The Sexual and Reproductive Health of Adolescents and Young Adults During the COVID-19 Pandemic

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The COVID-19 public health crisis is having rapid and profound effects on how people around the world are living their lives. Adolescents and young adults (AYA) aged 12–24 in the United States are at low risk for hospitalization and death from COVID-19 compared with other age-groups.* However, the disease may affect other aspects of their physical, mental and social health. Sexual and reproductive health (SRH) touches upon all of these domains, and involves intimate relationships, sexual activity, contraceptive use and abortion care. Evidence of the SRH impacts of previous large-scale disruptions in the United States, including natural disasters[1] and the 2008 recession,[2] suggests that the current pandemic will have serious and sustained effects on young people. AYA will experience the current pandemic in ways that reflect their unique developmental and cohort situations.[3] In this viewpoint, we review potential immediate and longer term impacts of the COVID-19 pandemic on the SRH needs and behaviors of AYA, and provide direct evidence of COVID-19 impacts where available.

Impact on Sexual and Reproductive Health

Adolescents' and young adults' sexual and reproductive health is being and will continue to be impacted by the COVID-19 pandemic through both distal and proximal pathways (Figure 1). The pandemic has brought about dramatic social and economic changes, including social distancing, a period of stay-at-home requirements, nearly universal school closures, increased engagement with parents or other household members, and growing economic insecurity. Among older AYA, college closings, financial issues and the desire to be with family have brought some back into their parents' household after a period of having gained some independence. These widespread social and economic shifts have disrupted AYA romantic and sexual relationships, as well as their access to affordable and confidential health care services and resources. We explore how these social, economic and proximal influences may affect AYA intimate and sexual behaviors and the use of a range of SRH services.

•Relationships and sex. The COVID-19 pandemic has interrupted many of the normative aspects of AYA development, a period that should be marked by growing independence[3] and strengthening peer relationships.[4] Many young people currently face increased parental monitoring and reduced privacy. This increased monitoring, diminished independence and reduced physical interaction with peers will likely have yet unknown effects on this cohort's developmental trajectory,† especially since we don't know how prolonged or widespread the disruptions will be, and whether they will recur.

For most young people, social distancing and stay-at-home guidelines have likely resulted in less partnered sex. However, during the pandemic's initial peak, about one-third of 13–17-year-olds in a national survey reported that they were still meeting close friends in person.‡[5] Some AYA will continue to engage in partnered sexual behaviors, either in established relationships (including cohabiting ones) or with new partners. Online social connections are also important. Today's youth are digital natives who are frequently online for entertainment, learning and socializing, and these digital interactions offer options to connect despite the social disruptions inherent in physical distancing and stay-at-home orders.[4] In fact, as a result of social distancing during the pandemic, 65% of teenagers were texting with friends and family, or interacting with them via social media, more often than usual.[5] These forms of digital communication also offer a means for romantic or sexual interactions, including conversations, online dating, sexting, virtual sex and other online activities.[6]

For AYA in established or new relationships, physical separation may influence relationship quality or stability. For some, physical distancing from partners results in less sexual or physical intimate partner violence (IPV).§ For individuals who cohabit with a partner, however, stay-at-home orders may increase the risk of experiencing IPV. Online emotional abuse by a partner may also occur for those who are currently physically separated. Disruptions such as school or workplace closures and reduced access to health care may exacerbate these issues and make it harder for young people to seek support or interventions.[7]

•Access to and use of SRH care. The pandemic has imposed economic and logistical barriers to obtaining contraceptive and other SRH services for all ages, but

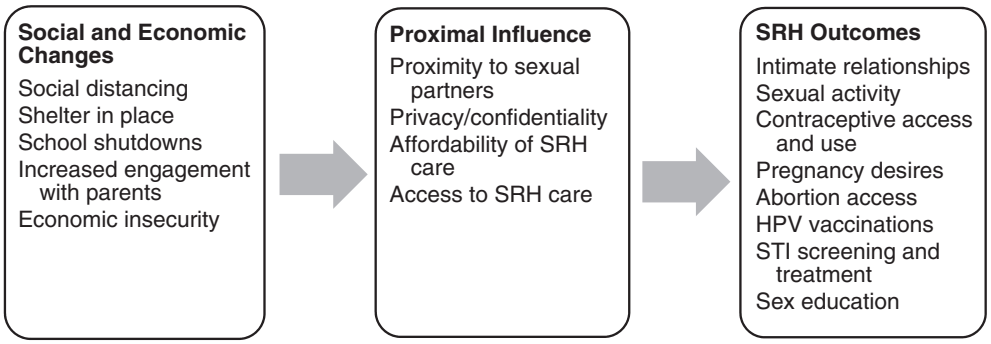
*There is growing concern about COVID-19 health impacts that have been seen in small numbers of children and adolescents.

