PUBLIC HEALTH ETHICS CASE STUDY

Assuring Equitable Access for Young People to Comprehensive Reproductive Health Services in School-Based Settings

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PIMA COUNTY HEALTH DEPARTMENT

Introduction

Ethics cut across everything we do in public health practice. Local health departments, as part of accreditation, are required to integrate ethical decision making into programs, policy, and practice to ground actions in core values and ethical principles outlined in the Public Health Code of Ethics. (APHA, 2020) Developing a robust public health infrastructure to embed ethical decision making in local public health produces multiple benefits to the organization and the public.

Pima County is the second most populous Arizona county with a population of 1,043,433 (2020 Census). While 90% percent of Pima County residents live in the Tucson area, most of the land within Pima County is rural and remote. Specific Pima County demographics according to the US 2020 Census include:

- Median age is 38.9.
- Racial/ethnic breakdown is 38.5% Hispanic/Latinx, 50.3% White, 4.5% Native American, 4.4% African American.
- Approximately 28.5% of the population speaks a language other than English and 30.1% speak English less than "very wel.l"
- Over 93% of County residents are U.S. citizens.
- In 2019, there were about 35,000 undocumented residents.
- Since the mid-1980s, more than 12,000 refugees have resettled in Pima County.

Pima County has a Social Vulnerability Index (SVI) of .92. The County has a higher percentage of persons living below the federal poverty level (15.1%) than the U.S. average (12.6%). Fourteen percent of the population lives in census tracts with poverty rates of 30% or more. The median household income in Pima County is $59,215, compared to U.S. median of $69,021. Poverty rates for residents of Pima County for 2020 were 19.0% for Hispanic/Latinx, 22.2% for Black/African Americans, 33.8% for Native Americans, 15.0% for Asian Americans, and 13.0% for White, Non-Hispanic Americans (American Community Survey, 5-year estimates).

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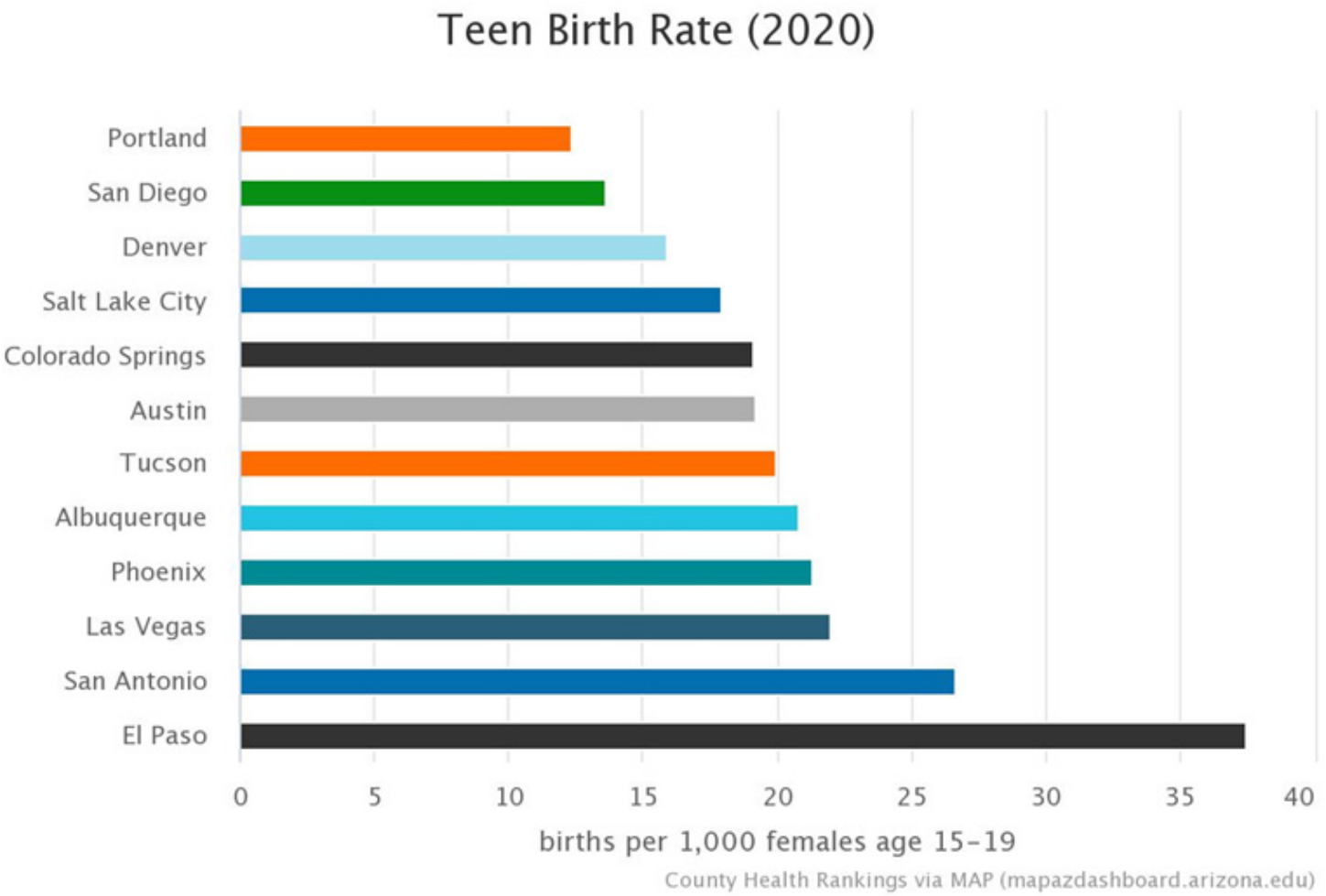
Background

