Navigating Care: Behavioural Determinants of Adolescent Sexual and Reproductive Health Service Delivery in Healthcare Organisations in the Greater Accra Region

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ABSTRACT

Over the years, Ghana's growing cultural and patient diversity has become increasingly evident in healthcare facilities, raising important concerns about how provider behaviours shape service delivery and health outcomes. However, little is known about how healthcare professionals' behaviours influence service delivery within multicultural healthcare settings. This study explored the behavioural determinants shaping healthcare professionals' (HCPs') delivery of adolescent sexual and reproductive health services (ASRHs) within healthcare organisations in the Greater Accra Region. The study employed a qualitative descriptive design, using two complementary theoretical frameworks; COM-B and Campinha-Bacote's models to understand the behaviours of the service providers. The study focused on HCPs delivering adolescent sexual and reproductive health services (ASRHs) to migrant adolescents in selected facilities in Greater Accra Region. Convenience sampling was used to recruit 10 HCPs after saturation was reached. Data were collected through (4) in-depth interviews (IDIs), (4) key informant interviews (KIIs), and 6 in the FGD, some HCPs participated in more than one data collection method. The study found that HCPs had limited confidence and cultural competence to effectively address cultural and communication barriers during service delivery. These challenges hindered discussions on sensitive topics such as family planning and safe abortion, resulting in reliance on untrained interpreters and inadequate community outreach services. The study concludes that limited confidence and capability among HCPs led to sub-optimal care, undermining ASRH service delivery within multicultural healthcare organisations. The study informs organisational policies and workforce practices that strengthen behavioural competencies among HCPs and enhance the quality of care in culturally diverse settings.

Keywords: COM-B model, cultural competence, healthcare professionals, adolescent sexual and reproductive health, migrant adolescents

1. INTRODUCTION

Healthcare professionals' behaviours are central to the delivery of equitable healthcare within culturally diverse settings. Evidence suggests that provider knowledge, cultural competence, communication skills, and organisational support influence the extent to which healthcare professionals can deliver responsive care to populations with diverse cultural backgrounds (Lie et al., 2011). The importance of HCP behaviour has become increasingly relevant as globalisation and population mobility have transformed the demographic composition of societies and healthcare populations worldwide. International migration has increased the movement of people across national boundaries, while internal migration has further diversified populations through rural-urban and interregional mobility (Zimmerman et al., 2011).

These population shifts have created healthcare environments where patients differ in cultural backgrounds, languages, beliefs, and health-related practices, highlighting the need for culturally congruent healthcare delivery. Culturally responsive care enhances patients'

comfort, trust, and confidence in healthcare systems while improving satisfaction and the overall quality of healthcare experiences (International Organization for Migration [IOM], 2020).

Ghana reflects these broader demographic changes, particularly within the Greater Accra Region, which serves as a major destination for internal migrants seeking employment, education, and livelihood opportunities. The region hosts diverse populations, including rural–urban migrant adolescents, many of whom migrate independently or with limited social support and encounter unique sexual and reproductive health needs (Ghana Statistical Service [GSS], 2012; Kwankye et al., 2021). Consequently, healthcare facilities serving these populations increasingly operate within multicultural contexts where healthcare professionals must navigate differences in language, cultural beliefs, and expectations regarding ASRHs. In multicultural healthcare settings, culturally responsive ASRH delivery is essential because HCPs' knowledge, attitudes, communication, and cultural competence influence the accessibility and quality of care for diverse adolescents. Consequently, understanding provider behaviour provides insight into the organisational level factors that may facilitate or constrain progress towards equitable ASRH outcomes among migrant adolescents (WHO, 2017), thereby improving access to quality ASRHs which is central to achieving the sustainable Development Goals (SDGs), particularly SDG 3.7, which calls for universal access to sexual and reproductive healthcare services, including family planning, information, and education.

Evidence suggests that migrant adolescents under utilise ASRH services due to multiple factors, including language and financial barriers, limited availability of adolescent-friendly services, stigma, confidentiality concerns, and institutional constraints. Although these structural and individual-level barriers are important, healthcare providers' behaviours have emerged as a critical organisational determinant of service access and utilisation. Evidence indicates that limited competences to deliver culturally responsive and adolescent-friendly care can undermine communication, trust, and adolescents' willingness to seek services (Dune et al., 2017). In multicultural healthcare settings, culturally competent communication and responsive practices are therefore essential for improving healthcare experiences and service quality (Williams et al., 2022).

Cultural responsiveness is one component of a broader strategy for addressing ASRH inequities, while strengthening HCPs' cultural competence can improve their knowledge, skills, and patient outcomes (Wilson-Stronks, 2008; Gallagher et al., 2015; Fisher et al., 2007). Cultural competence involves recognising cultural differences and adapting professional practices through respectful communication, active listening, shared decision-making, and appropriate use of interpreters (Fitzgerald, 2001).

