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Process evaluation of workplace health promotion in a sheltered workplace: a care ethics perspective

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Summary

Despite the potential health benefits of workplace health promotion for employees in sheltered workplaces, participation is often limited. The aim of this study was (i) to understand this limited participation, and (ii) to find opportunities for adapting workplace health promotion, such that it better meets the needs of the target population. A responsive process evaluation of an extensive multi-component workplace health promotion program targeting lifestyle behaviors, financial behaviors, literacy and citizenship, was performed in a large, sheltered workplace in the Netherlands (>3500 employees). To understand the limited participation, interviews with employees (n = 8), supervisors (n = 7) and managers (n = 2), and 10 participant observations were performed. To find opportunities for improving workplace health promotion in the sheltered workplace, 7 dialogs with employees were performed (n = 30). The interview data on the barriers for participation were evaluated through the lens of care ethics, as this allowed to understand the role of various stakeholders in the limited participation, as well as the indirect role of the institutional context. Findings showed that participation in workplace health promotion could increase if it is organized in a way that it encourages employees to work on health together, allow to tailor activities to different needs and capabilities of employees, and connects activities to employees' daily lives. A strength of this study is that the responsive process evaluation focused both on barriers for participation, as well as on opportunities to increase participation.

Lay summary

People who cannot participate in work without adaptations, for example, due to disability, can work in sheltered workplaces. These employees face various health risks, which are prompted by, for example, low income or low (health) literacy. More and more sheltered workplaces provide health promotion programs to improve health of their employees, such as educational workshops about physical exercise and healthy nutrition. However, participation of employees in such programs is limited. In this study, we investigated why participation is limited, and what are possible ways to make workplace health promotion programs that aim to improve health more attractive to employees in a sheltered workplace. We used different methods, such as interviews, group dialogs and participant observations. We concluded that workplace health promotion programs seem to rely too much on the individual employee, who prefers to work on health together with peers. Employees also value that activities in the health program are useful for their daily lives. This increases the relevance of the program for them and makes employees more inclined to participate.

Keywords: workplace health promotion, employees in sheltered work, process evaluation, participatory, disability

BACKGROUND

Participating in the labor market is not self-evident for everyone in society. People can face difficulties in getting and maintaining a job due to a form of vulnerability, such as disabilities, mental disorders or low literacy (European Commission, Directorate-General for Justice, 2012). Yet, some of these people can work, under the prerequisite that work is modified to their possibilities. Sheltered workplaces respond to this by offering modified and protected work (more information about sheltered workplaces in Box 1) (Bend and Priola, 2021). In addition, people working in sheltered workplaces often deal with health issues. For example, people with disabilities regularly face various health issues such as mental health problems, obesity, fatigue and pain (World Health Organization, 2021). Also, people in sheltered employment generally have low incomes, which creates an additional socioeconomic vulnerability for health (Shields and Shooshtari, 2001). Therefore, attention for health of employees in sheltered workplaces is warranted.

Box 1: Background information about various types of sheltered workplaces

In Europe, uniform definitions of sheltered workplaces definitions lack because of the variations of sheltered work that exist. Still, two main types of sheltered workplaces can be distinguished (Mallender *et al.*, 2014). The first type is the 'traditional' sheltered workplace, which offers modified work for people who are unable to participate on the open labor market. The second type is the 'transitional' sheltered workplace, which offers sheltered work but has the aim to eventually transit people from sheltered to non-sheltered workplaces. In the Netherlands, transitional sheltered workplaces have become more common since the introduction of the so-called Participation Act in 2015 (Capel, 2020). The reason for this is that like in many Western welfare states, policies in the Netherlands had to be adapted such that people that did not work or were working in sheltered employment, would be stimulated to enter on the open labor market as much as possible (Kocman and Weber, 2018; Bosselaar, 2020). Although sheltered work remains available for those employees that will not integrate in the open labor market, subsidies decreased and sheltered workplaces had to become more commercial in order to economically survive (Cedris, 2020). Despite these changes, sheltered workplaces in various forms still allow many people with a support need to participate in work.

One way to target health of employees in sheltered workplaces is through workplace health promotion (WHP). In the past decades, the interest in WHP has increased in organizations (Aldana, 2001; van der Put *et al.*, 2020), including in sheltered workplaces (SBCM, 2021). WHP includes all activities aimed at improving health of employees, for example, through interventions (e.g. educative workshops and counseling on various health themes), policies (e.g. preventative screenings), benefits (e.g. access to local fitness facilities) and environmental supports (e.g. measures to avoid safety threads) (CDC, 2016). The workplace is considered a suitable setting for health promotion, because it offers the social and physical infrastructure for health-promoting interventions (Baron *et al.*, 2014). Also, people spend much time of their lives at work (Stiehl *et al.*, 2018). Therefore, the workplace is a setting in which many and diverse people can be reached for health promotion.