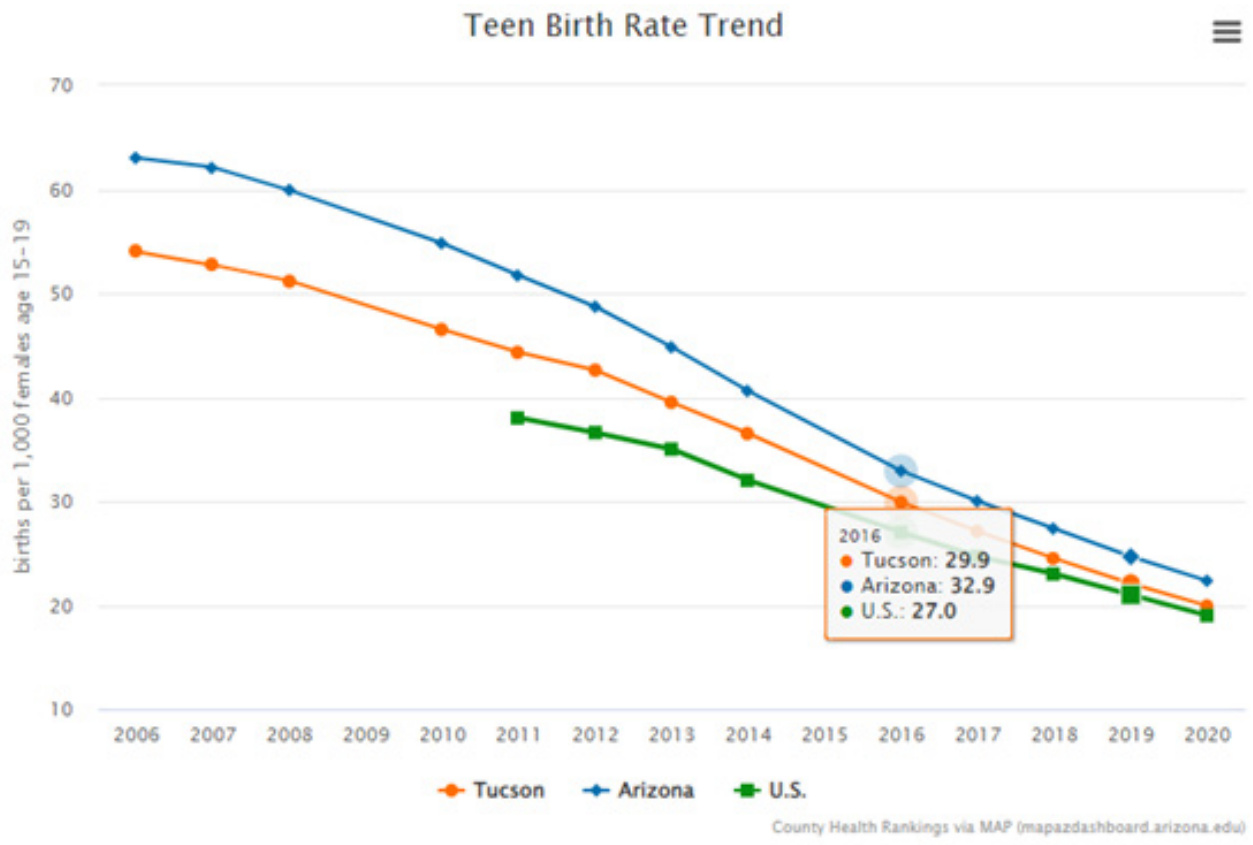
Adolescents and young adults need access to evidence-based, confidential sexual and reproductive health care services and education that support their lifelong health and well-being. Provision of accessible sexual and reproductive health services, including education and contraception, in school-based and community settings is an effective strategy to prevent unintended teenage pregnancies. Preventing teenage unintended pregnancy is important because teen parents and their children often face immediate as well as longer-term impacts related to their health, education, social, and economic opportunities. Teen mothers typically have lower educational attainment and are at greater risk of living in poverty. This in turn can have considerable social and economic costs to the community.