Within healthcare organisations, these behaviours are essential for professional performance, influencing provider-patient interactions, service quality, and the implementation of equitable care especially for diverse populations (Weech-Maldonado et al., 2012). Therefore, behavioural competencies of HCPs facilitate culturally responsive practice through effective communication, collaboration, and community engagement (Bean, 2006).

However, although Ghana has increasingly witness cultural diversity among healthcare users, limited empirical evidence exists on the behavioural drivers that shape HCPs' delivery of culturally responsive ASRHs within multicultural healthcare organisations. Previous research in Ghana has predominantly focused on adolescent sexual health knowledge, service utilisation barriers, and access-related challenges, with less attention given to the role of healthcare professionals' behaviours in shaping adolescents' experiences of care. This knowledge gap is particularly important in the Greater Accra Region, which represents one of Ghana's most

culturally and socially diverse healthcare environments due to sustained rural-urban migration. The selected healthcare facilities, located within densely populated urban communities of Greater Accra such as Accra Metropolitan, Old Fadama/Agbogbloshie, and La-Nkwantanang Madina, serve populations characterised by substantial ethnic, linguistic, and socioeconomic diversity due to sustained rural–urban migration (GSS, 2012).Therefore, the study explore the behavioural drivers influencing healthcare professionals' delivery of ASRH services within multicultural healthcare organisations in the Greater Accra Region of Ghana. The study contributes theoretically by extending the application of behavioural science approaches to understanding healthcare provider practices in multicultural settings, and empirically by generating context-specific evidence on provider-level determinants of ASRH service delivery among migrant adolescent populations in Ghana. The findings provide a foundation for developing targeted behavioural interventions to strengthen culturally responsive healthcare practices. The remainder of this paper presents the methodology, findings, and implications of the study for research, policy, and practice.

2. LITERATURE REVIEW

Healthcare Provider Behaviour in Organisational Contexts

Healthcare professionals (HCPs) are central to the delivery of quality and equitable healthcare, and their behaviour directly influences how services are accessed, experienced, and delivered. In healthcare organisations, provider behaviour is shaped not only by professional knowledge and technical competence but also by interpersonal skills, attitudes, motivation, workplace relationships, and organisational conditions. The World Health Organization (WHO, 2022) conceptualises health workforce competence as the integration of knowledge, skills, and attitudes demonstrated through observable behaviours. However, HCPs often work within resource-constrained and unpredictable environments characterised by limited time, staffing, supplies, information, and organisational support. These conditions can influence how providers translate their knowledge and professional responsibilities into everyday practice. A health-systems perspective therefore emphasises the importance of organisational and structural conditions, including the availability of equipment and supplies, staffing levels, training, supervision, workload, and remuneration, in shaping provider performance (Kalamar et al., 2023).

Behavioural Determinants of Healthcare Provider Practice

Although organisational conditions are important, they do not fully explain variations in healthcare provider behaviour. Provider practices are also shaped by individual and interpersonal factors, including knowledge, attitudes, beliefs, confidence, motivation, and social influences (U.S. Agency for International Development [USAID], 2023). Provider behaviour change research therefore emphasises the interaction between individual capabilities and work environments (Rowe et al., 2018). The COM-B model captures this interaction through capability, opportunity, and motivation, which respectively reflect the knowledge and skills, environmental conditions, and cognitive and emotional processes that influence behaviour (Michie et al., 2011). This perspective moves beyond individual deficits by considering how provider and organisational factors jointly shape practice.

Cultural Competence in Multicultural Healthcare Organisations

Healthcare providers have contributed substantially to advancing cultural competence through research, practice, and assessment tools. Although cultural competence alone cannot eliminate healthcare disparities, it remains important for equitable and culturally responsive care (Shen, 2015). Understanding clients' cultural values and norms can strengthen trust, communication, and provider–client relationships. Cultural competence extends beyond cultural sensitivity by incorporating the knowledge, skills, communication, engagement, and motivation needed to provide responsive care to culturally diverse populations (Foldy & Buckley, 2017).

Healthcare Provider Behaviour and ASRH for Migrant Adolescents

Healthcare provider behaviour is central to ASRH service delivery because adolescents require confidential, respectful, and responsive care for contraception, STI/HIV services, and pregnancy-related needs. Provider attitudes, knowledge, communication, skills, and confidentiality influence the quality and utilisation of adolescent SRH services in sub-Saharan Africa (Jonas et al., 2017; Ninsiima et al., 2021). These challenges may be greater for migrant adolescents due to language, cultural, socioeconomic, and health-system barriers. However, research has focused more on adolescents' barriers and service utilisation than on how HCP capability, opportunity, and motivation shape care for culturally diverse adolescents. Examining these determinants can therefore clarify how organisational and cultural contexts influence equitable ASRH delivery.

