# Workplace health promotion for home care employees in the Netherlands

*Exploring employers' and employees' perspectives and the role of cultural background*

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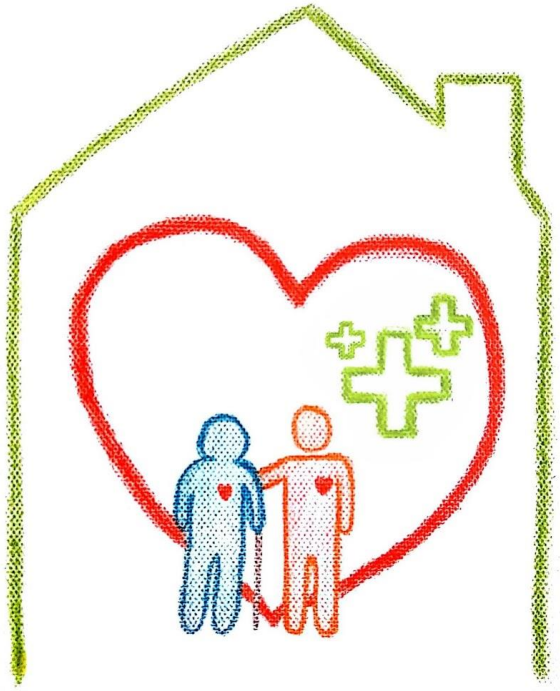

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**Preface**

Before you lies my Master thesis "Workplace health promotion for home care employees in the Netherlands", which is based on a literature review, a survey, and interviews conducted in several home care organizations in the Netherlands. It has been written to fulfill the graduation requirements of the Master Communication, Health & Life Sciences at the Wageningen University & Research. From September 2017 to June 2018, I was engaged in researching and writing this thesis.

I have always been interested in different cultures, which explains the focus on different cultural backgrounds within this research. Furthermore, the occurrence of health issues for health care employees has piqued my interest. By combining those two interests I could increase my knowledge on both topics. Conducting a survey and interviews were new experiences for me which helped me to develop both my qualitative and quantitative research skills.

I would like to thank my two supervisors for their outstanding guidance and support during this process. My first supervisor dr. Van Berkel kept her enthusiasm and motivated me till the end by providing excellent feedback and quickly answering any questions. I could not have wished for more! My second supervisor dr. L'Hoir was supportive and present at the right moments with very useful feedback. I would also like to thank all the respondents and in particular the ten home care employees I conducted interviews with. Without their cooperation, I would not have been able to accomplish this thesis.

A special thanks to my friends and family, who have always been there through both the hard and the good times. I could not have completed my thesis without their support, assistance, and inspiration.

I hope you enjoy reading this report.

Susanne Conradi

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**Abstract**

Home care employees make the most use of health care compared to other professionals inside and outside the health care sector. One explanation is high work pressure. This will most likely become higher due to the increasing age of elderly and the need for elderly to maintain independent living conditions for a longer period of time. Other factors that can be associated to home care employees' health are diversity in socioeconomic status, cultural background and working area. A lower socioeconomic status and a different cultural background than the majority could lead to health inequalities and difficult access to programs aimed at health improvement. Thus, it is warranted to explore ways to improve home care employees' health, taking the aforementioned factors into account. Workplace health promotion could be an option. The aim of this thesis is threefold. Firstly, which workplace health promotion programs for home care employees exist is explored. Secondly, team leaders' perspectives regarding home care employees' health and workplace health promotion programs are investigated. Thirdly, perspectives of home care employees on workplace health promotion are examined. To explore these various perspectives, mixed-methods are used, which are a literature review, a survey and interviews. The overall goal of this exploratory research is to uncover the role of cultural background in workplace health promotion for home care employees in the Netherlands. During the interviews was discovered that cultural background does not play a big role in the needs for workplace health promotion, but personal preferences and character do. The results of the survey were in line with the literature which dictates that workplace health promotion programs have been introduced for home care employees, and are often focused on physical activity and education. These programs, however, suffer low participation rates. Home care employees do not see traditional workplace health promotion activities, such as participating in offered physical activities, as a priority. Personnel shortage is perceived as the biggest problem that leads to health issues of home care employees. Another possible improvement mentioned by employees, is the communication within the organizations which was also seen as problematic. In practice, communication between both employer and employee and among employees could be improved, by being more receptive to each other's desires and needs. This communication improvement could have benefits for employees' health.

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## 1. Introduction

"I truly fear for the health of my team. Most elderly people are better tended to than how home care staff attend themselves" (translated, 5:14-5:21, Nederlands Publiek Omroepbestel [NPO], 2017). A nurse working in the *Achterhoek*, a rural area in the Netherlands expressed her concerns about home care employees' health in a documentary. She also stressed that the problems and difficulties in home care teams are mostly due to the lack of employees and a lack of time. She suggested that the health of home care employees should be improved.

It appears that home care employees have more health issues compared to people who work in a sector outside health care (CBS, 2016). This is problematic, as a good health is essential when providing care. The need for elderly to maintain independent living conditions is growing (Rijksoverheid, n.d.), as well as the need for additional home care employees (Uitvoeringsinstituut Werknemersverzekeringen [UWV], 2015). Furthermore, the number of people passing the 65-year mark will increase as well. Due to decreasing birth rates, it is estimated that in 2040, fifty per cent of the population will be older than 65 (Zorg voor Beter, 2017). Moreover, seventy per cent of the people who are older than 65 have a chronic disease, which means that health care is vital (Van der Horst, Van Erp and De Jong, 2011). There are relatively few people who can take care of these people. Currently, eighty per cent of home care organizations struggle with personnel shortage (UWV, 2018). The higher amount of elderly suffering from disease could instigate more pressure with regard to home care employees. Hence, it is warranted to explore ways in which sustainable employability of home care employees could be reached by focusing on health and workplace health promotion. Workplace health promotion (WHP) activities and programs aim at improving employees' health. The existing health issues for home care employees and health inequalities within the group of home care employees will be discussed in upcoming paragraphs.

### 1.1 The problem of sickness absenteeism

Even though in the Netherlands, 79.4 per cent of the population indicate their health is in (very) good condition (Centraal Bureau voor de Statistiek [CBS], 2017a), significant health inequalities do exist. Over one million people work in the health sector, of which 36 per cent work in home care and nursing homes (UWV, 2017). This branch shows the highest occurrence of personnel dealing with health issues, mostly due to work pressure and an inability to independent decision making. An example is the occurrence of burn-outs. According to Bakker, Schaufeli, and Demerouti (1999), people who work in health care are susceptible to burn-outs. One explanation for this susceptibility is that the high work pressure could lead to emotional exhaustion and an insecurity regarding the quality of care. This might lead to depersonalization, in other words, distancing oneself from clients which ensures less productivity and sometimes a burn-out as a result. Many factors might affect whether people develop a burn-out. The best known factors are work pressure, physical load, work-life balance, support of colleagues, self-

development and personality. The amount of burn-outs are increasing, causing absence due to sickness, higher work pressure and personnel shortage.

In the health care sector, the highest absence due to sickness rate occurs, namely 5.8 per cent compared to 4.3 per cent in all sectors. Within the health care sector, the employees working in nursing homes and in home care have the highest rate of absence due to sickness with 6.7 per cent (CBS, 2016). Employees working in nursing homes and home care make the most use of health care such as physiotherapy and mental health care compared to other professions outside the health care sector (IZZ, 2017). Besides the intensive work labor, it also requires fitness. The health problems of home care employees could be caused by the fact that firstly, they do heavy physical work. Secondly, it is a stressful job because scheduling is done by team leaders which means employees do not have much influence in managing their own time. Finally, they do not have much autonomy in their decision making (IZZ, 2017). Another factor influencing their health is the fact that home care employees often have a lower socioeconomic status, which in general causes other (health, financial, or family) problems (ZonMW, 2016). Current research mostly focuses on how to improve the health care of clients, disregarding the individual health of personnel and sustainable employability. This research focuses on employees' health and underlying factors for health inequalities.

