COVID-19 and access to sexual and reproductive healthcare for young people

An overview of the international literature and policy

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Background and objective
The COVID-19 pandemic has reduced the ability of young people to access appropriate and timely sexual and reproductive healthcare (SRH). The aim of this study was to summarise international innovations aimed at ensuring ongoing access.

Methods
This study was an overview of peer-reviewed literature and policy statements from international and national organisations related to SRH for young people during COVID-19.

Results
Innovations have focused on improving access to appropriate and timely SRH for young people, mostly through telehealth; increasing community and healthcare worker awareness of the heightened risk of gender-based violence and its consequences; and removing restrictions on contraception and abortion access. Despite this, a substantial decline in sexual wellbeing and SRH access has been reported from many parts of the world, although Australian data are lacking.

Discussion
Support for young people to access timely and appropriate SRH during the COVID-19 pandemic should be a priority for policymakers around the world.

SEXUAL AND REPRODUCTIVE HEALTHCARE (SRH) is a fundamental component of the services provided through general practice in Australia. The COVID-19 pandemic has presented enormous challenges to this area of general practice, as well as some emerging opportunities for innovation with the widespread adoption of telehealth. As a profession, it is important to learn from the experience of colleagues in other nations, who have often experienced a larger burden from COVID-19 than has been experienced in Australia to date.

The COVID-19 pandemic has affected population groups differently, but these variations have mostly been studied at the extremes of the age range, in children and the elderly, rather than in young people. For instance, the incidence of COVID-19 is lower in children than adults,[1] and the prevalence of severe disease is lower among children than adults.[2–4] Furthermore, medium-term sequelae (four months) have proven rare among children who recover from COVID-19,[5] and their case fatality rate is also lower than that of adults.[4] The World Health Organization (WHO) defines 'adolescents' as individuals aged between 10 and 19 years; however, research often focuses on 'young people', defined as people under the age of 25 years.[6]

SRH covers services that promote sexual wellbeing and reproductive health, and prevent and treat sexually transmissible infections (STIs) and blood-borne viruses (BBVs). Specific areas that may be included are:

- contraception, including emergency contraception
- STI and BBV screening (people without symptoms)
- STI symptoms and treatment
- abortions (medical, surgical or both)
- cervical screening and human papillomavirus (HPV) vaccination
- gender-affirming hormone therapy
- human immunodeficiency virus (HIV) care
- sexual assault care.

Young people seek SRH in primary care services, sexual health centres, family planning and abortion providers, and clinics specifically for young people, such as Australian 'headspace' centres specifically for mental health.[7] General practice is one of the few settings in which SRH is provided as part of a comprehensive, generalist healthcare service.

There are a number of recognised existing barriers for young people to access SRH that may be exacerbated by the COVID-19 pandemic, including confidentiality and privacy; cost to access services; and transport, especially for those who do not drive and are not located near public transport. Young people in rural and remote areas commonly experience more difficulties accessing healthcare.[8] Innovative models such as Teen Clinic in rural Australia have moved to address this barrier, offering nurse-led,

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walk-in appointments for young people at no out-of-pocket cost.[9]

Young lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) and gender diverse young people find access more difficult if they are not explicitly welcome at services.[10,11] LGBTQI youth have higher rates of mental health problems and suicide rates than the general population. Youth from culturally and linguistically diverse backgrounds may experience added barriers due to language issues, cultural norms and familial expectations.

Adolescence and young adulthood are risky times for the development of mental health problems, with most disorders commencing during this time; however, diagnosis may occur later if healthcare access is limited.[12] Young people are often reluctant to seek help, particularly if services are not specifically designed for young people.[13] Young people with poor mental health have higher rates of physical health problems, including those related to SRH.[12] This makes access to appropriate, high-quality mental healthcare for young people critical for maintaining their SRH.

This article summarises relevant information for policy related to sexual health services for young people during the COVID-19 pandemic. The aim of this study is to inform policymakers and practitioners who need to make urgent decisions about SRH access for young people across the globe.

Methods

Peer-reviewed literature was included from PubMed using combinations of the search terms youth, adolescents, COVID-19, sexual health, healthcare, termination of pregnancy, abortion, reproductive health. To be included, the article needed to have some focus on young people and the COVID-19 pandemic. Key papers from the WHO and the United Nations (UN) plus key policy papers from Australian-based SRH organisations were also identified. Literature was reviewed in full and extracted by one author (ES), who is an experienced clinician and post-doctoral researcher. This follows accepted practice in rapid reviews, especially when using a narrow scope and experienced reviewers.[14] A matrix of pre-determined relevant clinical and policy items was used for the extraction; other authors contributed key papers from their personal knowledge and reviewed the extraction document.