Evidence from Ghana and the African Context

In Ghana, increasing urban diversity provides an important context for examining healthcare provider behaviour in multicultural healthcare organisations. In Accra, adolescents' access to SRH services is influenced by provider practices, cultural norms, social networks, poverty, and health-system factors (Parmar et al., 2024). Gaps in adolescent-friendly services, including limited multilingual educational materials, further highlight challenges in meeting diverse communication needs. However, there is limited research how HCPs' capability, opportunity, motivation, and cultural competence shape ASRH delivery to migrant adolescents, particularly in multicultural healthcare settings (Kumah et al., 2024).

Unresolved Gap

Despite advances in provider behaviour change research, important gaps remain in understanding culturally responsive provider behaviour, particularly in multicultural healthcare settings (Kok et al., 2018; Rowe et al., 2018). Existing research has focused mainly on clinical practices and clients' barriers to SRH utilisation, with limited attention to how provider capability, opportunity, motivation, and cultural competence shape ASRH delivery. Evidence from Ghana is especially limited. This study addresses these gaps by exploring HCP behavioural determinants in multicultural healthcare organisations in Greater Accra, integrating COM-B and Campinha-Bacote's model to explain how behavioural, organisational, and cultural factors shape ASRH service delivery to migrant adolescents.

2.1 Theoretical Framework

The study was guided by the integration of two complementary theoretical models: the Capability, Opportunity, Motivation and Behaviour (COM-B) model (Michie et al., 2011) and Campinha-Bacote's Model of Cultural Competence in Healthcare Delivery (Campinha-Bacote, 2022). The integration of these models was based on the recognition that culturally responsive healthcare delivery is both a behavioural process and a culturally situated practice. While

COM-B provides a behavioural explanation of why healthcare professionals engage or fail to engage in specific behaviours, Campinha-Bacote explains what cultural knowledge, skills, attitudes, and experiences are required for effective cross-cultural care.

The COM-B model conceptualises behaviour as the result of interactions among capability, opportunity, and motivation. In this study, it provided a framework for examining whether healthcare professionals had the necessary psychological and physical capabilities (e.g., cultural knowledge, communication skills), organisational opportunities (e.g., supportive policies, resources, interpreter availability), and motivation (e.g., attitudes, professional values, commitment) to deliver culturally responsive ASRHs. However, COM-B does not provide detailed guidance on the cultural dimensions of healthcare interactions, such as recognising personal biases, understanding patients' cultural perspectives, or developing culturally appropriate communication practices.

Campinha-Bacote's Model of Cultural Competence addresses this limitation by conceptualising cultural competence as an ongoing process of becoming culturally responsive rather than a fixed achievement. The model highlights five interrelated constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. These components provide specific insight into the cultural capabilities and orientations required for healthcare professionals to engage effectively with diverse populations. However, while the model offers a comprehensive understanding of cultural competence development, it provides less emphasis on the broader behavioural and organisational conditions that enable or constrain providers from applying these competencies within healthcare systems.

The models therefore overlap in recognising that effective healthcare delivery requires appropriate knowledge, skills, motivation, and engagement with patients. Their integration enabled this study to understand cultural competence as a provider behaviour shaped by individual and organisational determinants. Analytically, COM-B was used as the overarching behavioural framework, with Campinha-Bacote's constructs informing the interpretation of culturally specific capabilities, motivations, and practices. For example, cultural knowledge and cultural skill were examined as components of provider capability; cultural desire was considered in relation to motivation; and cultural encounters were explored within the opportunities created through interactions with diverse adolescent populations.

Both models have limitations. COM-B has been criticised for its broad categorisation of behavioural determinants, which may require additional theories to explain context-specific behaviours in depth. Similarly, Campinha-Bacote's model has been critiqued for its emphasis on individual provider competence, which may under emphasise structural issues such as institutional policies, resource limitations, and power inequalities within healthcare systems. By integrating both models, this study addresses these limitations by understanding culturally responsive ASRH delivery as the product of interactions between provider capabilities, motivations, organisational conditions, and cultural engagement processes.

3. METHODS

The research was conducted across selected healthcare facilities within the Greater Accra Region of Ghana, namely Ussher Hospital (situated in James Town near Old Fadama), Mallam Attah Government Hospital (located in Accra New Town), and two facilities in Madina, Madina Polyclinic-Kekele and Pentecost Hospital. A criterion purposive technique was used to select the health care facilities based on their strategic locations and multicultural

environments, requiring HCPs to respond to diverse cultural and linguistic expectations among the populations they serve (GSS, 2012). Specifically, these facilities are situated either within or in close proximity to communities characterized by strong migrant networks which are known for their cultural heterogeneity and high concentration of internal migrants. This unique demographic composition makes the settings ideal for exploring multicultural interactions and experiences in healthcare delivery. Furthermore, these facilities represent different levels of healthcare provision within the public and Christian Health Association of Ghana (CHAG). The inclusion of both public facilities and (CHAG) facility enabled the study to understand provider behaviour across different organisational and institutional contexts, rather than treating multicultural healthcare delivery as uniform across the health system (GSS, 2012; Yaro et al., 2011).

