



Colombian adolescents' preferences for independently accessing sexual and reproductive health services: A cross-sectional and bioethics analysis

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ABSTRACT

Objective: Our study sought to (1) describe the practices and preferences of Colombian adolescents in accessing sexual and reproductive health services: accompanied versus alone; (2) compare actual practices with stated preferences; and (3) determine age and gender differences regarding the practice and these stated preferences. **Methods:** 812 participants aged 11–24 years old answered a survey in two Profamilia clinics in the cities of Medellin and Cali in Colombia. A cross-sectional analysis was performed to compare participants' answers based on the variables of gender and age.

Results: A quarter of participants visited the clinic alone (25.4%). Females were more likely to go alone in comparison to males (26.3% vs 14.1%; $p = 0.031$), and older participants went alone more often than younger participants ($p < 0.001$). Most participants – 72.7% (95 %CI: 69.3–75.9) – expressed a preference in being accompanied to the clinic, and more than 90% had their preferences met. The preferences of older participants were, however, less likely to be met than those of younger participants ($p < 0.001$), notably, because they predominantly wanted to be accompanied.

Conclusion: Contemporary public health and bioethics literature advocates in favor of developing health services that better meet the preferences of adolescents. The present research highlights an apparent blind spot related to the role that others (e.g., parents, friends, partners) can or should play in accompanying adolescent patients when they access sexual and reproductive health services. Respecting adolescents' preferences, and hence their autonomy, is not simply a matter of ensuring freedom from constraints (e.g., their right and ability to go alone). Rather, it should also consider the liberty to choose whether to be accompanied when accessing SHRS and by whom.

Introduction

Background

One of the leading global health challenges emerging from the literature on adolescent health is the recognition that adolescents have many unmet healthcare needs and demonstrate low use of healthcare services, particularly in the context of sexual and reproductive health [1–3]. Reasons include adolescents' inexperience and lack of knowledge regarding how to access healthcare services in their communities [4], conflicting schedules with school, lack of economic resources to pay for health services, and issues of confidentiality when consulting healthcare providers without parental consent [1,5]. Adolescents' autonomy is at the core of these challenges.

There are numerous different ways of defining and understanding the concept of autonomy, as evident in the philosophical, social sciences, legal, and biomedical literature [6]. In the context of this study, “autonomy” was framed – as commonly done in contemporary bioethics and health law – as “independence” and as having one's preferences regarding healthcare decisions met [7]. Adolescents' autonomy to access healthcare services is ethically complex, because their capacity to make healthcare decisions evolves over time, and with it, the degree of liberty they have to make such decisions. Hence, tensions can arise between adolescents, their families (or legal guardians), and health professionals. Such tensions are particularly evident regarding sexual and reproductive health, a sensitive context that can be a source of discomfort for many parents. What are and what should be parents' roles regarding adolescents' accessing SRHS? What are the limits of parental

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authority? Should parental consent be required for adolescents to access contraception, for example? And if so, until what age?

These ethical issues have been the subject of significant conceptual analysis and reflection in the academic literature [8–10]. What is arguably lacking is empirical data on how adolescents themselves conceptualize their autonomy, and how they view and experience these ethical tensions. Specifically, how do adolescents wish to access a clinic specialized in SRHS (e.g., alone or accompanied)? Providing an opportunity for adolescents to voice their opinions on access to SRHS can enable the development of healthcare policies and practices that would better reflect adolescents' preferences. Furthermore, such empirical data can ensure the effective operationalization of the ethical principles of beneficence and justice, that are essential to the deployment of adequately adapted and equitable healthcare policies [11]. Our study sought to contribute to the development of such empirical data by providing a description of how a group of adolescents accessed a clinic specialized in SRHS in Colombia, and what their preferences were regarding being accompanied.

There are several reasons for conducting our research in Colombia. First, there are no specific laws or policies regarding parental consent for adolescents to access some SRHS. This means that a 13-year-old girl in Colombia can, without parental consent, access contraceptives or have an abortion¹ – which would be impossible in most neighboring Latin American countries. Colombia is thus a particularly interesting context in which to explore adolescents' autonomy and preferences regarding being accompanied – or not – when they access SRHS, since they may legally exercise greater autonomy than their peers in other countries.² It is essential to highlight that while adolescents in Colombia can technically access some SRHS without parental consent, most adolescents are not aware of this. Furthermore, most research on adolescents is performed in high-income countries (HIC) – that have very different social, cultural, economic, and political contexts in comparison with low and middle-income countries (LMIC). This is even though 90% of adolescents worldwide live in LMIC, like Colombia [12,13]. As such, policy recommendations for equitable and appropriate access to SRHS that are based on empirical studies of adolescents in HIC do not fully describe the realities of adolescents in LMIC.