Results

Sexual and reproductive wellbeing of young people during the COVID-19 pandemic

In an Australian survey during lockdown (66.3% respondents aged 18–29 years), the frequency of sex with a partner varied depending on cohabitation, with the survey suggesting fewer casual partners and less group sex, while use of sex toys and masturbation increased.[15] Some women also reported delaying childbearing because of the pandemic.[16] Surveys from China reported reduced frequency of sex,[17] reduced number of partners,[17] increased relationship dissatisfaction[18] and increased use of pornography.[18] This is likely due to lockdown conditions and the high number of young people who live with their parents.[17,18] A US survey of sexual minority males aged 14–17 years mirrored this finding, with online sexting and messaging becoming more common.[19] This contrasted with data from African nations, where pockets of increased sexual activity[20] led to increases in teenage pregnancy.[21] School closures have been implicated with less visibility of children and increased potential for abuse from family and neighbours.[21]

One article highlighted the potential longer-term reduction in sexual wellbeing, with young people having reduced 'normative experiences' due to lockdown and increased parental scrutiny.[22] The authors suggested increasing focus on young people in post-lockdown periods to ensure their sexual wellbeing.[22]

Access to sexual and reproductive healthcare during COVID-19

In Australia and internationally, SRH – including access to contraception and abortion services, STI screening and treatment, and HIV care – is recognised as an essential service during the COVID-19 pandemic.[23–25]

Despite this recognition, a rapid survey of 64 nations found services were scaled back across all nations and 5633 SRH clinics closed;[26] 2700 young people from Africa reported reductions in access to SRH services due to clinic closures and fear of contracting COVID-19.[20] As a result, contraception, HIV care, abortion services and comprehensive sexuality education (including menstrual education)[20] for youth have been affected.[26]

A semi-rural area in the UK saw no people aged under 18 years access emergency contraception for six weeks, and there was a fall in accessing other sexual health services, especially for those aged under 18 years.[27] This may be appropriate (eg a result of reduced intimacy[18,22,27]) or inappropriate (eg a consequence of disruption to public transport).[28] The review also highlighted that young people may feel judged if they have broken lockdown restrictions and then need SRH.[27] Few articles were focused on SRH within a generalist setting, such as general practice, so issues such as opportunistic preventive healthcare, cervical screening and general healthcare were not discussed.

Telehealth is commonly suggested as a way to increase access to SRH for young people (Table 1). In the setting of SRH, telehealth can be used for contraception,[10,25,29–33] STI screening,[27,34] syndromic management of STIs[28,33] and medical abortion.[17,23,24,27,30,32,35] However, challenges to providing SRH via telehealth included:

- maintaining confidentiality and privacy; especially for young people in crowded housing during lockdown conditions[22,27]
- providing culturally appropriate care[22]
- examining sensitive body parts[33]
- institutional support to implement telehealth, including appropriate funding and access to technology.[33]

Telehealth is also more difficult for those without access to a device and for individuals with poor internet access.[22,31,33] Suggestions for overcoming these barriers are outlined in Table 1. In Australia from 1 July 2021, a Medicare Benefits Schedule rebate became

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Table 1. Telehealth options to ensure timely access to appropriate sexual and reproductive healthcare for young people during the COVID-19 pandemic

Telehealth innovation	Country, implemented or suggested
To assist with privacy and confidentiality, the young person should use headphones for the consultation, the provider can use yes/no questions, and the 'chat function' in the video conferencing software can be used.[33]	USA, implemented
Clinical decision scores can be used to determine the need for in-person examination or further testing.[33]	USA, implemented
Clinics can provide devices in separate rooms to allow for remote consultation; this can help overcome barriers for those without a device. This can assist with tertiary centre telehealth for patients who do not have access to a device. The room needs cleaning between patients.[33]	USA, implemented
Guidelines for the examination of sensitive body parts on telehealth; also, patients in USA have entered their own photos into their electronic medical records.[33]	USA, suggested
Mobile phone companies providing affordable packages for women and adolescents to try to overcome the 'digital divide'.[42]	Kenya, implemented
Peer–peer support for lesbian, gay, bisexual, transgender, queer and intersex groups and other at-risk youth.[36]	USA, suggested

Table 2. Innovations from Australia and the world to ensure timely access to appropriate contraception for young people during the COVID-19 pandemic