However, previous studies have shown that participation in WHP is limited. Especially people with a low socioeconomic position (SEP) are less well represented in WHP (Meershoek and Horstman, 2016). Generally, part of the people in sheltered workplaces has a low SEP, as they often have low incomes and low educational levels. Potentially, they are also less well represented in WHP. This was one of the findings in a qualitative study among several German sheltered workplaces, which showed that supervisors see limited interest of employees for WHP, and that they hardly participate in activities offered in the workplaces (Kordsmeyer *et al.*, 2022). Also, a systematic review on health promotion interventions outside of work for people with disabilities, who comprise a considerable part of the people that work in sheltered workplaces, showed that motivation of people with disabilities to participate in health promotion interventions is a significant challenge (Naaldenberg *et al.*, 2013).

Enhancing participation in WHP of employees with a low SEP, including those in sheltered workplaces, might contribute the reduction of health inequalities (van der Put *et al.*, 2020). It has been argued before that a mismatch between WHP and the lived experiences of employees, may explain part of the limited participation of employees in WHP (Meershoek and Horstman, 2016; Van Heijster *et al.*, 2020). This mismatch between WHP and employees may be even more prominent for employees in sheltered workplaces, because disability or other vulnerabilities, may pose another reason not to participate in WHP. However, considering the potential positive impact of WHP on health of employees in sheltered workplaces, understanding the limited participation is needed, as well as how WHP can be designed in a way that it better matches the lifeworld of employees in sheltered workplaces. In this study a 'responsive process evaluation' is

performed, in which a process evaluation is performed in a participatory manner (i.e. through active involvement of the target group). Participatory approaches have been increasingly acknowledged as a suitable way to better match interventions to the needs and lived experiences of various target groups (McVicar *et al.*, 2013; Abma *et al.*, 2019). However, to the best of our knowledge, using a participatory approach for a process evaluation aiming at understanding limited participation in WHP, is less common.

This responsive process evaluation of participation in WHP was performed within a sheltered workplace in the Netherlands (transitional sheltered workplace, see Box 1). This workplace offered an extensive WHP program, consisting of educational programs on various lifestyle-related topics such as diet, cooking, smoking, relaxation and physical activity, discounts for local fitness facilities and support sessions about issues such as debts and addiction, including information and referral to help outside of the organization. The employees of the sheltered workplace hardly participated in these activities.

AIMS

This study aims (i) to understand limited participation in WHP of employees in a sheltered workplace, and (ii) to find opportunities to better tailor WHP to the needs of employees.

METHODS

Setting

The study was conducted in a sheltered workplace located in the south of the Netherlands, with locations spread over various municipalities. The sheltered workplace employed ~3500 employees spread over six units (production work, facilities, greenhouse agriculture, groundskeeping, secondment, organizational and employee support). The organizational population was diverse in terms of cultural background (e.g. Dutch, Turkish, Moroccan, Polish and Syrian). Like in other sheltered workplaces in the Netherlands, the majority of the population in the sheltered workplace was above 40 years old (Cedris, 2020).

Design

A responsive design (responsive evaluation) was used to understand limited participation in the existing WHP program and to find opportunities for improvement. This form of participatory research takes the perspectives of stakeholders as the starting point for evaluation and improvement of a program or intervention (Abma, 2005). Dialog among stakeholders is fundamental in responsive evaluation, as it serves as a vehicle for mutual learning among stakeholders, such as employees in sheltered workplaces, their supervisors and higher management levels. For Aim 1 of this study (participation in current WHP), data sources were interviews and participant observations. For Aim 2 of this study (opportunities for improvement), data sources were guided dialogs with employees, and interviews with members of the management team.

Data collection was paused due to the COVID-19 pandemic and contact-restraining measures at two moments, between April 2020–August 2020 and between October 2020–February 2021. Findings were presented to members of the management team on four formal moments. Besides that, there was continuous and frequent informal contact with the sheltered workplace about the process and progress. Figure 1 provides an overview of the methods for Aims 1 and 2 and formal feedback moments.