### 1.2 Factors of health inequality

Besides the aspects of the job and the sector, other factors could play a role in health inequalities. Bertens and Van Kesteren (2011) state that both people with a lower socioeconomic status and people with a non-Western background more often have an inactive lifestyle and more health problems. Therefore, the target group of this thesis consists of home care employees with a lower socioeconomic status and with different cultural backgrounds, focusing on exploring the intersection of socioeconomic status and cultural background. The work area has been taken into account as well in order to explore the influence of this factor on health and access to WHP.

A socioeconomic status is linked to educational level and profession. Employees in home care can have various educational levels but this thesis focuses on employees with maximum an MBO (profession oriented) level 3 education. Most jobs in home care are performed by employees with an MBO education level between 1 and 3. These jobs are personal health care assistant, caregiver, and household assistant and are related to a lower socioeconomic status. Burdorf, Robroek, and Brouwer describe in their knowledge synthesis report that lower educated people with a lower socioeconomic status, live six to seven years shorter on average compared to people with a higher education or socioeconomic status. One of the causes is an unhealthy lifestyle, i.e. less exercise and unhealthy food intake, which is more common for people who have a lower socioeconomic status (ZonMW, 2016). The living environment also plays a role in health. People who live in an urban area often have more health issues compared to people living in a rural area (Verbeij, Van de Mheen, De Bakker, Groenewegen & Mackenbach, 1998).

Another factor which induces health inequalities is cultural background. According to the annual rapport of Arbeidsmarkt, Zorg en Welzijn ([AZW], 2012), thirteen per cent of home care employees are immigrants and therefore have a non-Dutch cultural background and nationality. This number is quite high compared to other professions within health care. Having a different cultural background than the majority could lead to more health issues (Napier et al., 2017). For instance, migrants with a non-Dutch cultural background have up to 9.2 per cent more frequent burn-out complaints compared to people with a Dutch cultural background (StatLine, 2018). In health research, the focus is not directed to cultural background. Immigrants often feel excluded from health research because they do not feel connected, they do not speak the language or they live more isolated and are not easily reached (Singer, Dressler, George & Panel, 2016). Cultural background is also known as a barrier to participation in WHP activities (Napier et al., 2017), and therefore, the cultural background has been included in this research.

Employees' perspectives on WHP need to be included as well, to find out their needs and why they participate or refuse participation. Although employees are the target group, their perspective is often not taken into account in developing and evaluating WHP programs and activities (Nöhammer, Schusterschitz & Summer, 2013).

Therefore, the perspectives of home care employees have been explored. The main goal of this study is to explore the role of cultural background in WHP programs or activities. The aim of this thesis is threefold. The first part is to find out which programs or activities exist for home care employees. The second part is to find out whether programs or activities have been implemented to improve the health of the target group. The third aim is to explore the perspectives of home care employees (with different cultural backgrounds) on WHP. To explore why home care employees have more health issues compared to people with different jobs, specific features of the group are taken into consideration.

### 1.3 Research questions

In sum, most employees working in home care have more health issues than people working in another sector. Besides inequalities in health between sectors, health inequalities exist between people of different socioeconomic status and between people from different cultural minority groups in the Netherlands. People with a lower socioeconomic status and/or people with a non-Western background experience more health problems than people with a high socioeconomic status and/or with a Dutch nationality. However, people living in the Netherlands with a non-Dutch nationality or cultural background participate less often in health-promoting programs. Interventions for people with a lower socioeconomic background and/or a non-Dutch cultural background have been attempted. Those interventions did not focus on one specific work sector. Furthermore, WHP is mainly implemented in white collar jobs, while people with a blue collar job have more health issues (Bertens & Van Kesteren, 2011). Therefore, this research aims to fill the knowledge gap between the role of culture in WHP and

how the gained knowledge on this topic could be used for future development of WHP. The main research question is as follows:

*What is the role of cultural background in workplace health promotion for home care employees in the Netherlands?*

In order to answer this main research question, other information is needed and therefore the following three sub-questions have been explored:

1. *What is known about the type of workplace health promotion for home care employees, its effects, and its challenges?*
2. *Which workplace health promotion programs or activities are currently implemented for home care employees in the Netherlands?*
3. *What are the needs and perspectives of home care employees with different cultural backgrounds on workplace health promotion?*

### 1.4 Outline

First, background information about home care employees will be given. The next chapter is the conceptual framework, where concepts will be defined and explained. After the conceptual framework, the used methods will be explained and lastly, the three sub-questions will be answered. This is built-up as follows.

First, a literature review was carried out to discover what is already known in the field of WHP programs for home care employees. Second, a survey based on the literature study was performed to identify if and which WHP activities have been implemented for home care employees in the Netherlands. Third, interviews have been conducted with home care employees with different cultural backgrounds, to find out their perspectives on WHP activities.

After gaining all the information and insights, an answer to the main research question will be given in the concluding chapter. Last, in the discussion chapter, the main results, the reflections on methodology and ethics will be discussed. Recommendations have been drawn up in Appendix K.

## 2. Background information education home care employees

To find out why home care employees have more health issues, some background information about the profession and required education is needed. Health care is the sector with the biggest amount of jobs for lower educated people (UWV, 2017). According to UWV (2015), most employees working in the health sector have an MBO-education, namely 58 per cent. MBO means secondary vocational education and is profession-oriented education based on practical learning, preparing students for many different occupations on four different levels (Government of the Netherlands, n.d.). Level 1 is assistant training and is considered as lower education while level 4 is middle-management training. Achieving one of those levels makes it is possible to attain a job within home care. Home care employees are mostly educated with an MBO level 3 education: 34 per cent is "Verzorgende IG (Individuele Gezondheidszorg)" which means personal health care assistant (Van der Windt & Bloemendaal, 2015). Twenty-one per cent of the home care employees have a VMBO-education, which is preparatory secondary vocational education (UWV, 2015). Furthermore, employees educated with MBO level 1, 2, and 4 are also common within home care. In Figure 1, the most common occupations within home care are given (Van de Windt & Bloemendaal, 2015).

Table 1

*Number of home care employees per 2014 (Van der Windt & Bloemendaal, 2015)*

| | Amount | % |
|---|---|---|
| Personal health care assistant (Level 3) | 42814 | 34 |
| Other employees | 28554 | 23 |
| Caregiver (Level 1) | 222220 | 18 |
| Nurse (Level 4) | 10931 | 9 |
| Nurse (Level 6) | 8759 | 7 |
| Household assistant (Level 2) | 5533 | 4 |

The tasks of home care employees differ per educational level and per organization. However, all employees need to stimulate clients to take care of themselves as well as possible.

A "Zorghulp" (caregiver, MBO level 1) is someone who helps clients with housekeeping, such as grocery shopping and making the bed (De Nederlandse Zorg Site, n.d.-d). A "Helpende (Zorg en Welzijn)" (household assistant, MBO level 2) is similar to a caregiver but it adds some responsibility, for example helping people get dressed (De Nederlandse Zorg Site, n.d.-a). The biggest group is "Verzorgende Individuele Gezondheidszorg (IG)", (personal health care assistant, MBO level 3). With this level, different jobs can be attained, such as maternity nurse or caring for elderly or sick or disabled people. Within home care, three possible jobs with this education exist. Those jobs are (family) caretaker C or D or district caretaker. Family caretaker C implies mostly helping people wash, undress, eat, and

household tasks. Family caretaker D means helping clients wash and undress, but instead of helping with housekeeping, they assist in following doctor's orders such as administering medication and helping people with exercises and help to get in and out of bed. District caretakers may also do simple nursing tasks such as giving injections and helping with the rehabilitation of clients (De Nederlandse Zorg Site, n.d.-c). By obtaining an MBO level 4 degree people can become a nurse and within home care a "Verpleegkundige in de wijk" (nurse in the district). Their job is to provide nursing assistance to people who recover from surgery or have disabilities. Tasks include inserting an IV or a catheter and guiding people with psycho-social problems (De Nederlandse Zorg Site, n.d.-b). This selection of jobs encompasses only a part of the whole variety of jobs found in health care facilities. In this thesis, the primary focus lies on these specific jobs which can be performed with an MBO education level 3 or lower since it concerns the majority of health care personnel and could be linked to a lower socioeconomic status.

