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ORIGINAL RESEARCH

A Mixed-Methods Study Exploring Colombian Adolescents' Access to Sexual and Reproductive Health Services: The Need for a Relational Autonomy Approach

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Abstract This study's objective was to understand Colombian adolescents' experiences and preferences regarding access to sexual and reproductive health services (SRHS), either alone or accompanied. A mixed-method approach was used, involving a survey of 812 participants aged eleven to twenty-four years old and forty-five semi-structured interviews with participants aged fourteen to twenty-three. Previous research shows that adolescents prefer privacy when accessing SRHS and often do not want their parents involved. Such findings align with the long-standing tendency to frame the ethical principle of autonomy as based on independence in decision-making. However, the present study shows that such a conceptualization and application of autonomy does not adequately explain Colombian adolescent participants' preferences regarding access to SRHS. Participants shared a variety of preferences to access SRHS, with the majority of participants attaching great importance to having their parents involved, to varying degrees. What emerges is a more complex and non-homogenous conceptualization of autonomy that is not inherently grounded in independence from parental involvement in access to care. We thus argue that when developing policies involving adolescents, policymakers and health professionals should adopt a nuanced "relational autonomy" approach to better respect the myriad of preferences that Colombian (and other) adolescents may have regarding their access to SRHS.

Keywords Adolescent · Autonomy · Bioethics · Colombia · Reproductive health · Sexual health

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Introduction

In 2017, the World Health Organization (WHO) introduced the *Global Accelerated Action for the Health of Adolescents* (AA-HA!) (WHO 2017), which stressed that, as a group, adolescents have been neglected in global health research and the delivery of adapted health services. Addressing adolescents' health-related needs has been recognized as urgent and a part of the United Nations (UN) Sustainable Developmental Goals for 2030 (Every Women Every Child 2015; United Nations 2015). Many of the health problems encountered by adolescents are due to their low use of health services (Patton et al. 2012, 2016), many of which are related to adolescent's autonomy

(e.g., parental consent laws, lack of knowledge on navigating local health system). To address this issue, AA-HA! suggests "fostering the autonomy" of adolescents to empower better access to health services (WHO 2017). While a laudable affirmation, there are still serious challenges in understanding what are (or should be) the bases for adolescent autonomy in healthcare and how this autonomy might be fostered (Brisson et al. 2021). The study presented in this article sought to shed light on these questions and explore some of the interrelated ethical questions by using the case of access to sexual and reproductive health services (SRHS) for Colombian adolescents.

One of the main reasons for choosing Colombia is that there is no official minimum legal age for an adolescent to access some SRHS without their parents, i.e., a thirteen-year-old can be prescribed contraceptives without requiring parental consent. As such, in principle, Colombian adolescents can have their autonomy respected in healthcare decision-making (with some exceptions),[1] which makes it very different from neighbouring countries with strict parental consent laws. From a methodological perspective, the Colombian context makes it particularly relevant to explore adolescents' autonomy to access healthcare services since, technically, they may choose to access SRHS alone or to be accompanied. However, it is important to note that Colombian adolescents are not necessarily aware of their rights and so may instead believe that they must have parental consent to access SRHS.

The topic of sexual and reproductive health can be a highly taboo and sensitive subject for adolescents, especially in comparison to other types of health services (e.g., ophthalmology, physiotherapy, odontology). Previous research in different cultural contexts has shown that very often, adolescents do not want their parents (or others) knowing that they wish to access SRHS, suggesting that adolescents want their autonomy respected through the protection of their independence and patient privacy and confidentiality (Fuentes et al. 2018; Garside et al. 2002; Reddy et al. 2002). Thus, it is appropriate to use the case of SRHS[2] to explore the question of adolescents' autonomy to access health services since adolescents may express wanting to make autonomous decisions related to their health but be unable to do so for various reasons (e.g., parental prohibition to use contraceptives).

The ethical principle of autonomy plays a central role in contemporary bioethics thinking—e.g., the ethical imperative to respect patients' healthcare decisions (Beauchamp and Childress 2012)—and has been widely operationalized, particularly in North America and Europe, in health professional training and professional codes of ethics, as well as being enshrined in law. Yet, while laws and professional guidelines have clearly circumscribed how and why autonomy should be respected for adults—and under what circumstances this autonomy might be justifiably limited—the same cannot be said for adolescents. There are no biological or objective markers to define at what age a person becomes autonomous to make health related decisions (Dahl et al. 2018) or when as a patient they should have their autonomy respected. If the common age threshold of majority, i.e., eighteen years, is used without nuance to define adulthood and determine when a person can autonomously decide to access SRHS, critical injustices may result; adolescents are entitled to be heard on topics that directly concern them, including regarding their sexuality (Mabaso et al. 2016). This view is notably reflected in the concept of "progressive autonomy" (Turner and Varas Braun 2021; Espinoza 2017) and articulated in the United Nations' Convention on the Rights of the Child, which argues that adolescents are entitled to be heard and express their views even if they are not yet adults (United Nations 2011).

The concept of autonomy can represent different notions—e.g., agency, liberty, independence, maturity (Soenens et al. 2017). For this study, the concept was understood as involving both independence (i.e., going to a clinic alone) and respect for choice (i.e., from the classical framing of the ethical principle in contemporary bioethics). The period of adolescence is a stage where one starts to develop autonomy at different levels, which was also considered in the study

[1] For example, one needs to be at least eighteen years old to be sterilized in Colombia. Nonetheless, an adolescent younger than eighteen years old would be allowed to consult a doctor to obtain information about sterilization procedures without legal obligations for the doctor to inform the adolescent's parents or legal guardians.

[2] For this research, "sexual and reproductive health services" was an inclusive concept representing all related services (e.g., contraceptives, vasectomy, abortion, HIV/STI testing).

design and data analysis. As shown in the Results section and explored in the Discussion, it is important to pay attention to these different components of autonomy, which interconnect and overlap, especially as they relate to access to SRHS.