Innovation for contraception access	Country, implemented or suggested
Proactively manage supply chain issues for contraceptive products[6,29,36,37]	Multiple countries, especially low-income countries, suggested
Good communication with healthcare providers so they are able to plan for interruptions and provide alternative contraception for patients[23]	Multiple countries, suggested
Relax prescription requirements to allow for multi-month supply[23]	Multiple countries, suggested
Renewal of contraception without a new prescription[30]	France, implemented
Prescriptions by pharmacists for contraception, including emergency contraception[23]	USA, suggested
Teach patients how to self-inject contraceptive depots[23,28]	USA, implemented
Drive-through injectable contraceptive services[30]	USA, implemented
Ensure ongoing access to long-acting reversible contraception (LARCS; eg contraceptive implants, intrauterine devices), with clinics performing initial review via telehealth and then having a short face-to-face procedure for insertion[30,32]	Multiple countries, implemented
The Royal Australian and New Zealand College of Obstetricians and Gynaecologists has stated that the 52 mg levonorgestrol intrauterine contraceptive device (Mirena) can remain for six years (instead of five) for contraceptive cover[24]	Australia, implemented
Consultations for oral contraceptive pill, contraceptive patches (not available in Australia) and vaginal rings can be done via telehealth,[33] with prescriptions sent directly to pharmacies;[30] the medication could be then mailed to the patient[28]	USA, implemented
Access to the progesterone-only pill, as it does not require blood pressure monitoring, and allowance of a one-year supply without prescription[30]	UK, Canada, implemented
Free contraception to Syrian refugees[30]	Lebanon, implemented
Medicare Benefits Schedule access for nurse-led access to LARCs[32]	Australia, suggested

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available for telehealth consultations related to BBVs and/or sexual or reproductive health issues without the requirement for the patient to have an established clinical relationship with the physician. This sought to increase access, recognising barriers due to privacy or limited service provision.

School closures are also problematic for healthcare access, with less time available for health promotion to students[6,20–22] as well as the closure of school-based health clinics, which is referenced in the USA.[36]

Contraception access

Shortage of contraception during the COVID-19 pandemic was reported, with supply chain issues particularly for low-income countries[6,18,26,37,38] and private insurance barriers in the USA.[22] Limited access has been related to clinic closures or cessation of face-to-face services, while fear of COVID-19 prevented some young people from attending.[6,20,22,26,27,31,37] While telehealth has been highlighted as an option (Table 1), some jurisdictions have age restrictions for contraception access via telehealth.[31] Access to contraception has been affected by COVID-19-related reduction in earnings or employment, either for young people or their families.[22] These issues increase the risk of unintended pregnancies, especially in the setting of gender-based violence. Table 2 outlines innovations to ensure access to contraception for young people.

Abortion access

Based on prior experience of disasters and humanitarian crises, there is likely to be an increase in unintended pregnancies in adolescent girls during the global pandemic.[6] Despite its recognition as an essential service,[13,14] difficulties for young people in accessing abortion during COVID-19 include:

- reprioritisation of health services for COVID-19 plus unwell healthcare staff leading to a reduction in abortion services[22]
- lack of personal protective equipment (PPE) for abortion providers and inability to provide in-person care[25]
- barriers due to transport and movement restrictions, plus pandemic-related financial strain[32]
- in some jurisdictions, if parental consent cannot be obtained, the young person has other judicial consent processes, which are all slowed because of the pandemic (particularly relevant in the USA)[21,22,31]
- supply chain issues for medical abortion.[25]

There is emerging evidence that telemedicine is an acceptable option for abortion access for women[39,40] even during the pandemic,[41] but no studies focus specifically on the needs of young people.

These difficulties are likely to increase the number of women seeking unsafe abortion via online means or alternative providers.[35] When reviewing individuals seeking information about self-managed abortion online during the COVID-19 pandemic, a US study showed that 41% were under the age of 17 years.[34] These barriers to abortion can be overcome as outlined in Table 3.

Gender-based violence and sexual assault

The UN Population Fund forecasts that COVID-19 will lead to a one-third reduction in progress towards their goal to end gender-based violence by 2030.[37] Most publications highlighted the increased risk of gender-based violence, including sexual assault for young people.[22–29,34,37,42] Factors such as school closures,[20,43] movement restrictions,[27] reduction of in-person healthcare and social services,[10,22,25] and potential lockdown with perpetrators[30,36] lead to escalating risk plus reduced visibility in the community.[17] Increased online abuse was also particularly relevant for young people.[22] Appropriate care after sexual assault is also more difficult,[6] especially in COVID-19 hot zones (Table 4).[44]

Female genital mutilation (FGM) and cutting is also expected to increase globally.[37] Internationally, this is due to movement restrictions and school closures making it less visible, plus

Table 3. Innovations from Australia and the world to ensure timely access to appropriate abortion for young people during the COVID-19 pandemic