## 3. Conceptual framework

To create a deeper understanding of the topic of home care employees' health issues, health and WHP have been defined. Home care employees belong to certain social categories which could affect health. This thesis focuses on possible social categories that affect health which are socioeconomic status, cultural background, and area of activity. Those concepts will be explained in this chapter. An intersectional framework has been used as well, in order to analyze what the role of those intersections between different social categories is. Lastly, a conceptual model has been created to show the focus of this research, which is the interaction between social categories and the connections with health and WHP.

### 3.1 Health and well-being

Health is defined in many broad and sometimes ambiguous ways. On the one hand, it could be described as the absence of disease (Emmet, 1991). While others define it as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization, n.d.-a). This definition also implements the term well-being which is another ambiguous term often entangled with health. Danna and Griffin (1999) describe how health and well-being could be seen as intertwined or as strictly divided: that well-being is something different and not connected to health. They defined health as "when specific physiological or psychological indicators or indexes are of interest and concern" and while they describe well-being as a broader concept, taking into account the "whole" person and where life experiences can be measured and used as an indicator (Danna & Griffin, 1999). In this case, job and life satisfaction are factors of well-being, which is important for this research.

Wiencke, Cacace, and Fischer (2016) identify difficulties concerning the definition of health also with regard to cultural perspective. People from different cultural backgrounds perceive health in many different ways. Well-being is in individual cultures more connected to happiness and self-esteem, while in more collective and inter-subjective cultures, well-being if defined by self-criticism and personal discipline (Ryff et al., 2014).

Since 1948 the amount of people living with a chronic disease has increased. Diseases are less often incurable due to better hygiene and health care. Having a chronic disease has become the norm. Therefore, much discussion about a new definition or concept took place, and Huber et al. (2011) created the concept of health as "the ability to adapt and to self manage" (p. 2). In this view, people who can cope with their (chronic) diseases and are able to maintain their quality of life on the social, mental and physical level, are healthy.

In this thesis, the definition of Hubert et al. (2011) is used because it does not exclude people who have a disease while maintaining a good quality of life. It is a positive way to view health, while well-being is also included in this concept and specifies the dimensions of health.

### 3.2 Workplace health promotion

The European Network for Workplace Health Promotion defines WHP as attempts made by employees, employers, and society to achieve better health and well-being of employees (World Health Organization, n.d.-b). Nowadays, the focus lies on improving the working environment to increase employees' participation, by focusing on both occupational and non-occupational factors such as promoting a healthy lifestyle. Some health promotion activities focus on one risk factor or one behavioral change, however, most of the times it is a combination of factors that contribute to impaired health. Nowadays, it is more common to take a broad approach in which all different levels that influence a person's health are included, such as organizational factors and societal factors (Cox, 1997). People's well-being is based on a more dynamic interaction between different influences from different environments.

According to Rimal and Lapinski (2009), interventions focusing on changing people's behavior (e.g. living a healthier life) are acts of communication. They state that it needs to be taken into account that the target group is part of a social network with social interactions between those networks. Selective perception of the health intervention and individual and macro-social factors play a role in the effectiveness of the intervention. Implementing health promotion in a work environment could be more effective than in other atmospheres because social networks are already created and the macro-social factors are partly similar for every employee. Furthermore, people spend most of their time at work (Cox, 1997).

Rongen, Robroek, Van Lenthe, and Burdorf (2013) mention the benefits of WHP, namely the potential reach, the natural social networks, and the possibility to interfere with their social environment. Implementing WHP could target one specific group of people in a working sector, which have the same working conditions and therefore may have the same health issues. WHP could improve employees' health by focusing on these issues (Cox, 1997). The World Health Organization (n.d.-b) emphasizes the importance of implementing health promotion activities at the workplace because the environment in which people work has a direct influence on their economic, social, mental, and physical well-being. Indirectly, this well-being affects the well-being of their communities and families. Furthermore, it is a great opportunity to reach a large audience and to support their health. Giving attention to employees' health has many benefits, for example, employees will be more productive, less stressed, more satisfied with their job and they may increase their skills for health protection.

A safe workplace contributes to sustainable development, pollution that endangers health may become less if there is a focus on occupational health, employability might improve and health care costs for the organization might reduce. Greater benefits are achieved in organizations with many low-paid employees who work in a high-risk working environment, where WHP activities could decrease inequities (WHO, n.d. a). WHP has benefits for employees' health, well-being. and productiveness.

Implementing WHP is always complex because of the relationship dependency between employer and employee (Van Berkel et al., 2014). Improvement of collaboration and communication between employer and employee are important to increase social support, which could promote a quick recovery (ZonMW, 2016).

Participation in the programs or activities is voluntary and depends on how much the employee values a healthy life (Cox, 1997). The effectiveness of these programs and activities is often small and therefore it is important to examine which factors affect this (Rongen et al., 2013). For this specific target group, some challenges occur. Home care employees experience high work pressure and work in a changing environment, namely at their clients' homes. Home care employees could benefit from WHP because they often suffer from several health troubles at the same time.

According to Rassia (2017), effective WHP can be considered as a continuous process to improve work and health, instead of a one-off activity. Most health-promoting programs strive for behavioral change. This is achieved by persuading groups of people to alter their behavior. In other words discouraging risky unhealthy behavior such as smoking, alcohol consumption, and sleep deprivation and providing incentives for a healthier lifestyle can be attained by WHP. Intense programs with weekly activities over a longer period of time and several components appear to be most effective. Health checks could lead to positive effects when they are combined with additional interventions. A first health check with attention to work and a healthy lifestyle could be an attractive starting point for individual interventions to redirect unhealthy lifestyles. In short, implementing WHP could have positive results for both employer and employees.

Health-promoting programs are difficult to implement and to evaluate because usually, a program analysis does not investigate whether people would have shown the same behavior without the program, nor the role of the environment and individual driving forces.

### 3.3 Socioeconomic status

Socioeconomic status is often based on education level, working sector, and income of people (Shavers, 2007; ZonMW, 2016). This thesis focuses on employees working with an MBO level 1, 2 and 3. This usually indicates people with a lower socioeconomic status. Socioeconomic status relates to health inequalities.

People with a lower socioeconomic position are often found to have worse living and working conditions. About five percent of the total disease burden is due to unfavorable working conditions. Also, social factors play a role, such as less support from their social environment. People are more likely to have a social network that consists of people of the same socioeconomic status. This network influences their behavior, which makes it even more difficult to change it (ZonMW, 2016). It is all

interconnected: lower educated people more often have jobs with an irregular working schedule and more job insecurity, which causes stress.

A lower socioeconomic status often goes intertwined with an unhealthier lifestyle, which causes health issues and less "healthy years" compared to higher educated people (ZonMW, 2016). According to the Central Bureau for the Statistics (Knoops & Van Den Brakel, 2010), men who have the lowest income level have a life expectancy of 73.9 years, while men with a high-income level have a life expectancy of 81.1 years. For women, this is respectively 78.8 years compared to 85.5 years old. Furthermore, the difference in the number of healthy years is even bigger: the difference between men with the lowest and highest income is 17.8 years of living in (very) good health and the difference for women is 17.6 years. This proves income as a strong indicator of health.

This also works the other way around, people who have health issues or chronic diseases more often struggle to find a job on a level that fits them and are thus more likely to have lower income jobs (Kunst, 2010). So, not only socioeconomic status affects health, but health affects socioeconomic status as well, which is important to take into account.

As mentioned in the knowledge synthesis (ZonMW, 2016), health issues and an unhealthy lifestyle affect how employees participate in their work. Their work environment affects their stress level and on the long-term, the number of healthy years. One important cause of socioeconomic health inequalities according to ZonMW (2016), is the issue of having multiple problems, e.g. problematic living conditions and having debts or having a child with psychological problems. These problems cost time and energy and are usually in need of a 'quick fix' while improving health and preventing health problems are less pressing matters. Short-term problems need to be solved, before activities to improve lifestyle and health can get attention. Another important predictor of prolonged absence due to sickness is lack of self-efficacy. Other mentioned factors to explain socioeconomic health inequalities are the pressure to perform, bad communication between employee and employer, no support from management or colleagues, and lack of facilities (ZonMW, 2016). Therefore, decrease in healthy years seems to be related to multiple problems and bad working conditions. Implementing WHP activities could improve working conditions. A closer look is taken at the provision of WHP for people with a lower socioeconomic status.