The first part of this paper presents quantitative data and describes how a sample of adolescent patients in Colombia wished to access services at Profamilia, a clinic specialized in SRHS. Then, the qualitative data are presented to share adolescents' opinions and experiences related to their autonomy to access SRHS. Finally, the paper discusses the ethical questions emerging from the data related to AA-HA!'s call to foster adolescents' autonomy to access health services. Our main argument is that instead of mobilizing an individualist "asocial" view of autonomy as equivalent to "freedom from parental intervention," health professionals and policymakers in Colombia (and possibly other contexts) would benefit from using a "relational autonomy" approach that sees individuals (i.e., adolescents) as rooted within social networks (e.g., family, friends), as this better conceptualizes the different ways that Colombian adolescents (and others) may wish to access SRHS. For example, a relational autonomy approach would recognize the importance that an adolescent might attribute to having their mother accompany them to a clinic in order to choose a contraceptive option, while another adolescent might instead appreciate the support of their friend. In both instances, the adolescents desire the involvement of others in actualizing their autonomy to access SRHS—they do not wish for complete independence throughout the whole process.

Objectives

The first objective for this study was to develop a descriptive portrait of adolescents' preferences regarding accompaniment to consultations with health professionals regarding their sexual and reproductive health, e.g., alone or accompanied by a parent (or friend). The second objective was to observe if there were differences between how adolescents wanted to access the clinic itself (either alone or accompanied) and when consulting a health professional (either alone or accompanied). The third objective was to understand the reasons for adolescents' preferences as it touched upon their autonomy to access SRHS. Those objectives reflect an essential approach in empirical bioethics to first have a descriptive portrait of patients' preferences and experiences before addressing the ethical issues at hand (Kon 2009). Finally, the last objective was to analyse the emerging ethical questions in relation to the WHO's call to foster adolescents' autonomy to access health services.

Methods

A mixed-method approach was used to achieve the research objectives. The first part consisted of a survey with Colombian adolescents, with a view to generating a descriptive portrait through a cross-sectional analysis of how adolescents wanted to access a clinic specialized in SRHS. The second part involved semi-structured interviews with adolescents (not necessarily the same participants from the survey) to better understand their preferences regarding how they wished to access SRHS (e.g., participants were invited to explain why they would want to go alone to a clinic or to be accompanied). For this study, a convergent design was used with both methodological approaches occurring simultaneously (Guetterman et al. 2015) over a period of six months between August 2019 and February 2020.

Participants

In global health research, a new definition of adolescence has been proposed that includes individuals aged ten to twenty-four years old (Sawyer et al. 2018). Extending the definition of adolescence beyond eighteen years has important methodological and policy implications because it allows for a more accurate and nuanced understanding of the transition from childhood to adolescence and then from adolescence to adulthood. As already mentioned, there are no biological or objective markers to define when one ceases to be an adolescent and begins to be an adult (Dahl et al. 2018). Often, it is social factors or cultural events (e.g., rituals) that define the start of adulthood (Worthman and Trang 2018). As such, the only inclusion criteria for participating in this study—for both the survey and interviews—were to be between ten and twenty-four years old. Participants from different

demographic backgrounds were invited to participate in order to have a diverse sample. The research took place in Colombia's departments of Antioquia and Valle del Cauca.

Cross-Sectional Study (survey)

For the cross-sectional analysis, a survey was used with adolescents who presented themselves at a Profamilia clinic in the large Colombian cities of Medellin and Cali. Profamilia is a network of non-profit clinics across Colombia that provide SRHS, including youth-friendly services. Adolescents who presented themselves at Profamilia clinics were invited to independently answer a survey on the topic of their autonomy to access SRHS while they were in the waiting area.[3] The use of a cross-sectional study allowed for an analysis of statistical trends while paying attention to potential differences in demographic groups. Such a methodological approach is particularly relevant for studying the question of adolescents' autonomy as it allows for the observation of differences and similarities between younger and older participants.

The initial plan was for the receptionists at the clinics to offer the survey to every patient aged ten to twenty-four. However, shortly after the start of the study, the receptionists expressed that it was too challenging to invite every patient in that age group due to periods of higher patient volume. The sampling approach was changed to convenience sampling: receptionists would invite patients to answer the survey when deemed appropriate. It is important to acknowledge that this sampling approach increases the risk of representation bias. Nonetheless, for every invitation to participate in the study, receptionists would mark a calendar which allowed us to calculate the participation rate.

Participants who expressed an interest in answering the survey were first given an information sheet detailing the study, to make an informed decision prior to choosing whether to answer the survey. The information sheet explained in accessible language the purpose of the study, that the answers would be anonymous and that the choice to participate would not influence the quality-of-care they would receive at the clinic. When the participants were done answering the survey independently, they were asked to put it in a locked box in the waiting area for which only the researcher had the key.

For the analysis presented in this paper, the two independent variables of study were gender and age, and the main variables of study were related to categorical preferences. Since the study variables were categorical, z-tests and chi-square tests of independence were used to analyse the associations between variables and participants' answers. The goal was to observe if there were significant similarities or differences between demographic groups, e.g., to see if younger and older adolescents both equally preferred to consult a healthcare professional alone. Statistical significance was evaluated as $p < 0.05$, and percentages were rounded to the nearest tenth (including confidence intervals). The variable "age" was grouped in blocks of three years: 10–12, 13–15, 16–18, 19–21, 22–24. Because of lower participation rates for the group ten to twelve years old, the data for the categories "10–12" and "13–15" were merged for the statistical analyses but are presented separately in the tables. The survey was not pretested.

Interviews

The use of semi-structured interviews enabled adolescent participants to express their opinions and share their experiences and preferences related to their autonomy to access SRHS, data that helps provide context and meaning to data generated in the cross-sectional study. Before starting the interviews, participants were asked to read an information sheet and then sign a consent form, and they were afterward asked demographic questions (e.g., how they identified their gender, level of formal education). The individual interviews, which were conducted by the first author, were audio recorded, and then transcribed and translated from Spanish to English. The interview questions were not pretested.

