding it Up: Investing In Sexual And Reproductive Health 2019*. New York: Guttmacher Institute.
6. Azzopardi PS, Hearps SJC, Francis KL, et al., 2019. “Progress in Adolescent Health and Wellbeing: Tracking 12 Headline Indicators for 195 Countries and Territories.” *The Lancet* 393(10176): 1101-18.
7. UNAIDS (Joint United Nations Programme on HIV and AIDS), 2003. *Regional Factsheet: Asia and the Pacific*.
8. Patton GC, Sawyer SM, Santelli JS, et al., 2016. “Our Future: A Lancet Commission on Adolescent Health and Wellbeing.” *Lancet* 387(10036): 2423-78.
9. UNFPA (United Nations Population Fund), 2020. “Policy Brief: Eliminating Teenage Pregnancy in the Philippines.” Mandaluyong City.
10. WHO (World Health Organization), 2019. *Adolescent Health: The Missing Population in Universal Health Coverage*. Geneva.
11. UNFPA (United Nations Population Fund), 2007. *UNFPA Framework for Action on Adolescents and Youth*. New York.
12. UNFPA (United Nations Population Fund), 1994. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. A/CONF.171/13/Rev.1. New York.
13. WHO (World Health Organization), 2004. *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets*. Geneva.
14. Starrs AM, Ezeh AC, Barker G, et al., 2018. “Accelerate Progress – Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission.” *The Lancet* 391(10140): 2642-92.
15. UNFPA (United Nations Population Fund), 2019. *Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage*. New York.
16. WHO (World Health Organization), 2024. [UHC Compendium: Health Interventions for Universal Health Coverage](#).
17. World Bank, 2023. “World Bank Country and Lending Groups.” Washington, DC.
18. UNFPA (United Nations Population Fund) and Burnet Institute, 2021. *My Body Is My Body, My Life Is My Life: Sexual and Reproductive Health and Rights of Young People in Asia and the Pacific*. Bangkok.
19. IHME (Institute for Health Metrics and Evaluation), 2025. *Global Burden of Disease Study 2023*. Seattle: University of Washington.
20. *The Lancet*, 2023. “The Unfinished Agenda of Communicable Diseases Among Children and Adolescents Before the COVID-19 Pandemic: A Systematic Analysis of the Global Burden of Disease Study 2019.” 402(10398): 313-35.
21. Denno DM, Hoopes AJ and Chandra-Mouli V, 2015. “Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support.” *Journal of Adolescent Health* 56(1 Suppl): S22-41.
22. WHO (World Health Organization) and UNAIDS (Jointed United Nations Programme on HIV and AIDS), 2015. *Global Standards for Quality Health-Care Services for Adolescents: A Guide to Implement a Standards-Driven Approach to Improve the Quality of Health Care Services for Adolescents*. Geneva.
23. Joint Learning Network for Universal Health Coverage, 2015. [Country Reform Profiles](#).
24. WHO (World Health Organization), 2014. [Health for the World’s Adolescents: A Second Chance in the Second Decade](#).
25. Waddington C and Sambo C, 2015. “Financing Health Care for Adolescents: A Necessary Part of Universal Health Coverage.” *Bulletin of the World Health Organization* 93(1): 57-9.
26. Kaba MW, Baesel K, Poch B, et al., 2018. “IDPoor: A Poverty Identification Programme That Enables Collaboration Across Sectors for Maternal and Child Health in Cambodia”. *British Medical Journal* 363.