### 3.4 Workplace health promotion for people with a lower socioeconomic status

Verdonk, Seesing, and De Rijk (2010) describe known factors that affect the participation of employees in the WHP program. In their study, WHP consists of encouraging physical exercise and/or trying to increase knowledge by giving information and advice. Mentioned factors that affect people's choice to participate in the program are:

- Equality in access to participate with regard to age and education

- Individual health perception
- Willingness to change possible risk factors
- Work pressure and well-being
- Ability to combine exercise with work responsibilities
- Support of managers and presence personalized services
- Supervision of high quality

Colleagues also play an important role in supporting other colleagues to feel accepted and appreciated. Thirty-four per cent of the bigger companies (with more than fifty employees) regularly offer some form of physical exercise for their employees. This number is much lower in branches where lower socioeconomic positions are more common (ZonMW, 2016). Equality in access to WHP is not yet achieved.

Socioeconomic factors play a role in perceiving and responding to health messages in the short and long term. Barriers can be seen in some health interventions, which can make people feel less connected or persuaded by the intervention. Lower socioeconomic groups are a difficult target group because they often lack motivation due to multiple problems (ZonMW, 2016). It is important to know which factors could be barriers to participating in WHP programs for the target group.

Interventions did not show a difference in participation in WHP activities of employees with lower or higher socioeconomic positions. However, there were variations in preferences. Lower educated people preferred an intervention to quit smoking (because more people smoke), while higher educated people were more likely to feel the need to have a health program related to exercising and stress management. Lifestyle interventions are usually more effective for white-collar workers than for blue-collar workers. High educated people are reached more easily by these interventions. Most interventions focus on cognitive changes, providing more information about health. This information needs to be understood and applied, which is more difficult for people with a lower socioeconomic position (ZonMW, 2016). Not many work-related lifestyle interventions have been implemented for people with a lower socioeconomic position in the Netherlands, while these people generally have the most health issues. According to Bertens and Van Kesteren (2011), the effectiveness of those interventions is unclear. The need for WHP varies along socioeconomic status and jobs. Therefore this research focuses specifically on home care employees.

### 3.5 Workplace health promotion in rural and urban areas

Bertens and Van Kesteren (2011) did an assessment of existing WHP interventions for people with a low socio-economic status and/or a non-Western background in the Netherlands between 2000 and

2010. It is remarkable that most interventions took place in urban areas. No specific article was found about WHP in rural areas. Therefore, differences and similarities between health and WHP in rural and urban cities might occur and are one of the focuses of this research.

### 3.6 Culture

Culture can be viewed in various ways, but in this research, it is defined as giving meaning and interpreting how the world works and should work by having certain assumptions, beliefs, values, and perceptions. Communication is important in this mechanism because culture is shared through communication. Communication can only take place if there is some shared culture. There are also intercultural and individual differences. Culture is dynamic and always changing, and people are usually not aware of their own culture. However, culture also has a never-changing core on which people base personal conduct, expectations, and perspectives with regard to reality (Aarts, 2008).

According to Schein (1999), culture consists of three layers, namely the visible artifacts, the constrained values, and the implicit assumptions. Only the first layer can be observed by people from other cultures.

Culture can be seen as both objective and subjective. The foremost objective aspects consist of institutional, political and economic systems. A subjective approach refers to "the experience of social reality formed by a society's institutions" (Landis, Bennet & Bennet, p. 150, 2003). This means that a worldview is created by society, perceived differently by each individual.

Culture has primary and secondary characteristics. Primary characteristics are for example gender, race and religion. Secondary characteristics consist of socioeconomic status, occupation, and reason for migration (Purnell, 2009). When doing research about health promotion, it is important to be sensitive to the different cultural aspects or group dynamics. Cultural sensitivity is when you are aware of the beliefs, values, and norms of other's and of your own biases (Al-Bannay, Jarus, Jongbloed, Yazigy & Dean, 2013). Culture has an influence on people's well-being: physically, mentally and emotionally (Boddington & Räisänen, 2009).

Culture can be approached as static, which means that it stays constant and homogeneous. It can also be seen as dynamic, which means that people have dynamic, contextual relationships that interact with personal dynamics and changes identity over time (Martin & Nakayama, 2010). In this thesis, the dynamic perspective on culture will be adopted and the changes in identity over time are considered. Immigrants have different ethnic and religious backgrounds with their own values and norms (Lonner & Berry, 1986; Trimble, 1990; Harris et al., 2009). Some people adapt to the main culture of where they live, and others are not able to adapt. Furthermore, coming from a certain country does not immediately mean that people will behave similarly in a foreign environment. According to Singer et al. (2016), not all people with the same cultural background have exactly the same visions and values, especially when they migrated. Emigration is different for everyone and could cause a mixture of cultures or staying true

to the original culture, which also influences the next generation. Therefore, it is important to take individual cultural backgrounds into account.

### 3.7 Challenges towards including culture in workplace health promotion

Napier et al. (2017) enlighten how migration could lead to health issues. Migrating people leave their country and culture and sometimes do not feel directly connected to and integrated into the culture of their new country. They could feel excluded and marginalized, which may increase their desire to belong. The desire to belong exists in communities with people with similar (cultural) backgrounds. This may increase well-being in the short-term, but not necessarily in the long-term, due to the effects of isolation with regard to the general population. Isolation and not feeling integrated have a big influence on developing (chronic) health problems and diseases (Singer et al., 2016). The interaction between immigrants and inhabitants is also important. When inhabitants do not understand the fears of people who were forced to migrate, more misunderstanding and even anxiety may develop. Immigrants can get a feeling of distrust and exclusion when living in a new country (Napier et al., 2017), which has a bad effect on well-being as well.

As Al-Bannay et al. (2013) describe, people with a different cultural background than the main culture in a country are in the minority, which makes them more vulnerable. Thomas, Fine and Ibrahim (2004) mention the importance of focusing on different aspects within a minority culture, to create a health intervention that can affect all the individuals within the group to increase acceptance and salience of health promotion activities. They describe that "…factors such as belief systems, religious and cultural values, life experiences, and group identity act as powerful filters through which information is received". Their perception of health and their expectations about health care may differ. Furthermore, lifestyle is an important factor which affects health, and lifestyle is influenced by and connected to cultural background.

Bertens and Van Kesteren (2011) state that it is important to focus on non-Western people when developing health promotion programs because health improvement is most needed in this group. People living in the Netherlands with a non-Dutch background often are the ones who do not participate or partly participate in health-promoting programs or activities. The interrelation of different interventions as well as the collaboration between implementers and their target groups should be enhanced. Bertens and Van Kesteren (2011) found some aspects that should be taken into account while designing an intervention study for lower socioeconomic status people with a non-Western cultural background. In order to reach the target group, it is advised to use key actors and intermediaries. The most effective factor they found was mouth-to-mouth advertising. However, this cannot be planned beforehand which is why it is difficult to include this in an intervention strategy. Involvement of the target group while developing an intervention is essential to reach that group.

Napier et al. (2017) explain some of the pitfalls why people with a different cultural background might feel less targeted with health interventions. Vulnerable populations are often not easily involved in well-being studies or do not feel the urge to get involved, especially when they have more daily troubles that need attention. Power imbalance may cause biases and increase the differences between majority and minority groups, for example, with a different cultural background.

### 3.8 Intersectional framework

To better understand the interaction of different personal features and how they affect people's lives, an intersectional framework can be used. Intersectionality describes how an identity is created by the mix of different personal features, to include all individual factors of a person that might have an influence on each other (Cole, 2009). People from minority groups could have different individual features, which might create a minority within a minority. This intersection of individual features creates an identity which shapes people's thoughts and behavior.