Profamilia clinics advertised the research in their waiting area, and health professionals who saw adolescent patients (e.g., youth psychologists, social workers) shared information about the study with

[3] At the request of the Profamilia staff, patients who were at the clinic for STI/HIV testing were not invited to answer the survey. At Profamilia, young people receiving tests for STI/HIV need to fill out paperwork and receive counselling from a nurse on safe sex practices, which can be time consuming for the patient. To not overwhelm patients seeking such testing, they were not invited to participate in the survey.

their patients. Further, a nurse presented the study in a high school. The most effective recruitment approach was through snowball sampling, where participants shared information about the study with their friends and peers, who then contacted the researcher.

The semi-structured interviews had core questions that were asked to all participants (e.g., the first time you accessed SRHS, did you go alone or accompanied, and did you want to be alone or accompanied?). For data analysis, the participants' answers were regrouped by core questions and then categorized by similarities (Paillé and Mucchielli 2008). This approach enabled the identification of trends and differences (e.g., various steps involved) regarding adolescents' understanding of and preferences for access to SRHS (Imbert 2010). It enables analysis of the pertinence of AA-HA!'s concept of "fostering adolescents' autonomy", e.g., determining how the concept could be implemented in light of the participants' answers. Subsequently, a mapping was done of the different processes and experiences of participants to access SRHS. Through this categorization and mapping of answers, it was then possible to compare the qualitative interview data with the cross-sectional survey data to see if there were similarities, for example, related to trends of answers in connection to gender and age groups.

Research Ethics

The University of Montreal's Research Ethics Committee in Science and Health first evaluated and accepted the research project. The Profamilia Research Ethics Committee, which included a lawyer, then evaluated and approved the research. For both the survey and the interviews, parental consent was not asked. This decision was supported by the *International Ethical Guidelines for Biomedical Research Involving Human Subjects* which argues that under certain conditions, it is acceptable to waive parental consent when the research involves low risks for adolescent participants and when parental consent might prevent young people from participating due to the research topic (Council for International Organizations of Medical Sciences 2017). It was explained to the participants that a summary of the findings of the research would be made available at Profamilia clinics, in their youth sections.

Table 1. Characteristics of participants for the surveys

Number of participants	812
Age, *n*	
10–12	8 (1.0%)
13–15	137 (16.9%)
16–18	244 (30.0%)
19–21	225 (27.7%)
22–24	167 (20.6%)
Missing	31 (3.8%)
Gender, *n*	
Male	64 (7.9%)
Female	742 (91.4%)
Missing	6 (0.7%)
Estrato, n	
1	166 (20.4%)
2	283 (34.9%)
3	249 (30.7%)
4	40 (4.9%)
5	18 (2.2%)
6	3 (0.4%)
Missing/unknown	53 (6.5%)
National Status, *n*	
Colombian	**754** (92.9%)
Venezuelan	**14** (1.7%)
Missing	**50** (6.2%)

Results

The first part of the results section presents the quantitative data of the cross-sectional study to generate a descriptive portrait of participants' answers, and to identify emerging tendencies (e.g., more prevalent answers within certain demographic groups). The presentation of the interview excerpts then follows to provide further meaning and explanations to the statistical data.

Cross-Sectional Results

Table 1 presents the characteristics of the participants who answered the survey. Of the 1,272 adolescents who were invited to participate in the survey, 911 agreed to participate. However, ninety-nine were excluded because they did not answer enough questions for data analysis (e.g., unanswered demographic section). As such, a final sample of 812 completed

surveys were used for data analysis, i.e., a 63.8 per cent participation rate.

The study allowed for participants aged ten and older to answer the survey; however, the youngest participants were eleven years old. The majority of participants were female (91.4 per cent), which reflects the general trend of patients who visit Profamilia clinics across Colombia. Participants were given the opportunity to answer as being trans or to write down their own gender, but none of those answers were chosen. The distribution of participants' *estratos* (socio-economic classes assigned based upon area of residency—e.g., neighbourhood—with one being the lowest and six the highest) reflects the country's *estratos* distribution: the majority of participants were concentrated in the lower three *estratos*.

Table 2 presents participants' preferences, by gender and age, on whether they preferred to be alone or accompanied to a consultation with a health professional regarding their sexual and reproductive health. Approximately half of participants wished to be alone when consulting a health professional regarding SRHS, a result similar for males and females. For age groups, it is possible to observe a statistically significant difference: as participants get older, they are more likely to want to be alone when consulting a health professional.

The second most frequent answer was wanting to have one's mother present when consulting a health professional, which was the case for approximately one-fifth of the participants. However, there was a statistically significant difference between genders, with women being more likely to want to consult with their mother in comparison to men (21.0 per cent vs. 6.3 per cent). As for age groups, there was a statistically significant difference for younger participants, who were more likely to want to consult with their mother in comparison to their older peers. In parallel, only 1.0 per cent (under the gender category) of participants expressed wanting to be accompanied by their fathers. This data suggests that there might be an important gendered dimension to the question of Colombian adolescents' autonomy to access SHRS, which calls for further research on the question. For example, it would be pertinent to evaluate how mothers could be engaged in public health initiatives (e.g., educative measures), as our data suggests that an important number of participants appreciate the involvement of their mothers in accessing SRHS.

About one-fifth of participants answered that they did not mind if they were alone or accompanied to consult a health professional regarding SRHS. Yet, when dividing the answer by gender, there was a statistically significant difference for a quarter of men (26.6 per cent), but only around a tenth of women (10.9 per cent). As for age, there was a statistically significant increasing tendency within participant age groups in not minding if they are alone or accompanied to consult a health professional. The same phenomenon was observed for the "partner category." More men than women preferred to be accompanied by their partner (17.2 per cent vs. 8.9 per cent). This phenomenon was also seen as participants got older, with a statistically significant increasing tendency to be accompanied by a partner.

Table 3 presents the preferences for how participants wanted to access Profamilia (alone or accompanied), and their preference for consulting a health professional (alone or accompanied), compared by gender and age. The purpose of this analysis was to see if there were any consistencies between preferences of accompaniment to access the clinic *and* consulting the healthcare professional.