The research employed a qualitative descriptive design to gain in-depth knowledge of the experiences and perspectives of healthcare professionals, which is crucial in developing patient-centered healthcare models and interventions (Neegard et al., 2009). This approach was deemed appropriate as it allows for a rich description of how individuals perceive and make sense of their experiences within specific social and cultural contexts. Furthermore, the study was underpinned by a constructivist paradigm, which posits that reality is socially constructed through interactions between the researcher and participants. This philosophical perspective established a framework for comprehending knowledge as co-constructed, highlighting the subjective meanings and interpretations of participants. By adopting this orientation, the study was able to illuminate the multiple realities that shape individuals' perceptions, attitudes, and behaviours within their social environment (Guba & Lincoln, 1985). The researcher's public health background facilitated rapport and understanding during data collection but may have influenced participants' responses and interpretation. To minimise potential bias, the researcher avoided asking leading questions during data collection.

The study involved healthcare providers engaged in the delivery of ASRHs across the selected study sites. Participants included midwives, nurses, community health nurses, and public health nurses who provide both preventive and curative services to adolescents within these facilities. These professionals were recruited through convenience sampling, meaning that those who were available and willing to participate in the study were invited to take part. They were also selected because they constitute the front-line workforce directly interacting with adolescents during clinical consultations, counselling sessions, and outreach activities. Their central role in service delivery places them in a unique position to influence adolescents' access to care, decision-making processes, and overall health outcomes. Therefore, understanding their experiences, attitudes is therefore critical to effective ASRH service provision. Their various insights also offer valuable perspectives on how existing policies and institutional cultures shape adolescent healthcare delivery in multicultural urban settings.

An initial target of 15 HCPs was set for recruitment across the selected study sites.The final sample comprised 10 unique participants, with recruitment discontinued when data saturation was achieved. An initial target of 15 HCPs was set for recruitment across the selected study sites, with recruitment discontinued when data saturation was achieved, resulting in 10 unique HCPs. Of these, 4 participated in IDIs, 4 in KIIs, and 6 in the FGD. Some HCPs participated in more than one data-collection method. Saturation was assessed iteratively during data collection, with recruitment discontinued when three consecutive interviews failed to generate new themes or substantive insights, consistent with the stopping criterion proposed by Francis et al. (2010).

Within the selected facilities, HCPs who directly provided care to migrant adolescents during clinical encounters were recruited through convenience sampling. Participants were eligible

for inclusion based on their direct involvement in the care of migrant adolescents and their availability and willingness to participate at the time of data collection (Dörnyei, 2007).

The use of multiple qualitative methods generated complementary forms of evidence. IDIs provided detailed accounts of individual experiences, perceptions, and behaviours; KIIs provided broader perspectives on organisational practices, service delivery processes, and contextual factors; while FGDs explored shared experiences, interactions, and areas of agreement or disagreement among participants (Finch et al., 2014). Data triangulation was achieved by comparing findings across these data sources to identify areas of convergence, complementarity, and divergence. Themes that emerged consistently across methods were considered convergent evidence, whereas differences were examined in relation to participants' roles, experiences, and the context in which the data were generated. This approach strengthened the interpretation of findings by providing multiple perspectives on healthcare professionals' behavioural influences and ASRH service delivery.

Data were collected using semi-structured interview guides developed from the study objectives and the COM-B and Campinha-Bacote theoretical frameworks. The guides explored key domains including healthcare professionals' experiences of providing ASRH services to migrant adolescents; communication and cultural competence; providers' capability, opportunity, and motivation; provider adolescent interactions; organisational barriers and facilitators; and factors influencing culturally responsive service delivery. The interview guides were not piloted however they were reviewed by a senior colleague qualitative research expert to determine their clarity, relevance, and alignment with the study objectives and theoretical frameworks and appropriate revisions were made before the main data collection.

HCPs were approached, informed about the purpose and procedures of the study, and invited to participate at mutually convenient times. The principal investigator (PI) conducted the IDIs and KIIs and moderated the FGDs. Four trained research assistants supported the data collection process by assisting with participant recruitment and scheduling, taking field notes, managing audio recordings, and documenting relevant contextual observations. The research assistants were trained in qualitative interviewing and were familiar with the study context.

Interviews and FGDs were conducted in locations within the healthcare facilities where adequate privacy could be maintained and interruptions minimised, including offices and adolescent-friendly corners. Although nurses' stations were used when appropriate, interviews involving sensitive ASRH issues were conducted there only when sufficient privacy could be ensured; otherwise, a more private location was used. With participants' consent, all sessions were audio-recorded, while field notes were taken to capture non-verbal cues, contextual observations, and reflections. Each session lasted between 40 minutes and 1 hour, depending on participants' availability and the depth of discussion.