†The adolescent developmental trajectory includes physical, cognitive, emotional and social changes that are typically defined as beginning at puberty and ending with the attainment of adult roles and responsibilities.

‡This survey was conducted by Common Sense Media between March 24 and April 1, 2020, and collected data from 849 individuals aged 13–17; data were weighted for age and sex using the U.S. Census Bureau's American Community Survey to reflect the demographic composition of this age-group.

§Before the pandemic, 8% of high school students reported having experienced physical dating violence, and 7% sexual dating violence, in the last year.

FIGURE 1. Pathways of COVID-19–related influence on the sexual and reproductive health of adolescents and young adults



has particular implications for AYA. Loss of their own or parents' earnings or health insurance creates economic barriers to accessing care and paying for contraceptive methods. Beyond cost issues, the ability to obtain SRH care that is confidential and private is hampered for young people sheltering in place with parents or guardians and may influence their behaviors. Research has found that AYA who have concerns about confidentiality are less likely to use SRH services and report lower levels of contraceptive use.[8,9] Pandemic-driven changes in how services are provided, such as limiting in-person care and deferring new and walk-in patients, also create barriers. In addition, individuals may want to avoid obtaining in-person care during this time to reduce the risk of viral transmission. Recently, a group of clinicians offered guidelines and practice protocols for providing contraceptives to young people as an essential service despite COVID-19 disruptions, as well as strategies for maximizing access and confidentiality.[10]

Increasing use of telemedicine approaches (by either video or phone) and online contraceptive provision may ultimately expand access to SRH care for AYA. But for now, many issues make telemedicine particularly challenging for this age-group.[11,12] Although medical guidelines strongly endorse patient privacy, such privacy may be difficult to obtain during a young person's telemedicine visit.[13] Young people at home with family may not have a private place where they won't be overheard. Further, many commercial telemedicine services do not accept insurance or offer sliding-fee scales.[14] Telemedicine visits generally require that prescriptions be submitted to a pharmacy, which means AYA who are uninsured must pay the retail cost of these medications, rather than the low out-of-pocket costs they would pay in many SRH clinics. Moreover, the "digital divide" that exists in the United States means that individuals who live in certain areas or have low socioeconomic status may not have adequate access to online health care.[15]

The pandemic has increased barriers to SRH care for already underserved youth, including LGBTQ young people, unhoused individuals, and those in the foster care system, the criminal justice system and immigrant detention centers. Although telemedicine may be an option for some, these groups are less likely than others to have an established relationship with a health care provider and may find the cost of services prohibitive. Furthermore, providers who are available through telemedicine may not offer inclusive or culturally aware care, or be able to provide needed specialized services; for example, access to gender-affirming hormone therapy may still require in-person visits, and providers report delaying new visits for such care.[16] The pandemic may also increase the need for SRH care for the most vulnerable youth if trading sex for money or food becomes a more common survival strategy.[17]

•Preventive and screening services. The COVID-19 pandemic is also impacting young people's use of SRH preventive and screening services. Analysis of pediatric electronic health records found that HPV vaccinations declined by 68% from February to early April of 2020; this decline was greater than that observed for other pediatric vaccines (e.g., measles, mumps and rubella shots dropped by 50%).[18] Similarly, the Centers for Disease Control's tracking of vaccine-ordering statistics through late April found less of a decline in vaccinations for children younger than two than for those two or older,[19] and vaccination data for New York City echo this.[20] Together, these data suggest that adolescents are more likely than younger children to miss well-visits or receive incomplete ones.

Although STI testing and treatment are critical for health, access for young people is likely diminished in the absence of regular well-visits.[14] Routine screening for STIs may not occur, despite medical guidance for universal chlamydia screening of sexually active females younger than 25.[21] STIs are often asymptomatic, so missed screenings will result in untreated infections, which may have serious negative sequelae. Telemedicine treatment for patients and their sex partners can minimize in-person health care contacts. Although young people's STI rates may decline because of reduced physical access to sexual partners, delays in getting screened and treated, or the inability to do so, will make the situation worse for those infected.