In 2020, the Tucson Metropolitan Statistical Area (MSA) had a rate of 19.9 births per 1,000 females aged 15-19. This was down from 22 per 1,000 births in 2019. Tucson ranked seventh among similar peer western cities.



Pima County's teen birth rate is lower than the state rate of 22.3. The teen birth rate declined by 63.1% in the Tucson MSA between 2006 and 2020, compared to 64.6% in the state of Arizona, and 50.0% in the U.S. since 2011.

[Teen Birth Rate | MAP AZ Dashboard (arizona.edu)]



While improved access to comprehensive family planning services has contributed to the decline in teen birth rates, disparities persist. In 2020 in the Tucson MSA, Hispanic teens had the highest birth rate with 27.0 births per 1,000 females aged 15-19. The teen birth rate for Black or African Americans was 20.7 and 10.9 for White.

According to the Guttmacher Institute, a leading research and policy organization committed to advancing sexual and reproductive health and rights, in 2011–2015, 31% of females aged 15–17 and 56% of those aged 18–25 reported having received contraceptive services in the last year. About one-quarter of both age-groups had received this care from publicly funded clinics and the rest from private health care providers. In 2014, nearly one million women younger than age 20 received contraceptive services from publicly supported family planning centers that helped prevent 232,000 pregnancies that they wanted to postpone or avoid. There are still significant gaps in access to sex education for US adolescents, with only about half receiving sex education that meets the minimum standard articulated in national goals, according to a nationally representative survey between 2011 and 2019. (Lindberg LD, Kantor, LM, 2022)

LARC methods, specifically subdermal implants, are just one of the contraception options available through PCHD's family planning clinics. LARC is one of the most

effective reversible methods of contraception, particularly among teens, because their efficacy is not reliant on patient compliance. (Hansen and Arora, 2018) Offering same-day LARC placement to adolescents has been shown to increase the use of these contraceptives. There is a higher rate of both satisfaction and continuation among teens who choose LARC's compared to those who use other short term contraceptive methods. (Op Cit) In addition to already established constitutional precedent in the United States since 1976, twenty-one states, including Arizona, explicitly allow minors to obtain contraceptive services without parental consent, if the eligible teen can provide informed consent.

Case Description

From 2017–2018, 55 LARC Nexplanon implants were provided to young people through the teen mobile clinic after receiving counseling and information at several different junctures. When providing reproductive health care, providers must provide objective counseling practices and cannot coerce or influence a youth's decision, which is prohibited by Title X Federal Regulations.

In October 2018, after one of the school sites received a complaint from a parent of a student who obtained a Nexplanon implant, LARC placements were discontinued on the teen mobile clinic. The parent claimed their teen was not at risk for pregnancy. Due to confidentiality reasons, information could not be shared with the parent. The student participated in pre-conferencing, counseling, and a personalized consultation with the clinician, where she was informed of the advantages of involving parents. The teen opted to proceed with the implant without parental involvement.