Several strategies were used to enhance the methodological rigour of the research finding. First, member checking was conducted with 10 participants who reviewed their interview transcripts and preliminary themes. Participants were invited to clarify, correct, or elaborate on the researchers' interpretation of their accounts. Feedback from the member-checking process did not result in changes to the interpretation of theme(s). Thus, member checking was used as an opportunity to assess the accuracy and plausibility of the researchers' interpretations rather than being treated as an automatic indicator of credibility.

An audit trail was maintained throughout data collection and analysis by the principal investigator, documenting methodological decisions, changes to the interview guides, coding and theme-development decisions and analytical reflection. A qualitative expert reviewed the

audit trail and analytical decisions to enhance transparency and dependability. Where a codebook was used, the research team independently reviewed the coding framework, and disagreements in coding or interpretation were resolved through discussion and consensus. These procedures provided a transparent account of how the data were transformed from raw transcripts into codes, categories, and themes and strengthened the dependability and confirmability of the findings.

Participants were eligible if they were HCPs working in the selected ASRH facilities and had prior experience providing care to migrant adolescents. Rather than excluding participants based solely on cultural identity, the study sought to include individuals with experience of cross-cultural clinical encounters and, where relevant, perspectives that differed from those of the migrant adolescents they served. Cultural background was considered in relation to participants reported cultural, linguistic, and social experiences rather than being treated as a fixed or homogeneous category. This approach was intended to facilitate examination of how HCPs navigate cultural differences during ASRH service delivery without assuming that individuals from different cultural groups necessarily hold different beliefs or practices. To minimise selection bias, eligibility was primarily based on participants' direct experience providing care to migrant adolescents, while variation in professional and cultural experiences was sought where feasible.

Ethical clearance for the study was obtained from the Ghana Health Service Ethics Review Committee (Clearance Number: GHS-ERC 016/04/22), in accordance with the principles outlined in the Declaration of Helsinki report. Written informed consent was obtained from each participant before data collection. Participation was voluntary, and participants were informed of their right to withdraw from the study at any stage without penalty or loss of benefits. To protect confidentiality, participants were assigned unique identification codes, and their names and other direct identifiers were removed from transcripts and study records. Potentially identifiable information about healthcare facilities and providers was also de-identified or generalised during transcription and reporting to minimise the risk of identification. Audio recordings, transcripts, consent forms, and field notes were stored securely in password-protected digital files, with access restricted to the principal investigator and authorised members of the research team. Consent forms and other identifying information were stored separately from research data. Hard-copy materials, where applicable, were kept in a locked and secure location accessible only to the research team. Data will be retained securely for 10 years in accordance with the institutional review board's requirements and will be securely destroyed after the retention period. These procedures were implemented to protect participants' privacy and confidentiality and to ensure the secure management and integrity of the research data.

4. ANALYSIS

Data were analysed thematically using NVivo 11 to organise, code, and interpret the data in relation to the research objectives. The analysis followed the six-phase approach of Braun and Clarke as cited by Maguire and Delahunt (2017): familiarisation with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. The analysis began inductively. The researchers repeatedly read the transcripts and generated initial codes directly from participants' accounts without applying the theoretical frameworks. An iterative codebook was developed and refined as new patterns and meanings emerged from the data. Following the initial coding stage, the COM-B and Campinha-Bacote models were introduced deductively to organise and interpret the established codes. COM-B was used to examine behavioural determinants in terms of capability, opportunity, and motivation, while Campinha-Bacote's model was used to interpret culturally

relevant dimensions of provider practice, including cultural awareness, knowledge, skill, encounters, and desire. Codes were subsequently mapped onto the relevant theoretical constructs where conceptual alignment was evident. However, data that did not fit either framework were retained and analysed as emergent categories rather than being forced into predefined constructs. Themes were developed from the relationships and patterns identified across the initial codes and were subsequently examined in relation to the theoretical frameworks. Thus, the frameworks informed interpretation and explanation of the findings rather than determining the themes in advance. This sequential inductive deductive approach enabled the analysis to remain grounded in participants' experiences while using COM-B and Campinha-Bacote to provide theoretically informed explanations of healthcare providers' behavioural and culturally responsive practices.

5. FINDINGS/RESULTS

In total, 10 HCPs participated in the study *(see* Table 1). Of these, 8 were female and 2 were male. Of these 3 participants each were aged between 31 and 32 years, and 35–36-year age group respectfully. Regarding educational attainment, 7 participants held a tertiary diploma, while the remaining 3 had other educational qualifications. By professional designation, senior midwives constituted the largest group, with 4 participants. Six participants worked in reproductive and child welfare clinic departments. In terms of work experience, 4 participants had worked in healthcare for 6–10 years, representing the most common category of years of professional experience among the participants.

