

Understanding the influence and acceptability of health and wellbeing coaching in underserved populations: A qualitative systematic review

Ian Litchfield

i.litchfield@bham.ac.uk

University of Birmingham

Christine Burt

Birmingham Community Healthcare NHS Trust

Nabila Gardner

Ways for Wellbeing

Ollie Hart

Peak Health Coaching

Hamid Lea

Ashiana Community Project

Clare Harewood

Birmingham Voluntary Services Council

Jenni Naisby

Personalised Care Institute

Izabella Natrins

United Kingdom and International Health Coaching Association

Nicole Adams-Quakenbush

Birmingham Voluntary Services Council

Nathan Thomas

NHS Birmingham, Black Country, and Solihull Integrated Care Board Cluster

Susannah Wilson

Birmingham Voluntary Services Council

Zhiyi Zhao

University of Birmingham

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Abstract

Background

In high-income countries around the globe, the challenges presented by the growing prevalence of chronic conditions, obesity, and mental ill health are exacerbated for those in minoritized and economically marginalized communities (“Underserved populations”). One approach that has the potential to address persistent health inequalities in such underserved populations is health and wellbeing coaching. Its ability to offer flexibility of timing and location, equitable communication, tailored content, and cultural congruency mean it is well-suited to engage with populations that mainstream care fails to adequately engage. To help understand the extent to which this is the case, this review will systematically explore the perspectives and experiences of health and wellbeing coaching amongst underserved populations, with the intention of identifying and exploring barriers and facilitators to its success and where possible suggesting practical strategies for improving its effectiveness and impact.

Methods

Electronic databases including Medline/PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Web of Science, PsycINFO, Cochrane Library and EMBASE were consulted. Included studies were qualitative, conducted in underserved populations with adults > 18yrs (i.e. rural areas, ethnic minorities, lower socioeconomic backgrounds, and other disadvantaged groups); where the interventions were categorised as health and wellbeing coaching delivered by trained coaches. The results are presented in an amended version of the Theoretical Framework of Acceptability.

Results

A total of 483 studies were identified with nine included in the review from four different countries. In summary, participants were satisfied with health and wellbeing coaching noting the strength and value of their equitable relationship with the coach, how external responsibilities and economic pressures limited engagement; the benefits of demographically similar coaches that met linguistic and cultural preferences. The use of hybrid mHealth interventions were broadly welcomed, with the interventions tending to be successful in delivering notable change to mutually agreed goals.

Conclusions

The techniques used in the identified studies reflect the strategies recommended in overcoming inequalities in access and utilisation of health and social care in a range of settings and the use of health and wellbeing coaching appears to offer viable and practical means of supporting lifestyle change and improving self-management.

Registration:

The review was registered on PROSPERO registration CRD42023472159

Introduction

In high-income countries around the globe, the challenges presented by the growing prevalence of chronic conditions, obesity, and mental ill health are exacerbated for those in minoritized and economically-marginalized communities (collectively defined here as underserved populations, [1, 2]). These disparities are influenced by a range of socio-economic and cultural influences such as poor transport, housing, language barriers, and low health literacy [3–6]. One approach that has the potential to address these inequalities is the use of health and wellbeing coaches [7]. Their work is grounded in theories of patient-centred behaviour change, working with individuals to set mutually agreed and personalized goals and helping them gain the ability, information, and confidence necessary to reach these objectives [8–10]. These are summarised in Fig. 1 [11]. The characteristics of the offer such as equitable communication, tailored content, cultural congruency, and flexibility of timing and location [12–16], suggest that health and wellbeing coaches are particularly well-suited to engage with underserved populations helping to mitigate, if not overcome, many of the barriers to engagement with positive health-related behaviours [17, 18].

There is evidence that where appropriately trained and deployed health and wellbeing coaches can improve a range of health and lifestyle factors including physical activity, weight loss [19] healthy eating [20], oral health promotion [21], mental health and well-being [22, 23], as well as supporting self-management in a range of long term conditions [24, 25]. However, if these effects are to be consistently observed in underserved populations, then a greater understanding of existing experiences of health and wellbeing coaching (HWBC) in underserved populations is required to better shape the content, methods, and contextual support needed by these groups [15]. The aim of this work is to undertake a systematic review of qualitative data describing the perspectives and experiences of health and wellbeing coaching amongst underserved populations, with the intention of identifying and exploring barriers and facilitators to its success and where possible suggesting practical strategies for improving its effectiveness and impact.