Objectives

This study's objectives are to (1) provide a description of how a sample of Colombian adolescents aged 11 to 24 accessed a clinic specialized in SRHS: accompanied vs. alone; (2) compare actual practices with stated preferences; and (3) determine differences by age and gender in the practice and stated preferences for being accompanied or going alone when accessing SRHS.

Hypotheses

Previous research on the topic has shown that confidentiality plays a crucial role in accessing healthcare services for adolescents, especially as it relates to sexual and reproductive health [14–16]. Research shows that adolescents tend not to want their parents to know that they wish to use SRHS. Hence, the central hypothesis for our study was that most participants would want to access the SRHS clinic by themselves, rather than be accompanied. The second hypothesis was that younger adolescents would be more likely to access the clinic accompanied than older adolescents, based on view that autonomy as independence increases

with age. The third hypothesis was that older adolescents (e.g., 18 and older) would be more likely to have their preferences to access SRHS realized than younger adolescents since, as adults, they can exercise greater independence and agency in health-related decisions.

Methods

Study setting & design

A cross-sectional study design was used to identify and analyze the differences and similarities of answers between participants based on demographics (e.g., age groups and gender). Participants were asked a series of questions, in Spanish, to build a descriptive portrait of how they accessed the clinic. For example, they were asked what the main reason was for being at the clinic that day (e.g., vaccination, contraceptives, counselling, abortion), if they came alone or were accompanied (and by whom), and if they wanted to be alone or accompanied.

Data collection took place between August 2019 and February 2020 in two Profamilia clinics in two Colombian cities, Medellín and Cali, both have populations of approximately 2.2 million habitants. Profamilia is a network of non-profit clinics specialized in providing accessible SRHS in Colombia (e.g., HIV/STI testing, abortions, contraceptives, vasectomies), including specialized services for young people (e.g., counseling). Adolescent patients who presented at the clinic were asked to fill out a survey while waiting for their appointment. The survey had questions on demographics and the topic of access to SRHS.

Sampling & recruitment

The primary inclusion criteria was adolescents aged between 10 and 24 who presented themselves at the two Profamilia clinics. The choice of this age range was based on the new more expansive definition of adolescence in use in global health research [17]. Adolescence is viewed as an important and lengthy transition period between childhood and adulthood, in which autonomy as independence is developed. Using this broader age range in our study would also allow for a better understanding of the similarities and differences between different age groups (e.g., younger vs. older adolescents).

Initially, the study's plan was for the receptionists at the two participating clinics to offer every patient aged between 10 and 24 an opportunity to answer independently the survey while they were in the waiting area. This sampling approach would have reduced representation biases since *all* eligible participants would have been invited to answer the survey. However, soon after the start of the study, the receptionists explained that some periods had higher volumes of patients, making it too challenging to invite all adolescent patients to answer the survey. The recruitment approach was thus modified to convenience sampling; the receptionists would invite participants to answer the survey when deemed appropriate (e.g., less busy periods). While less empirically rigorous due to potential sampling bias (i.e., the invitation to participate was dependent on the receptionist's availability), this was somewhat mitigated by receptionists being asked to track, on a calendar, the number of individuals invited to answer the survey, i.e., they would make a mark on the corresponding calendar day for every invitation. At the end of the week, it was then possible to calculate the level of participation from the answered surveys in relation to the number of invitations.

Testing for HIV and other sexually transmitted infections (STI) is an essential service provided by SRHS clinics. However, at Profamilia, this service involves patients filling out substantial paperwork and receiving counseling from a nurse (e.g., teaching about safe sex practices). Staff and the research team were concerned that participation in the study might be too time-consuming and overwhelm already anxious adolescent patients, so participants at Profamilia for HIV/STI testing were not invited to answer the survey.

¹ Abortion is legal in Colombia (ruling C-355 of 2006).

² There are some exceptions. One needs to be at least 18 years old to get a sterilization procedure in Colombia. But an adolescent would have the possibility to consult a healthcare professional to obtain information related to sterilization and the healthcare professional would not have a legal obligation to inform the parent/legal guardian of the adolescent.