Sampling and recruitment

Employees from different units, supervisors and employees in management positions were eligible for participation in the interviews and dialogs. Supervisors were asked to recruit employees for the interviews and dialogs, primarily based on willingness to participate. They were encouraged by the researcher to recruit a diversity of employees, in terms of gender, age and cultural background. Also, participant observations were used to recruit employees.

Participants

Interviews and participant observations

Seventeen individuals were interviewed for Aim 1 of the responsive process evaluation (Figure 1), among which employees (8), supervisors (7) and members from the

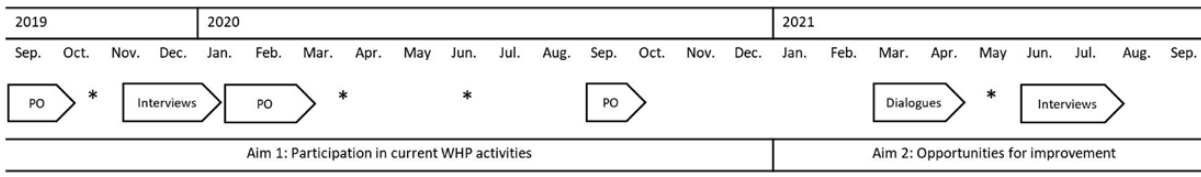

Fig. 1: Overview of methods for each aim. PO = participant observation. * = formal feedback moments between researchers and sheltered workplace.

management team (2). Forty percent of the participants were female. Most participants were above 40 years of age, which corresponded with the overall age distribution in the organization. One third of the participants had a non-Dutch cultural background (Turkish/North-African), the rest had a Dutch cultural background. At the end of the responsive process evaluation the findings of the dialogs were presented to three members of the management team. A follow-up interview was performed with one of these members.

Participant observations took place during three days of the 'Vitality week', in which the sheltered workplace promoted its WHP activities through short workshops. Also, the researchers (HvH, JvB and/or a student) each worked one day at all three different locations of the sheltered workplace. HvH also participated in group discussions organized by the sheltered workplace about employee satisfaction.

Dialogs

Seven dialogs took place at seven locations of the sheltered workplace, covering different units of the organization, such as production, greenhouse agriculture and groundskeeping and facilities. In total, 30 employees participated in the dialogs. Most of the participants in the dialogs were female (56%). The vast majority had a Dutch cultural background, despite efforts of the researchers to recruit employees with a non-Dutch cultural background, as this would be more representative for the organizations' population.

Data collection

Interviews (Aim 1: understand limited participation)

All interviews were semi-structured. Interview themes were perspectives, experiences and needs regarding health, health-promoting behavior and participation in the WHP program offered by the organization. Time was taken in the interviews to understand the work context of the participant and to create a picture of how health played a role in their daily lives. Participant observations were also used for this purpose, as well as to ask employees about (participation in) WHP. The interview with the HR-manager performed at the end of the responsive process evaluation focused on plans regarding adapting WHP, after the input and perspectives of employees brought forward in the dialogs. All interviews were audio-recorded and transcribed verbatim. Field notes were taken of participant observations. The interview protocols are provided in Supplementary File 1.

Dialogs (Aim 2: find opportunities for improvement)

The aim of the dialogs was to find opportunities to improve WHP and enhance participation. The barriers for participation found in the first stage of the responsive process evaluation were the starting point of the dialogs, aiming to find ways to remove or soften those barriers. The dialogs were roughly structured as follows: (i) check-in and introduction of the moderator and participants, (ii) explanation of the aim of the dialogs and the study, (iii) reflection on the barriers and facilitators to participate in WHP identified in the first stage of the study, (iv) deliberating on what could be helpful regarding the identified barriers, also taking into account the potential role the sheltered workplace and (v) summarize and deliberate upon how the findings of the dialogs could be shared with the management. In addition, the structure of the dialogs was also inspired by the principles of moral case deliberation (MCD). This study was part of a larger project in which MCD was used as a form of dialogue in WHP, as MCD allows to centralize employee experiences and to reflect upon what is acceptable when it comes to WHP (Van Heijster *et al.*, 2020). The principles of MCD that were used for the guideline of the dialogs included: (i) attention for the daily experiences of the participants, (ii) probing on diverging perspectives and (iii) deliberating on the various options participants have in a situation. Illustrations were used to enhance the comprehensibility of the structure of the dialogs and fuel associations among the participants. These illustrations depicted the barriers for participation of employees in WHP and were designed by professional designers. The protocol of the dialogs and the supporting illustrations are available in Supplementary File 2A and B. All dialogs were audio-recorded and transcribed verbatim.