As observable in the table, the most frequent answer was wanting to be accompanied to the clinic *and* also accompanied when seeing the health professional. This was the case for one-third of the participants. When dividing the answers by gender, there is a statistically significant difference between genders: women more than men wanted to be accompanied to the clinic *and* when seeing the health professional (34.8 per cent vs. 15.6 per cent). As for age groups for the same category, there was a statistically significant decreasing tendency with age for wanting to be accompanied to the clinic *and* when seeing the health professional. In parallel, the second most prevalent answer was wanting to be accompanied to the clinic but to be able to see the health professional alone. This was the case for more than a quarter of participants. When looking at the answer by gender and age, there were no statistically significant differences. In comparing the answers by gender for each category, the distribution for women is predominantly concentrated in four main answers, whereas for men, there is more variability. The latter phenomenon is observed for age groups: for younger participants, there is more limited diversity of prevalent answers, whereas for

Table 2. Preference of accompaniment to consult a health professional regarding sexual and reproductive health (by gender and age)

PREFERENCE	GENDER				AGE						
	Man n (%) [95%CI]	Woman n (%) [95%CI]	*p* value*	TOTAL n (%) [95%CI]	10–12 n (%) [95%CI]	13–15 n (%) [95%CI]	16–18 n (%) [95%CI]	19–21 n (%) [95%CI]	22–24 n (%) [95%CI]	*p* value[1,2]	TOTAL n (%) [95%CI]
I prefer to be **alone**	30 (**46.9**) [34.3–59.8]	369 (**49.9**) [46.2–53.5]	0.645	399 (**49.6**) [46.1–53.1]	1 (**12.5**) [0.3–52.7]	56 (**40.9**) [32.6–49.6]	115 (**47.3**) [40.9–53.8]	126 (**56.0**) [49.2–62.6]	94 (**56.3**) [48.4–63.9]	0.004	392 (**50.3**) [46.7–53.8]
I prefer to be with my **mother**	4 (**6.3**) [1.7–15.2]	155 (**20.9**) [18.1–24.1]	0.005	159 (**19.8**) [17.1–22.7]	6 (**75.0**) [34.9–96.8]	55 (**40.1**) [31.9–48.9]	61 (**25.1**) [19.8-31.0]	21 (**9.3**) [5.9–13.9]	10 (**6.0**) [2.9–10.7]	< 0.001	153 (**19.6**) [16.9–22.6]
I prefer to be with my **father**	1 (**1.6**) [0.0–8.4]	7 (**0.9**) [0.4–1.9]	0.581	8 (**1.0**) [0.4–2.0]	1 (**12.5**) [0.3–52.7]	2 (**1.5**) [0.2–5.2]	2 (**0.8**) [0.1–2.9]	1 (**0.4**) [0.0–2.5]	1 (**0.6**) [0.0–3.3]	0.500	7 (**0.9**) [0.4–1.8]
I prefer to be with **another family member**	1 (**1.6**) [0.0–8.4]	38 (**5.1**) [3.7–7.0]	0.201	39 (**4.9**) [3.5–6.6]	0 (**0.0**)	6 (**4.4**) [1.6–9.3]	15 (**6.2**) [3.5–9.9]	10 (**4.4**) [2.2–8.0]	5 (**3.0**) [1.0–6.9]	0.490	36 (**4.6**) [3.3–6.3]
I prefer to be with a **friend**	0 (**0.0**)	24 (**3.2**) [2.1–4.8]	0.146	24 (**3.0**) [1.9–4.4]	0 (**0.0**)	1 (**0.7**) [0.0–4.0]	7 (**2.9**) [1.2–5.8]	8 (**3.6**) [1.5–6.9]	5 (**3.0**) [1.0–6.9]	0.400	21 (**2.7**) [1.7–4.1]
I prefer to be with **my partner**	11 (**17.2**) [8.9–28.7]	66 (**8.9**) [7.0–11.2]	0.030	77 (**9.6**) [7.6–11.8]	0 (**0.0**)	5 (**3.7**) [1.2–8.3]	19 (**7.8**) [4.8–11.9]	28 (**12.4**) [8.4–17.5]	23 (**13.8**) [8.9–20.0)	0.005	75 (**9.6**) [7.6–11.9]
Does not matter	17 (**26.6**) [16.3–39.1]	81 (**10.9**) [8.8–13.4]	<0.001	98 (**12.2**) [10.0–14.7]	0 (**0.0**)	12 (**8.8**) [4.6–14.8]	24 (**9.9**) [6.4–14.3]	31 (**13.8**) [9.6–19.0]	29 (**17.4**) [11.9–24.0)	0.048	96 (**12.3**) [10.1–14.8]
TOTAL	**64**	**740**		**804**	**8**	**137**	**243**	**225**	**167**		**780**

*z-score (two-tailed)

1. The categories “10–12” and “13–15” were merged for analysis.

2. Chi-square test of independence

Table 3. Preferences related to accessing SRHS and consulting a health professional in relation to gender and age