Methods

Study design

We conducted a systematic review of qualitative literature [26]. The search strategy combines search terms based on the SPIDER framework for qualitative research [27]. The results of our search are described in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist [28]. The data are analysed using a directed content analysis [29, 30] to populate Sekhon's Theoretical Framework of Acceptability (TFA) [31]. The review was registered on PROSPERO registration CRD42023472159

Theoretical lens

The TFA was developed by Sekhon et al to explore acceptability of health care interventions from the perspectives of providers and patients [31]. It consists of seven domains: affective attitude, burden, ethicality, intervention coherence, opportunity costs, perceived effectiveness, and self-efficacy. Together they describe whether those receiving (or delivering) an intervention consider it to be appropriate based on anticipated or experiential cognitive and emotional responses [31]. It has been successfully used in a range of settings and circumstances including the treatment of HIV [32], breast cancer [33] and mental health [34] and the acceptability of community health workers amongst ethnic minorities with diabetes [35]. See Fig. 2 for a summary of each domain of the TFA.

Search strategy

The search strategy was constructed in line with the SPIDER tool and is contained in Supplementary File 1. Electronic databases including Medline/PubMed, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Web of Science, PsycINFO, Cochrane Library and EMBASE were consulted. Furthermore, the bibliographies of included papers were examined until no unreviewed studies surfaced, complemented by manual searches in Google Scholar.

Study selection

The last author [ZZ] first performed title screening where studies with irrelevant titles were excluded. Studies with relevant titles proceeded to abstract screening, and those not meeting the criteria were excluded. The first author acted as second reviewer [IL] and conducted a full-text review of the remaining studies to assess their eligibility. Ultimately papers were included following consensual agreement between the two reviewers.

Studies which met the following criteria were included; Underserved populations (such as those in rural areas, ethnic minorities, lower socioeconomic backgrounds, or other disadvantaged groups); research conducted with adults (18 years and older); where interventions were categorised as health coaching or health and wellbeing coaching; studies containing qualitative data (e.g., interviews, focus groups, or mixed-methods); peer-reviewed articles published in English within the last 20 years (to reflect recent health system environments).

Quality assessment and data extraction

The two authors, [IL and ZZ] independently assessed the quality of each included study. The Mixed Methods Assessment Tool (MMAT) [36] was used for qualitative studies and those studies of mixed-method design with qualitative components. The scores are reported within the table summarizing study characteristics. The first author IL extracted data including publication information, study characteristics, participant information, and outcomes. Where studies employed mixed methods, quantitative data were also summarised to provide additional context. The data included in the analysis consisted of verbatim quotes from participants and the study authors’ summaries of findings.

Data analysis

The data were analysed using a directed content analysis, populating the TFA using Elo and Kyngas’s open matrix approach that allowed for the inclusion of emerging constructs within existing domains [29, 30]. The process was collaborative, with IL and ZZ independently allocating data within the framework with the final allocation consensually agreed by all authors.

Results

Characteristics of included studies

The screening and study selection are outlined in the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram (Figure 3). The study selection and data extraction templates can be found in Supplementary File 2. Studies were excluded because of duplication, not including interventions delivered by health and wellbeing coaches, or not being original peer-reviewed research. The PRISMA flowchart is shown in Figure 3.

A total of nine studies were included. These consisted of two qualitative studies [37, 38], and seven mixed methods [39-45]. They were conducted in four different countries: six in the United States of America (USA) [37, 39, 41, 43-45], one in Canada [40], one in China [38], and one in the UK (and China) [42]. The characteristics of included studies are further summarized in Table 1 including where available contextual quantitative data on outcomes to add context to the qualitative data.

Table 1. Characteristics of included studies

Author (date)	Country	Study design (Quality)	Health coaching intervention	Participants	Qual data collection	Outcome data (where applicable)	Summary of qualitative data
Boykins et al 2025 [39]	USA	Mixed methods (High)	Provided individual and group health coaching Content focused on chronic illness management, exercise, or nutrition.	Medically underserved clients (n= 1,355) Median age = 66.5 years, 93% Black/African American, 71% female	Semi-structured interviews (n=14)	The majority (of 1,355) (68.3%) participated in individual health coaching. Sixty-eight group sessions had an average of 4 participants (range 1-13).	Coaching can expand access to primary care and address social barriers to self-management in chronic conditions
Hohenadel J, et al 2007 [40]	Canada	Mixed methods (Medium)	Specially trained coach navigators provided information and resources tailored to patients with cancer (part of a personal coaching program involving health and social care providers)	Cancer patients (n=63)	Semi-structured interviews (n=11), Post intervention surveys (n=27)	Positive impact of coaches was reported in 6 domains: Cancer information, practical support for living, emotional support, communication with health care professionals, practical health needs and support with friends and families.	Participants were highly satisfied with the program and believed it had positive implications for both physical and emotional health
Russell et al 2018 [41]	USA	Mixed methods (Low)	A program to address the social, health, and long-term disaster recovery needs (post-hurricane)	Community residents (n=732)	Notes were taken during each encounter (n=unrecorded)	Referrals to medical and dental services (29%), city-issued identification cards (27%), and health insurance and other entitlements (23%).	Improvements in self-reported health, health care utilization, and confidence managing health issues.
Steinman et al 2023 [44]	USA	Mixed methods (High)	Part of a community-academic partnership to build capacity for evidence-based depression care	Participants (n=152)	Participant testimonials (n = 9)	Participants showed significant reductions in depression severity at 5 months (98% clinical response rate [mean (SD), 13.7 (3.9) drop in pre/post PHQ-9; $p < 0.001$]	Effective elements included adaptability, staff buy-in, alignment with organization mission, ongoing reflection and evaluation during implementation
Schoenberg et al 2021 [37]	USA	Qualitative (high)	Healthy lifestyle app supported by personalized health	Participants (n=54) Rural population in 4 states in	Focus groups (n=4) Semi-structured interviews	N/A	Use of personal technology is feasible and desirable. Barriers include