Even though there were policies and procedures in place, consistent with Title X regulation, including informed consent and use of best practice pre-conferencing and counseling, Nexplanon placements were paused on the mobile clinic services at all school-based sites. They were still available at the three PCHD 'brick and mortar' clinics in the County. Only oral contraceptives and Depo-Provera were available through the school-based mobile clinics. Young people, those from historically underserved communities, no longer had access to LARC's (Nexplanon) in the mobile clinic, even though they are highly effective for this population. In August 2021, the PCHD Director received a request from a community partner that the department review its policy regarding LARC placements on the school-based teen mobile clinic, asking that this service be reinstated.

On November 10, 2021, the Ethics Committee met and conducted a deliberation, using the ethical decision-making framework, to analyze the question of whether PCHD should reinstate delivery of LARC placements to teens in its mobile clinic settings for young people.

Ethical Challenge

Despite a body of evidence that public health prevention programs and strategies improving access to comprehensive reproductive health services for young people are effective in reducing unintended pregnancies and HIV/STI's, not all stakeholders agree on the methods that should be used.

While parents are recognized as having decision-making authority over their minor's medical decisions, under federal law and established precedent, adolescents have 'limited right to privacy' to access contraception without parental consent. (Hill, 2015, cited in Hansen and Arora, 2018)

> "The principle of autonomy can also be used to justify affording those adolescents with sufficient decision-making capacity to consent to contraception with decision-making authority." (Salter EL, 2017, cited in Hansen and Arora, 2018)

Nevertheless, some parents are not comfortable with their teens having access to sexual and reproductive health information outside of the family. They also may not be aware that federal and state law allows young people 14 years or older to access these services without parental permission, if they are of mature age to provide informed consent. Some parents mistakenly think that providing such information and resources encourages underage sexual activity. Religious and po-

litical beliefs and cultural factors often influence parental support for access to teen family planning services and can create stigma. Despite young people receiving counseling of the benefits of involving their parents in the decision-making process, many teens choose not to for a variety of reasons including disapproval and stigma. Schools have a vested interest in ensuring their students have the necessary supports and resources for them to succeed in educational attainment. However, schools have limited resources to meet the health and wellbeing needs of their students and rely on community partners, such as PCHD to fill the gaps.

The ethical questions inherent in this case is whether the risk of providing LARC's over other less invasive forms of contraceptives, where informed consent is secured from an eligible teen for this procedure, warrants restricting access to LARC's in mobile settings.

In November 2021, the PCHD Director sought guidance from the Ethics Committee (EC) on:

- Should the department reinstate provision of LARC's on the mobile school-based clinics that primarily serve young people in areas of high social vulnerability?
- Is it equitable to offer LARC services in the static clinics and not via mobile services that are equipped to do so?

The Pima County Health Department Ethics Committee was formed in November 2020, as a means to embed ethical decision making into departmental policy, programs, and services, include diverse community stakeholder perspectives and ultimately, advise the Director of potential courses of actions when key ethical issues or concerns arise. Formation of the EC began pre-pandemic, but constrained resources (remdesivir) during the pandemic hastened its formation. This led to a rapid development and integration of the department's ethical commitment as foundational infrastructure, and to embedding ethical decision making into public health practice (consistent with PHAB accreditation standards).

Committee membership was selected through a recruitment process to represent a diverse range of perspectives, interests, and areas of expertise, which can be found on **PCHD's website**. Two members of the Pima County Board of Health (BOH) also were appointed to the EC.

The EC members received a rapid on-boarding process and met regularly to provide advice to the Director on the department's COVID-19 response. The Committee is resourced and facilitated by a senior manager in the Office of the Director. Regular updates are provided to the BOH and County Administration and shared in the department's All Staff newsletter.

The Ethics Committee underwent training on the application of a 3-step public health ethical decision-making framework (**Attachment 1**). The EC members also received a range of online public health ethics training resources available through NACCHO and the CDC websites, including case studies as well as articles published on public health ethics in the literature. Articles, presentations, and publications on public health ethics were shared as part of the monthly agenda as resources to build ethical decision-making capabilities.

