Attitudes to and perceptions of workplace health promotion amongst employees from ethnic minorities in the UK: A scoping review.

PLATTS, Katharine, SCOTT, Emma, GRIFFITHS, Kerry <http://orcid.org/0000-0002-3396-6827> and CARTER, Anouska <http://orcid.org/0000-0002-6419-9042>

Published version

PLATTS, Katharine, SCOTT, Emma, GRIFFITHS, Kerry and CARTER, Anouska (2024). Attitudes to and perceptions of workplace health promotion amongst employees from ethnic minorities in the UK: A scoping review. Work, 1-17.

Table 1. Six Stages for conducting a scoping review [15].

Six Stages for conducting a scoping review
1. Identifying the research question
2. Identifying relevant studies
3. Selecting studies
4. Charting the data
5. Collating, summarizing, and reporting the results
6. Consulting knowledge users

Table 2. PICO framework to determine scope for review and search criteria.

PICO	**Scope**	**Search Criteria**
Population	UK ethnic minorities in part-time or full-time employment, focusing on larger UK minority groups (using ONS census data)	Multicultural OR Ethnic* OR Minorit* AND
Interest/Intervention	Health promotion or wellbeing interventions	Health Promotion OR Well-being OR Wellbeing OR Wellness AND
Context/Comparator	Studies conducted in UK workplace or relevant to the UK workplace	Employ* OR Workforce OR Workplace OR Corporate AND
Outcome	Studies reporting findings on experiences (attitudes, perceptions, barriers, facilitators) of workplace wellbeing intervention/promotion from the perspectives of ethnic minorities	Attitude OR Perception OR Barrier OR Facilitator OR Experience
Study Design	Longitudinal, experimental, qualitative, pilot/feasibility, mixed methods	

Table 3. Websites searched for relevant grey literature and findings of relevance.

Organisation/website	**Findings**	**Count and relevance**
Academy of Royal Medical Colleges (AMRC) https://www.aomrc.org.uk/ / Royal College of Nursing (RCN) https://www.rcn.org.uk/ / Allied Health Professional Federation (AHPF) http://ahpf.org.uk/	1 Consensus Statement	1NRI
British Occupational Health Research Foundation https://www.bohrf.org.uk/	8 Articles	8NRI
Chartered Institute of Personnel and Development (CIPD) https://www.cipd.org/uk/	0	
Department of Health, now Department of Health & Social Care (DoH, DoHSC) https://www.gov.uk/government/organisations/department-of-health-and-social-care	1 Report	1NRI
Department of Work & Pensions (DWP) https://www.gov.uk/government/organisations/department-for-work-pensions	1 Report 1 Bulletin	2NRI
Faculty of Occupational Medicine, Business in the Community (BITC) https://www.fom.ac.uk/about-us	2 Toolkits	2NRI
Health & Safety Executive (HSE) https://www.hse.gov.uk/index.htm	5 reports	4NRI 1PRI
Mental Health First Aid.org. https://www.mentalhealthfirstaid.org/	1 Blog	1NRI
National Institute for Health and Care Excellence (NICE) https://www.nice.org.uk/	35 Reports	34NRI 1PRI
Partnership for European Research in Occupational Safety and Health (PEROSH) www.perosh.eu	4 Conference Papers 3 Articles	7NRI
Public Health England (PHE), now Office of Health Improvement & Disparities (OHID, part of DHSC) https://www.gov.uk/government/organisations/office-for-health-improvement-and-disparities	1 Report	1NRI
Wellbeing at Work Conferences – coordinated by PEROSH https://perosh.eu/repository/programme-wellbeing-at-work-2022/	4 Conference Papers 3 Articles	7NRI
Wellcome Trust Home | Wellcome	1 Report	1PRI
Total	**71**	**68NRI** **4PRI**

NRI = Not Relevant Information, PRI = Potentially Relevant Information, RI= Relevant Information

Table 4. Inclusion and exclusion criteria for article screening.