			coaching, accelerometer and financial incentives.	southeast USA	(n=16)		lack of healthy lifestyle awareness, habitual behaviour, and financial constraints
Van Charante et al., 2024 [42]	UK	RCT (Medium)	Health coaches guide participants through mHealth platforms to manage dementia risk factors and assist them in using mHealth apps.	Participants from lower socio-economic status and at least two risk factors for dementia (n=1488). Age = 55-75 yrs Male (n =601) and Female (n=887) Intervention (n=734) Control (n=754)	Questionnaires and oral feedback to coaches.	After a mean follow-up of 16 months (SD 2.5), the mean CAIDE score improved 0.16 points in the intervention group versus 0.01 in the control group (mean difference – 0.16, 95% CI – 0.29 to –0.03).	The mHealth intervention was considered appropriate and acceptable.
Willard Grace et al. 2021[45]	USA	Mixed methods (High)	Health coach provided COPD education, review correct inhaler use, counsel on smoking cessation, and facilitate other behaviour changes (contact included in-person meetings, phone calls, and medical visits).	Participants with COPD n=20 Average age = 62 yrs Female =30%	Semi-structured interviews with patients (n=20)	13.7 interactions with health coach per patient. Improved COPD management, symptom awareness, and behaviour change. patients included those experiencing substance use or homelessness	Strength of the health coaching relationship and flexibility of the role were cited as key elements
Yuan et al., 2022 [43]	USA	Mixed methods. (Medium)	Health coach facilitator implementing a purposely designed mobile app. Content includes education on core areas of integrative health, homework exercises, and evaluation activities.	Participants (n=40) Female (n=30) Average age 45.4 yrs Hispanic (n=19)	User satisfaction surveys data from group sessions (n=5) and individual sessions (n=36).	Patients in the group setting had the highest rate of goal completion Significant ($p < .05$) changes in overall wellbeing, global physical health, BMI, vigorous physical activity, and eHealth literacy	Most participants found the app helpful for behaviour change and health management.
Zhang et al, 2025 [38]	China	Qualitative	Health coaches guide	Participants involved in the	Semi-structured interviews (n=50) at 3, 12	N/A	Remote coaching convenient, and

(High)	(high)	participants through mHealth platforms to manage dementia risk factors and assist them in using mHealth apps.	PRODEMOS trial (n=14).	and 18 months into the intervention	the PRODEMOS app easy to use, although asynchronous communication with coach an issue
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Qualitative findings

The TFA as developed by Sekhon et al has been refined to bring greater clarity and concision to the presentation of the results: the domain '*Ethicality*' has been renamed '*Cultural sensitivity*', a phrase more precisely describing the domain and its constructs as represented in this review. Due to overlaps in the findings '*Burden*' and '*Opportunity Costs*' were grouped to form one domain as were the related domains of '*Intervention Effectiveness*' and '*Self-efficacy*' resulting in five final domains and a total of 11 constructs. Table 2 presents definitions of the domains and emergent constructs. Below we explore the findings within each domain and construct, using example participant quotes (shown in italics).