For the analysis of the surveys and interviews, the questions of the intersectional framework (Cole, 2009) have been taken into consideration and have been used to get more insight into the interaction between minority features and WHP and health in general. Those three questions are:

1. Who is included within this category?
2. What role does inequality play?
3. Where are the similarities?

As a socioeconomic status, cultural and demographic background, age, gender, and working conditions might intersect, an intersectional framework is useful. An intersectional framework is a framework that takes into account that people have individual features and multiple identities that intersect with each other and interact on the social-structural level (Bowleg, 2012). Bauer (p. 10, 2014) explains intersectionality as a theory "developed to address the non-additivity of effects of sex/gender and race/ethnicity but extendable to other domains, allows for the potential to study health and disease at different intersections of identity, social position, processes of oppression or privilege, and policies or institutional practices". This means that intersectionality can be considered in health research to identify health inequalities.

In this thesis, many social categories are used to define the target group. First of all, it focuses on people with a lower socioeconomic status. Socioeconomic status has a big influence on people's lives and is defined by identities such as profession, social environment, and community. Furthermore, cultural background affects people's identity. Just as explained above, culture shapes people's thoughts and people often define themselves and others by their cultural background and/or nationality. Living in a country where your culture is a minority, influences behavior and could lead to oppression. Thirteen

percent of home care employees are immigrants (AZW, 2012), which could impact their perception of health in general and health promotion specifically. Nationality could be one of the identity factors that leads to some kind of oppression or privilege. In addition, 91.8% of home care employees are women (Van Essen, Kramer, Van der Velde & Van der Windt, 2015), which could have an effect and intersects with the other features. Women are more often absent due to sickness compared to men. This absenteeism also increases when they get older (CBS, 2017b). Therefore, age is also an aspect that is taken into account during the analysis of the survey. The last defined feature that shapes a person's identity is living and working in a rural versus an urban area. On the one hand, health issues are more present in urban areas (Verheij et al., 1998). On the other hand, in rural areas, there are relatively fewer facilities in the vicinity, which could lead to less institutional practices such as opportunities for WHP.

The intersectional framework is useful in this research because it focuses on people differences in nationality, cultural background, and socioeconomic status. This creates a different, unique identity for everyone, and could expose them to forms of oppression and discrimination. In health research, few studies have used this framework. It is important to take individual identity and corresponding privileges or oppression into account (Bowleg, 2012). Population health research could be more valid if it is aware of how different aspects intersect. More attention to those intersecting aspects and to the causes of health inequalities could make health promotion more effective (Bauer, 2014). The focus of this study is on the health of home care employees and how cultural background plays a role in WHP, to find out what role inequality plays. It is important to find out how individuals are affected by their social categories and how this could influence their participation in WHP activities.

### 3.9 Conceptual model

To make this conceptual framework (see § 2.1-2.9) more visual and clear, a conceptual model has been developed to show how these concepts are related. This is shown in Figure 2. The arrow shows that there is a reciprocal connection between one concept and another.

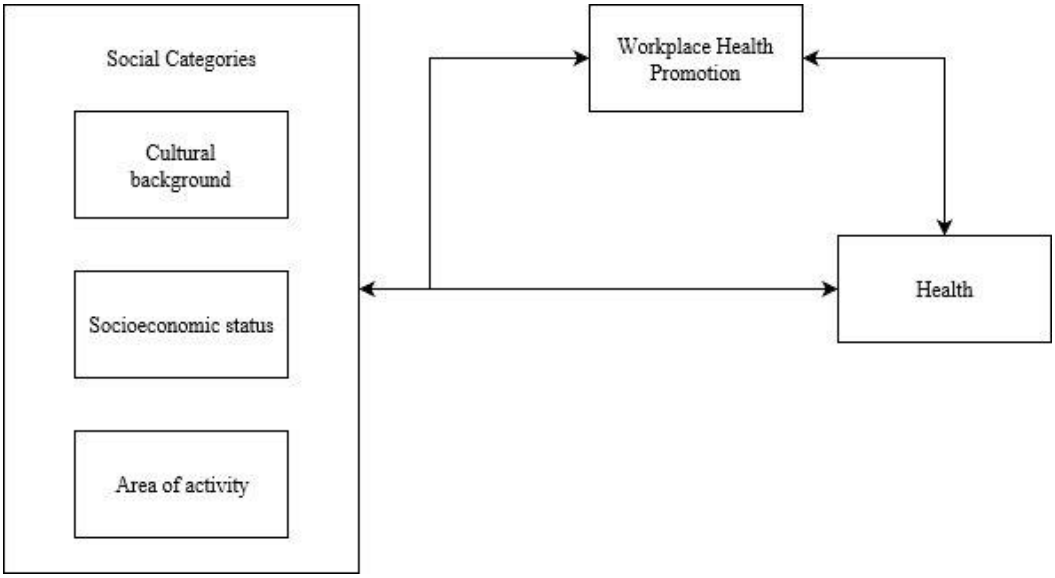


*Figure 2: Conceptual model*

## 4. Methods

To answer the main research question: 'What is the role of cultural background in workplace health promotion for home care employees in the Netherlands?', mixed-methods have been used. Mixed-methods combine both quantitative and qualitative data for analysis in one study. There is growing interest in mixing qualitative and quantitative methods, to explore and explain a problem (Creswell, p. 208, 2013). For this research, it means that three sub-questions are answered using three different methods. In the next part, the three methods will be explained.

### 4.1 Literature review

First, a literature review was carried out, in order to find an answer to sub-question: 1: 'What is known about the type of workplace health promotion for home care employees, its effects, and its challenges?'.

#### 4.1.1 Literature review procedure

What is already known about interventions for home care employees to improve their health has been found in the literature. A literature review is a method by which relevant literature about an under-explored topic is analyzed (Harlen & Schlapp, 1998).

This literature review has been done using PubMed (www.pubmed.com), a medical literature website. Different searching terms have been used to find useful literature to discover what kind of programs and activities to promote health for home care employees already exist.

The term that is used to address home care employees differs per article and research. In a relevant article of Flannery, Resnick, Galik, and Lipscomb (2011), it is referred to as direct care workers. To start with, no term for workplace health promotion was used because a broader perspective was used to include all interventions that could indirectly improve employees' health. Articles about all interventions used for direct care workers to improve some aspect of work have been taken into account. The search terms were "'direct care workers"' intervention' and 'workplace health promotion home care workers'. The term workplace health promotion was used because the word intervention did not lead directly to health programs.

For the first search term, 61 articles were found and the term 'workplace health promotion home care workers' gave 115 results. The next step in the search for relevant articles, was screening the titles to filter the useful ones. Words as 'intervention' or 'health promotion' had to be included in the title, as well as 'direct care workers' or 'home care aides'. Those articles were scanned, to find out if it was really about an intervention for direct care workers focusing on health improvement. Of the 61 articles, four important and relevant articles have been chosen. From the 115 results of the second search term, four were chosen to use for analysis. The other articles could not be used because they were not focused on home care employees. More articles about the same intervention were found and the most recent containing the most suitable research questions have been selected.

### 4.1.2 Literature review analysis

The eight articles have been analyzed, first by putting the relevant information of every article in categories in a table. The categories were article, title, author and year, journal, topic, methodology and results, recommendation, and conclusion. The table was used to get an overview and to retrieve insight into the most important information of the articles. The four articles found with the search term "'direct care workers" intervention' were about challenges while developing a WHP intervention, and insights in the available knowledge about this have been collected. The four articles found with the search term 'workplace health promotion home care workers' focused more on challenges while implementing WHP. Two of them were published in 2017 and the results and recommendations were used as input for this research. The insights on both challenges for developing and implementing WHP for home care employees created an answer to the first sub-question, forming a sound base for the survey, which was the next step in this research.

## 4.2 Survey

The survey has been created after the literature review, to get an answer on sub-question 2: 'Which workplace health promotion programs or activities are currently implemented for home care employees in the Netherlands?'. The survey is used to create general insight into the health issue of home care employees and which programs have been implemented or what the reasons are for not implementing WHP programs. The target group of the survey was home care organization team leaders or managers. The survey has been created in Dutch with the use of Qualtrics and can be found in Appendix B.