27. Kesterton AJ and Cabral de Mello M, 2010. "Generating Demand and Community Support for Sexual and Reproductive Health Services for Young People: A Review of the Literature and Programs." *Reproductive Health* 7: 25.
28. Azmat SK, Shaikh BT, Hameed W, et al., 2013. "Impact of Social Franchising on Contraceptive Use When Complemented by Vouchers: A Quasi-Experimental Study in Rural Pakistan." *PloS One* 8(9): e74260.
29. Rob U, Rahman M and Bellows B, 2011. "Evaluation of the Impact of the Voucher and Accreditation Approach on Improving Reproductive Behaviors and RH Status: Bangladesh." *BMC Public Health* 11: 257.
30. Bellows B, Warren C, Vonthanak S, et al., 2011. "Evaluation of the Impact of the Voucher and Accreditation Approach on Improving Reproductive Behaviors and Status in Cambodia." *BMC Public Health* 11: 667.
31. Kennedy E, Azzopardi P, Sweeny K, et al., 2023. *Investment Case for Integration of Adolescent Health in Primary Health Care in East Asia and the Pacific: Indonesia*. Project report. Bangkok: UNICEF.
32. Kennedy E, Azzopardi P, Sweeny K, et al., 2023. *Investment Case for Integration of Adolescent Health in Primary Health Care in East Asia and the Pacific: Cambodia*. Project report. Bangkok: UNICEF.
33. Hoang A, Nguyen CQ and Duong CD, 2018. "Youth Experiences in Accessing Sexual Healthcare Services in Vietnam". *Culture, Health & Sexuality* 20(5): 545-59.
34. United Nations, 2020. *Asia-Pacific Migration Report 2020: Assessing Implementation of the Global Compact for Migration*.
35. Baigry MI, Ray R, Lindsay D, et al., 2023. "Barriers and Enablers to Young People Accessing Sexual and Reproductive Health Services in Pacific Island Countries and Territories: A Scoping Review." *PloS One* 18(1): e0280667.
36. Maharjan B, Rishal P and Joar S, 2019. "Factors Influencing the Use of Reproductive Health Care Services Among Married Adolescent Girls in Dang District, Nepal: A Qualitative Study." *BMC Pregnancy and Childbirth* 19(1): 152.
37. Pike V, Kaplan Ramage A, Bhardwaj A, et al., 2021. "Family Influences on Health and Nutrition Practices of Pregnant Adolescents in Bangladesh." *Maternal & Child Nutrition* 17 Suppl 1: e13159.
38. Newman PA, Tepjan S, Fongkaew K, et al., 2023. "Multilevel Factors Impacting PrEP Engagement Among Young Gay Men and Young Transgender Women in Thailand: A Qualitative Analysis." *Journal of the International Association of Providers of AIDS Care* 22: 23259582231188221.
39. Sekine K, Khadka N, Carandang RR, et al., 2021. "Multilevel Factors Influencing Contraceptive Use and Childbearing Among Adolescent Girls in Bara District of Nepal: A Qualitative Study Using the Socioecological Model." *BMJ Open* 11(10): e046156.
40. Thongmixay S, Essink DR, De Greeuw T, et al., 2019. "Perceived Barriers in Accessing Sexual and Reproductive Health Services for Youth in Lao People's Democratic Republic." *PloS One* 14(10).
41. Mattebo M, Bogren M, Brunner N, et al., 2019. "Perspectives on Adolescent Girls' Health-Seeking Behaviour in Relation to Sexual and Reproductive Health in Nepal." *Sexual & Reproductive Healthcare: Official Journal of the Swedish Association of Midwives* 20: 7-12.
42. United Nations, 2019. [General Comment No. 20 on the Implementation of the Rights of the Child During Adolescence](#).
43. Petroni S, Das M and Sawyer SM, 2019. "Protection Versus Rights: Age of Marriage Versus Age of Sexual Consent." *The Lancet Child and Adolescent Health* 3(4): 274-80.
44. UNFPA (United Nations Population Fund), UNESCO (United Nations Educational, Scientific and Cultural Organization), UNAIDS (United Nations Joint Programme on HIV and AIDS), et al., 2020. *Young People and the Law: Laws and Policies Impacting Young People's Sexual and Reproductive Health and Rights in the Asia-Pacific Region: 2020 Update*. Bangkok.
45. Lim L, Wong H, Yong E, et al., 2012. "Profiles of Women Presenting for Abortions in Singapore: Focus on Teenage Abortions and Late Abortions." *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 160(2): 219-22.
46. Sahadevan S, Dar Iang M and Dureab F, 2023. "Effect of Adolescent Health Policies on Health Outcomes in India." *Adolescents* 3(4): 613-24.
47. Barua A, Watson K, Plesons M, et al., 2020. "Adolescent Health Programming in India: A Rapid Review." *Reproductive Health*