Table 2: Mapping of domains, defined constructs and emerging findings

Domain	Definition	Construct	Definition	Summary of review findings
1.Affective Attitude	How participants feel about health and wellbeing coach-led interventions	1.1 Overall satisfaction with coach and intervention	Satisfaction with the concept and the coach	- Participants described overall satisfaction with and acceptability of health coaching [37, 39, 40, 42] - The importance of the client-coach relationship [37, 39, 40, 43-45].
		1.2 Client -coach communication	The communication strategies and approaches used by coaches	- Coaches spoke to clients as equals flattening hierarchy [38, 45] - Informal non-clinical coaches can mitigate client concerns around health provider competency [45]
2.Burden/ Opportunity Costs	Perceived amount of effort required to participate / Benefits or values that must be given up to enable participation	2.1 Health implications	The impact of physical or mental health on ability and motivation to participate	- Health implications affected ability to participate [40, 45]. - Personal concerns and awareness of risks of ill health were a motivating factor [43]
		2.2 Socio economic barriers	The time and resources required for intervention participation	<i>Impact on participation of</i> - Care or work responsibilities [38, 45] - Poverty [37, 39, 40] - Social isolation [40] - Food security [37, 39]
3.Cultural sensitivity	How well intervention aligns with individual beliefs and values	3.1 Cultural and community awareness of coach	Cultural and community influences on engagement with healthcare communities including health related customs and traditions	- The influence of social networks, religious beliefs, and gendered roles [37, 44, 46] - Preferences for coaches who shared demographic characteristics or health experience [39] - Understanding of gendered roles i.e. <i>machismo</i> and <i>familio</i> in Latino populations [44]
		3.2 Language	Delivery of the intervention in multiple languages and using careful phraseology	- The use of alternative languages [44] - Sensitively worded explanations [37]
4.Programme coherence	How far participants understand HWBC interventions and their construction	4.1 Content, methods and materials	Educational content, and strategies	- Information on managing specific conditions; cancer [40], Depression [44], Dementia [38, 42], COPD [45], Cardiovascular risk [46] and chronic illness self-management [39] - Broader learning around multiple aspects of health, lifestyle, and social support [37, 38, 41-43] - Setting mutually agreed goals [37-45].

		Communication modes		
				• Telephone and videoconferencing [43, 45] • The use of mHealth apps [38] data [37, 42, 43] • Issues with digital literacy [38] and impersonal and asynchronous communication [43]
		4.2 Structure	The use of group and/or one-to-one sessions and their frequency and duration	• Support of peers noted in group sessions [38] • Individual sessions favoured for personalised support [37, 40, 41, 44-46] • Frequency of contact varied [45, 46] • Lengthier conversation [38]
5. Effectiveness and self-efficacy	The degree to which the intervention achieved and sustained its aims	5.1 Changed health behaviours	Impact of interventions on a range of self-management and lifestyle behaviours	• Substantive behaviour changes made with the support of their coach [37, 39-44]
		5.2 Increased self-efficacy and sustained change	The confidence and improved self-esteem when independently managing health behaviours	• Increased confidence in managing health and well-being [39, 41, 43, 45] • The influence of the coach stayed with them after the programme ended [38, 45]

1. Affective attitude

1.1 Overall satisfaction with intervention and coach

Studies reported participants' overall satisfaction with HWBC [37, 42], noting that they met their broad requirements for support and signposting that were necessary to improve a range of health behaviours [38-40]. A key element of satisfaction was the strength of the relationship developed with the coach, with participants describing its foundation in mutual trust and respect [40, 43] and a source of meaningful emotional support [37, 39, 43-45]. As one participant described:

"So, she was instrumental in...just keeping a good attitude, I guess....[I] could always call her up or text her - or something - with a question, and she always came back with an answer and it made me smile or feel good." [45]

For some, the closeness of the relationship also became a motivating factor for adherence to the program, with participants in one study describing how they felt compelled to commit to the intervention to prevent disappointing the coach:

"When you do it by yourself, most people will fail. But, if they have a coach... that accountability is there where you are not just letting yourself down...you don't let your friend down." [37]

1.2 Equitable communication

Coaches were recognized for the informal and more natural communication style which meant participants found it easier to discuss their issues and challenges [39, 44, 45], including in one study potentially sensitive conditions such as depression [44]. As one participant described:

"...The other thing is that a health coach can be someone who has medical training but they're not a doctor. People are intimidated by doctors. They don't see a doctor as somebody they can just sit down and have a cup of coffee and talk about their health." [45]

2.0 Burden/Opportunity costs

2.1 Health implications

The impact of physical or mental health on the ability to participate was described, including the influence of competing co-morbidities [40, 45]. However, concerns over health were also a significant motivating factor, particularly when there was personal experience of ill-health [38, 40]. As a participant from an intervention into decreasing the risk of dementia explained:

"I take my health more seriously now. Last year, my brother died suddenly at the age of 66, which was a big blow for me. So, I thought that we should be kinder and more responsible to ourselves." [43]

2.2 Socio-economic barriers

There were a number of barriers to participation reported including poverty [37, 39, 40], social isolation [40], and a lack of food security [37, 39]. The perceived economic challenges of pursuing a healthier diet were summarized by a participant in rural USA:

"...the health issues that we have here in eastern Kentucky are a byproduct of financial burdens. The old joke is nutrition is more expensive than drugs". [37]

Participants also described how caring responsibilities [45] and work commitments [38] were significant barriers to their ability to participate:

"I am not fully retired and still working, so my time available for health management and the app usage is still relatively limited because I rarely have a chance to rest when I am busy with my work/routines." [38]

By way of contrast, some participants did not feel external factors, including the HWBC intervention extended overdue influence on their ability to change health behaviour, instead crediting their personal willpower, as one explained:

Interviewer: Do you think there's anything a health coach could do to help you quit?