Data analysis

Some of the data presented in the tables is descriptive (e.g., percentages) and is meant to provide an overview of participant characteristics and their access to the clinic. For the purpose of this article, only the first table presents the data divided by cities. For the subsequent data analysis, the data from the two cities were merged. A sampling approach analysis was used despite the convenience sample. Statistical significance was evaluated as $p < 0.05$ for all tests. Percentages were rounded to the nearest tenth, including confidence intervals. Since the variables were categorical, chi-square tests of independence were performed to analyze the relationship between variables (e.g., gender).

To analyze the homogeneity between groups, z-tests (two-tailed) were performed for proportions. These statistical tests allowed identification of associations between groups and a better understanding of similarities and differences between groups on the question of autonomy to access SHRS. The main independent variables were gender and age. As noted in the Results, because of lower participation rate for the “10–12 years old” category, this was merged with the “13–15 years old” category for some of the data analysis.

For participants who were accompanied to the clinic, they were asked who accompanied them. Participants could answer that they were accompanied by more than one person (e.g., mother and sister), which led to recoding data for analysis (i.e., was entered as one entry). For participants who were accompanied by more than one person, this data was recoded in relation to parental status (i.e., “mother”), meaning that if a participant was accompanied by a parent and another person (e.g., aunt, partner, friend), the data was counted under the respective parent as one entry. If the participant was accompanied by a friend and their partner, the data was counted once under the partner. If accompanied by a family member and a friend or partner, the data was counted once under the respective family member. The only category for data analysis that included two people of accompaniment was for participants accompanied by both parents, which was counted as one entry.

The categories of preference for accompaniment were recoded as follows: the data of the categories “went alone and wanted to be alone,” “went accompanied and wanted to be accompanied,” and “does not matter” were merged to give the category of having one’s preference met, i.e., “satisfied.” The categories “went alone and wanted to be accompanied” and “went accompanied and wanted to be alone” were merged under the category “unsatisfied.”

Research Ethics

Adolescents who expressed an interest in participating in the study were given an information sheet by the receptionists to read in order to make an informed decision about whether or not they wanted to participate. The information sheet clearly explained the purpose of the study, that all the answers would be anonymous, that the choice to participate, or not, would in no way affect the quality of care they would receive at Profamilia, and that participation was entirely voluntary. Participants were free to keep that information sheet if they wanted, which also contained contact information to reach out to if they had questions or concerns. Once they consented, participants received the anonymous survey to complete confidentially and independently in the waiting room; when completed, they were asked to fold it and put in a locked box in the waiting area, to which only the researcher had access. This approach enabled the protection of participant anonymity, both with regards to the clinic staff and the researcher.

Parental consent was not required nor requested for adolescents to participate in the survey. For one, it would have been challenging for adolescent patients who came alone to the clinic to ask for parental consent. More importantly, however, asking for parental consent was deemed a potential barrier to participation. The decision to not ask for parental consent was based on Guideline 17 (Research Involving Children and Adolescents) of the *International Ethical Guidelines for*

Biomedical Research Involving Human Subjects [18], where it is argued that under certain conditions, it is possible to waive parental permission when it is not possible or desirable, and the research involves low risk for participants.

The University of Montreal’s Ethics Committee in Health and Science first evaluated and accepted the research, reference number: CERSES-19-049-P. Subsequently, the Research Ethics Committee of Profamilia (which included a lawyer) evaluated and approved the research.

Results

Characteristics of study participants

A total of 1,272 adolescents were invited to participate, of whom 911 answered the survey (initial participation rate of 71.6%). From those who answered the survey, 99 were excluded because they did not answer enough questions for data analysis (e.g., left blank the demographic section). Hence, 812 surveys were used for data analysis (63.8% participation rate).

Table 1 summarizes the participants’ demographics by city: 73.0% of participants were from Medellin and 27.0% from Cali. Most respondents were female (91.4%); participants were able to answer “trans” or write their own gender if they wished, but none chose those options. Participants ranged in age from 11 to 24, although they were concentrated between 16 and 21 (57.8%). One out of ten participants were internally displaced people (10.2%), which is reflective of the country’s situation as having one of the world’s highest rate of internally displaced people because of violence [19]. The representation of *estratos* (i.e., socio-economic classes assign to citizens based on area residency, such as neighborhood) amongst participants is similar to that of the country, where the majority of the population are in the lowest three *estratos*, and the remaining minority in the upper three *estratos* (1 = lowest; 6 =

Table 1
Baseline data for participants.