•Abortion care. The logistical and economic challenges to obtaining needed SRH care as a result of the COVID-19 pandemic are even more significant regarding young people's ability to obtain abortions. As of May 19, 2020, at least 11 states had exploited the pandemic to ban or restrict access to abortion, ostensibly on the grounds that abortion provision is "nonessential health care";[22] these declarations

contradict the statements of leading medical experts asserting that abortion remains an essential and time-sensitive health service during the COVID-19 crisis.[23] Moreover, the abortion bans increase patients' costs and travel distances, which may cause AYA to delay obtaining an abortion or make such care completely inaccessible.[24] For young people living in states with COVID-19–related abortion bans, the option of traveling out of state may not be as feasible as it is for older women, owing to lack of transportation or financial resources, and lack of autonomy and privacy. Evidence from earlier state efforts to limit minors' access to abortion showed that the distance to providers is a significant barrier.[25] For minors who need an alternative to meeting parental permission requirements, the process of obtaining a judicial bypass has become even more complicated and burdensome during the pandemic. Although most adolescents who decide to terminate their pregnancy involve a parent,[26] others fear that their parents will react with violence or kick them out of their home.[27] The current crisis may also shift AYA pregnancy desires away from intending or wanting to have a child. Data collected online in early May found that nearly four in 10 female respondents aged 18–24 reported that because of the pandemic they now want to have a baby later than they had previously planned.[28]

•***Sex education.*** Sex education is critical to AYA sexual and reproductive health and is associated with positive health outcomes.[29,30] Before the pandemic, schools were a key source of formal sex education for young people.[31] Sex education, which was already limited in many areas of the country,[32,33] has likely not been included in the national shift to online learning. Even when in-person schooling resumes, missed sex education instruction is unlikely to be made up, given the modest attention it received prior to the pandemic. Exacerbating this missed instruction, funding for sex education may be cut as a result of the economic downturn, and hence schools may reduce its provision even more. AYA often go online to find SRH information, and such resources will become more critical for youth who are unable to obtain information from schools or health care providers. Yet young people may receive inaccurate information when they search for answers online, and specific information may be unavailable.[34] For example, guidelines for making sex safer during the pandemic that were released by the New York City Department of Health and Mental Hygiene were removed from their website at one point because of controversy (the guidelines were later reinstated when that action became public).[35] The risk of contracting COVID-19 from sexual transmission is still unknown, but the virus has been identified in semen.[36]

Future Shifts in Behavior and Health Care

Although the impacts of the pandemic are still unfolding, there are potential longer term consequences that will shape AYA sexual and reproductive health. These may include shifts in individual SRH behaviors and outcomes, and in the health care services and systems that serve young people. All of these elements will influence future SRH trends.

First, behavioral shifts among adolescents and young adults may continue. As social isolation and physical distancing practices diminish, there may be a period of "making up for lost time" in which sexual activity increases; this may be particularly true in the upcoming summer months when schools are closed and conventional summer activities are hampered. Also, psychological fatigue from following behavioral restrictions because of COVID-19 could lead to AYA having more unprotected sex, especially if restrictions persist over the long term.[37] Young people's ability to leave abusive relationships will likely be constrained by financial factors, including high levels of sustained unemployment.

Second, some of the potential adverse health outcomes of the COVID-19 crisis may be mitigated if in the months following the end of stay-at-home orders there is a period of health care catch-up and individuals seek out delayed care, including well-visits, contraceptive care and HPV vaccinations. The demonstrated decline in vaccination uptake may eventually be made up, but it is unclear how long it will take to get those rates back to their previous levels, and this could lead to higher rates of cervical cancer for this cohort. One positive outcome of the epidemic could be that the appetite for a COVID-19 vaccine may shift the public's perceptions of vaccines in a positive direction and ultimately increase HPV vaccine acceptance.