PREFERENCES OF ACCESS AND CONSULTATION	GENDER				AGE						
	Man n (%) [95%CI]	Woman n (%) [95%CI]	*p* value*	TOTAL n (%) [95%CI]	10–12 n (%) [95%CI]	13–15 n (%) [95%CI]	16–18 n (%) [95%CI]	19–21 n (%) [95%CI]	22–24 n (%) [95%CI]	*p* value[1,2]	TOTAL n (%) [95%CI]
Wanted to go **alone** to clinic and wants to be **alone** with health professional	7 (**10.9**) [4.5–21.3]	81 (**10.9**) [8.8–13.5]	0.992	88 (**11.0**) [8.9–13.3]	0 (**0.0**)	5 (**3.7**) [1.2–8.4]	16 (**6.6**) [3.8–10.5]	36 (**16.0**) [11.5–21.5)	30 (**18.0**) [12.5–24.6]	< 0.001	87 (**11.2**) [9.1-13.6]
Wanted to go **alone** to clinic and wants to be **accompanied** with health professional	1 (**1.6**) [0.0–8.4]	9 (**1.2**) [0.6–2.3]	0.781	10 (**1.2**) [0.6–2.3]	0 (**0.0**)	1 (**0.7**) [0.0–4.1]	3 (**1.2**) [0.3–3.6]	2 (**0.9**) [0.1–3.2]	3 (**1.8**) [0.4–5.2]	0.800	9 (**1.2**) [0.5–2.2]
Wanted to go **alone** to clinic and **does not matter** if alone/accompanied with health-care professional	0 (**0.0**)	3 (**0.4**) [0.1–1.2]	0.612	3 (**0.4**) [0.1–1.1)	0 (**0.0**)	0 (**0.0**)	0 (**0.0**)	1 (**0.4**) [0.0–2.5]	2 (**1.2**) [0.2–4.3]	0.223	3 (**0.4**) [0.1–1.1]
Wanted to go **accompanied** to clinic and wants to be **alone** with health professional	12 (**18.8**) [10.1–30.5]	212 (**28.7**) [25.5–32.1]	0.090	224 (**27.9**) [24.8–31.2]	1 (**12.5**) [0.3–52.7]	44 (**32.6**) [24.8–41.2]	75 (**30.9**) [25.1–37.1]	65 (**28.9**) [23.1–35.3]	38 (**22.8**) [16.6–29.9]	0.263	223 (**28.7**) [25.5–32.0]
Wanted to go **accompanied** to clinic and wants to be **accompanied** with health professional	10 (**15.6**) [7.8–26.9]	257 (**34.8**) [31.4–38.4]	0.002	267 (**33.3**) [30.0–36.7]	7 (**87.5**) [47.4–99.7]	63 (**46.7**) [38.0–55.4]	93 (**38.3**) [32.1–44.7]	57 (**25.3**) [19.8-31.5]	34 (**20.4**) [14.5-27.3]	< 0.001	254 (**32.7**) [29.4-36.1]
Wanted to go **accompanied** to clinic and **does not matter** if accompanied/alone with health professional	6 (**9.4**) [3.5–19.3]	40 (**5.4**) [3.9–7.3]	0.190	46 (**5.7**) [4.2–7.6]	0 (**0.0**)	6 (**4.4**) [1.7–9.4]	8 (**3.3**) [1.4–6.4]	16 (**7.1**) [4.1–11.3]	14 (**8.4**) [4.7–13.7]	0.100	44 (**5.7**) [4.1-7.5]
Does not matter to go accompanied/alone to clinic and wants to be **alone** with health professional	11 (**17.2**) [8.9–28.7]	75 (**10.2**) [8.1–12.6]	0.083	86 (**10.7**) [8.7–13.1]	0 (**0.0**)	6 (**4.4**) [1.7–9.4]	24 (**9.9**) [6.4–14.3]	25 (**11.1**) [7.3–16.0]	26 (**15.6**) [10.4–22.0]	0.012	81 (**10.4**) [8.4–12.8]
Does not matter to go accompanied/alone to clinic and wants to be **accompanied** with health professional	6 (**9.4**) [3.5–19.3]	23 (**3.1**) [2.0–4.6]	0.010	29 (**3.6**) [2.4–5.2]	0 (**0.0**)	4 (**3.0**) [0.8–7.4]	8 (**3.3**) [1.4–6.4]	9 (**4.0**) [1.9–7.5]	7 (**4.2**) [1.7–8.5]	0.900	28 (**3.6**) [2.4–5.2]
Does not matter to go accompanied/alone to clinic and **does not matter** to be accompanied/alone with health professional	11 (**17.2**) [8.9–28.7]	38 (**5.2**) [3.7–7.0]	<.001	49 (**6.1**) [4.6–8.0]	0 (**0.0**)	6 (**4.4**) [1.7–9.4]	16 (**6.6**) [3.8–10.5]	14 (**6.2**) [3.4–10.2]	13 (**7.8**) [4.2–12.9]	0.630	49 (**6.3**) [4.7–8.2]
TOTAL	**64**	**738**		**802**	**8**	**135**	**243**	**225**	**167**		**778**

*z-score (two-tailed)

1. The categories "10–12" and "13–15" were merged together.

2. Chi-square test of independence.

older participants, there is more variability amongst the distribution of preferences.

In looking at both Tables 2 and 3, we can observe a heterogeneity of participant preferences regarding how they wish to access SRHS and consult with healthcare professionals. Within demographic groups (gender, age), there is also a notable variety of preferences. As will be explored in the Discussion section, it is critical to recognize this multiplicity of preferences for adolescents as it relates to their autonomy to access SRHS and consult with health professionals; and just as importantly, the data highlights the pertinence of a "relational autonomy" approach instead of an individualistic perspective.

Interviews Results

Building on the descriptive portrait generated by the cross-sectional data, the data from the semi-structured interviews can then help provide further meaning. It is important to note that the participants in the interviews did not necessarily have experiences specifically with Profamilia. Some had accessed SRHS[4] through other clinics or with their family doctor, while others had never used SRHS, for example, because their parents prohibited them from accessing such services. In this section, the demographic profiles of participants are first presented, followed by the steps involved in accessing SRHS, which help clarify the complexity of the question of adolescents' autonomy. This presentation is intended to demonstrate the variety of adolescent preferences and experiences, while also paying attention to the question of autonomy. The interview excerpts are all identified by pseudonyms.

Table 4 presents the characteristics of the interview participants. Participants were free to define their own gender at the beginning of the interview. Of the forty-five participants, twenty-one identified as male, twenty-three as female, and one as non-binary. The youngest participant was fourteen and the eldest was twenty-three years old. The majority of participants were from *estratos* two and three. Forty-four point four per cent came from the department of Antioquia: Medellin (large city), Rionegro (small city), and Santa Fe de Antioquia (rural area); and 55.5 per cent from the department of Valle del Cauca: Cali (large city) and Palmira (small city). All participants were Colombian, although Venezuelan migrants were also invited to participate.