48. Mahalakshmy T, Premarajan KC, Soundappan K, et al., 2019. "A Mixed Methods Evaluation of Adolescent Friendly Health Clinic Under National Adolescent Health Program, Puducherry, India." *Indian Journal of Pediatrics* 86(2): 132-9.
49. Bahl D, Bassi S, Manna S, et al., 2023. "Adolescent Friendly Health Clinics (AFHCS) in India and Their Compliance with Government Benchmarks: A Scoping Review." *F1000Research* 12: 517.
50. Dayal R and Gundi M, 2022. "Assessment of the Quality of Sexual and Reproductive Health Services Delivered to Adolescents at Ujala Clinics: A Qualitative Study in Rajasthan, India." *PloS One* 17(1): e0261757.
51. Banerjee A, Paul B, Das R, et al., 2023. "Utilisation of Adolescent Reproductive and Sexual Health Services in a Rural Area of West Bengal: A Mixed-Method Study." *Malaysian Family Physician* 18: 26.
52. CREHPA (Centre for Environment Health and Population Activities), 2015. *Assessing Supply-Side Constraints Affecting the Quality of Adolescent Friendly Health Services and the Barriers for Service Utilisation*. Kathmandu: Centre for Environment Health and Population Activities, Burnet Institute, UNFPA, UNICEF, Family Health Division, Government of Nepal.
53. Wadhwa R, Chaudhary N, Bisht N, et al., 2018. "Improving Adolescent Health Services Across High Priority Districts in 6 States of India: Learnings from an Integrated Reproductive Maternal Newborn Child and Adolescent Health Project." *Indian Journal of Community Medicine: Official Publication of Indian Association of Preventive & Social Medicine* 43(Suppl 1): S6-s11.
54. Pathfinder International, 2011. *Integrating Youth Friendly Services into the Government's Reproductive Health Network: Vietnam Experience*. Vietniane: Pathfinder International and UNFPA.
55. Hoopes AJ, Agarwal P, Bull S, et al., 2016. "Measuring Adolescent Friendly Health Services in India: A Scoping Review of Evaluations." *Reproductive Health* 13(1): 137.
56. Mehra D, Rajak R, Deo S, et al., 2023. "Centres of Excellence for Adolescent Health and Development: A Case Study from Uttar Pradesh, India." *International Journal of Environmental Research and Public Health* 20(4): 3042.
57. Gouda HN, Hazard RH, Maraga S et al., 2019. "The Epidemiological Transition in Papua New Guinea: New Evidence from Verbal Autopsy Studies." *International Journal of Epidemiology* 48(3): 966-77.
58. Napit K, Shrestha KB, Magar SA, et al., 2020. "Factors Associated with Utilization of Adolescent-Friendly Services in Bhaktapur District, Nepal." *Journal of Health, Population, and Nutrition* 39(1): 2.
59. Violita F and Hadi EN, 2019. "Determinants of Adolescent Reproductive Health Service Utilization by Senior High School Students in Makassar, Indonesia." *BMC Public Health* 19(1): 286.
60. Taylor C, 2007. "Services for Young People. A Review Of Stakeholder Experiences." Bangkok: EU/UNFPA Reproductive Health Initiative for Youth in Asia.
61. Bhat A, Yasmeen J, Jan R, et al., 2019. "Adolescent Friendly Health Centres: A Review from North India." *IOSR Journal of Dental and Medical Sciences* 18(8): 44-8.
62. Bali S, Yadav K and Alok Y, 2020. "A Study of Physical Infrastructure and Preparedness of Public Health Institution for Providing Adolescent Friendly Health Services in Central India." *Indian Journal of Preventive & Social Medicine* 51(4): 196-203.
63. Luo X, Zheng R, Jin X, et al., 2020. "Barriers to Adolescent Health Care in Maternal and Children's Healthcare Hospitals: Based on a National Survey in China." *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine* 67(5S): S32-S7.
64. Pandey PL, Seale H and Razee H, 2019. "Exploring the Factors Impacting on Access and Acceptance of Sexual And Reproductive Health Services Provided by Adolescent-Friendly Health Services in Nepal." *PloS One* 14(8): e0220855.
65. Shrestha S and Wærdahl R, 2020. "Girls' Access to Adolescent Friendly Sexual and Reproductive Health Services in Kaski, Nepal." *Asia and the Pacific Policy Studies* 7(3): 278-92.
66. Muthmainnah NI, Siswantara P, Diana RR, et al. 2019. "Mixed Methods: Expectations Versus Facts on the Implementation of Adolescent Care Health Service." *Indian Journal of Public Health Research & Development* 10(5).
67. Jensarikorn P, Phlanoi S, Phlanoi N, et al., 2019. "Accessibility to Reproductive Health Rights Among Adolescents in Three Provinces of Thailand." *Journal of Health Research* 33(1): 35-42.
68. Hazariah AHS, Fallon D and Callery P, 2021. "An Overview of Adolescents Sexual and Reproductive Health Services Provision in Malaysia." *Comprehensive Child and Adolescent Nursing* 44(2):