Data analysis

Interviews (Aim 1)

First, an inductive open coding strategy was applied. Based on this first coding round, supervisors seemed to play an important role in participation of employees in WHP. Therefore, it was decided to use an analytical framework that allowed to take into account both supervisors' and employees' perspective on participation in WHP. The phases of the care process of 'care ethics', described by Tronto (Tronto, 2013), were used as sensitizing concepts (Blumer, 1969). Care ethics is based on a broad definition of care devised by Tronto and Fisher, in which care is defined as '*everything we do to maintain, continue, and repair 'our world' so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environments, all of which we seek to interweave in a complex, life-sustaining web"* (Tronto, 1993, p. 103). In care ethics, a distinction is made between different phases of care in which either the 'care receiver' or the 'care giver' plays a major role. In this study, the employees were defined as the care receivers, and the supervisors

and management as the care givers. Bottlenecks for good care can arise in different phases. In this study, the emphasis was on barriers in the different phases for participation in WHP.

In the process of care, Tronto distinguishes five phases, namely: (i) caring about, (ii) taking care of, (iii) care giving, (iv) care receiving and (v) caring with. Each phase has a specific moral quality, which function as normative criteria for evaluating care practices (Tronto, 1993). These moral qualities corresponding the five phases are (i) attentiveness, (ii) responsibility, (iii) competence, (iv) responsiveness and (v) plurality, communication and respect. It was analyzed whether these moral qualities could be realized in the current situation, which from a care ethics perspective, provides insight into the quality of care, which in the current context consisted of WHP.

The first three phases and corresponding moral qualities were used to analyze the supervisors' role and perspective in the limited participation in WHP. To analyze the role and perspective of the employees, the fourth phase and corresponding moral quality was used as an analytical lens.

Dialogs (Aim 2)

In the analysis of the dialogs (Aim 2), the focus was on identifying opportunities to tailor WHP to the needs of employees, using thematic content analysis.

Atlas.ti 9 was used as a software for qualitative data analysis.

RESULTS

Aim 1. Participation in the current WHP program

Attentiveness: supervisors want to be attentive, but perceive time constraints due to a commercialized organization

In the sheltered workplace, supervisors were closest to employees and therefore most likely to be attentive to health needs of employees. In fact, supervisors often mentioned the well-being of employees and facilitating their participation in work as a major motivation to work in the sheltered workplace. Apart from the operational management their work consisted of, supervisors were highly motivated to spend time on employees' personal well-being and development. However, since the sheltered workplace has become a 'transitional' sheltered workplace, more focus was placed on employees' productivity (see Box 1 for background information on transitional sheltered workplaces), and supervisors indicated that since that change they have had less time to be attentive to the needs of employees:

> *"You used to come in and see someone that did not comb his hair or did not shave. Then I used to say: hey, what is going on? You look unkempt today. And then the whole story comes out, and I would act right away"...."Nowadays, he goes to work looking unkempt, no one sees it and he sinks further down. And in the end, you have lost him."*—Interview supervisor

The commercialized focus of the sheltered workplace was also perceived by higher-level managers, who expressed their worries about supervisors getting an additional responsibility by having to inform and motivate employees for WHP:

> *"Those supervisors are already very busy"..."Like they have nothing else to do, we are an employer here. So, you expect a supervisor to lead a team and not do all that kind of peripheral stuff [referring to WHP]."*—Interview manager

Responsibility: supervisors want to help employees but perceive lack of response

Supervisors saw a role for themselves in motivating employees to participate in WHP and to engage in health-promoting activities in general:

> *"Well, what we often do, is to give a bit of advice. Where they must be and where they can go [for information about WHP]."..."When people try something (e.g., go to a dietician) you [as a supervisor] are the stimulator or give compliments."*—Interview supervisor

Supervisors explained that in the past, when the sheltered workplace had still the 'traditional' form (Box 1 about traditional and transitional sheltered workplaces), employees were 'protected' as much as possible (i.e. not really expected to take personal responsibilities). In current times in the transitional sheltered workplace, however, employees were expected to take more individual responsibility when it comes to work and health. However, according to supervisors, this responsibility is often not taken by employees:

> *"More is expected from people now. We try to give responsibilities back, and for some people that is very difficult. We give them opportunities to think for themselves; how exactly are you going to do this? Or how can you stay healthy? But in the end, they think that we [supervisors, the sheltered workplace in general] are the ones responsible for that."*—Interview supervisor

In the last sentence of the quote, the supervisor seems to show some frustration about some employees not taking responsibility for their own health. In addition, supervisors perceive a lack of response to the efforts they make to help employees:

> *"For example, the budget coach. We have plenty of people that have an issue with that, but do not go there anyway. Some people say: 'I am under administration anyway, so it is easy, I do not have to do it myself.' So, I say, we encourage it, but it is up to the people themselves to decide whether to do it."*—Interview supervisor

Competence: supervisors experience lack of resources to motivate employees for WHP

Supervisors mentioned that they do not have the resources to properly inform and motivate employees. Time is one of the resources that supervisors lack. They attributed this to the increased need to focus on productivity after becoming a translational sheltered workplace (see Box 1 for background information), and because of this, the reduced time they must spent on the personal interaction with employees.