Table 4. Characteristics of participants for the interviews

Number of Participants	45
Gender, *n*	
Male	21 (46.7%)
Female	23 (51.1%)
Non-Binary	1 (2.2%)
Age, *n*	
14	1 (2.2%)
15	4 (8.9%)
16	5 (11.1%)
17	2 (4.4%)
18	3 (6.7%)
19	11 (24.4%)
20	2 (4.4%)
21	10 (22.2%)
22	5 (11.1%)
23	2 (4.4%)
Estrato, n	
1	3 (6.7%)
2	12 (26.7%)
3	25 (55.6%)
4	4 (8.9%)
5	0 (0.0%)
6	0 (0.0%)
Unknown	1 (2.2%)
Residence of Participant, *n*	
Medellin, Antioquia	9 (20.0%)
Rionegro, Antioquia	6 (13.3%)
Santa Fe de Antioquia, Antioquia	5 (11.1%)
Cali, Valle del Cauca	2 (4.4%)
Palmira, Valle del Cauca	23 (51.1%)

The Initial Choice

Prior to accessing SRHS, a person must make the decision to use SRHS—for example, to want to start using contraceptives or to get an HIV test—and know how to access those services. Participants

[4] It should be noted that the expression "sexual and reproductive health" was challenging to understand for an important number of participants. As shown in the interview excerpts, the expression "family planning" (*la planificación*)—which is popularly used in Colombia—was instead used during some of the interviews.

were thus invited to share how they came to make the choice to access SRHS. For an important number of participants, that initial decision came from themselves, by recognizing a need. In terms of autonomy, this phenomenon reflects a common practice where an adolescent starts to make health decisions by themself. However, for other participants, there were external influences, such as was the case for Natalia (twenty-one years old):

> Natalia: I started family planning with the implant at seventeen years old.
> Interviewer: And how did you end up choosing that option?
> N: It had been two months that I was seeing my boyfriend and my parents saw that I was spending a lot of time with him, so they sat down with me and told me I had to start family planning. They didn't ask details, but they asked me if I had started my sexual life and then told me that I had to start family planning. So, it was like a little push from them (…) Then I went to the *EPS* [subsidized health-promoting entities in Colombia], I asked for a consult to see which method was the best and that is how I started.
> I: Did you go alone?
> N: I went with my boyfriend.
> I: Did you want to go alone or accompanied?
> N: I wanted to go accompanied.
> I: Accompanied by whoever?
> N: No. I did not want to be accompanied by my mom or dad, I wanted to be with my boyfriend.

Within the classical bioethics framing of the principle of autonomy, it is usually interpreted as being problematic when others "push" individuals into making specific health-related decisions since this can represent a form of coercion and thus not be a genuine or autonomous choice for the patient. Yet, when asked if she disliked this intervention by her parents in "pushing" her to start using contraceptives, Natalia expressed that she appreciated their gesture. In this case, Natalia's parents could be seen to having engaged in a form of "fostering autonomy" to access SRHS, which Natalia appreciated. But it is important to recognize that other participants expressed that they greatly disliked having their parents telling them what to do with regards to their sexual and reproductive health or that they simply did not talk about sex with their parents. As for Natalia's case, when it came to actually accessing a clinic, she clearly knew her preference and decided to go accompanied by her partner as opposed to going alone or with her parents.

The Actual Choice to Access SRHS

While an adolescent might want to access SRHS, this may not translate into knowing exactly how to do so (e.g., knowing which clinic to go to for HIV/STI testing, knowing if there are fees for the services) nor knowing which choice to make (e.g., which contraceptive option to use). As such, before accessing a clinic, an adolescent might seek guidance within their social network (e.g., friend, cousin, parent, teacher), which could embody another form of fostering the adolescent's autonomy by obtaining information from others. For example, as the following interview excerpt shows, the initial choice to start using contraceptives may come from the adolescent herself. However, the concrete decision of which contraceptive option to choose and the question of how to access SRHS can involve the assistance of another person, i.e., the adolescent's mother in the following excerpt:

> Paola (eighteen years old)
> Interviewer: Did you go alone or with your parents? (the first time to access SRHS at seventeen years old)
> Paola: I went with my mom. My mom always accompanies me in everything! (laughs)
> I: So, it was important for you to go with your mom?
> P: Yes. Yes, it was important because I was confused, and she had my back. I want to make the right decisions in life, and I want to do the right things, so my mom has always been a person in who I could have trust in. So, I spoke with her and she said "ok, let's go check it out to see what we will do" and then she brought me to Profamilia.
> (…)
> I: And you did not mind that your mother was present in the room with the doctor?
> P: No (…) For example, she was asking, "And this will not cause harm? Will this cause her anemia?", because I've had bad symptoms before to medications, so my mom was asking a lot of questions (…)

It is worth noting that Paola wanted the assistance of her mother to help in choosing a contraceptive option. Yet, her mother did not necessarily have more knowledge than Paola to help her daughter make an informed decision on which contraceptive option to choose, as shown by the mother's questions to the doctor. Nonetheless, we can observe that Paola's mother engaged in a form of fostering the autonomy of her adolescent daughter's choice to use contraceptives by bringing her to Profamilia and asking pertinent questions to the healthcare professional.

Accessing the Clinic

After deciding to use SRHS comes the issue of accessing these services, which can be done alone or accompanied. With the previous two examples, we can understand the participants' appreciation for some parental involvement. However, that was not the case for all participants. As the following participant illustrates, he explicitly did not want his mother to know that he planned to access SRHS, and instead would like the choice to have his friend accompany him to the clinic but then remain in the waiting room.

> Diego (twenty-one years old)
> Interviewer: Would you prefer to go alone or accompanied (to get HIV/STI testing)?
> Diego: Accompanied
> I: By whom?
> D: A friend.
> I: Why is that?
> D: It's because I would not be able to tell my mom. And with my friend, I have a lot of trust in him and I know that if I would need help, he would help me.
> I: And to see the health professional?
> D: Alone.
> I: Why not with the friend?
> D: It's because in case of something, the professional will help with that and then afterward, the friend will help emotionally.
> I: So, you would like your friend to wait for you in the waiting room?
> D: Yes.

Diego's case highlights the clear distinction there can exist in autonomous preferences regarding accessing the clinic and consulting a healthcare professional. This phenomenon was notably reflected in the cross-sectional data presented above, where participants had a variety of preferences. For those who wished to access the clinic accompanied but see the healthcare professional alone, one of the common explanations was the need for confidentiality, which echoes data on the topic from previous research (Fuentes et al. 2018). Nonetheless, other participants shared that they wanted the whole process to be confidential, which is why they did not want others to know they were using SRHS and so wanted to access the clinic alone.