Patient: No. I just have to make up my mind to quit.

Interviewer: All up to you?

Patient: Yeah, it's up to me. [45]

3.0 Cultural sensitivity

3.1 Cultural and community awareness

Participants described how the influence of their religious and cultural roles and activities influenced their engagement with health coaching [37, 44]. For example, a participant in a study in rural USA noted how their church-going peers were becoming increasingly aware of the influence of lifestyle on chronic disease:

"People are getting more interested in physical activity and want to do better. Being African American, I know I have many friends who are concerned with blood pressure and diabetes" [37]

The importance of coaches understanding the customs, traditions, and cultural implications of their clients was described by participants [39, 44]. This included in one study how their experience was improved by providers who shared their gender, race, and cultural background [39]. In another conducted in Latino populations the benefits of coaches being aware of the inhibitive influence of cultural values of "*familismo*" (commitment and loyalty to family expected of mothers) meant they were able to provide explicit encouragement to put their needs before their adult children [44].

3.2 Language

Conversations around behavioural change are often complex and nuanced and where relevant were conducted in participants' preferred language [44]. Health literacy can also vary in underserved populations, but it is important that this is reflected in language and vocabulary that does not talk down to the participant:

"I think you have to watch with people in this area about how you present things as well. They are easily made to feel like they didn't know 'that' so they must be dumb" [37].

4.0 Intervention coherence

4.1 Content, methods and materials

Interventions included information on health and care, lifestyle factors, and social support [37, 38, 41-43], with some including more specific information on long-term conditions specifically cancer [40], depression [44], dementia [38, 42], chronic obstructive pulmonary disease (COPD) [45], and chronic illness self-management [39]. All interventions involved setting mutually agreed goals [37-45], six used remote methods, including telephone and videoconferencing [43, 45] and/or a HWBC app [37, 38, 42, 43]. The app was noted for its ability to offer a more flexible and accessible alternative to seeking information [37, 42, 43]. As one participant explained:

"The advantage of the project is that we can communicate about these things online... and the app and coach always give me advice..." [43]

There were however some concerns around the use of the app: some felt communication was impersonal and the asynchronous delay in communication too long [43]. Meanwhile, elderly participants felt the interface could be better designed to integrate data directly from worn technologies minimizing the work of entering measurements. As one participant described:

"The app should be designed to be more concise, with fewer entering procedures" [38].

4.2 Structure

The health coaching interventions, included individual [37, 40, 41, 44, 45] and/or group sessions [38, 39, 42, 43]. The benefits of both were described, with participants that used individual sessions appreciating their personalized approach and the individual encouragement:

"A lot of people are too scared to start. By getting the one-on-one alone time it will help people to not give up and they will be more likely to follow through".[37]

There were also advantages reported specific to group sessions including emotional support provided by "classmates." [39] and the power of encouragement delivered by peers:

"I believe we can encourage each other to exercise more. It's like, we could be each other's reminder, you know?" [38]

None of the studies included in the review provided information on the length of each health and wellbeing coaching session or their frequency. However, participants in one study noted that coaches had more time to listen than busy clinical staff and that the frequency of contact was instrumental to their adherence. Leading one participant to comment:

"To be honest, I probably couldn't stick with it if the coach didn't regularly supervise me." [38].

5. Effectiveness and self-efficacy

5.1 *Changed health behaviours*

Participants described how interventions improved their health and care behaviours in a number of ways, including facilitating their better engagement with care and other services [39-41]; specific patient outcomes [39, 42, 45]; physical and mental health and wellbeing [40, 41, 43, 44]; and a number of related lifestyle factors [43, 45]. As one participant with COPD described:

"I quit smoking and quit drinking and everything. I do exercises every day. I come down to [name of] Park, and I walk two laps every day to build up my lungs and my breathing." [45]

5.2 *Increased self-efficacy and sustained change*

Participants described how their coaches support grew confidence in their own ability to successfully manage a range of health and care related lifestyle behaviours [39, 41, 43, 45]. In one study a participant with COPD described how these changes were sustained after the end of the intervention through the strategies provided by their coach:

"She was always asking questions... "Oh, before you have a drink, what are you thinking about?" That was like, "Whoa." But it was good because now when I want to have a cigarette or get an extra beer, I always say, "Why do I want to do this?" ... I think about it, and most of the time when I start thinking about it, then I don't do it". [45]