Innovation for abortion access	Country, implemented or suggested
Telehealth to provide complete care for medical abortion and triage and assessment prior to surgical abortion[22,24,32]	Multiple countries, implemented
Forecast increased need for abortion services and ensure appropriate levels of stock are available to support medical and surgical abortion[23]	Multiple countries, suggested
Prioritise access to appropriate levels of personal protective equipment for healthcare workers providing in-person abortion services[25]	Australia, suggested
Ensure self-referral for abortion is available[24]	Australia, suggested
Increase from nine to 10 weeks' gestation for medical abortion covered by the Pharmaceutical Benefits Scheme[25]	Australia, suggested
Implement robots and drones to deliver medical abortion medication to women[42]	India, suggested
Home administration of medical abortion[30]	UK, implemented
No anti-D is needed for abortions prior to 10 weeks' gestation[30]	Australia, Canada, UK, implemented
Increase pharmacy access to medical abortion (The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommendation)[24]	Australia, suggested
Medicare Benefits Schedule access for nurse-led medical abortion, which would assist with rural and remote access[32]	Australia, suggested

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Table 4. Innovations from Australia and the world focusing on the increased risk of gender-based violence for young people during the COVID-19 pandemic

Innovations focused on gender-based violence	Country, implemented or suggested
Actively inform adolescents how to get support during restrictions through traditional modes of media and social media[23]	Multiple countries, suggested
Ensure confidentiality is protected for young people[23]	Multiple countries, suggested
Ensure medical, legal and police mechanisms are augmented[24]	Australia, suggested
Ensure availability of appropriate personal protective equipment and training for forensic medical staff working in COVID-19 hot zones[44]	Australia, suggested
Advise healthcare workers to be on alert for presentations of gender-based violence and how to manage them[23]	Multiple countries, suggested
Set up helplines and safe houses[23]	Multiple countries, suggested
Increase awareness of reproductive coercion by healthcare workers and how this might be increased with higher levels of telehealth[25,32]	Australia, USA, suggested
Raise awareness of the likely global increase in female genital mutilation[6,37]	Multiple countries, suggested

Table 5. Innovations from Australia and the world to ensure timely access to screening and management of sexually transmissible infections (STIs), blood-borne viruses (BBV) and human immunodeficiency virus (HIV) for young people during the COVID-19 pandemic

Innovations for STI, BBV and HIV care	Country, implemented or suggested
Provision of online, home-based STI testing (online consultation and mailing of STI testing kit)[27]	UK, implemented
Ensure condoms and lubricants are available by increasing the number of different types of outlets that provide free items[28,30,46]	Australia, USA, suggested
Provisions made for self-collection testing kits for STIs and HIV (ie not collected by a health provider)[23]	Multiple countries, suggested
STI and BBV testing performed at nurse-led clinics after telehealth consultation or directly at laboratory providers[33]	USA, implemented
HIV medications to be mailed to the patient[46]	Australia, suggested
Increased general practitioner provision of STI testing and treatment[46]	Australia, suggested
Provision of home-based STI treatment kits following telehealth consultation[27]	UK, suggested
Ensure appropriate and ongoing access to human papillomavirus vaccination[22]	USA, suggested

withdrawal of community-based programs to avert FGM and cutting.[6,22] Most cases of FGM in Australia are performed overseas, organised by parents and families.[45] Table 4 outlines innovations focused on the heightened risk of gender-based violence.

Sexually transmissible infections, blood-borne viruses and human immunodeficiency virus

Screening and management of STIs, BBVs and HIV is considered essential healthcare.[23] Lower rates of screening were expected during the COVID-19 pandemic because of reduced face-to-face services,[22] lack of staff PPE and the need to maintain social distancing in walk-in clinics,[46] patient fear of contracting COVID-19,[20] and lost opportunistic testing for young people in primary care.[22] Some Australian laboratories were low on reagents as a result of COVID-19 testing,[46] and venues that provided free condoms were shut or had reduced hours.[46] Table 5 offers suggestions for maintaining appropriate access for young people.

LGBTQI and gender diverse youth

Young people in the LGBTQI community have a higher baseline risk for poor mental and physical health and a higher rate of suicide than the general population.[47] They are at increased risk during COVID-19 because of:

- lack of access to support networks during school closures and movement restrictions[36]
- lockdown with potentially unsupportive family members, or no support at home if they have not disclosed their status.[35]

It was noted that only two articles mentioned gender-affirming hormone treatment, with one clinic in the USA determining that this was non-essential care and could be deferred;[22] this is in contrast to WHO guidance, which deemed gender-affirming hormone treatment to be essential SRH.[23] Strategies to support LGBTQI youth include increasing online peer–peer support networks and ensuring policies are broader than 'cisgender and heteronormative' when reviewing the SRH needs of young people during the pandemic.[36]

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Conclusion

SRH is an essential service, and the sexual wellbeing of young people is likely to be particularly affected by the pandemic. General practice has an important part to play in ensuring the sexual health and wellbeing of young people and has the added advantage of providing comprehensive, generalist healthcare services. Research and real-time data to investigate the success of new innovations is needed as the pandemic progresses, as well as more detailed understanding of contextual factors that influence successful implementation. International strategies to ensure appropriate, timely access to SRH for young people should be considered to inform policy and practice around the world.

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