Ethical Principles

The EC identified the following guiding ethical principles inherent in this case:
Applying the Belmont principles, the EC identified the following:

1. Respect for persons:
    a. Autonomy or rights of the individual- informed consent and privacy protections.
    b. Respect for people who are vulnerable and may not be able to exercise their autonomy or rights through personal empowerment.
2. Fairness, equity, and justice
    a. Assuring access to services for all and addressing inequities, within legal parameters.
    b. Safeguarding the right under Title X for young people of mature age access confidential comprehensive family planning services.

c. Ensuring the risks and benefits of offering LARC services are fairly and equitably distributed across the population served.
d. Considering whether it would be fair to deny access to LARC services at school-based mobile services based on potential or actual parental objections.

Drawing on the Public Health Code of Ethics, the EC affirmed the following values:

Health: This action intends to protect the health of young people by providing access to accurate information about, and access to, sexual and reproductive health services to prevent STI's/HIV and unintended pregnancies. It intends to promote health and wellbeing through a safe, confidential, and supportive environment for young people that respects their rights.

Community: Public health interventions are best designed in collaboration with service users, stakeholders impacted and community partners to build trust, maximize buy-in and center equity.

Evidenced informed action: Public health is both an art and a science, applying data-informed approaches and best practice whenever possible.

The key public health ethical principles at play included:

1. Addressing root causes of unintended pregnancy and HIV/STI prevention
2. Respect for community members rights; in this case the right of young people to equitable access to services
3. Gain community trust
4. Establish collaborations
5. Advance health equity
6. Evidenced-based practice
7. Client privacy and confidentiality
8. Judicious use of data from surveillance
9. Assure competence of practitioners
10. Give stakeholders a fair hearing

Stakeholder Concerns

There were diverse perspectives and competing moral claims among stakeholders associated with this case. The concerns raised by the county administration were primarily about minimizing potential risk from coercive practices, complications from LARC procedures, and addressing parental concerns when students choose not to include them in their decision.

The teen mobile staff and providers felt strongly that their procedures and clinical practices followed best practice and were in compliance with Title X regulations and standards of care around informed consent and counseling. They believed the department should continue to offer the best quality services and bring the most effective medical treatments to all young people including communities with high social vulnerability. They were confident that their practices adhered to their provider professional code of ethics. They wanted the department to back the program and support their policies and practices when under scrutiny from a parent that perceived wrongdoing.

The school nurses, personnel and administration continued to be supportive of improving access to reproductive health care for students that they are not adequately resourced to provide.

The school districts and administrators continued to support mobile clinic services onsite at high schools, but LARC's were no longer available.

Parents at schools hosting the mobile clinics are notified of the teen mobile services available to the students by the school personnel. Students are notified via texts, posters, flyers, word of mouth and referrals from school nurses and staff.

Discussion Questions

1. What would you advise the director to do and why?
2. What public health problem does the teen mobile program aim to address?

3. Who is most impacted by providing/restricting access to LARC's on the mobile clinic in school-based settings?
4. What are the diverse values and viewpoints present?
5. What do you think are the main ethical principles at play?
6. Can your recommendation be justified legally, ethically and based on the evidence?
7. What other actions would you recommend taking to build and maintain the public's trust in the health department?

Health Department's Response to the Ethical Challenge

The EC convened to deliberate the ethical challenge and provide a recommendation to the Director on courses of action. Due to the Covid-19 pandemic, this was done remotely via TEAMS. The Ethics Committee used a 3-step ethical decision-making framework to guide their deliberation. Additional stakeholders were invited to broaden representation and perspectives. This included a member of a youth-led peer education sexual and reproductive health program from El Rio Community Health Center, the Health department's attorney, and key staff and clinical providers serving this population.

Key issues raised during the deliberation were:

- Under Title X, young people aged 14 years and older (or of reproductive age and able to give informed consent) have a legal right to access confidential family planning services in the State of Arizona.
- The laws apply equally to mobile clinics and fixed site clinics.
- Young people have a fundamental right to comprehensive accurate and youth centered sexual and reproductive health information and services
- Young people and adults should work as equal partners on projects to improve access to youth sexual and reproductive health services.
- Young people have a right to choose LARC forms of birth control, such as Nexplanon, with informed consent, and have their autonomy respected.
- The mobile clinic space is important in terms of removing barriers to services such as transportation, health literacy, cultural and income barriers, and navigating healthcare systems.
- Assuring access and equity is impeded by not offering LARC in mobile school-based settings.
- Discussing parental involvement with the young person is a requirement of adolescent family planning assessments conducted under Title X funding and is included, as a matter of course, in current pre-conferencing, counseling and clinician interactions.
- PCHD must be prepared to defend its programs to uphold patient/client rights when we have legal standing and there are clear policies and procedures. Creating scripts that can be used to justify our actions would be useful for future situations.
- PCHD providers are committed to delivery of evidenced-based practice and standards of care in order to provide the best possible care to people of all ages and backgrounds we serve.