Discussion

General summary

Interventions led by health and wellbeing coaches offer the potential to overcome some of the persistent socio-cultural barriers to underserved populations engaging with health and care services and health and wellbeing-related behaviours. The review confirmed much of this potential and the TFA proved a useful means of structuring our findings. In summary by domain: Participants described, their satisfaction with the HWBC intervention, noting the strength and value of the equitable relationship with their coach (*Affective attitude*); how participation was inhibited by work and carer responsibilities and economic constraints (*Burden/opportunity costs*), the benefits of demographically similar coaches and their ability to understand and address cultural pressures on lifestyle change (*Cultural sensitivity*); the content of interventions, including a range of lifestyle and social support elements, group and individual sessions, and mHealth apps (*Intervention coherence*); finally, participants reported fundamental and lasting changes in a range of health and wellbeing-related behaviours (*Effectiveness and self-efficacy*).

Strengths and limitations

The review collated the valuable perspectives of underserved populations participating in health and wellbeing coaching of various design and purpose. The TFA's comprehensive structure added to the review's methodological rigour which followed best practice throughout [47]. Although the overall quality of the studies was high, the number of studies identified was small and their design heterogenous. One study of low quality was included because of the desire to explore all available evidence [48]. It is also worth noting that attritional bias may also impact the findings with the likelihood that only those most engaged in the intervention completing surveys or interviews [49]. Despite these limitations, the findings suggest that the methods and strategies used in HWBC were not only broadly acceptable to participants but also preferred over medically oriented and clinically delivered alternatives. In doing so they reflect existing evidence that underserved patients better engage in health and social care and support that understands their socio-cultural attitudes and status, health literacy, and self-efficacy, mitigating barriers that otherwise negatively impact engagement and adherence to a range of positive health-related behaviours [3, 5, 50].

Specific findings

Affective attitude

Participants in multiple studies described the importance of the open and collaborative relationship developed with their coach [37, 39, 40, 43–45]. This reflects previous evidence that highlights how the longitudinal relationships between coach and client can develop trust and understanding and are a foundational element of successful health and wellbeing coaching [10, 51, 52]. It is recommended that clinicians develop similarly equitable and constructive relationships to maximize their therapeutic alliance with the patient [53, 54], yet attempts to share clinical decision making have failed to gain traction [55, 56] perhaps offering further explanation as to why participants preferred to speak with coaches instead of clinicians [38, 45].

Burden and opportunity costs

The review described a range of familiar barriers to engaging with changes in lifestyle behaviour including ill health [40, 45], care and work responsibilities [38, 45], and economic and social disadvantages, including the cost of food [37, 39, 40]. The prohibitive expense of "healthy" eating has figured before in attempts to encourage healthier lifestyles [57], and there is evidence that the use of food coupons or prescriptions might be helpful in future iterations [58, 59].

One motivating factor which emerged in the review was the recent personal experience of ill-health amongst family or relatives [38]. However, evidence of the impact of personal motivation on initiating or maintaining behaviour change is unclear [60, 61], particularly in underserved populations [62, 63]. Related to this was the attitude of one participant who felt the ability to change was solely due to their will power failing to consider the impact of external factors [45], a seemingly common misperception in lifestyle change [64].

Cultural sensitivity

There are a range of culturally specific influences that are acknowledged as impacting healthy behaviours in minoritized populations including gender, religion, and custom [4], and it is widely recognised that any support for behaviour change accommodates these socio-cultural traits [65, 66]. In Latino populations these cultural factors include strongly gendered roles for men and mothers [67, 68] and the review noted the benefit of their health coach understanding these challenges [44]. Another way familial pressures might be addressed is by delivering family-level interventions that reduce the pressure placed on mothers otherwise confronted with pursuing changes in lifestyle alone [69].

The importance of using a patient's preferred language is also widely understood across multiple health and care services and support [70]. The provision of coaching and supporting materials in Spanish for Latino populations described in the review [44] follows previous recommendations for delivering self-management and behavioural interventions in the preferred language of recipients [71], including the use of Spanish in HWBC in Latin populations [72]. However, providing content in a familiar language does not itself overcome issues of health literacy which can predominate in underserved populations [73, 74]. One study identified in the review noted that care should be taken to provide support in a language that is readily understandable without being patronising [37]. The importance of tailoring health communication and adapting content to meet individual needs and context is well-established [73] and one approach that has previously improved comprehension of health-related information in a range of settings is co-production; a process that consensually generates content with target populations and other stakeholders [75, 76].

