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Editorial

The Sexual and Reproductive Health of Adolescents and Young Adults during a Pandemic

By now, you are likely quite ready to be done with the topic of the SARS COVID-19 pandemic. Aren't we all? Unfortunately, the virus isn't done with us yet. As I write this editorial in August, 2020, many southern states in the United States are experiencing rising numbers of cases and deaths, and the counties of my own San Francisco Bay Area of California are on the state watch list for rising numbers of cases. Variations of shelter in place orders and recommendations, as well as social distancing measures, and mask guidelines continue to be necessary, and will likely be needed into the foreseeable future.

So what does the pandemic mean for the sexual and reproductive health of adolescents and young adults (AYA)? Those of us who provide care for this age group have been concerned about the implications. The position statement from Drs Nichole Tyson, Elise Berlan, and Geri Hewitt in collaboration with the Advocacy Committee of North American Society for Pediatric and Adolescent Gynecology states unequivocally that reproductive health care is an essential component of health care, and that access to contraception is essential for teens during a pandemic.[1] The North American Society for Pediatric and Adolescent Gynecology position statement highlights telehealth as an effective modality for providing contraception counseling and prescription contraceptives, and options such as switching from intramuscular depot medroxyprogesterone acetate to the subcutaneous formulation. An algorithm for contraception care for young people during a pandemic is described in *JAMA Pediatrics*.[2]

Broader effects of the pandemic are described in the latest issue of the journal, *Perspectives on Sexual and Reproductive Health*, in which the authors note that the social and economic challenges of the pandemic, including social distancing, shelter in place, school shutdowns, increased engagement of teens and young adults with parents, and individual and family economic insecurity have many possible consequences—short term and longer range.[3] In the short term, individuals might have less contact with sexual partners, their privacy and confidentiality might be compromised by shelter in place, sexual and reproductive health care might be less affordable by the family, and there might be less access to care. The longer term outcomes will almost certainly affect sexual activity and intimate relationships; contraceptive access and effective use; access to abortion, human papillomavirus vaccinations, and screening for sexually transmitted infections; and sex education might be a casualty of the shift to online learning for schools.[3] The implications for health care policies in the future are notable and as described by these authors, afford opportunities for policies that: prioritize confidential care for AYA; continue to support and allow innovations in telehealth care, including the provision of medication abortion through telehealth appointments; support ongoing preventive services that were initiated with the Affordable Care Act; provide insurance coverage for those individual and families who might have lost their employer-sponsored health insurance with the economic fallout of the pandemic; increase funding for the Title X national family planning program; promote online comprehensive sex education curricula; and monitor the issues of sexual and reproductive health with particular attention to vulnerable youth, including those of color and LGBTQ individuals.[3]

This issue of the *Journal of Pediatric and Adolescent Gynecology* (JPAG) includes several reports that address contraception for AYA. A review by Dr Elise Berlan and a number of her colleagues—well-recognized experts in family planning—provides best practices for counseling adolescents about the etonogestrel implant.[4] This review reads like a playbook for contraceptive counseling for AYA in general, with more specifics about the implant. Other issues around contraception and counseling are also addressed in this issue of JPAG, including a focus on reproductive autonomy and its importance in counseling about long-acting reversible contraceptives,[5] a report of the experience from one institution with bleeding patterns for individuals using the levonorgestrel intrauterine device,[6] and a randomized controlled trial of vaginal misoprostol vs vaginal dinoprostone, which showed that women were more satisfied and clinicians found the procedure easier with either of these medications compared with placebo, although pain scores were reduced only in the dinoprostone group.[7]

Moving beyond contraception, this issue of JPAG contains the usual potpourri of pediatric and adolescent gynecology (PAG) topics. Dr Bob Rosenfield provides his perspectives on the international recommendations for the diagnosis and treatment of polycystic ovary syndrome in adolescents in the format of a Commentary.[8] If you have struggled with understanding the differences in the recommendations of the 3 international conferences, check out Dr Rosenfield's perspectives.

Puberty and menarche are perennial favorite topics in JPAG, and Dr Frank Biro contributes another report about the onset of puberty. He and his coauthors conclude that mothers' reports on an increase in shoe size, which occurred somewhat earlier, but correlated with the onset of

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breast development, was as accurate as other indirect methods of determining the onset of puberty such as patient or mother's estimate of the onset of breast development.[9] I love the subtitle of this article: Mother Knows Best. From Israel, we learn of data about menarche from 2 national surveys of Israeli youth, which document an earlier age of menarche in 2016 compared with 2003.[10] The authors conclude that greater body mass index was associated with the decline in age of menarche, but that other factors are likely involved.

Other topics in this issue address pelvic and menstrual pain, endometriosis, and dysmenorrhea and endometriosis in transgender adolescents.[11–13] As PAG clinicians, we all see girls and young adults with eating disorders, including the new *Diagnostic and Statistical Manual of Mental Disorders* (fifth edition) diagnosis of avoidant restrictive food intake disorder; this issue contains a survey done in a tertiary care PAG clinic in which 7 of 190 (3.7%) of girls between the ages of 8 and 18 were found to be at risk for avoidant restrictive food intake disorder.[14]

As always, may JPAG inform your clinical care.

Please stay safe; we are still experiencing a pandemic that is profoundly affecting us, our clinical care, and our AYA patients.

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