### 4.2.1 Survey measuring instruments

In order to answer the second sub-question, the survey questions were about health issues of home care employees within teams and whether WHP programs were provided and which. In the beginning, some general questions were asked to get an idea about the size of the organization and the main area of activity (rural or urban). After that, some statements were used to find out team leader's perspective on health and their responsibility towards their employees' health. For those statements, a 5-point Likert scale has been used. This scale has been chosen because a neutral option is possible and the nuances can be shown. Later on, a question regarding why employers do or do not implement WHP were asked. In case they have implemented WHP, a question concerning which programs was asked to find out if the programs found in literature are also currently implemented in the Netherlands. Afterwards, their satisfaction with the participation rate in these programs was asked. This could show whether the problem is that programs exist but employees are not willing to participate. When the organization did not implement WHP programs or activities, the question was whether employers think those programs are needed. Reasons for why employers were of the opinion they should or should not provide it were given in the next question. In the end, a question about whether employees with different nationalities

and/or cultural backgrounds work for the organization was asked to find out if the organization has employees within the target group, in order to conduct interviews.

### 4.2.2 Survey procedure

Before creating the survey, personal communication with a direction advisor of a home care organization took place to get more inside information about the current situation within home care and employees' health issues. Furthermore, questions to include in the survey and practical information about how to get more response were discussed. With this advice, the survey was created for team leaders or managers of home care organizations, because they are responsible to create and implement programs or activities to improve their employees' health. In Appendix A, an example of the sent e-mail can be found. The goal of the e-mail was to make clear why it would benefit the organizations to fill out the survey and what the main aim of the research was. Also, some information about the interviews was given, in order to inform the team leaders or managers there would be a next phase of this research where their employees could participate in. The e-mail gave a clear time indication and emphasized that it would be anonymous. A link to the survey was included in the e-mail. The survey can be found in Appendix B.

The survey was sent to 194 different e-mail addresses from 93 different organizations, gathered from the website Zorgkaart Nederland (2017). The website www.zorgkaartnederland.nl/thuiszorg (Zorgkaart Nederland, 2017) was used to find the target group, by selecting "thuiszorg" (home care) and "persoonlijke verzorging" (personal care). All organizations spread over the Netherlands were selected. Some organizations had different locations and only one e-mail address, others had one e-mail addresses for all home care teams. Therefore, people from the same organization, but responsible for different teams, had the opportunity to fill out the survey. The respondents needed to have knowledge about the organizational side and be influential in the decision-making process, which needed to be made clear in the e-mail.

After 10 days, a reminder e-mail (Appendix C) was sent to the 80 organizations that possibly had not yet filled out the survey. Because the survey provided the possibility to remain anonymous, it was not clear how many organizations filled out the survey yet. The reminder e-mail was sent in order to get a higher response rate and create more interest in filling out the survey and receiving the results. In this e-mail was mentioned that people could only fill it in within one week, as the results were needed shortly to be able to continue the research. One week after the reminder was sent the survey closed down, after being open for in total 17 days. This time frame was set to give people the chance to fill out the survey and as the first e-mail was sent on Friday, the reminder was sent on Monday, to be able to reach people with different work schedules.

To find out how the area of activity relates to WHP and health, all organizations both in rural and in urban areas have been included in this research. In the survey was asked where their organization was

most active, in order to find differences between rural and urban areas. The found literature about existing WHP interventions for people with a lower socioeconomic status or a non-Western background mostly concerns people within cities (Bertens & Van Kesteren, 2011), while there are also home care organizations in rural areas that might have fewer resources to improve their employees' health and where many different nationalities work together. The survey was conducted among all home care organizations in the Netherlands, in order to gain more insight into the differences between urban and rural areas.

#### 4.2.3 Survey analysis

The survey has been analyzed to investigate the current situation and explore employers' perspectives on WHP and employees' health. All surveys have been used for the analysis, including the partly completed ones. The original survey was in Dutch (Appendix B), but for the analysis, the answers have been translated into English. Different figures have been created with Qualtrics. Furthermore, SPSS has been used to perform Chi-Square tests, in order to find out relationships between different variables.

There has also been focused on different features mentioned in the intersectional framework and conceptual model, in order to find out the interrelation between social categories and WHP and health. Open answers have been collected and used to get more insight into underlying reasons. For analysis, the three questions of the intersectional framework have been used (Cole, 2009). Those questions were: Who is included within this category? What role does inequality play? Where are the similarities? Those questions helped to find out interactions, differences and similarities between different categories and intersections. The respondents have been given an overview of the most relevant answers that could help them developing WHP. Furthermore, the survey has been used to prepare the interviews and has served as a tool to detect organizations where interviews could be held.

### 4.3 Interviews

#### 4.3.1 Type of interview

To get an answer to sub-question 3: 'What are the needs and perspectives of home care employees with different cultural backgrounds on workplace health promotion?', interviews with home care employees have been conducted. After finding out perspectives of employers by conducting the survey, perspectives of employees have been explored to find out differences and similarities between employers and employees. Employees' perspectives are often not the focus when evaluating workplace health promotion programs (Nöhammer et al., 2013). However, differences in perspectives and needs could play a role in whether employees participate and therefore, semi-structured in-depth interviews with employees have been conducted, following the example of Verdonk et al. (2010). This thesis focuses on the differences and similarities between different cultural backgrounds, aiming to examine the role of personal features within the effectiveness or possibilities of WHP programs. The aim of the

interviews is to find out which role culture and/or nationality play and if they affect the effectiveness of WHP programs, and whether differences in needs exist. Semi-structured interviews will be used as a method to get more in-depth insights into the situation.

### 4.3.2 Interview procedure

Through the survey analysis was found which organizations were willing to participate in interviews. Fifteen different organizations indicated that they were willing to participate in interviews. A sampling from those organizations was needed because there were too many organizations. It was decided to conduct interviews with two employees from five different organizations, to get a total of ten interviews. In order to create a diverse group of interviewees, a purposive sampling method was used. Purposive sampling means selecting interviewees based on specific features (Tashakkori & Teddlie, 2010).

Six organizations were contacted via e-mail (Appendix E) based on purposive sampling (Appendix D), aiming for a maximum variability in specific features. However, due to sickness absenteeism (flu epidemic) and high working pressure, not all organizations were still able to let their employees participate. Therefore, changes in the sampling were made while trying to keep diversity high. The sampling was based on different features of the organization and the outcomes of the survey and can be found in Table 3. The features were the main area of activity, size of the organization, whether WHP was provided, and whether cultural diversity within home care teams existed. Differences in these features were used to get a diverse group of organizations and employees. Organizations without differences in cultural backgrounds or nationalities in their teams were contacted too. These organizations present the Dutch perspective, and the role of Dutch cultural background could be explored. The ten interviews have been conducted in five different provinces of the Netherlands.

Table 3

*Sampling organizations for interviews*

| Sample number | City/Rural area | Size of the organization | Workplace health promotion | Cultural diversity |
|---|---|---|---|---|
| 1 | It depends | 26-50 employees | Yes | No |
| 2 | City | 26-50 employees | No | Yes |
| 3 | City | >75 employees | No | Yes |
| 4 | Rural | 11-25 employees | No | No |
| 5 | Rural/It depends | >75 employees | No/Yes | No/Yes |

The features of Organization 5 are determined by three surveys by three different respondents. Team leaders filled in the questions based on their own team, therefore, differences between the responses appeared.

Before the interviews took place, an informed consent was created and a topic list was designed. The informed consent needed to be signed by the interviewees, in order to inform them what the research was about and to make sure they agreed that the interview would be recorded and used for analysis while staying anonymous. This informed consent form can be found in the Appendix H.

### 4.3.3 Interview guidelines

Semi-structured in-depth interviews have been conducted with employees working in home care with different nationalities and backgrounds. The role of nationality and culture has been explored in these workplaces. Before the interview started, an introduction to the research and the interview was given (Appendix G). The topic list with some of the example questions can be found in Table 4.