144-60.

69. Tiwari A, Wu WJ, Citrin D, et al., 2022. "Our Mothers Do Not Tell Us': A Qualitative Study of Adolescent Girls' Perspectives on Sexual and Reproductive Health in Rural Nepal." *Sexual and Reproductive Health Matters* 29(2): 2068211.
70. Chi H, Thanh Thuy H, Thi Kim Oanh L, et al., 2021. "The Content and Implementation of Policies and Programs on Adolescent Sexual and Reproductive Health in Vietnam: Results and Challenges." *Health Services Insights* 14.
71. Lamichhane A, Rana S, Shrestha K, et al., 2021. "Violence and Sexual and Reproductive Health Service Disruption Among Girls and Young Women During COVID-19 Pandemic in Nepal: A Cross-Sectional Study Using Interactive Voice Response Survey." *PloS One* 16(12): e0260435.
72. Rizvi F, Williams J, Bowe S, et al., 2020. "Factors Influencing Unmet Need for Contraception Amongst Adolescent Girls and Women in Cambodia." *PeerJ* 8: e10065.
73. Wang X, Du T, Shi X, et al., 2021. "Attitude and Practice on Human Papilloma Virus Infection and Vaccination Among Students from Secondary Occupational Health School: A Cross-Sectional Study." *Human Vaccines and Immunotherapeutics* 17(11): 4397-405.
74. Wang X, Pan J, Yan B, et al., 2024. "Inequities in Human Papillomavirus Vaccination Among Children Aged 9-14 Years Old Under Constrained Vaccine Supply in China." *International Journal for Equity in Health* 23(1): 112.
75. O'Connor M, Rawstorne P, Iniakwala D, et al., 2018. "Fijian Adolescent Emotional Well-Being and Sexual and Reproductive Health-Seeking Behaviours." *Sexuality Research and Social Policy* 16(3): 373-84.
76. Wiwatkamonchai A, Mesukko J, Klunklin P, et al., 2023. "Youths' Perceptions Regarding Access to Sexual and Reproductive Health Services." *Pacific Rim International Journal of Nursing Research* 27(1): 121-37.
77. Yu YJ, Schieber E, Janamnuysook R, et al., 2024. "Barriers and Facilitators to Pre-exposure Prophylaxis (PrEP) Uptake and Adherence Among Men Who Have Sex with Men (MSM) in Thailand: A Qualitative Study." *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*.
78. Tobey E, Jain A and Mozumdar A, 2023. "Differences in Quality of Care of Family Planning Services Received by Age and Contraceptive Continuation Among Young Mothers in India." *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine* 72(1): 88-95.
79. Irinyenikan TA, Aderoba AK, Fawole O, et al., 2022. "Adolescent Experiences of Mistreatment During Childbirth in Health Facilities: Secondary Analysis of a Community-Based Survey in Four Countries." *BMJ Global Health* 5(Suppl 2).
80. Meherali S, Abdul Rahim K and Lassi ZS, 2022. "Sexual and Reproductive Health Needs and Priorities of the Adolescents in Northern Pakistan: A Formative Evaluation." *Adolescents* 2(2): 263-85.
81. Duff P, Evans JL, Stein ES, et al., 2018. "High Pregnancy Incidence and Low Contraceptive Use Among a Prospective Cohort of Female Entertainment and Sex Workers in Phnom Penh, Cambodia." *BMC Pregnancy Childbirth* 18(1): 128.
82. Zhang XD, Kennedy E, Temmerman M, et al., 2014. "High Rates of Abortion and Low Levels of Contraceptive Use Among Adolescent Female Sex Workers in Kunming, China: A Cross-Sectional Analysis." *European Journal of Contraception and Reproductive Health Care* 19(5): 368-78.
83. Dean L, Tolhurst R, Khanna R, et al., 2017. "'You're Disabled, Why Did You Have Sex in the First Place?' An Intersectional Analysis of Experiences of Disabled Women with Regard to Their Sexual and Reproductive Health and Rights in Gujarat State, India." *Global Health Action* 10(sup2): 1290316.
84. Asnong C, Fellmeth G, Plugge E, et al., 2018. "Adolescents' Perceptions and Experiences of Pregnancy in Refugee and Migrant Communities on the Thailand-Myanmar Border: A Qualitative Study." *Reproductive Health* 15(1): 83.
85. United Nations, 2014. *Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development: Beyond 2014*.
86. UNFPA (United Nations Population Fund), 2017. *State of World Population 2017, Reproductive Health and Rights in an Age of Inequality*. New York.
87. WHO (World Health Organization), 2006. *Reproductive Health Indicators: Guidelines for Their Generation, Interpretation and Analysis for Global Monitoring*. Geneva.