A second constraint was that supervisors do not have the resources to adapt information about WHP to all the different needs regarding communication of employees. There is large diversity among employees in needs regarding communication, for example, due to low literacy, limited digital skills and limitations in processing information. This becomes more complicated because WHP in the sheltered workplace consists of a very extensive program, resulting in a lot of information that is hard to oversee, let alone adapt all the information in a proper way for different employees with different needs. According to some supervisors, it could help if employees would be more involved in setting up WHP:

> *"It is really a push system, from the organization. That we do all sorts of things, instead of employees themselves saying: well, I could use help on this or that. They [the employees] would not quickly do that either."*—Interview supervisor

Some supervisors also showed doubts about whether WHP in its current form can sufficiently help employees, which is exemplified by the following quote:

> *"Then there is another training on smoking cessation, and they [referring to employees] say: 'I would not do it again, because I cannot sustain it anyway.' I do not know if this is because of their social environment or social situation, but in any way it is a shame."*—Interview supervisor

Responsiveness: current WHP program requires mental, physical and practical flexibility

One of the barriers to participate in WHP is related to the accessibility of certain activities in the sheltered workplace as well as in general (e.g. accessibility of the local fitness club). Employees of the sheltered workplace face several challenges in their daily lives, such as limited physical and mental energy and mobility, low literacy, need for structure and predictability, insecurity and responsibilities towards close ones such as informal care. Some of these challenges are exemplified by the following quotes:

> *"Because it is after work hours and yes. And then I must exercise for one hour. Oh, I cannot do that at all."*—Interview with employee
>
> *"You are used to finish at 5, being home at 5.30 and having dinner at 6 p.m.. That is the rhythm of people, and you should not make too many changes in it."*—Interview with employee

Also, the communication and information provision about the current WHP program formed a barrier for employees to participate in the program. Although mentioned by several employees, one employee and participant of the interviews, who was involved in the workers council and was, in his own words, more eloquent than most other employees, explained that the organization did not put enough effort in providing information in an understandable manner:

> *"There are those who can read, but I can also read something, but it does not mean I understand it. That is a big difference of course"...."So, you must use different language, come up with examples."*—Interview employee

Another barrier was that some employees indicated that they did not have a need for WHP, or thought that WHP in its current form was not relevant and suitable for them. For example, because of the nature of their work, like employees who work in the cleaning business that involves physically demanding tasks, indicated that they were not interested in sports because they were already physically active all day. Also, employees often receive support in various domains of health through other institutes, such as health advice from medical doctors and financial aid through the municipality. Furthermore, employees do not always acknowledge a role for their employer, the sheltered workplace, in promoting their health:

> *"I need to lose weight, but I cannot say today I will only eat vegetables or something. Just eating*

normal."...."[Name organization] cannot help with that, I must do that myself."—Interview employee

Aim 2. Opportunities for improvement

The dialogs with employees brought forward three themes that could possibly enhance the *responsiveness (phase 4 of phases of care within care ethics)* to WHP. These themes were collectivity, intertwinement, and tailoring and are elaborated upon below.

Collectivity can enhance social contact and motivation, and reduce some barriers

The first theme was to stimulate *collectivity* among employees when engaging in health-promoting behavior, that is, doing it together with others. Working in a more collective manner on health, for example, by stimulating to subscribe to activities with a colleague of the same team, would be appreciated by employees for several reasons. First, it creates a possibility for employees to meet new people and have social interactions, important for many employees who have a limited social network. Second, working together on health is considered more motivating by employees, and offers the social control that some employees do not have in their private situation. Third, collectivity can take away some of the practical and mental barriers of participating, such as limited mobility or insecurity.