Table 4

*Topic list interview*

| Topics | Example questions |
|---|---|
| Work (in general) | What does a normal working day look like? |
| Health (in general) | Which factors affect health, according to you? |
| Health in relation to work | How important is it to be healthy in your work?<br>- Why? |
| Workplace health promotion (when provided) | Are you participating in the programs?<br>- Why does this (not) fit you? |
| Workplace health promotion (when not provided) | How would you like it if your organization would provide workplace health promotion?<br>- What kind of program? Why? |

The complete topic list can be found in Appendix I and is in Dutch because the communication with the organizations and employees was in Dutch as well. In Table 4, the differences in questions can be found based on whether WHP is provided. In case health-promoting activities were implemented, the questions had a stronger focus on how they perceive those activities and what could be improved or changed. When no health promoting activities were implemented, the questions focused on potentials for WHP.

Finding out the role of cultural background and/or nationality has been done implicitly: it has been purposely chosen to not ask directly about employees' background but to create an open atmosphere. Cultural background was approached dynamically (Singer et al., 2016). Interviewees were free to create their own identity. In this way, it was found out whether their cultural background played a role in their needs and perspectives on WHP or that other factors played a role.

First, a test interview was held to find out what could be improved and how. After this interview, it was discussed which kind of questions were effective and in which way more information could be gathered, in order to improve the topic list. During the interview period, for every organization, the topic list was

adapted in order to be more fitting to the organization. The WHP programs and activities mentioned in the survey by the managers of the organization have been discussed in the interview to find out whether the employees were familiar with them and what their perspectives were.

### 4.3.4 Interview analysis

In the same way, as in the research conducted by Verdonk et al. (2010), interviews have been analyzed by using a thematic content analysis, in order to detect patterns, differences, and similarities between the interviews. This could help to get insight in the role of culture in (the possibility of) WHP in home care and to give recommendations about what to take into account when developing WHP activities. This research was explorative, to create a complete picture of the current situation. As the interviews were semi-structured, home care employees could give more attention to topics they viewed as most important. Innovative and adaptive mixed-methods research is essential to advancing human health and well-being (Al-Bannay et al., 2013).

The interviews were prepared with a topic list used as a guideline, adapted to whether the organization provided WHP. The interviews were recorded and lasted on average 32:34 minutes - sometimes time was limited, for example when interviews took place during lunch breaks. The recordings were transcribed and coded. The transcripts have been coded using the program Atlas.ti. First, open coding was done, which is the selection of relevant parts and the use of descriptive codes (Ritchie, Lewis, Nicholls & Ormston, 2013). Open coding led to 818 different codes in total. Second, the codes were analyzed and covered themes were explored (Ritchie et al., 2013), which created 23 different theme codes. Those theme codes were used to find out the most important topics discussed by interviewees. The complete code list can be found in Appendix J. Coding helped to create an overview of which topics were mentioned by interviewees. Some interviewees explicitly said, for example, that they did not have health issues or no ideas for WHP, and those quotes were still categorized under the theme codes “health issues’ and ‘workplace health promotion idea’. By placing all related descriptive codes under those theme codes, differences and similarities in experiences and ideas could be found. Table 5 shows the created theme codes. As can be seen in the overview of theme codes, several topics came out as important to the interviewees. About some topics was asked directly (Appendix I), others came up spontaneously. The themes fitting in the topics of the topic list were discussed, complemented by topics important to employees.

Table 5

*Theme codes*

| Number | Theme code |
|---|---|
| 1 | Opinion about work |
| 2 | Organization |
| 3 | Health behavior |
| 4 | Need for improvement |
| 5 | Communication |
| 6 | Team collaboration |
| 7 | Workplace health promotion idea |
| 8 | Support |
| 9 | Physical exercise |
| 10 | Health issues |
| 11 | Workplace health promotion participation |
| 12 | Contact with clients |
| 13 | Change |
| 14 | Task |
| 15 | Tools |
| 16 | Work pressure |
| 17 | Health meaning |
| 18 | Age |
| 19 | Personnel shortage |
| 20 | Work-life balance |
| 21 | Prevention coach |
| 22 | Money |
| 23 | Taking action |

## 5. Literature review results

In this literature review, PubMed was used to discover which kind of health-promoting programs and activities for home care employees already exist. Already implemented WHP for home care employees and whether it helps to improve home care employees' health have been explored. Most articles concerned factors that affected job satisfaction or job turnovers. Few interventions focused on the improvement of the personal health of direct care workers. Eight important and relevant articles have been analyzed. Table 4 gives an overview of those eight articles. Based on the first four articles, insights about which challenges exist for the development of WHP programs or activities for home care employees have been formed.

### 5.1. Challenges while developing health interventions

It could be summarized that the literature was more focused on what to take into account when developing an intervention for direct care workers, than on which interventions already exist for direct care workers. One overview article (Flannery et al., 2011) exists about which interventions have been implemented and their effects, but all other studies focused on (the challenges of) one single intervention. In all articles, the authors mention the importance of developing health interventions for direct care workers because health issues are a big problem for these employees. Therefore, it is relevant to further explore what is already known about the effects of existing programs.

Flannery et al. (2011) recommend that interventions should be based on the social ecological model and self-efficacy theory to be effective. The social ecological model concerns four different levels that need to be included, namely: individual, social/cultural, organizational, and community level. This recommendation is in line with the conclusions of Rassia (2017) and Thomas et al. (2004), who stress the importance of including community, and individual and cultural features when developing health promotion activities. Therefore, this could be used as an analysis tool to find out if the existing WHP programs take those levels into account or if there are any challenges for certain levels. Possible WHP activities are explored by Barbosa, Nolan, Sousa, and Figuelrede (2014). The intervention in this article focuses on educational support with or without supportive components. Providing both educational and supportive components led to a decrease in stress and burn-outs. Braun, Cheang, and Shigeta (2005) mention also the importance of knowledge increase for home care employees. More knowledge about health-related topics could cause less insecurity within their work. Therefore, WHP focused on education could lead to improved health for home care employees. All articles mention the possible positive effect of WHP on employees' health. Job satisfaction could increase and sickness absenteeism could decrease.

In the research of Larsson, Karlqvist, Westerberg, and Gard (2012), direct care workers point out the importance of self-efficacy too. Self-efficacy concerns intrinsic and extrinsic motivation that can lead to behavioral changes. Intrinsic motivation is more effective on long-term behavioral change. The self-

efficacy theory could be used to develop questions for the interview, to find out how the home care employees perceive their self-efficacy and what motivates them on which level.

When analyzing WHP, it could be suggested to take the ecological model and self-efficacy into account, to find out if the needs of home care employees are in line with the different levels of the social ecological model and the different aspects of the self-efficacy theory.

Table 6

*Overview Literature Search*

| Article | Title, Author and Year | Journal | Topic | Methodology + Recommendation | Results + Conclusion |
|---|---|---|---|---|---|
| 1. | Physical Activity and Diet-Focused Worksite Health Promotion for Direct Care Workers (Flannery, Resnick, Galik & Lipscomb, 2011) | Journal of Nursing Admini-stration | How to develop WHP for direct care workers and why. | • Literature review and analysis of previous studies.<br>• WHP should be developed based on social ecological model and self-efficacy theory. | Implementing WHP → improved productivity, job satisfaction, reduced stress, absenteeism, health care costs and turnover. Indirectly improve patients health → direct care workers are more likely to exchange their health knowledge. |
| 2. | Identifying work ability promoting factors for home care aides and assistant nurses (Larsson, Karlqvist, Westerberg & Gard, 2012) | BMC Musculo-skeletal Disorders | Factors that promoted work ability and self-efficacy for home care assistant nurses. | • Cross-sectional data of questionnaire in Sweden.<br>• Data should be used for more research and practice. | The assistant nurses mentioned "self-efficacy, personal safety and musculoskeletal wellbeing" as important. They linked "the work ability of the care aides" with the safety climate, seniority, and age. |
| 3. | Supporting direct care workers in dementia care: effects of a psychoeducational intervention (Barbosa, Nolan, Sousa & Figuelrede, 2014) | American Journal of Alzheimer's Disease & Other Dementias | Psycho-educational intervention for direct care workers to improve their communicative behaviors towards people with dementia. | • Intervention with educational and supportive components.<br>• Interviewing female direct care workers in focus-groups and using self-administrated instruments, thematic analyzes. | Psychoeducational intervention led to less emotionally exhausted, more group cohesion, self-care awareness and emotional management. Both groups with psychoeducational or only educational support had increased feelings of self-worth, more knowledge about dementia and the patient and person-centered care awareness. Providing educational and psychological support for direct care workers working is helpful to decrease stress and burnouts. |
| 4. | Increasing knowledge, skills, and empathy among direct care workers in elder care: a preliminary study of an active-learning model (Braun, Cheang & Shigeta, 2005) | The Geronto-logist | To increase direct care workers' knowledge, skills and empathy towards elderly people. | • Questionnaires about direct care workers' knowledge, attitudes and their perception of how their understanding, empathy, and skills were improved. | Direct care workers increased their knowledge and had higher scores on attitude measurements, felt more competent, more empathic towards the elderly and had more self-esteem. |
| 5. | Building Health Promotion into the Job of Home Care Aides: Transformation of the Workplace Health Environment | Internatio-nal journal of environ-mental research and public health | Importance of improving health care for home care aides' clients + to increase their own health + to | • Intervention about how to motivate your clients and a training in simple exercises during four months. Health care aides shared their experience with the health program in a focus group. | Home care aides who were older than 50, did more often the physical exercises they taught their clients. However, no more time was spent on physical activities irrespective of age. It increased their knowledge about how to execute exercises and how to motivate people to do it. Challenge to |