Inclusion	**Exclusion**
Study took place in a UK workplace or has relevance to the UK workplace	Studies that do not report population by ethnic group
Study includes at least 1 ethnic minority as outlined by ONS	Studies taking place outside the UK with no application to the UK workplace
Studies written in English	Studies not written in English
Study taken place in last 10 years (expand to 20 if needed)	Studies older than 10 years from data of search
FREE full text only	

Table 5. Summary of Scoping Review Citations.

Citation /Country of Origin	Research Question	Design/ Methodology	N=	Age	Gender	Ethnicity	Context	Type of Intervention	Key Findings
Bertotti et al. [18] UK/London	(1) Understand the context and approach to staff well-being within Chinese owned businesses based in London (2) identify any potential levers, barriers, and triggers for engaging Chinese-led businesses with workplace well-being initiatives	Qualitative - Semi-structured interviews and focus groups Cross-sectional Thematic Content Analysis	Interviews - n=11 employees; n=17 employers; focus groups - n=10 employees	Interviews (employees): 25-35 n=7 35-45 n=1 65-75 n=2 Interviews (employers): 25-35 n=1 30-40 n=3 35-45 n=3 40-50 n=4 45-55 n=3 50-60 n=1 55-65 n=2 Focus group: not reported	Interviews (employees): 7 male; 4 female Interviews (employers): 12 male; 5 female Focus group: not reported	Chinese living in London	Chinese SMEs in London	No intervention - cross-sectional exploration of attitudes towards workplace wellness and willingness to engage	• Employers' attitudes towards workplace wellbeing were reactive rather than proactive, informal, and characterised by in-house on the job health and safety training. But they would make changes if a convincing business case could be made. • Few employers demonstrated awareness of the impact of issues such as salary levels, working conditions, workers' rights, and relationships between colleagues which, in contrast, were key concerns of the employees. • Generation of owner - first generation Chinese vs British-born Chinese effects willingness to embrace more western approach to business, including workplace wellness.
Verburgh et al. [19] Netherlands/ Amsterdam	What is the impact of the Work-Life Program on women's health and work functioning?	Mixed methods - before and after questionnaire; semi-structured in-	Quantitative n=56; Qualitative n=12	Only 45-60yrs old eligible; mean age 52.6 +/- 4.5yrs	All Female	Quantitative: Ethnic majority – (Dutch)	Low paid jobs at Amsterdam University	Integral approach which encompasses an intake session to explore	• Quantitative findings - only menopausal symptoms showed any significant difference between pre- and post-intervention; psychological, somatic, and vasomotor symptoms,

	aims to support female workers during menopause and midlife in making choices that will enhance their health and wellbeing in both their working and private lives.	depth interviews Longitudinal				n=34 Ethnic minority n=36 (21 different backgrounds) Qualitative: Ethnic majority (Dutch) n=5 Ethnic minority n=7	Medical Centre	participant needs and general health check, health education on menopause, lifestyle coaching to improve work-life balance, and physical training. 8x 1hr sessions, flexible scheduling over 2-4mths	depression and overall score all improved. Anxiety and sexual dysfunction did not. No change in work functioning, quality of life or work ability. • Qualitative findings - The WLP initiated a process of mental empowerment (defined as a form of self-efficacy) in most participants; participants said they felt stronger and freer. This has been associated with changes in behaviour, physical health, mental well-being and in the workplace. • Findings suggest that female workers in low paid jobs experience positive impact from the WLP. It empowers them to make choices that benefit their health and wellbeing both at work and in their private lives. Additional qualitative methods are indispensable for evaluating the impact of an intervention among a very heterogeneous study population.
Verburgh et al. [20]	How can we reach and engage an ethnically diverse group of midlife women with a low socioeconomic position (SEP) in the	Qualitative evaluation of the implementation of the WLP using the RE-AIM framework (Reach, Effect,	Interviews - n=12 Intervention participants; n=5 professionals involved in implementing intervention (out of 10 involved);	As Above	As Above	Ethnic majority (Dutch) n=34 Ethnic minority n=36 (21	As Above	As Above	• Reach - Personal invitation letter most influential to participate; information meetings also perceived to have added value, even if they had already decided to participate, especially for those who could not read or fully understand the letter.