City	Medellin	Cali	TOTAL
Participants, n	593	219	812
Age, n (%)			
10–12	8 (1.3)	0 (0.0)	8 (1.0)
13–15	115 (19.4)	22 (10.0)	137 (16.9)
16–18	172 (29.0)	72 (32.9)	244 (30.0)
19–21	155 (26.1)	70 (32.0)	225 (27.7)
22–24	118 (19.9)	49 (22.4)	167 (20.6)
Missing	25 (4.2)	6 (2.7)	31 (3.8)
Gender, n (%)			
Male	54 (9.1)	10 (4.6)	64 (7.9)
Female	533 (89.9)	209 (95.4)	742 (91.4)
Missing	6 (1.0)	0 (0.0)	6 (0.7)
Estrato, n (%)			
1	111 (18.7)	55 (25.1)	166 (20.4)
2	236 (39.8)	47 (21.5)	283 (34.9)
3	178 (30.0)	71 (32.4)	249 (30.7)
4	24 (4.1)	16 (7.3)	40 (4.9)
5	7 (1.2)	11 (5.0)	18 (2.2)
6	0 (0.0)	3 (1.4)	3 (0.4)
Missing/unknown	37 (6.2)	16 (7.3)	53 (6.5)
Displaced Person, n (%)			
Yes	75 (12.6)	8 (3.7)	83 (10.2)
No	466 (78.6)	193 (88.1)	659 (81.2)
Missing	52 (8.8)	18 (8.2)	70 (8.6)
Relationship Status, n (%)			
Single	358 (60.4)	113 (51.6)	471 (58.0)
Serious relationship	168 (28.3)	83 (37.9)	251 (30.9)
Free union	21 (3.5)	10 (4.6)	31 (3.8)
Married	19 (3.2)	5 (2.3)	24 (3.0)
Missing	27 (4.6)	8 (3.7)	35 (4.3)
National Status, n (%)			
Colombian	554 (93.4)	199 (90.9)	753 (92.7)
Venezuelan	10 (1.7)	4 (1.8)	14 (1.7)
Missing	29 (4.9)	16 (7.3)	45 (5.5)

Table 2
Did participant come alone to clinic (by gender and age)?

GENDER	Total n	Came Alone n (%)	p value
Male	64	9 (14.1)	0.031
Female	742	195 (26.3)	
Total	806	204 (25.3)	
AGE GROUPS	Total n	Came Alone n (%)	p value*
10–12	8	0 (0.0)	< 0.001
13–15	137	6 (4.4)	
16–18	244	45 (18.4)	
19–21	224	80 (35.7)	
22–24	167	70 (41.9)	
Total	780	201 (25.8)	
GENDER BY AGE GROUP	Total n	Came Alone n (%)	p value
Younger Male (10–18 years old)	20	2 (10.0)	Between Males: 0.543
Older Male (19–24 years old)	38	6 (15.8)	Between Females: < 0.001
Younger Female (10–18 years old)	368	49 (13.3)	Between Younger Age: 0.671
Older Female (19–24 years old)	354	144 (40.7)	Between Older Age: 0.003
Total	780	201 (25.8)	

* The categories “10–12” and “13–15” years old were merged together.

highest). More than half were single (58.0%), whereas almost one third were in a serious relationship (30.9%). A minority of participants reported being Venezuelan migrants (1.7%) and the remaining participants who answered the question on nationality were Colombian (92.7%).

The main reason for participants being at Profamilia was to access contraceptives (73.8%), followed by wanting to access information related to sexual and reproductive health (6.6%) and sterilization (6.5%). It is important to note that sterilization in Colombia is only available for individuals 18 years or older. Participants were also asked if they were at Profamilia for other services. Close to three-quarters of the participants were not looking for other services (72.0%), whereas the two main other reasons for being at Profamilia were to receive counseling (e.g., from a youth psychologist) (14.5%) and access information related to sexual and reproductive health (12.2%).

Accessing Profamilia

Participants were invited to tell how they came to Profamilia on the

Table 3
Who accompanied the participant to the clinic (by gender and age)?