Annex

Review methods

Scoping review

Peer-reviewed articles were identified by searching key terms and subject headings in the Medline, Embase and Scopus databases (Annex box 1). Articles were included if they: 1) were primary research or review articles, 2) focused on adolescents aged 10–18 (including disaggregated data on participants aged 10–24) or at least one adolescent SRH service; 3) focused on at least one of the universal health coverage domains; 4) were published after 1 January 2019; and 5) were published in English.

Titles and abstracts were imported into Endnote and duplicates removed. Publications were screened for eligibility and full texts sought for articles that met the inclusion criteria. The combined database search identified 3,479 articles, of which 95 met the inclusion criteria. Targeted Google Scholar searches and searches of reference lists of relevant articles identified an additional 20 peer-reviewed articles that met the inclusion criteria. Grey literature articles and technical reports were identified by searching key terms in Google and the websites of key non-governmental

and United Nations organizations. Technical reports, evaluations and reviews were included if they met the criteria above. This process identified 27 grey literature articles. Data were extracted using an Excel template to capture the document title, author, year, type and key findings against the conceptual framework domains.

Most included articles were from India (25) and Nepal (19), followed by Indonesia (14), Bangladesh (13), China (10) and Thailand (10). A few articles focused on Cambodia (3), Lao People's Democratic Republic (3), Myanmar (3) and Pakistan (3), with limited articles from Pacific countries such as Fiji (2) and Papua New Guinea (1). Maternal healthcare was the most common topic covered by articles (43), followed by general SRH services (21), models of adolescent-friendly health services (20) and contraception (19). Fewer articles covered prevention and care for STIs and HIV (13) and comprehensive sexuality education (12). A limited number of articles focused on abortion (4), HPV vaccination (3) and gender-based violence (1).

Annex box 1.

Search terms

adolescen* OR student* OR teen* OR young adult? OR young people OR young person? OR youth? OR young m?n OR young wom?n OR young girl? OR young boy? OR young female? OR young male? OR pubescent girl? OR pubescent boy?

abortion OR antenatal care OR ante-natal care OR contracepti* OR family planning OR gender-based violence OR AIDS OR acquired immunodeficiency syndrome OR HIV OR human immunodeficiency virus OR HPV OR human papillomavirus OR intimate partner violence OR maternal health OR maternal-child health service OR perinatal care OR peri-natal care OR postabortion care OR preconception care OR pre-conception care OR pregnanc* OR prenatal care OR pre-natal care OR reproductive health OR sex* education OR sex* offen?e* OR sexual health OR sexual violence OR sexually transmi* disease* OR sexually transmi* infection* OR spous* abuse OR sexually active OR sexual partner? OR menstrual health OR STI prevention OR STD prevention OR reproductive coercion OR sexual coercion OR reproductive anxiety OR sexual relationship* OR sexual behavio?r* OR condom use* OR safe sex OR protect* sex