	implementation of this workplace health promotion (WHP) intervention?	Adoption, Implementation, Maintenance). R: Quant plus interviews; E: mixed methods [19]; A: Focus group and interviews; I: interviews; M: focus groups Longitudinal	Focus group - n=6 organisation stakeholders			different backgrounds)			The presence of line managers of the same ethnic background at verbal invitation meetings was important to create trust. • Implementation - Facilitators: (1) accessibility of offering sessions in the workplace and in work time; (2) program was tailor-made and both individual and group sessions were an option; (3) practical support for low literacy and language barriers; (4) female facilitators/professionals especially for women from non-western backgrounds. • Implementation - Barriers: (1) practicality of creating time in the workday to attend sessions; (2) inconsistent time interval between sessions; (3) availability/location of rooms for sessions.

Table 6. Key quality appraisal results using the CASP questions [16].

Paper / CASP questions	**Bertotti et al. [18]**	**Verburgh et al. [19]**	**Verburgh et al. [20]**
1. Was there a clear statement of the aims of the research?	Yes	Yes	Yes
2. Is a qualitative methodology appropriate?	Yes	Yes	Yes
3. Was the research design appropriate to address the aims of the research?	Yes	Yes	Yes
4. Was the recruitment strategy appropriate to the aims of the research?	Unsure	No	Unsure
5. Was the data collected in a way that addressed the research issue?	Unsure	Yes	Yes
6. Has the relationship between researcher and participants been adequately considered?	No	Yes	Unsure
7. Have ethical issues been taken into consideration?	Yes	Yes	Yes
8. Was the data analysis sufficiently rigorous?	Unsure	Yes	Yes
9. Is there a clear statement of findings?	Yes	Yes	Yes
10. How valuable is the research?	Unsure	Unsure	Yes
TOTAL SCORE/20 **(Yes=2, Unsure=1, No=0)**	**14**	**17**	**18**

Table 7. Summary of grey literature from scoping review.

	Title	**Possible Transferable Findings**
Health and Safety Executive (HSE) [22]	RR242 – *The evaluation of occupational health advice in Primary Care (2004).*	Focus on ethnic breakdown of access to primary care, such as reasons for consultation, frequency of contact etc. Features data from London and Sheffield sites, London cohort much more ethnically diverse.
National Institute of Clinical Excellence (NICE) [23]	*Mental wellbeing at work (NG212; March 2022)*	Mention of ethnicity in the Recommendations for Research which asks: • What specific needs of employees from different groups (such as income levels, ethnic groups, male or female groups, and age groups) need addressing to facilitate access to individual-level interventions? • How effective are individual-level interventions across different groups (such as income levels, ethnic groups, male or female groups, and age groups)?
Wellcome Trust [24]	*Putting Science to Work – Where next for workplace mental health?* (2022)	Highlights the lack of evidence looking at how workplace wellness interventions may work (or not) for people of different ages, genders, ethnicities, and socio-economic groups. Recommends further work in this area.

Table 8. Five principles for adapting behavioural interventions with examples and potential crossover to the workplace (Adapted from Netto et al. [28]).

Principle	**Examples**
1. Use of community resources to publicise the intervention and increase acceptability.	Use ethnic specific media and networks, community leaders and events to publicise events. Workplace adaptation: Utilise any current networks that are already in place for ethnic minorities in the workplace to publicise events or develop such networks.
2. Identify and address barriers to access and participation.	Tailor timing and location of events to BME women to account for caring responsibilities. Workplace adaptation: Arrange a discussion group to learn what barriers there are and how best they can be overcome.
3. Develop communication strategies that are sensitive to language use and information requirements.	Bilingual facilitators. Use spoken rather than written language to communicate with low literacy groups. Workplace adaptation: Work with people from ethnic minorities to adapt literature, using common and familiar terms. For example, a nutrition leaflet should include examples that use ethnic foods as well as western.
4. Work with cultural or religious values that either promote or hinder behavioural change.	Highlight compatibility of health promotion messages with religious beliefs. Workplace adaptation: As above.
5. Accommodate varying degrees of cultural identification.	Account for generation and migration history difference by more intensively exposing first-generation migrants to the intervention. Workplace adaptation: As above.