Intervention coherence

Interventions in the review included information targeting chronic illness [38–40, 42, 44–46]. This is reflective of the increasing use of HWBC in self-management [77–81], with statistically significant improvements being reported in a range of physical and mental health indicators in the broader population [82]. The interventions in the review also offered information around multiple lifestyle factors [37, 38, 41–43, 83], reflecting the varied roles of coaches as cultural mediators, liaison workers, navigators, and advocates [84]. Both navigation and advocacy are particularly critical for underserved populations where they have been linked to a reduction in health inequalities [85, 86].

Multiple studies described setting mutually agreed goals [37–45, 83], a personalised approach that is central to HWBC and has produced positive effects in a range of settings and conditions [87–90]. This personalised approach understands that individuals more carefully consider the elements of a message that are targeted and personally relevant [91, 92]. Although the strategy is effective across the broader population, there is increasing evidence that it is particularly helpful in underserved populations where it can help accommodate challenging and individual socio-cultural contexts [50, 93].

A number of studies reported a positive reaction to the increased accessibility provided by hybrid mHealth facilitated interventions [37, 38, 42, 43], reflecting the growing use of complementary digital technologies in HWBC [94]. Used appropriately there is evidence in other elements of the population that they can improve communication and enable all involved to evaluate fidelity to the intervention, monitoring progress and adverse events, and identifying areas for improvement [95]. Latterly this includes the rise of AI-based technology in multiple apps that also appears to support health behaviour change [96, 97].

Implementing any digital health tool is subject to issues of connectivity, affordability, and digital literacy, and these factors have so far limited uptake in underserved populations [98, 99]. Digital literacy was also an issue raised in the review, manifest in concerns around the digital interface and the onerous nature of uploading data [38, 43]. The latter might be overcome by better integrating wearable technologies [100], with examples now emerging of their favourable use in complementing HWBC interventions [101].

The studies we identified included various combinations of individual [37, 40, 41, 44–46] and group sessions [38, 39, 42, 43], with debates over the advantage and efficacy of each ongoing for decades, with little clear evidence in favour of either [102, 103]. However, group sessions offer the potential for cost savings and greater reach [104]. The presence of peers can also provide additional motivation as observed in the review [38] and reflected in previous evidence that indicated witnessing similar individuals making positive changes can boost self-efficacy and empowerment [105–107].

Effectiveness and self-efficacy

The combined characteristics unique to HWBC can support self-efficacy and meaningful behavioural change in populations that mainstream health services often fail to engage [17, 18, 108]. This ability appears to have been supported by the evidence of this review where the HWBC intervention increased self-efficacy [39, 41, 43, 45] and supported positive change in various health-related behaviours [37, 39–44, 83]. Participants in two studies described how the influence of the coach remained beyond the intervention

[38, 45]. What was less clear was how long change was maintained, an element frequently underreported in HWBC studies though with some evidence that it can be sustained [109, 110]. It has been recommended that longevity can be supported in chronic conditions where it is embedded within the care team and they use the same language and strategies as coaches [108]. This integration presents its own issues of compatibility, and more work is required to embed HWBC into existing clinical models of care to overcome challenges of organizational understanding and support [11, 111].

Conclusions

This review offers further evidence of how the unique combination of characteristics of HWBC i.e. flexibility, consensual goal setting, and equitable relationships can mitigate challenges of culture, health literacy and logistical restrictions experienced in underserved populations. Greater consistency in study design and reporting would strengthen the evidence base and help inform future HWBC programs for underserved populations.

Abbreviations

CINAHL
Cumulative Index to Nursing and Allied Health Literature
HWBC
Health and Wellbeing Coaching
MMAT
The Mixed Methods Assessment Tool
PRISMA
Preferred Reporting Items for Systematic Reviews and Meta-Analyses
TFA
Theoretical Framework of Acceptability
UK
United Kingdom
USA
United States of America

Declarations

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Competing Interests

Dr Ollie Hart is director and shareholder of Peak Health Coaching. All other authors have reported no competing interests

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Author Contribution

IL, NG, HL, and CH were responsible for the overall design of the review. IL and ZZ collated and analysed the data. IL produced the initial draft of the manuscript. This was then edited for content following the recommendations of CB, NG, CH, HL, JN, IN, OP, SW, NQ, and ZZ. All authors read and approved the final manuscript.