PERSON WHO ACCOMPANIED	GENDER			AGE						TOTAL n (%)
	Female n (%)	Male n (%)	Missing n	10–12 n (%)	13–15 n (%)	16–18 n (%)	19–21 n (%)	22–24 n (%)	Missing n	
Both parents	5 (0.9)	0 (0.0)	0	1 (12.5)	1 (0.7)	2 (1.0)	1 (0.7)	0 (0.0)	0	5 (0.8)
Mother	220 (40.2)	11 (20.0)	1	4 (50.0)	90 (68.7)	79 (39.7)	27 (18.8)	21 (21.6)	11	232 (38.3)
Father	24 (4.4)	2 (3.6)	0	2 (25.0)	6 (4.6)	10 (5.0)	4 (2.8)	3 (3.1)	1	26 (4.3)
Friend	96 (17.6)	8 (14.5)	0	0 (0.0)	6 (4.6)	30 (15.1)	37 (25.7)	27 (27.8)	4	104 (17.2)
Partner	85 (15.5)	29 (52.7)	2	0 (0.0)	3 (2.3)	32 (16.1)	46 (31.9)	29 (29.9)	6	116 (19.2)
Cousin (female)	21 (3.8)	0 (0.0)	0	0 (0.0)	1 (0.7)	9 (4.5)	6 (4.2)	5 (5.2)	0	21 (3.5)
Aunt	15 (2.7)	2 (3.6)	0	0 (0.0)	7 (5.3)	7 (3.5)	2 (1.4)	0 (0.0)	1	17 (2.8)
Uncle	2 (0.4)	0 (0.0)	0	0 (0.0)	0 (0.0)	2 (1.0)	0 (0.0)	0 (0.0)	0	2 (0.3)
Sister	36 (6.6)	1 (1.8)	0	0 (0.0)	9 (6.9)	7 (3.5)	13 (9.0)	7 (7.2)	1	37 (6.1)
Sister-in-law	6 (1.1)	0 (0.0)	0	0 (0.0)	1 (0.7)	2 (1.0)	1 (0.7)	2 (2.1)	0	6 (1.0)
Mother-in-law	6 (1.1)	0 (0.0)	0	0 (0.0)	0 (0.0)	4 (2.0)	1 (0.7)	0 (0.0)	1	6 (1.0)
Grandmother	22 (4.0)	0 (0.0)	0	1 (12.5)	3 (2.3)	13 (6.5)	3 (2.1)	1 (1.0)	1	22 (3.6)
Other ¹ /Missing	9 (1.6)	2 (3.6)	0	0 (0.0)	4 (3.1)	2 (1.0)	3 (2.1)	2 (2.1)	0	11 (1.8)
TOTAL	547	55	3	8	131	199	144	97	26	605

¹ E.g., maid, neighbor, social worker.

day they completed the survey: alone or accompanied. A quarter responded that they came alone (25.4%), and the others were accompanied (74.6%). Table 2 presents the participants’ answers – by gender and age group – on whether they came alone to the clinic (excluding participants who did not answer the demographic questions). Female adolescents were more likely than their male counterparts to go alone to the clinic (26.3% vs. 14.1%). Nonetheless, for both genders, participants predominantly went to the clinic accompanied. As for age groups, an older participant was statistically much more likely to go to the clinic alone in comparison to a younger participant, which aligns with our hypothesis that younger adolescents would tend to go to the clinic accompanied, in comparison to older adolescents. However, for all age groups, more than half of the participants were accompanied.

To control representation bias, data were regrouped by gender and age group: “younger” (10–18 years old) and “older” (19–24 years old). There was no statically significant relation, for male participants (younger and older), in terms of accompaniment to the clinic (10.0% vs 15.8%), whereas for female participants, there was a statistically significant association, with older participants much more likely to go alone to the clinic in comparison to younger participants (13.3% vs. 40.7%). Amongst younger participants, there were no statistically significant differences between males and females, but there was a statistically significant difference between older participants, whereby older females were more likely to go alone to the clinic in comparison to older males. The present data thus suggest that participants who went alone tended to be older and female.

Table 3 presents the categories of people who accompanied participants to the clinic. Under those categories, the most prevalent person to accompany a participant was their mother, which was the case for more than one-third of participants who went to the clinic accompanied (38.3%; 95% CI: 34.5–42.4) – excluding the category of those who came with both parents. By contrast, only 4.3% (95% CI: 2.8–6.2) were accompanied by their father (and not their mother), and only 0.8% (95% CI: 0.3–1.9) of participants came with both parents. The proportion of participants accompanied by a family member (including mother-in-law and sister-in-law), as opposed to a non-family member, was more than half: 374/605 = 61.8% (95% CI: 57.9–65.7). The present data suggest that family members play an important role in accompanying Colombian adolescent participants when accessing SRHS.

Family members who accompanied participants were more often female (e.g., mother, aunt, sister) in comparison to male (e.g., father, uncle). The proportion of participants who came accompanied by at least one female family member (excluding those who came with both parents) was 340/368 = 92.4% (95% CI: 89.2–94.9), whereas the proportion of participants who came accompanied by at least one male family member (excluding those who came with both parents) was 28/

368 = 7.6% (95% CI: 5.1–10.8). The statistical difference between those proportions ($p < 0.001$) shows that participants who were accompanied by a family member, were statistically much more likely to be accompanied by a female than a male.