Table 9. Common barriers and facilitators to leading a healthy lifestyle among ethnic groups in the UK.

Health Behaviour	**Barriers and Facilitators**
General	Barriers • Financial constraints, childcare, time, accessing venues [34,35,36] • Language [2, 37] • Cultural and religious norms affect service utilisation [38] • Religious fatalistic attitudes [34,35] 'whatever happens is because of God's will' [34] Facilitators • Gender specific facilities [39] • Type 2 Diabetes diagnosis [2] • Information available in mother tongue [39]
Physical Activity (PA)	Barriers • Practical challenges; Childcare, time, motivation [25, 40] • Suitable environment that is culturally appropriate for physical activity [34,36,40] • Lack of same sex venues and acceptability of western exercise clothing [2] • Cultural expectations and social responsibilities [40] • Prioritising work over PA to provide for the family [2] • Fear of racial harassment when exercising [2] • Religion and religious fatalism [40] Facilitators • Exercise class in safe environment i.e., place of worship [2] • Awareness of links between physical activity and health [40] • Previous interaction and engagement with health professionals [40]
Healthy Eating	Barriers • Cultural barriers regarding serving and eating traditional foods [2,41] • Acculturation - assimilation to the dominant culture [41] • Interpretation of national guidelines as "foreign and inapplicable" [41] • Taste over healthiness of food [41] • Un-achievability and undesirability of a healthy BMI [41] • Different perceptions over healthy body weight [2] • Distrust of the health-care system [41]