access* to health* OR cash transfer* OR delivery of health care OR delivery of healthcare OR essential service* package* OR health access* OR health barrier* OR barrier* to health* OR health benefit* package* OR healthcare access* OR health care access* OR health care affordabilit* OR healthcare affordabilit* OR healthcare barrier* OR affordable health* OR health care delivery OR healthcare delivery OR health care personnel OR healthcare personnel OR health* service delivery OR health care service delivery OR health care service affordabilit* OR healthcare service affordabilit* OR health service affordabilit* OR health* service personnel OR health care service personnel OR health coverage OR health disparit* OR health equit* OR health expenditure* OR health financ* OR health inequit* OR health inequalit* OR health insurance OR health service* access* OR national health program* OR out of pocket OR patient satisfaction OR quality of care OR quality of health care OR quality of healthcare OR right to health* OR universal health care OR universal healthcare OR universal health coverage OR universal health insurance

Afghan* OR (Asia* adj4 Pacific) OR (Asia* NOT Asian American*) OR South Asian* OR Central Asian* OR Southeast Asian* OR South-East Asian* OR East Asian* OR Asia Pacific OR Bangladesh* OR Burma OR Burmese OR Bhutan* OR Cambodia* OR China OR (Chinese NOT Chinese American*) OR Fiji* OR Micronesia OR (India* NOT American Indian*) OR Indonesia* OR Kiribati OR Lao? OR Malaysia* OR Maldives or Maldivian OR Marshall Islands OR Micronesia* OR Mongolia* OR Myanmar OR Burmese OR Naoero OR Nepal* OR Oceania OR Pakistan* OR Papua New Guinea OR Philippines OR Filipin? OR Pacific Island* OR Pacific Countr* OR Samoa* OR Solomon Island* OR Melanesia* OR Sri Lanka* OR East Timor OR Thai* OR Timor-Leste OR Timorese OR Tonga* OR Tuvalu* OR Vanuatu OR Viet Nam OR Vietnam*

Review methods

Policy review

Existing policies and legislation were sought from the WHO Maternal, Newborn, Child and Adolescent Health and Ageing data portal, health ministry (or equivalent) websites of each of the 30 countries and targeted Google searches. Where documents were not located, assistance was sought from UNFPA regional and country offices.

Policies were included if they were: 1) national-level policies, plans, strategies, guidelines, legislation or regulations; 2)

covered at least one of the universal health coverage domains and 3) were available in full text. The most recent versions of policies were sought. Policies were excluded if they were: 1) not an official government document; 2) subnational in scope or 3) clinical guidelines, conference and meeting proceedings, abstracts or media releases. Data were extracted using an Excel template to capture the document title, author, year, type and key findings against the conceptual framework domains.

Secondary analysis of national-level data

A core set of adolescent SRH indicators was defined to quantify current adolescent SRH needs and coverage of essential SRH services per the conceptual framework. This process drew on the global indicator framework for the SDGs,⁸⁵ UNFPA *State of World Population*

reports,⁸⁶ the ICPD Beyond 2014 Monitoring Framework,⁸⁵ WHO reproductive health indicators,⁸⁷ commonly used DHS and MICS measures that relate to SRH and the 2021 UNFPA Asia and the Pacific report on young people's SRH¹⁸ (Annex table 1).

Annex table 1.