The relation between participants' gender and the gender of the family member that accompanied them (excluding those who were accompanied by both parents) was not significant ($p = 0.45$). Similarly, the relationship between age groups and the gender of the family member that accompanied the participant (excluding those who were accompanied by both parents) was not significant ($p = 0.89$). Hence, there was no statistically significant association between participants' gender or age, and the gender of the family member who accompanied them.

The data from Table 3 hint that there are important gendered dimensions to the question of accompaniment to a SRHS clinic. Over 90% of participants who were accompanied by a family member were accompanied by a female family member; and female participants were more likely to come with their mother (40.2%) as opposed to their male peers (20.0%). In parallel, 52.7% of males who came were accompanied by their partner (as opposed to 15.5% for females). It is important to note that the gender of the partner was not asked. Further, younger participants were more likely to be accompanied by their mother, whereas older participants were more likely to be accompanied by their partners.

Preferences of participants

With this description of how the participants accessed two clinics specialized in SRHS, it is essential to also explore what were their preferences regarding their access to the clinic. Table 4 presents the distribution of participants' preference of accompaniment and how they came to the clinic according to gender and age group. Most participants (60.1% under the gender category) were accompanied *and* wanted to be accompanied, and approximately one fifth of the participants did not mind whether they came alone or accompanied (20.4% under the gender category). By contrast, only 11.1% of participants (under the gender category) went alone to the clinic and wanted to be alone, with only 2.2% (under the gender category) who were accompanied but wanted to be alone. The present data challenge our hypothesis that most participants would want to go to the clinic alone – in reality, only a minority of participants wanted to go alone.

Less than a tenth of participants did not have their preference met by either having to go alone to the clinic but wanting to be accompanied, or having been accompanied to the clinic but wanting to go alone. The relation between gender and the realization of preferences was not significant ($p = 0.114$), so it does not appear that one gender was more likely than the other to have their preferences met. For the variable of gender, the only two statistically significant results were for the categories “went accompanied and wanted to be accompanied” and “does not matter.” Thus, a female participant was more likely than her male counterpart to be accompanied *and* wanting to be accompanied (61.6% vs. 43.8%); and male participants were more likely to not mind whether they were accompanied or come alone to the clinic (43.8% vs. 18.4%).

The relation between age group and met preference was significant ($p < 0.001$). Younger participants were statistically more likely than their older peers to have their preferences met. From the table it is possible to observe a decreasing tendency of being “satisfied” as one gets older (86.8% for the eldest group vs. 98.6% for the youngest). However, it is important to note that the proportions are relatively high – over 85% for each category – meaning that the vast majority of participants for each age group had their preferences met. In terms of tendency, there is a clear decreasing tendency as participants get older to respond, “went accompanied and wanted to be accompanied.” For the categories “went alone and wanted to be alone” and “does not matter,” there is an evident increasing tendency as participants get older. Overall, based on data from the gender variable, the majority of participants wanted to be

Table 4
Preference of accompaniment to access clinic in relations to gender and age.