Table 1

Socio-Demographic Characteristics of Study Population (N=10)

Characteristics	**n**
Gender	
Male	2
Female	8
Age	
29-30	1
31-32	3
33-34	1
35-36	3
37-38	1
39-40	1
Education	
Diploma	7
First Degree	3
Job Title	
Senior midwife	4
Senior health nurse education officer	1
Principal community health nurse	2
Senior nursing officer (Public health)	3
Department/Unit	

Reproductive and child health unit	6
Adolescent ART unit	3
Public health education unit for adolescents	1
Length of Work	
Less than a Year	1
1-5 Years	2
6-10 Years	4
10-15 Years	3

Note: N = 10 healthcare professionals.

Main themes and sub-themes

The analysis generated overarching behavioural and cultural domains that influenced healthcare professionals' delivery of adolescent sexual and reproductive health (ASRH) services. The findings were mapped onto the COM-B model and the Campinha-Bacote Model of Cultural Competence to identify the behavioural and cultural mechanisms underlying service delivery. *Table 2* summarises the main themes, sub-themes, and their corresponding theoretical domains. The narrative that follows presents each theme and illustrates the findings using participants' accounts.

Table 1

COM-B and Campinha-Bacote Domains Underpinning Healthcare Professionals' Behaviours

COM-B	Campinha-Bacote	Main Theme	Sub theme
Psychological capability	Cultural skill	Language barriers to effectively communicate with medication instructions	–
Psychological capability	Cultural awareness	–	Limited adaptation of care to migrant adolescents' backgrounds
Psychological capability	Cultural knowledge	–	Limited knowledge of adolescents' cultural backgrounds and lived experiences
Social Opportunity	Cultural skill	Reliance on untrained interpreters due to limited language support mechanisms	–

Social Opportunity	Cultural knowledge/skill	Biomedical practices do not align with clients' cultural beliefs, thereby hindering reproductive health discussion	–
Social Opportunity	Cultural knowledge/skill	–	Health education and counselling efforts by HCPs hampered by client misconceptions about family planning
Social Opportunity	Cultural knowledge	–	Adolescent work-related demands limit opportunity for HCPs to engage clients during routine clinic hours
Social Opportunity	Cultural encounter	Difficulty building rapport and engaging in clinical interactions	–
Reflective motivation	Cultural desire	HCP commitment to providing care despite organisational challenges	–

Note: HCPs = healthcare professionals; COM-B = Capability, Opportunity, Motivation-Behaviour. Cultural competence= cultural awareness, skill, encounter, knowledge, desire

Language barriers to effectively communicate with medication instructions

Language barriers emerged as an important challenge on HCPs' ability to communicate effectively with migrant adolescents especially regarding difficulties explaining medication instructions and reinforcing adherence. From a COM-B perspective, this reflected limited psychological capability, while Campinha-Bacote highlighted the cultural skill required to communicate effectively across linguistic and cultural differences.

One participant explained:

> *Medication adherence is a major challenge. When they come with low HB and are given medication, their HB may remain low because they do not understand the instructions. We give them our numbers and sometimes call to repeat the instructions, but they still do not understand* [Senior Midwife, FGD].

Another participant similarly described the difficulty:

> *As for the language barrier issue, it is a whole issue altogether; I can only say we are managing it with them* [Senior Nursing Officer, IDI].

Limited adaption of care to clients similar to non-migrant adolescents

The absence of HCPs' psychological capability and cultural awareness had influence on their inability to recognise and respond appropriately to cultural differences in care. Participants reported limited adaptation of care to migrant adolescents' cultural backgrounds.

The following was observed:

> *No, I don't have any different approach in dealing with them. Basically, I use the same approach as that of non-migrants* [Senior Nursing Officer, KII].

Poor knowledge of adolescent's cultural backgrounds and lived experiences

According to participants poor knowledge of migrant adolescents' cultural backgrounds and lived experiences constrained culturally responsive health education and communication, reflecting inability in psychological capability within COM-B and cultural knowledge within the Campinha-Bacote model. As one participant explained:

> *What we do in our facilities is that we normally provide services without really understanding our clients' backgrounds, and this makes it hard to give adolescents the kind of culturally sensitive care they actually need* [Principal Community Health Nurse,IDI].

Reliance on unprofessional interpreters

Provider behaviour was shaped by COM-B social opportunity with limited cultural skill contributing to reliance on friends, relatives, or other clients as interpreters. Although this addressed immediate communication needs, participants reported concerns about inaccurate information and breaches of confidentiality, particularly during sensitive services such as antiretroviral treatment.

This also came to light:

> *Most clients come along with their friends or we ask other patients on visits to assist with interpretation. The challenge is that the information is often not communicated accurately, which can affect diagnoses and treatment. In addition, involving friends in the process raises concerns about patient confidentiality like when it involves antiretroviral treatments* [Senior Nursing Officer, IDI].