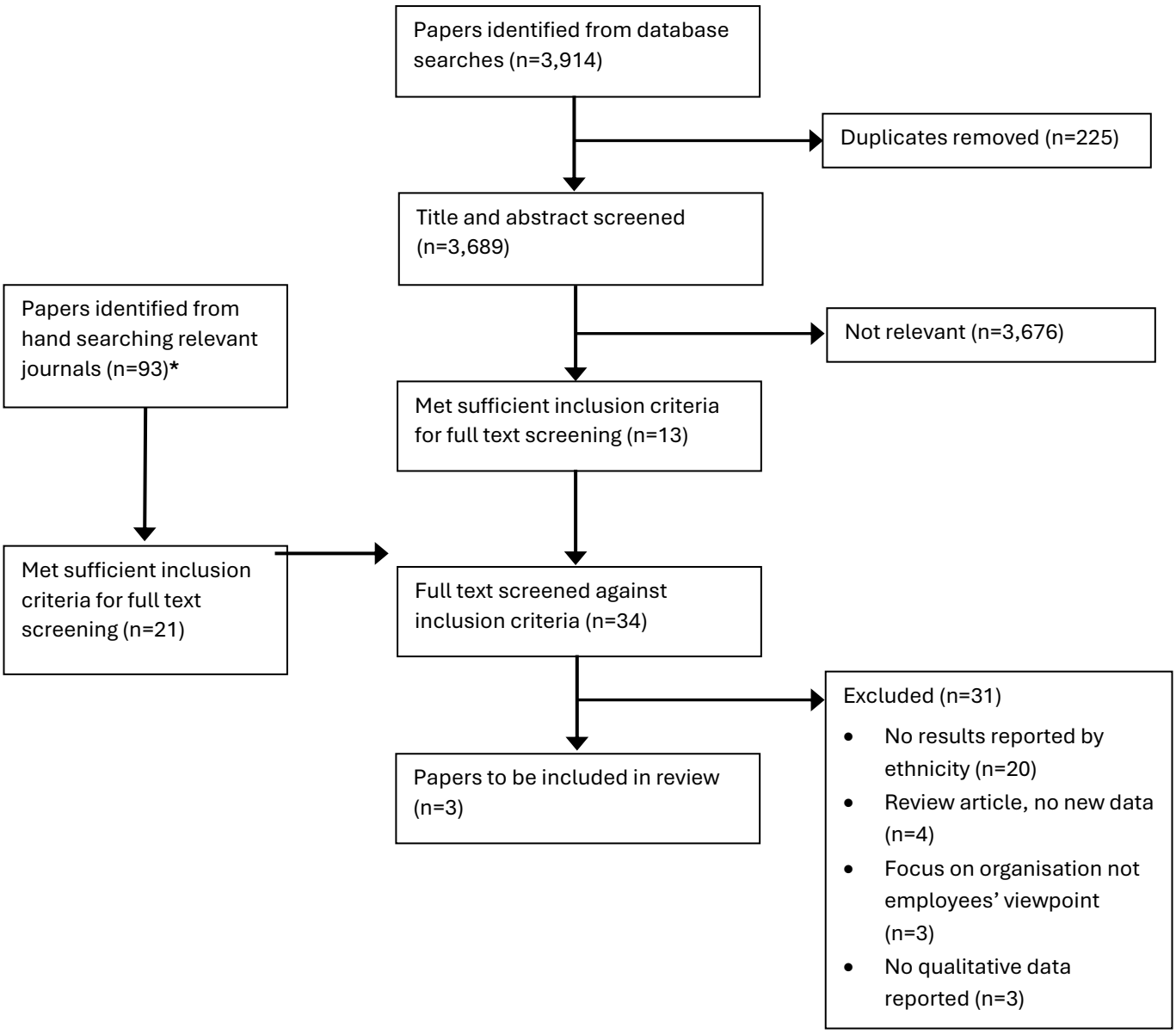

Figure 1. Adapted PRISMA flow chart.

*Journals hand searched: International Journal of Workplace Health Management (9 papers found), Journal of Occupational and Environmental Medicine (5 papers), American Journal of Health Promotion (5 papers), Ethnicity and Health (56 papers), Journal of Racial and Ethnic Health Disparities (18 papers).

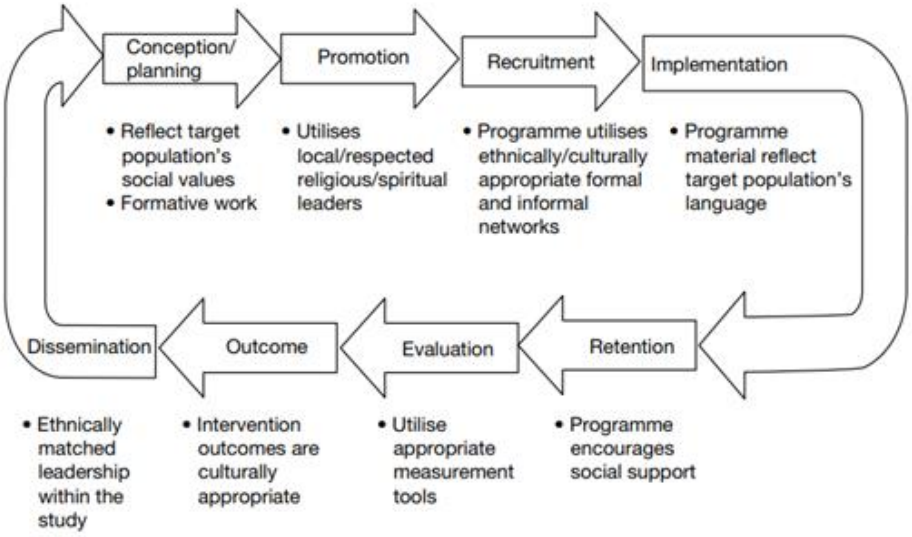

Figure 2. Programme theory of adapted health promotion interventions with examples of adaptations at each stage, reproduced from Liu et al. [12].