A third pandemic-driven shift involves telemedicine. If this remains an option for SRH services moving forward, we expect AYA to be the age-group most likely to continue that approach rather than returning to traditional in-person visits. Innovations in health care service provision, such as use of telemedicine and obtaining contraceptives and STI testing by mail, will help expand access to SRH care for young people. However, use of these innovative approaches to care may increase access differentially (e.g., between the insured and the uninsured) and heighten service gaps for particularly marginalized young people, such as homeless youth, youth living in or transitioning out of foster care, incarcerated youth and immigrants in detention. Shifts in contraceptive method mix will be another important area to evaluate over the coming years, as anticipation of future waves of coronavirus infection could further the trend toward use of long-acting reversible methods. Ongoing and future research is needed to follow this cohort's individual experiences and interactions with the SRH care system.

Another development that may occur encompasses SRH services more broadly. The SRH field has often been innovative in advancing service provision and reducing onerous medical requirements. For example, same-day start of contraception, elimination of pelvic exams for obtaining birth control and telemedicine-directed medication abortion are examples of expanding access to and availability of care. Greater use of telemedicine for AYA care and providing many contraceptive methods by mail could go a long way to improving overall access to SRH services. However, such

mode of delivery changes will not be enough to compensate for the inability to pay for care because of young people's loss of parents' or their own employer-provided insurance.

Finally, many reproductive health care providers and SRH facilities that are part of larger systems may go out of business as a result of the pandemic-driven reductions in patient volume. In addition, demands on state budgets may cause further closures and restrict access to needed services for years to come. Economic public policies for health care during the COVID-19 crisis have focused primarily on supporting hospitals rather than the freestanding health centers and individual practices at which most SRH care is provided. The publicly funded clinic network, especially the segment funded by Title X, has always served the most marginalized AYA, including those who are low-income or without insurance, or who need the confidentiality protections assured through Title X mandates. In the 2010–2015 period, more than one-fourth of AYA women who received contraceptive care went to a publicly funded clinic.[38] Service demand at these clinics may increase as young people's loss of private insurance makes care at private providers unaffordable. However, Title X–funded clinics are not well positioned fiscally to meet such increased demand, especially given that the network's service capacity has been slashed nearly in half by the imposition of the domestic "gag rule"—and its restrictive regulations that prohibit referrals for abortion care—that led clinics to leave the program.[39]

Policy Recommendations

The COVID-19 pandemic has highlighted a number of critical policy opportunities that can improve SRH care and services for adolescents and young adults. Proposed policies focus on the need to approach SRH care, including contraceptive services, as essential health care for all people regardless of age.[40,41] Future policies must also remain responsive to the unique and changing needs of AYA. To support and strengthen young people's sexual and reproductive health, new policies should:

- Prioritize the provision of confidential care for AYA and ensure privacy for their insurance and medical records.
- Eliminate restrictions on any SRH service that can be provided via telemedicine, including those on telemedicine medication abortion, and support providers in expanding digital access.
- Ensure continued coverage of birth control methods and counseling, HPV vaccinations and other SRH preventive services through the Affordable Care Act and within public and private health care plans.
- Create effective programs to assist AYA and their families to sign up for the Child Health Insurance Program (CHIP), Medicaid or other insurance coverage for those who are newly uninsured or experiencing reduced income because of COVID-19–induced economic changes.
- Increase funding for the Title X national family planning program to address the likely growing numbers of uninsured individuals and increased demand for publicly funded SRH services among AYA.
- Reduce barriers to meeting AYA health care needs by removing inappropriate restrictions that ban Title X–funded providers from sharing information about abortion and by assuring that young people's care is confidential.
- Develop and disseminate online sex education curricula, and ensure the availability of both in-person and online instruction in response to school closures caused by the pandemic.
- Fund ongoing surveillance of young people's SRH in light of the widespread COVID-19 disruptions, including methodologies that allow for robust analyses of vulnerable subpopulations such as young people of color and LGBTQ individuals.

Efforts to support adolescents and young adults must also attend to broader impacts on their sexual and reproductive lives, including their ability to form and maintain romantic relationships and experience their sexuality in positive ways. How they navigate their transitions to adulthood—including decisions about education, work, union formation and fertility—may be affected by the pandemic and its economic and societal consequences. Even when social distancing is no longer as necessary, the COVID-19 pandemic will have caused and may continue to create far-reaching social disruptions in young people's lives, which may continue to affect their health. During the current public health crisis, the sexual and reproductive health of adolescents and young adults must not be overlooked, as it is integral to both their and the larger society's well-being.

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