	GENDER			AGE					TOTAL n (%) [95 %CI]	p value ^{2,3}
	Female n (%) [95 %CI]	Male n (%) [95 %CI]	p value ¹	TOTAL n (%) [95 %CI]	10–12 n (%) [95 %CI]	13–15 n (%) [95 %CI]	16–18 n (%) [95 %CI]	19–21 n (%) [95 %CI]		
Went alone and wanted to be alone	83 (11.2) [9.1–13.7]	6 (9.4) [3.5–19.3]	0.660	89 (11.1) [9.0–13.5]	0 (0.0)	5 (3.7) [1.2–8.4]	15 (6.2) [3.5–10.0]	38 (16.9) [12.2–22.4]	31 (18.6) [13.0–25.3]	89 (11.4) [9.3–13.9]
Went accompanied and wanted to be accompanied	455 (61.6) [58.0–65.1]	28 (43.8) [31.4–56.7]	0.005	483 (60.1) [56.7–63.6]	8 (10.0) [6.7–10.0]	112 (83.0) [75.5–88.9]	164 (67.5) [61.2–73.3]	113 (50.2) [43.5–56.9]	68 (40.7) [33.2–48.6]	465 (59.8) [56.2–63.2]
Does not matter	136 (18.4) [15.7–21.4]	28 (43.8) [31.4–56.7]	< 0.001	164 (20.4) [17.7–23.4]	0 (0.0)	16 (11.9) [6.9–18.5]	48 (19.8) [14.9–25.3]	48 (21.3) [16.2–27.3]	46 (27.5) [20.9–35.0]	158 (20.3) [17.5–23.3]
Went alone and wanted to be accompanied	49 (6.6) [5.0–8.7]	0 (0.0)	N/A	49 (6.1) [4.6–8.0]	0 (0.0)	1 (0.7) [0.0–4.1]	10 (4.1) [2.0–7.4]	22 (9.8) [6.2–14.4]	17 (10.2) [6.0–15.8]	50 (6.4) [4.8–8.4]
Went accompanied and wanted to be alone	16 (2.2) [1.2–3.5]	2 (3.1) [0.4–10.8]	0.643	18 (2.2) [1.3–3.5]	0 (0.0)	1 (0.7) [0.0–4.1]	6 (2.5) [0.9–5.3]	4 (1.8) [0.9–4.5]	5 (3.0) [1.2–3.3]	16 (2.1) [1.2–3.3]
TOTAL	739 [674 (91.2)–803 (93.2)]	64 [62 (96.9)–89.2 (99.6)]	0.114	803 [736 (91.7)–895.5 (93.5)]	8 [1.41 (98.6)–95.0 (99.8)]	135 [135 (99.8)–135 (99.8)]	243 [227 (93.4)–277 (96.2)]	225 [199 (88.4)–251 (92.3)]	167 [145 (86.8)–189 (91.6)]	778 [712 (91.5)–847 (93.4)]

1. z-test for two-tailed hypothesis.
 2. The data “10–12 years old” and “13–15 years old” were merged together.
 3. Chi square test of independence.

accompanied: $532/732 = 72.7\%$ (95 %CI: 69.3–75.9).

The biggest discrepancy occurred among participants aged 19–24, where a tenth went alone but wanted to be accompanied, as opposed to their younger peers (<1%). The present data challenge our hypothesis that older participants, who can exercise greater agency and independence as legal adults, would be more likely to have their preferences met than younger participants. This tendency appears to be explained by the fact that most participants wanted to be accompanied.

Discussion

The purpose of this cross-sectional study was to describe the preferences of adolescents to access SRHS and identify whether there are significant differences between groups of adolescents in terms of autonomy (i.e., preference being met) to access a clinic specialized in SRHS in Colombia. A quarter of the participants went alone to the clinic: more females than males went alone, and older participants were more likely to go alone than younger participants. Those who came accompanied were predominantly accompanied by a family member who tended to be female (the most prevalent answer being the mother). Hence, the research data suggest there are important gendered influences on the question of Colombian adolescents' access to SRHS.

Our initial hypothesis proved to be wrong. Based on previous research on the topic [14,15,16], we assumed most adolescents would want to access the clinic alone, as opposed to being accompanied. Our survey data show the contrary, i.e., that the vast majority of participants (approximately two-thirds) wanted to be accompanied and around one-fifth did not have a preference regarding whether they went to the clinic alone or were accompanied. These findings challenge the common assumption that parental presence may impeded the autonomy of adolescents in relation to healthcare access. Generally speaking, in Western bioethics, the principle of autonomy is often framed in highly individualistic terms [20,21]. The conclusion is often that patients, and in this case, adolescents accessing SRHS, will likely be constrained by parents and health professionals, e.g., because parents can be uncomfortable in relation to adolescent sexuality. It follows then that to ensure ethical access to SRHS, adolescents should be able and empowered to access health services alone, so they can exercise autonomous choice.

However, the findings of our survey show that an important number of participants in the Colombian context did not want to go to the clinic alone, but rather wanted to be accompanied. This data can help reframe how both healthcare professionals and policy makers think about service provision that best meet the wishes of Colombian adolescent patients in relations to SRHS. In a patient-centered view, healthcare professionals have a deontological duty to respect patient autonomy (e.g., preferences for type of care and how it is provided) and work for the patient's best interests, as defined by the patient [7,22]. Similarly, policy makers are encouraged to develop health policies that promote patient autonomy, e.g., by creating situations in which patients can authentically articulate their choices for service provision [23].