Consulting the Healthcare Professional

The previous examples underscore the importance that adolescents can attach to their preferences of being accompanied (or alone) to access SRHS. However, as was shown in the cross-sectional data section, some participants did not have a specific preference even with regards to consulting the healthcare professional. This was notably the case for Martin (twenty-one years old):

> Interviewer: If you would have had the option, would have you preferred to be accompanied or you preferred to be alone? (to get STI/HIV testing)
> Martin: Normal. If there would have been a family member with me, I would have done it with a family member. It depends on the context. I was leaving work and saw the opportunity, so I took advantage of it. But I would have not had a problem that a family member comes with me or that I be alone. It is the same for me. Family is family.

This lack of a specific preference regarding how participants consulted a healthcare professional—either alone or accompanied—was a more prevalent answer for men in both the interviews and the survey (as shown in the previous section, 26.6 per cent vs. 10.9 per. cent). This study did not investigate in-depth the influences for the gendered responses. The data suggests that the question of gender might influence the experience of autonomy for Colombian adolescents to access SRHS, which points to the need for further research on this specific topic, e.g., to explore why adolescent boys may be more inclined towards independence to access SRHS in

comparison to adolescent girls who tend more to prefer to be accompanied.

Discussion

The data from this study can help contextualize and clarify AA-HA!'s concept of "fostering adolescents' autonomy" to access health services. The study invites reflection on what "fostering autonomy" might actually entail in practice and supports further reflection on the interrelated ethical issues. Here, we explore the pertinence of using a relational autonomy approach as it relates to Colombian adolescents' autonomy to access SRHS and make suggestions for practical application by policymakers and healthcare professionals, that also consider the possible ethical challenges for adolescents (and the other stakeholders).

The Pertinence of Relational Autonomy for Colombian Adolescents

As previously mentioned, respect for autonomy is a core principle in bioethics and enshrined in professional codes of ethics, guidelines, and the law. The origins of the concept's development are rooted within a specific Western tradition that might not always easily translate to other cultural contexts (Candib 2002; Dove et al. 2017; Frosch and Kaplan 1999; Ravez 2020). The autonomous subject (e.g., patient) is thus often framed as needing to make choices independently and without external influences—the subject needs to be self-reliant in order to protect their agency and autonomy (Gómez-Vírseda et al. 2019). From this framing is often derived a highly individualistic, ahistorical, and asocial view of the patient (or research participant). In application, to show respect for individual human dignity means that health policy and the practice of health professionals should strive to promote patient–clinician relations and clinical practices that respect patient autonomy as independence (Ho 2008). Conversely, when external influences affect a patient's choices, e.g., when doctors or family members influence patients' decisions, these are understood as problematic or even unethical because they are disrespectful of the patient's right to self-governance. Thus, in contemporary bioethics there is strong advocacy for respect for autonomy, for example, through ensuring free and informed consent for patients and research participants, with the goal of ensuring respect for one's personhood (Beauchamp and Childress 2012). In parallel, as previously mentioned, on the question of adolescents' access to SRHS, previous studies in different cultural contexts have shown that adolescents wish for their autonomy to be respected in terms of independence (Fuentes et al. 2018; Garside et al. 2002), such as by not requiring parental consent to access SRHS and protecting adolescents' confidentiality.

When applying such a conceptualization of autonomy to the data generated in our study, it is possible to observe some important disconnects. Note that we are not here challenging the importance of ethical principles at the heart of contemporary bioethics, e.g., that a patient's independence and personal choices should be respected. For example, if a woman wishes to use a contraceptive option, she should have her choice fully respected, without any restrictions. Rather, our intention is to point to the need to reframe the concept of autonomy—in both health policy and professional practice—to move it beyond a narrowly individualistic model so that it is pertinent for Colombian adolescents and the promotion of AA-HA!'s notion of fostering autonomy. More concretely, we wish to challenge the notion that self-reliance and independence in healthcare should be an ethical ideal or be conceived as more important than a patient's desire to have the support of others in healthcare decisions (e.g., parents). Instead, we argue that a relational autonomy approach could better respect and foster Colombian adolescents' autonomy to access SRHS, and thus effectively articulate in practice the "fostering autonomy" advocated by AA-HA!

Relational autonomy emerged from feminist philosophy (Heidenreich et al. 2018; Mackenzie and Stoljar 2000) in reaction to the aforementioned individualist and asocial conceptualizations of autonomy that focused on a patient's complete independence. Feminists sought to highlight how individuals (e.g., patients) are first and foremost social beings embedded within networks of relationships with others; as such, they are contextual beings and have important social identities that should not be ignored by healthcare professionals or policymakers (Ells et al. 2011; Gilabr and Miola 2015). Advocates of a relational autonomy view sought to challenge the notion

that patient self-sufficiency should be understood as intrinsically better than interdependency or that relying on others for help was a sign of insufficient autonomy and thus a form of ethical failure of the patient–clinician relationship or of broader health policies.

If interdependence is viewed as appropriate, even beneficial, then relying on help from others is not an expression of weakness. Instead, such help—when it is freely chosen and accepted—is an authentic expression of autonomy; the patient recognizes their own limitations and needs, and thus freely, i.e., autonomously, solicits help from another person. This help-seeking is voluntary, chosen and an authentic act of agency—in so doing, their autonomy is not reduced. On the contrary, such a relational view might enhance autonomy because having the aid of others in decision-making can support information acquisition and comprehension (i.e., the "informed" in informed consent) and give emotional strength to patients in the face of challenging decisions. Such support can thus enable a person to make more informed and voluntary decisions that they might find very difficult to make on their own and supports the U.N.'s notion of "progressive autonomy" for adolescents.