"When you are on your own, that step to go alone, I think that people also find that difficult. And if there is someone with you, they often like it, because then you are together."—Dialogue with employees

This quote shows how promoting collectivity, that is, participating in WHP together, could help employees that feel insecure regarding engaging in new activities, for example, due to negative experiences they have had in the past. These type of stories of employees, also led to understanding among members of the management team of the barriers employees face regarding participation in WHP:

"In general, people do know what is healthy and good for them. But doing it, that is a completely different thing. And that is not based on educational level, or income or whatever. It applies to everyone. And I thought that was an eyeopener. I also recognize it in myself, that I also think you know, going alone to the gym. That does not only apply to our 'target group', as we call them."—Evaluation interview

Intertwinement can enhance usefulness of WHP for daily life

The second theme brought forward in the dialogs was *intertwinement*. Employees explained that engaging in WHP would be easier for them if the offer of WHP would be relevant for their daily lives. A way to do this according to the employees in the dialogs, could be by organizing some small exercise breaks during the work time—which was already being done at some locations of the sheltered workplace.

Also, activities that give tools for daily life would be highly appreciated. For example, by focusing on cooking for one person in the cooking workshops, thereby considering the personal situation of many employees of the sheltered workplace. An employee that was moving from 'assisted living' to living on his own mentioned the relevance of such workshops:

"I want to learn to cook better by myself. A bit more variety. I mean making a pasta, that I can do, but not more than that."—Dialogue with employees

Cooking workshops were already offered by the sheltered workplace. Participation in these workshops was relatively high compared to other activities in the program. The dialogs confirmed the importance of activities such as cooking workshops—and other workshops in which it is, for instance, explained how to read food labels—that provide tools for daily life. More variety in such workshops and more time to properly explain things were mentioned as opportunities for improvement by employees in the dialogs.

After being informed about the findings of the dialogs, the sheltered workplace planned to start engaging employees before the start of WHP activities, to better match the content of the activities with the needs of the employees. This would also allow to take into account topics that are most useful for the daily lives of employees.

Tailoring allows to match WHP to physical, mental and practical possibilities of employees

Another way to improve WHP according to employees is through *tailoring*. This suggestion relates to the diversity among employees in terms of background, abilities and limitations, and also the type of work among employees at the various locations of the sheltered workplace. It was proposed by the employees to design WHP on a more local level, for example, at the level of the different locations. Next to tailoring, this would also decrease the number of possibilities offered to the employees, thereby reducing feelings of being overwhelmed by options, as well as the number of possibilities that require explanation by supervisors. Tailoring would also help to better match WHP to the physical and mental possibilities of employees, for example, by offering programs at various difficulty levels regarding physical load.

> *"I have participated a few times in the walks in the weekend, but then that is five kilometers or so. Then I think, you can do that differently, a walk of one or two kilometers, which is feasible. I can do five kilometers, but that does not mean I can continue working afterwards."*—Dialogue with employees

At the final evaluation of the responsive process evaluation, the sheltered workplace was planning to offer employees the possibility of a personalized platform that helps to choose WHP-related activities or tools for support that match their needs. The desire of employees for WHP activities that provide support in daily live, and low-key activities that support overall well-being was considered by the sheltered workplace as well:

> *"So you give people more space and freedom to make their own choices. And it does not matter whether you are going to learn to play the guitar, or whether you want a course for digital skills, or want to learn how to write and read. If you use it, that is what we would like. And if you do not use it, it (the budget) returns to the central pot, and we redistribute it every year."*—Evaluation interview

Prerequisite for such platform is that employees are digitally skilled, which the organization also planned to offer support for. Although the platform would allow for more tailored WHP, the sheltered workplace also recognized that such platform also individualizes WHP and requires more proactiveness of the employee. To minimize this, the organization was considering hiring a person in the role of 'vitality coach', that could offer professional support to employees in using the platform and making decisions on what could be most helpful for their health. By hiring this person, and by the sheltered workplace's plans to reduce the number of different activities in the WHP program, the organization aimed to reduce the burden on supervisors. Also, the organization planned to still offer part of the WHP program in groups to stimulate collective participation.

DISCUSSION

This paper aimed to understand the limited participation in WHP offered in a sheltered workplace, and to find opportunities for adapting WHP in such way that it better suits the needs of employees. By using care ethics as an analytical lens for the data, light could be shed on both the barriers for participation for employees and on the role that supervisors play in the limited participation. From the findings of this responsive process evaluation, it can be concluded that WHP within the sheltered workplace under study is too challenging for its employees in various ways, namely mentally (e.g. they face difficulties with understanding the activities in the WHP program), physically (e.g. they experience not being physically fit enough to participate) and practically (e.g. they experience a lack of time to participate due to other (private) obligations). Also, supervisors do not have enough resources to properly inform and motivate employees about WHP and to support employees in their well-being in general, partly due to an increasingly commercial organization. Also, views about the role of personal responsibility in health seem to differ between employees and supervisors. Although limited participation in WHP in sheltered workplaces has been studied before (Kordsmeyer *et al.*, 2022), this study differs from previous work by looking for opportunities for improvement as well.