In North America, these values have often been articulated through the protection of patient confidentiality and right to choose, even when this means, in the context of adolescents and access to SRHS, excluding parents from decision making in some situations (e.g., choosing a contraceptive option). In our study sample, the majority of participants wanted to be accompanied. This does not mean that adolescent participants in Colombia were less autonomous than their peers in North America, nor that the notion of autonomy is misapplied. What this difference clarifies is the importance of genuine and free choice to be accompanied or not when accessing SRHS. Thus, respect for autonomy does not only mean allowing adolescents to go alone, but rather involves providing diverse types of support, such as having the possibility of choosing to have a trusted person present (e.g., parent, family member, friend), with whom to share the burden of decision making. Future research on this topic should explore the question of why adolescents might prefer to be accompanied, in order to understand the factors

behind this phenomenon.

Regarding the question of adolescents' preferences, our other main hypothesis also proved to be inaccurate. Interestingly, the preference of older adolescents was met less than their younger peers. It is commonly believed that with age, one gains greater independence and agency, which would suggest allowing one to actualize more easily one's preference in healthcare. However, most participants wanted to be accompanied. Around 10% of older adolescents (19–24 years old), who are by law defined as adults, went alone but wanted to be accompanied. The survey did not ask questions that would allow to explain this tendency. This calls for further research to better understand this trend. Nonetheless, the answers of older adolescents challenge the idea that being older translates to having one's preferences met more than when one is younger.

The data in our study also raise other ethical questions, notably for those being asked to accompany adolescents in accessing SRHS. For example, what are the ethical implications of a situation in which an adolescent wants to be accompanied by another person (e.g., by their mother) but that individual does not want to accompany the adolescent or is uncomfortable with discussing SRHS? This could be a source of tension or conflict between the adolescent and the person accompanying them, or refusing to accompany them, as well as the healthcare professional (e.g., duty to the patient vs. respect for the family member). The study did not explore these aspects, which would be important to develop further, e.g., through qualitative research, in order to articulate more clearly the potential challenges, as well as strategies to ensure effective and ethical access to SRHS. Common bioethical frameworks focus on the patients themselves and the deontological duties that health professionals have towards patients. However, the roles of an accompanying person (e.g., parent, friend, partner) constitute a blind spot that raises different sets of ethical questions in need of investigation.

Limits

One of the limits of the study was its convenience sampling approach, that introduces the possibility of representation biases, since not all potential participants had an equal chance of being invited to participate by the receptionists. A 63.8% participation rate can also hint towards representation bias, since those not willing to participate did not have their answers counted and may differ from those more eager to participate. Further, the survey was presented to adolescents who were at Profamilia, while adolescents who do not go to Profamilia may have different opinions on the topic. For example, Profamilia is popularly known as a clinic specialized in SRHS, whereas adolescents may have different type of preferences (and experiences) for accessing SRHS in a family medicine setting.

While participants were asked if they wanted to be accompanied, those who did were not asked by whom they wished to be accompanied (e.g., mother, friend, partner). Perhaps participants who were accompanied would have wanted to be accompanied by a different person. Furthermore, there might be differences in preferences by types of services. For example, an adolescent may want to be alone for one type of service (e.g., abortion) but may want to be accompanied for another service (e.g., contraceptives). Future research on the topic should take those elements into consideration.

There are other essential factors that can influence adolescents' autonomy to access SRHS, such as having knowledge on how to access health services, the opening hours of the clinic, living close enough to a clinic, having health insurance or the financial means to pay for health services, etc. It is also important to recognize that Colombian adolescents have different living situations and relationships with their family (e.g., parents) [24]. Some adolescents might not have one or both parents actively present in their lives or might be living with extended relatives (e.g., grandmother, aunt). Such diverse realities can greatly influence adolescents' experience of accompaniment by family members to access SRHS.

Conclusion

This study presented a quantitative description of how a sample of Colombian adolescents accessed and wished to access two clinics specialized in SRHS in two large Colombian cities. Most participants were accompanied *and* wanted to be accompanied to access SRHS. A much smaller proportion of participants than originally anticipated did not have their preferences met (<10%), and contrary to the initial hypothesis, older adolescents had their preference for access less met than their younger peers – the reason being that some older adolescents wanted to be accompanied but went alone to the clinic.

Previous research on the theme in other cultural contexts has shown that adolescents tend to want to access SRHS alone. However, the findings of this research show that most participants wanted to be accompanied when accessing SRHS. The fact that a significant number of Colombian adolescent participants wish to be accompanied to access SRHS raises important ethical insights regarding the respect of their autonomy that are in need of further investigation. Notably, it would be highly relevant to explore the ethical tensions raised by situations in which adolescents want to access SRHS accompanied, but the person they want to be accompanied by does not want to accompany them.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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