Biomedical practices conflict with clients' cultural beliefs, hindering reproductive health discussions

HCPs reported that differences in adolescents' reproductive health beliefs, including religious restrictions on discussing family planning and safe abortion, constrained preventive communication. These beliefs represented a social opportunity constraint within COM-B, while Campinha-Bacote emphasised the cultural knowledge and skills needed to navigate such beliefs appropriately.
The following observation was reported:

> *In some religious groups, they don't allow open discussion about abortion. They say their religion frowns on it. Because of that, many young people keep quiet until they attempt abortions with related complications before they come to us* [Public Health Nurse, IDI].

Inability to carry out health education due to misconception about family planning

HCPs reported that family planning misconceptions challenged effective contraceptive counselling, with some adolescents believing that contraceptive use could prevent future childbirth. From the standpoint of COM-B, these beliefs constrained social opportunity for counselling, while Campinha-Bacote raises concerns about the cultural knowledge and skills needed to address them appropriately.
A participants revealed the following:

> *Yes, majority of them have misconceptions about the family planning. Some say … family planning … when they do family planning for you, you won't deliver again* [Senior Midwife, FGD].

Work related demands of clients limit opportunity for engaging clients during routine clinic hours

Adolescents' occupational demands posed challenge to HCPs' opportunities to deliver ASRH services. According to the participants those engaged in kaya (head portering) often had limited time to attend clinics, reducing provider- client engagement.This presents a social opportunity restraints, and also reflecting the lack of cultural knowledge needed to understand and respond to adolescents' circumstances.
The following was observed:

> *Most of these girls are busy with kaya work; they think about the money they will earn rather than coming to the clinic. By the time they finish, they are too tired or don't have the time for health services* [Public Health Nurse, IDI].

Difficulty building rapport during clinical interactions

According to HCPs' circumstances made it difficulty in building rapport with clients. This was evident in poor cultural encounters and reflected social opportunity limitations on meaningful provider-client interactions.
A participant revealed the following:

> *It becomes particularly challenging in cases involving antiretroviral treatment, where direct interaction with the client is not possible* [Senior Nursing Officer, IDI].

Commitment to providing care despite organisational constraints

Reflective motivation is associated with the tendency by HCPs expressed strong commitment to providing care to migrant adolescents despite organisational and communication challenges, this is also associated with cultural desire demonstrate providers' willingness to engage with and support culturally diver e adolescents despite existing constraints.This following was reported:

> *Although it can be stressful, I feel happy after attending to them. It gives me a sense of fulfillment, and sometimes it even builds a relationship. They are not family or close friends, but over time, they become like another set of friends, and I am always happy to work with them* [Senior Midwife, IDI].

6. DISCUSSION OF RESULTS

The purpose of the study was to explore the behavioural determinants shaping healthcare professionals' (HCPs') delivery of ASRHs within healthcare organisations in the Greater Accra Region. The findings indicate that HCP behaviour is shaped by the interaction between psychological capability, social opportunity, and reflective motivation, with cultural competence dimensions influencing how these behavioural determinants are expressed in practice. Within psychological capability, language barriers constrained HCPs' ability to communicate treatment instructions clearly and effectively with migrant adolescents, with implications for medication adherence. This finding is consistent with Zendedel et al. (2018), who reported that language barriers can contribute to misinterpretation of health information, incorrect medication use, and missed doses. Viewed through the lens of both frameworks, the finding suggests that effective communication requires not only the psychological capability to convey and clarify health information but also the cultural skills needed to navigate linguistic and cultural differences. Thus, limited cross-cultural communication can restrict HCPs' capability to translate their professional knowledge into culturally responsive practice. The findings therefore highlight the need for structured language support and culturally adapted communication strategies that strengthen both the behavioural capability and cultural competence required for effective ASRH service delivery in multicultural healthcare settings.

The study also found that differences in biomedical practices and cultural health beliefs, particularly regarding reproductive health, posed challenge to HCPs when discussing sensitive issues such as family planning and safe abortion. Religious and cultural values sometimes discouraged open discussion, contributing to delayed care and complications from unsafe practices (Kwankye et al., 2021). These beliefs also influenced HCP behaviour by requiring providers to adapt communication and navigate sensitive topics. From a COM-B perspective, such beliefs represent social opportunity barriers, while Campinha-Bacote highlights the cultural awareness and knowledge needed to respond appropriately. Participants also reported limited knowledge of migrant adolescents' cultural and social contexts, which may hinder culturally responsive care. Integrating both frameworks suggests that provider capability requires not only clinical knowledge but also culturally informed knowledge and awareness, highlighting the need to strengthen cultural competence through professional and in-service training.

Misconceptions surrounding family planning further constrained health education efforts. Persistent beliefs that contraceptive use causes infertility contributed to adolescents' reluctance to adopt modern contraceptive methods, thereby limiting the effectiveness of counselling and reducing service uptake. This finding reflects well-documented evidence from sub-Saharan Africa, where misinformation and prevailing sociocultural beliefs continue to influence reproductive health behaviours despite the availability of services (Mwin et al., 2026). The study overemphasis the important role of sociocultural beliefs and misinformation across sub-Saharan Africa. Addressing these misconceptions requires context-specific health promotion interventions that engage trusted community actors and incorporate culturally responsive communication approaches.