For employees, an opportunity for improving WHP was enhancing collective participation in WHP together with colleagues. The importance of social support in health interventions has been acknowledged before for people with a low SEP (Mulderij *et al.*, 2020). This study shows that this might also be the case for people in sheltered workplaces, and provides in-depth information on how a collective approach allows employees to deal with various challenges they face in their daily lives varying from fear of participating in new activities alone or not having access to transportation to go WHP activities. This study also emphasizes the importance of diversity in needs of diverse employees when it comes to WHP, and the relevance employees see in WHP activities that affect health in a more indirect way than a healthy diet or physical activity, such as learning to play an instrument.

Values in WHP in sheltered workplaces

The disappointment of supervisors and the management team of the sheltered workplace about the limited participation, seems to be the result of high expectations of capacities and flexibility of employees. Supervisors expect that employees take personal responsibility for their own health. However, as the current WHP activities are challenging, and employees have different perspectives on what personal responsibility entails, this often does not happen. The high expectations in the sheltered workplace regarding personal responsibility are not random. Sheltered workplaces are part of the larger society in which certain values such as personal responsibility, autonomy and choice are prominent. The sheltered workplace in this study, like other sheltered workplaces for example in the United Kingdom, must increasingly work accordingly to a 'productivity-oriented work-logic' (Bend and Priola, 2021). It has been argued before that neoliberal values, such as individual responsibility, are increasingly reflected in

health promotion in Western societies (Meershoek and Horstman, 2016). This resonates with the extensiveness of WHP in the sheltered workplace, that provided employees with the freedom of choice and autonomy to choose from a large number of WHP activities. Although Kordsmeyer *et al.* (2022) recommended in their study to offer more different activities to improve WHP in sheltered workplaces, the current study shows that this is no guarantee of success. In fact, looking at the opportunities for improvement found in this study, less choice and a more collective approach rather than individualistic seem to be preferred by both employees and supervisors.

Theoretical and practical relevance

As in the sheltered workplace central in this study, it is common that the most extensive interventions do not have the desired effects, partly because participation in the intervention is low (van der Put *et al.*, 2020). This study provided new insights into the potential success factors and barriers in the implementation of interventions, in this case in particular for participation (Nielsen and Randall, 2013). Although it is increasingly acknowledged that participatory approaches allow to better match WHP interventions to the lived experiences of employees, the use of a participatory approach in a process evaluation is more innovative. One of the main objectives of responsive evaluation is to improve interventions in practice (Abma *et al.*, 2017), and participation is part of that. The focus on improving interventions for those who are targeted by it, encouraged, in addition to the barriers to participation, to map out the possibilities for improving participation.

This study also provides an empirical application of care ethics as a normative framework in a new field, namely WHP. Care ethics has been used before in various fields to incorporate ethics, such as robot design (Hamington, 2019), participatory health research to reflect on the role of researchers (Groot *et al.*, 2019) and exploring responsibilities in caregiving in parenting (Valarino, 2017), but its application is novel in the field of WHP. A care ethics approach allowed to understand the role of both the 'care givers' (supervisors and management) and the 'care receivers' (employees in sheltered employment) in the limited participation in WHP in a sheltered workplace. In addition, it facilitated thinking on WHP as a continuous process that is always developing and consist of various phases in which bottlenecks for good care can exist (Sevenhuijsen, 2003). This made it possible to get a more complete picture of the factors that contribute to the limited participation; the limited participation has not only to do with employees who do not want to participate, but also with reduced time and attention that supervisors in general have for the well-being of employees, due to the generally changed institutional context of sheltered workplaces (see Box 1). Using care ethics as an analytical lens to understand the limited participation in WHP, allowed to critically reflect on the role of the sheltered workplace besides the motivations of employees, and to acknowledge that certain expectations regarding WHP that organizations have, may not be realistic. Moreover, care ethics invites to think about the values on which WHP is based (Abma *et al.*, 2020). As described earlier in this discussion, the opportunities for improvement brought forward by employees did not seem to match so well with neoliberal values such as autonomy and individual responsibility. The values that underly care ethics, such as interdependence, vulnerability and the importance of relationships (Tronto, 1993; Held, 2006), seem to be more reflected in the proposed opportunities for improvement, such as stimulating collectivity in WHP. Based on this, it may be interesting to further explore whether care ethics is a relevant starting point for WHP, and perhaps as well for health promotion interventions for people in vulnerable positions in general.