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Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

Competing interests

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Figures

- *Personalised programmes* - tailoring interventions to accommodate factors such as socioeconomic status, cultural background, and existing health conditions
- *Provide information and resources* - to help clients make informed decisions about their health and well-being
- *Relational* – developing positive trusting relationships with clients to enhance engagement
- *Build autonomy, and self-efficacy* – enhancement of self-worth and self-belief
- *Enhance health literacy* - supporting understanding of health materials
- *Chronic disease self-management* - supporting clients in the development of skills, knowledge and confidence necessary to manage the medical, behavioral, and emotional aspects of their condition
- *Possess cultural competency* - equipped to serve diverse populations by understanding and respecting cultural norms, beliefs, and practices
- *Promote preventive care and early intervention* - encouraging clients to undergo regular screenings and check-ups
- *Provide advocacy* – supporting the navigation of health and social care systems, preparing individuals for shared decision-making, and otherwise supporting clients in attempts to access appropriate care

Figure 1

Key elements of health and wellbeing coaching

Affective attitude	Burden	Ethicality	Intervention Coherence	Opportunity Costs	Perceived Effectiveness	Self-efficacy
How participants feel about CHWP interventions	Perceived amount of effort required to participate	How well intervention aligns with individuals beliefs and values	How far participants understand CHWP interventions and how they work	Benefits or values that must be given up to participate in intervention	How well CHWP intervention achieves its outcomes	Participant's confidence that they can perform behaviours required to participate with an intervention

Figure 2

Summary of Sekhon's Theoretical Framework of Acceptability [31].

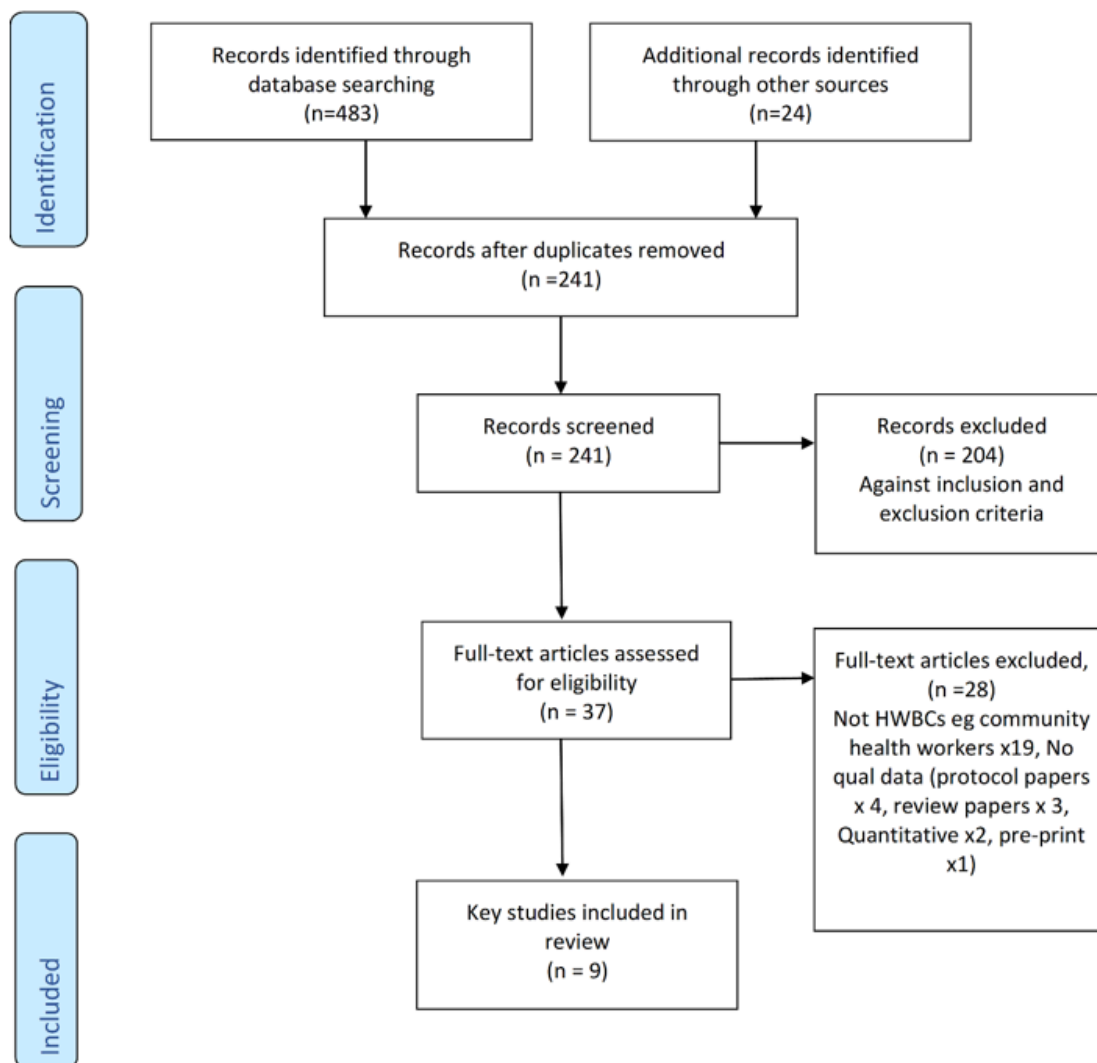


Figure 3

PRISMA flow diagram of the studies included in the review

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