Within social opportunity, reliance on untrained interpreters, including friends and peers, emerged as a key challenge. Although these arrangements provided immediate assistance, they risked communication errors and confidentiality breaches, particularly during sensitive services such as HIV care (Zendedel et al., 2018). This reflects an organisational gap rather than solely an individual provider issue, as limited access to professional interpreters and

organisational language support restricted HCPs' ability to communicate effectively. From a COM-B perspective, weak social opportunity can hinder provider behaviour despite strong motivation, while Campinha-Bacote highlights the importance of organisational support in applying cultural skills during clinical encounters.

Furthermore, participants expressed concerns about the quality of cross-cultural encounters with migrant adolescents. Although HCPs encountered migrant adolescents in clinical settings, language and communication difficulties sometimes limited meaningful interaction, particularly when delivering sensitive services such as antiretroviral therapy. This difficulty may reduce opportunities for HCPs to build trust, address misconceptions, understand adolescents' experiences, and develop therapeutic relationships. In relation to Campinha-Bacote's model, the finding highlights the importance of meaningful cultural encounters in strengthening providers' cultural competence. Rather than indicating an absence of encounters, the finding suggests that the quality and depth of provider-client interactions may determine the extent to which such encounters contribute to culturally responsive care.

Within the domain of social opportunity, participants identified adolescents' work-related demands as a contextual hindrance on HCPs' ability to engage migrant adolescents through routine ASRH services. Adolescents involved in income-generating activities, such as head portering, often had limited time to attend health facilities, particularly during routine clinic hours. These competing demands reduced opportunities for HCPs to reach and engage adolescents through facility-based services. The finding therefore represents a client-level external constraint on provider behaviour rather than an indicator of HCP reflective motivation. It emphasizes the need for organisational responses, such as flexible service hours, outreach programmes, and adolescent-responsive models of care, to create opportunities for HCPs to translate their willingness to provide ASRH services into practice.

Despite these challenges, HCPs demonstrated strong motivation and commitment to caring for migrant adolescents, reflecting COM-B's reflective motivation and Campinha-Bacote's cultural desire (Campinha-Bacote, 2011). However, motivation alone may not ensure culturally responsive practice. Language barriers and limited cultural knowledge hampered capability, while inadequate interpreter services and organisational support limited opportunities to act on motivation. Thus, effective culturally responsive care requires alignment of motivation, capability, and opportunity, supported by appropriate organisational resources and cultural competence interventions.

7. CONCLUSION

This study explored behavioural and cultural factors influencing HCPs' delivery of ASRH services to migrant adolescents in multicultural healthcare organisations in Greater Accra. Findings revealed provider-level challenges, including language and cross-cultural communication difficulties, limited cultural knowledge, and inadequate adaptation of care. Organisational constraints, particularly limited professional interpreter services and support mechanisms, also restricted culturally responsive practice, while diverse client beliefs and work demand added contextual challenges. Despite these barriers, HCPs expressed strong commitment to caring for migrant adolescents, suggesting that service gaps were not solely attributable to low motivation.

Integrating COM-B and Campinha-Bacote showed that culturally responsive care depends on both behavioural and cultural competencies and the organisational conditions that enable their application. The findings suggest that improving ASRH delivery requires interventions that

combine cultural competence development with organisational support, including professional interpreter services and communication mechanisms responsive to migrant adolescents' needs.

8. IMPLICATIONS

The study has implications for facility managers, Ghana Health Service, Christian Health Association of Ghana (CHAG), and policymakers. Facility managers should provide regular training in cultural competence, culturally sensitive communication, and adolescent-friendly care, while strengthening interpreter services and culturally appropriate adolescent-friendly spaces. GHS and CHAG should institutionalise culturally responsive ASRH care through operational guidance, interpreter support, multilingual materials, referral mechanisms, and integration of cultural competence into staff orientation and continuing professional development. Policymakers should establish standards for culturally responsive ASRH care, including language-access protocols, workforce competencies, CPD requirements, and monitoring indicators such as interpreter use, multilingual information, and adolescents' experiences of care. These measures can strengthen accountability and embed culturally responsive ASRH services within Ghana's health system.

9. LIMITATIONS AND FUTURE RESEARCH

A key limitation was the exclusion of health facility managers and health directorate officials, whose perspectives could have provided insight into organisational leadership, resource allocation, and policy influences. Limited adolescent representation also constrained service-user perspectives. However, these limitations did not compromise the overall quality of the findings. Although COM-B and Campinha-Bacote guided the analysis and may have influenced interpretation, data that did not fit the frameworks were retained. Future studies should include leadership stakeholders and larger, more diverse samples across regions.

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