Limitations

Although the previously described added value of care ethics for the analysis in this study, it may also have limited it too much to the dynamics between supervisor and employee regarding WHP. The results in this paper namely also indicate that the changed institutional context expressed by the transition from traditional to transitional sheltered workplaces and leading political ideologies influence what WHP constitutes of and what is expected from employees regarding WHP. Although the lens of care ethics preeminently suited the aim of this study, it does not provide in-depth insight in the workings of the institutional context and political ideologies. Given that those structural aspects underpin WHP, but possibly also other workplace processes, it is recommended to explore them more in-depth in future research.

Related to the limitations of care ethics as an analytical lens, are the limitations of the scope of this study. In this study, a responsive process evaluation of an existing program, implemented in the real world (i.e. not in a research setting), was performed. The aim of a responsive evaluation in general is to ensure a better fit between the lifeworld of people involved, and the intervention under study (e.g. van Heijster *et al.*, 2022). Structural changes could very well be part of that. However, the research question in this study mainly focused on participation in the existing WHP program. Therefore, this study did not address non-programmatic approaches for WHP, such as systems approaches (Robroek *et al.*, 2021). As a result, inferences on which

approach of WHP would sort most effects cannot be drawn based on this study.

Another limitation of this study was the underrepresentation of employees with a non-Dutch cultural background in the dialogs, who in fact comprised a significant part of the population of the sheltered workplace in this study. Although participants in the first phase of the study comprised a diverse group that informed the analysis of participation in the current WHP activities, people with a non-Dutch cultural background hardly played a role in finding opportunities for improvement in the dialogs. This was despite efforts of the researchers to recruit a diverse group of employees in the dialogs by emphasizing this to supervisors, whose role was to recruit employees for the dialogs. Before the COVID-19 situation, participants were also recruited through participant observations, which allowed the researchers to ask diverse employees to participate. However, as minimal contact was part of the governmental measures during and in between revivals of the virus, recruiting via the supervisors remained the only way for the dialogs. Still, the fact that both researchers were white, highly educated women, not working in sheltered employment, could have influenced who participated in the dialogs, as some employees may have perceived a distance between themselves and the researchers (Jacobson and Mustafa, 2019). Despite the adaptations that were made to make the dialogs as accessible as possible, a setting in which people have to express themselves through a language that they may not understand and/or speak well, might not have helped in attracting employees with different cultural backgrounds (Quintanilha *et al.*, 2015). Engaging employees with a diverse cultural background in the recruitment process may have been helpful in this situation as they could form a bridge for the language and other barriers between researcher and the people that are being researched (Quintanilha *et al.*, 2015; Abma *et al.*, 2019).

CONCLUSION

This responsive process evaluation showed the various barriers for participation in WHP in a sheltered workplace. In addition to the barriers for employees, the role of other stakeholders and the institutional context seemed to matter as well for participation. The responsive process evaluation also resulted in concrete opportunities for improvement to enhance participation in WHP in a sheltered workplace. Participation in WHP of employees in sheltered employees may be improved if WHP is organized in a collective rather than individual manner, if WHP can be tailored to the diverse needs of employees, and if WHP has a direct connection with daily life, in which employees from sheltered workplaces generally already experience challenges. Future research should aim to understand if the contextualized findings from this study also hold in other work contexts.

SUPPLEMENTARY MATERIAL

Supplementary material is available at *Health Promotion International* online.

AUTHORS' CONTRIBUTIONS

H.v.H., J.v.B., C.B., and E.d.V. provided intellectual input for the design of this study. H.v.H., M.B., and J.v.B. made adaptations in the intervention and evaluation for the particular work setting, a sheltered workplace. H.v.H. collected data and analyzed the data, together with J.v.B. H.v.H. drafted this paper, and all authors provided feedback and intellectual input after which it was revised multiple times.

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CONFLICT OF INTEREST STATEMENT

None declared.

ETHICS APPROVAL

This study was approved by the Social Ethics Committee, on behalf of Wageningen University and Research. For interviews and dialogs, all participants were asked for written informed consent. The forms were presented on a literacy level that is understandable for most citizens in the Netherlands (B1 literacy level). If participants were not able to read the form, they were explained to the participants verbally. Oral informed consent was obtained for participant observations.

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