SRH indicators and main data sources

Indicator	Definition	Main data source	Years
Ever had sex	Percentage of adolescents aged 15–19 who have ever had sex	DHS, MICS	2014–2023
Sex by 18	Percentage of 20–24-year-olds who report first sexual intercourse by age 18	DHS, MICS	2014–2023
Sex before marriage	Percentage of never-married young people aged 15–24 years who have had sexual intercourse	DHS, MICS	2014–2023
Currently married	Percentage of adolescents aged 15–19 years who are currently married or in union	DHS, MICS	2014–2023
Adolescent childbearing	Percentage of women aged 20–24 years who gave birth before age 18	DHS, MICS	2014–2023
Intimate partner violence	Percentage of ever-partnered girls aged 15–19 who have experienced physical and/or sexual violence by a current or former intimate partner in the last 12 months	DHS, MICS	2014–2023
Adolescents with HIV	Number of adolescents aged 10–19 years living with HIV	UNAIDS	2023
HIV knowledge	Percentage of adolescents aged 15–19 years with comprehensive and correct knowledge of HIV	DHS, MICS	2014–2023
Total demand for family planning: all	Percentage of all women aged 15–19 years who have a demand for family planning	DHS, MICS	2014–2023
Total demand for family planning: sexually active unmarried	Percentage of sexually active unmarried women aged 15–19 years who have a demand for family planning (all, married, unmarried sexually active)	DHS, MICS	2014–2023
Met need for family planning	Demand for family planning satisfied by modern methods among women aged 15–19 (all, married, unmarried sexually active)	DHS, MICS	2014–2023
HPV vaccination	HPV vaccination coverage by age 15, first dose, females	WHO/UNICEF Joint Reporting Form on Immunization	2023
Antenatal care	Percentage of women aged <20 years who had a live birth in the last two years who received at least four antenatal care visits during their most recent pregnancy	DHS, MICS	2014–2023
Skilled birth attendance	Percentage of women aged <20 years who had a live birth in the last two years whose most recent birth was attended by a skilled health provider	DHS, MICS	2014–2023
Facility birth	Percentage of women aged <20 years who had a live birth in the last two years whose most recent live birth was delivered in a health facility	DHS, MICS	2014–2023
Postnatal care mother	Percentage of women aged <20 years who had a live birth in the last two years who received a health check while in a facility or at home following delivery, or a postnatal care visit within two days after delivery of their most recent live birth	DHS, MICS	2014–2023
Postnatal care newborn	Percentage of live births to women aged <20 years in the last two years who received a health check while in a facility or at home following delivery, or a postnatal care visit within two days after delivery	DHS, MICS	2014–2023
ART for adolescents	Percentage of adolescents aged 10–19 years living with HIV who are receiving ART	UNAIDS	2021
Coverage of health insurance	Percentage of 15–19-year-olds covered by any health insurance	DHS, MICS	2014–2023
Out-of-pocket expenditure	Out-of-pocket expenditure as a percentage of current health expenditure	WHO	2021
Problem accessing care: any	Percentage of adolescents aged 15–19 years who reported they have big problems in any of the specified problems accessing care for themselves when they are sick	DHS, MICS	2014–2023
Problem accessing care: cost	Percentage of adolescents aged 15–19 years who reported they have problems accessing care for themselves when they are sick due to the cost of treatment	DHS, MICS	2014–2023
Unintended pregnancy	Percentage of all births to women aged <20 years that were mistimed or unwanted	DHS	2015–2022
Maternal mortality	Maternal mortality ratio for adolescents aged 15–19 years (deaths per 100,000 live births)	Global Burden of Disease Study	2023
HIV incidence	Number of new HIV infections among adolescents aged 10–19 years	UNAIDS	2023
HIV mortality	Deaths due to HIV/AIDS per 100,000 population aged 10–19 years	Global Burden of Disease Study	2023

Review methods

Nationally representative and comparable data were sought from DHS, MICS and other reproductive health surveys for each included country. Data were also sought from United Nations databases and reports (AIDS Data Hub, UNICEF Data, United Nations Department of Economic and Social Affairs SDG Indicators Database, UNFPA *State of World Population* reports and the WHO Global Health Observatory). Where no household or population survey data were available, modelled estimates were sought from the Global Burden of

Disease Study. Data reported prior to 2014 were excluded. Where available, data disaggregated by age, marital status, sex, location, education and wealth were also included. Data were only available for males and females, with no national data available for adolescents with non-cisgender/non-binary identities for the included indicators. Data were analysed using STATA MP and visualized using Tableau Desktop 2022.2.



650 MILLION REASONS

**Achieving Universal Health Coverage
for Adolescent Sexual and Reproductive
Health in Asia and the Pacific**



UNFPA Asia & the Pacific Regional Office

Bangkok, Thailand
Published September 2026