The findings from our study show that most participants placed significant importance on having others (especially parents) be involved, to varying degrees, in their autonomous access to SRHS. From an ethical perspective, it should not be interpreted as problematic or worse that an adolescent might appreciate the involvement of others in accessing SRHS, in comparison to an adolescent who might want to go through the whole process independently and without additional support. When engaging in initiatives to foster adolescents' autonomy to access health services, as advocated by AA-HA!, in the context of Colombia, this should not be done exclusively with the goal of achieving absolute independence. Rather, there needs to be recognition of the legitimacy of Colombian adolescents' wish to have others involved—with the nature and scope of this involvement determined by the adolescent—in supporting their autonomy to access SRHS.

A Policy Suggestion

As highlighted by Gómez-Vírseda et al. (2019) relational autonomy is often theorized but there is a lack of literature on how to apply it in practice. Our research shows the pertinence of applying a relational autonomy approach when developing health initiatives and policies related to Colombian adolescents' access to SRHS (and potentially other types of health services), which aligns with AA-HA!'s objective of fostering adolescents' autonomy.

Historically, when it comes to comprehensive sex education for adolescents, public health initiatives have tended to be very individualistic in their approach. For example, having teachers or nurses teach sex education directly to young people so that they can make their own individual, autonomous decisions. It is essential to provide the skills to adolescents on how to be self-reliant when making choices related to their sexual and reproductive health (e.g., teaching how to use condoms). However, there has not been the same effort invested in teaching adolescents how to access SRHS, for example, by teaching the steps involved in getting a prescription for contraceptives at a clinic (Guttmacher Institute 2015). Providing this information to adolescents—e.g., with tools that are adapted according to age, gender, education, and are easily accessible—should be part of a comprehensive sex education curriculum in schools, that informs both individual action (e.g., how to use a condom) and the processes or contexts in which that action can be deployed (e.g., where, how, and under what conditions they can obtain condoms or access SRHS).

Based on our research findings, which show that many Colombian adolescent participants place a high value on having others—including friends and parents——accompany them in their access to SRHS, it would be worth investing in initiatives that involve and empower parents to foster adolescents' autonomy. For example, this could be done through the development of public health campaigns encouraging parents to talk more openly with their adolescents and explain that they would be willing to accompany them to access SRHS, all the while respecting their adolescent's choice if they preferred to consult the healthcare professional alone once at the clinic. Instead of laying all the responsibility on adolescents themselves to independently navigate their access to SRHS (i.e., autonomy as self-reliance), providing skills to parents on how they can foster the autonomy of their adolescents could be a promising approach to explore, at least in the Colombian context.

There are certainly challenges to engaging in public health initiatives targeted at parents of adolescents. One is obviously the possibility of an underlining moralistic messaging in telling parents what they should do with their children. Also, if those public health recommendations do not align with the parents' values, this can raise another set of ethical issues that should be explored, notably, with parents themselves. There is additionally a potential ethical issue of equity since some adolescents may have healthier (e.g., more open, active listening, share decision-making) parent–child relationships than their peers, which could lead to some adolescents being more likely to have their preferences respected than their peers. For example, a parent can disapprove of their adolescent wanting to be sexually active and refuse to talk about the subject or assist them in accessing SRHS; whereas the parent of another adolescent may be more supportive and help schedule an appointment in a clinic to assist their adolescent in accessing the needed SRHS. Depending on the parent–child relationship, adolescents will not necessarily have equitable access to SRHS nor have their preferences met or respected.

Limits

This study used the case of sexual and reproductive health services, which includes different types of services—there could potentially be important differences in answers and preferences between the types of health services, which were not explored in depth in this study. An adolescent might have one type of preference for a certain health service but a different preference for another. A further limitation of the study is that the quality of the parent–adolescent relationship was not investigated as it pertains to adolescent participants' preferences for access to SRHS; and the quality of this relationship could be an important influencing factor. For example, adolescents who can talk more openly with their parents about sexuality might be more prone to have their parents assist them to access SRHS, as opposed to parents who refuse to talk about sexuality with their adolescent. Future research should explore those differences with adolescents and their parents.

Another limitation is the representation of the sample, both for the surveys and interviews. For the survey, there is a representation bias due to its convenience sampling approach. Another limitation relates to participants who might not know how to answer the questions (e.g., survey). It is also important to note that the patients who presented themselves at Profamilia are most likely not representative of adolescents who do not go to Profamilia. On the question of access to SRHS, it is important to note that a multiplicity of factors can influence an adolescent's autonomy in accessing SRHS (e.g., the adolescent's agency, knowledge of available services, location, and hours of the clinic), but in the context of this study, those factors were not addressed. It would be pertinent, for example, to conduct research with Colombian adolescents who do not access SRHS in order to explore their opinions on the topic of autonomy as their experiences and preferences may be different from the adolescent participants in our study.

Conclusion

The WHO's AA-HA! recommendations underscore the urgency of addressing issues related to adolescents' autonomy with the goal of implementing change to ameliorate the health of adolescents. The present study explored the question of Colombian adolescents' autonomy to access SRHS. Our findings revealed that adolescent participants expressed a multiplicity of preferences and experiences as these relate to their autonomy to access SRHS. The findings also showed that the common understanding of the ethical principle of respect for autonomy as articulated in contemporary bioethics and professional codes of ethics (i.e., individualistic and asocial) and as described in research with adolescents in different cultural contexts, does not resonate with most Colombian adolescent participants. For the vast majority of participants, an important component of their autonomy was closely related to the involvement of others (e.g., friends, family), to different degrees, in how they accessed SRHS. We therefore advocate in favour of adopting a relational autonomy approach to better support Colombian adolescents' autonomy and access to SRHS. The present findings are rooted within a specific cultural context and this conclusion might not be transferable to other cultural settings. Nonetheless, in many other cultural contexts, including in North America and Europe, a relational autonomy view

could be pertinent as it explicitly highlights the reality of human interdependence, something that is particularly important when a young person is seeking healthcare services. Further empirical research with adolescents and their parents, and in different cultural contexts, could help enrich reflections on how to operationalize relational autonomy approaches to respecting adolescents and fostering their autonomy in access to important healthcare services, such as SRHS.

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Data Availability The data that support the findings of this study are not available due to ethical restrictions.

Declarations

Conflict of Interests My coauthors and I have no conflicts of interest to disclose.

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