Based on its deliberation, the EC members recommended that LARC provision be reinstated in the PCHD mobile school-based clinic settings.

The Committee also suggested that the department develop a comprehensive youth family planning services strategy, for both mobile and fixed site clinics, to strengthen the PCHD's capacity to implement best practices across its clinical settings with clients, school personnel and the school community, including parents.

The EC offered suggestions for improvements to current practice:

- Stronger stakeholder involvement in program design and implementation,
- Consistent communications with the parent and school community, and
- Capacity building with staff to ensure best practices continue to be adopted and any perceived, coercive counseling on the part of providers is avoided.

Reflections on the Deliberation Process

As this was the first deliberation using the 3-step ethical framework, it was helpful to have an experienced facilitator familiar with the process, who understood the intent behind the questions and the application in the real world of public health practice.

Involving additional stakeholders proved to be helpful to the process as it allowed the group to hear directly from key stakeholders, such as young people and prospective service users, as well as clinical providers and staff, which helped to tease out the moral claims and diverse perspectives. Including legal representation in the process enabled a clear authorizing environment for the deliberation to proceed. Having a structured process to guide the discussion, even though at times it limited the flow of the discussion, helped the group navigate a complex and emotionally charged discussion.

What Was the Outcome?

The Ethics Committee's recommendation to the Director was presented to the Board of Health and to County Administration, which was endorsed by both. LARC placements are again being offered in PCHD mobile school-based clinics as well as the static clinic settings.

This is consistent with the conclusions made by Hansen and Arora (2018) that:

"Title X facilities must be permitted to continue to provide equitable, comprehensive contraceptive coverage to adolescents without parental consent requirements."

In the past six months, 14 Nexplanon implants have been provided and IUD's also will soon be available. Agreements with school districts were renewed and the PCHD mobile teen clinic has increased its partnership with fourteen schools, both public and charter. PCHD is developing a comprehensive youth family planning services strategy, for both mobile and fixed site clinics. In the past six months, we have significantly increased provision of comprehensive services via the teen mobile clinic. The department is also strengthening its youth led peer-to peer health education partnerships in the areas of sexual and reproductive health.

In the wake of the Dobb's decision, at the direction of the Pima County Board of Supervisors, PCHD has convened an Access to Reproductive Health Community Collaborative comprising multiple provider groups and community-based organizations to assess and respond to barriers to comprehensive care.

In hindsight, including representatives from the parent school community and school personnel in the EC deliberation would have been useful to hear their perspectives, concerns and moral claims which could have led to further program refinement to prevent future challenges. Involving youth voice was particularly powerful and highlights the need for greater youth participation in co-design and delivery of services. Being able to provide incentives for youth participation, through community partners, was important to show that we value their input and time. Including program staff and clinical providers was also helpful as they had a chance to present their experience, which was particularly challenging at the time. The EC members gained first-hand experience using the 3-step framework, which can be found on pages 89-90 of the **Good Decision Making in Real Time: Public Health Ethics Training for Local Health Departments**, and recognized the benefit of applying it to real world ethical challenges. Overall, having an ethics committee in place allowed PCHD to resolve this ethical concern to the satisfaction of the key stakeholders affected. It also enabled us to achieve the goal of centering access and equity and evidenced based practice for the community of focus.

One of the critical lessons for local health departments reinforced during the COVID-19 pandemic is that building and maintaining public trust is essential to successfully fulfilling local health departments' mission. Effective public health actions require meaningful engagement with community stakeholders, especially when examining the full range of ethical considerations inherent in public health actions. Given the complex nature of public health policy and practice, involving multiple stakeholders with diverse perspectives, and competing moral claims, Local Health Department's must seek to balance competing community interests to achieve our common goals.

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