| | | | | | |
|---|---|---|---|---|---|
| | (Muramatsu, Yin & Lin 2017) | | test a health promotion intervention | • Not much known about how appropriate workplace health promotion can be implemented. | implement WHP, but there are opportunities when you involve both client and employee in a health program. |
| 6. | Health Behaviors and Overweight in Nursing Home Employees: Contribution of Workplace Stressors and Implications for Worksite Health Promotion (Miranda, Gore, Boyer, Nobrega & Punnett, 2015) | The Scientific World Journal | Examining the influence of working environment on health and which physical and organizational stressors at work cause health issues. | • Questionnaires for employees in nursing homes, with questions about physical exercise, smoking, BMI, job control, psychological demands of work, support of colleagues and support of a supervisor.<br>• WHP is not always focused on work environment effects on health, improving the design of those programs with reducing work stressors could make the implementation more effective. | Responding employees: 34% obese, 24% smokers and 23% not physically active outside of work. 88% experienced high psychological demands of their job. Important stressors for unhealthy behavior were: awkward postures while working, no safe environment, lifting heavy weights, and no balance between family and work. If attention is paid to reducing those stressors, the health inequality might become smaller. Concluding recommendations: training, improved job design, and organizational changes to decrease those work stressors. |
| 7. | Effects of a Worksite Program to Improve the Cardiovascular Health of Female Health Care Workers (Low, Gebhart & Reich, 2015) | Journal of cardiopul-monary rehabilita-tion and prevention | How female health care workers with an increased risk for cardiovascular diseases could be influenced by motivational risk communication and program participation. | • All participants got access to the gym and could go to classes on different health-related topics such as stress, diet, and exercising. Half of the participants had motivational counseling every week for six months in total, the rest of the participants did not.<br>• The employees had to answer questions about their work and physical aspects such as weight and blood pressure were measured.<br>• Concerns regarding weight, stress, physical activity, and smoking had to be ranked, and after one year, their weight, physical activity and stress were measured again. | The group that participated in the motivational counseling lost more weight, was less stressed and exercised a bit more per week than the group that did not participate in the counseling. However, there was not a high participation rate for the program. There is still not much attention to health risks for health care employees, while this is of great importance to improve care quality towards others. Suggestions are to implement wellness services and more support to motivate health care workers to care for themselves. |
| 8. | Burnout After Patient Death: Challenges for Direct Care Worker (Boerner, Gleason, Daniela & Jopp, 2017) | Journal of Pain and Symptom Manage-ment | Direct care workers do not have enough support and training from employers when patients come to die, which leads to many burnouts and turnovers. | • With interviews, the impact of a patient's death on the direct care worker (comparing home health aides with certified nurse assistants) was identified, by asking questions regarding characteristics of the institution, patient and staff, grief symptoms and avoidance and burnout dimensions such as emotional exhaustion and depersonalization. | Most home health aides were Hispanic, young and unmarried, who had often taken care of the patients less long compared to nurse assistants. However, after a patient died, the levels of grief were almost the same just as the likelihood to get a burnout or depersonalization. Support of supervisors led to a positive effect on burnout while support of coworkers was likely to cause depersonalization and emotional exhaustion. |

### 5.2 Challenges for implementing workplace health promotion

In order to get more insights into the challenges when implementing WHP for home care employees, four other articles have been reviewed. The four articles (number 4-8 in Table 6) that focus on WHP for home care employees/direct care workers are published in 2015 and 2017, which means that it is quite a new and relevant topic. Most articles were about factors that influenced job satisfaction or job turnovers. Job satisfaction affects health and is, therefore, a factor for health improvement but is not always the focus of WHP activities an programs. Muramatsu, Yin, and Lin (2017) and Miranda, Gore, Boyer, Nobrega, and Punnett (2015) mention that further research is needed about how to create and implement an effective WHP program for home care employees. Much is unknown about how to improve health issues for health care employees while this is a big problem. Therefore, this thesis continues exploring the problem those four studies mention. Especially the article by Muramatsue et al. (2017) gave relevant insights. They explored that work could have a bad influence on health. Especially work for lower socioeconomic status people, which could be an explanation for health inequality. This is in line with previous studies. Unhealthy behavior could also be caused by the tasks of providing home care. Miranda et al. (2015), stress out the health problems for home care employees due to bad body posture and an imbalance in work-life. Therefore, it is vital to explore ways in which home care employees work healthier.

One insight is that it is hard to implement WHP for home care employees because they do not have a fixed workplace. Home care employees work at people's home, which means that their working environment is always changing during the day and over a longer time. This is a challenge and could be an explanation of why it is hard to find WHP programs for home care employees in the Netherlands.

Besides the social category of lower socioeconomic status, only one research has included culture in their research (Boerner et al., 2017). Some other studies used sociodemographic information or found out that most direct care workers were from a cultural minority, but the direct role of culture in WHP has not been identified in the articles about challenges of WHP.

In the article from Low, Gebhart, and Reich (2015), the participants got access to the gym and health lessons, and one group got motivational counseling over e-mail or phone. The effects of this intervention were bigger for the group who got the counseling. However, the low participation rate was a challenge. They recommend to do more research on health risks for health care employees and find out how to increase the participation rate in health-promoting programs. In the conceptual model (§3.4-3.5), inequality in accessibility in WHP programs have been explored, just as the barriers of participating for people with a different cultural background or a lower socioeconomic status.

Muramatsu et al. (2017) see an opportunity to improve both employees' health and health care provision. This opportunity is to let home care aides motivate their patients to live healthily and safely. Both patients and employees could benefit from it. WHP interventions focused on the patient is having a

positive influence on (especially older) direct care worker's health. The direct care workers were taught how to motivate clients and how to execute certain activities and had to teach this to their patients. It was focused on increasing their knowledge, which they could use for improving care for their patients and patient's health and had a positive effect. Motivation to live healthier and to participate in a health-promoting program is bigger when the purpose of the program is to increase also care quality and health of the patients. This intervention worked only for older employees. Younger employees did not experience benefits for their health and did not become more physically active. When developing WHP for home care employees, how to motivate employees to participate should be considered.

Most research has been done in the United States but the challenges of implementing WHP for home care employees are applicable in the Netherlands as well because the job and work environment are similar. However, it is important to take employees' age but also socioeconomic status and cultural context into account when developing an effective WHP program for home care employees.

### 5.3 Conclusion literature review

This literature review had the aim to answer the sub-question: 'What is known about the type of workplace health promotion for home care employees, its effects, and its challenges?'. The first finding is that only one overview of existing WHP interventions for direct care workers exists. However, this is not an article about which programs exist, but focuses on what is important to take into account when developing such program. It is advised that the program or intervention should be based on the social ecological model and self-efficacy theory. In general, it has been described that implementing WHP improved productivity and job satisfaction and decreased sickness and health care costs. Different articles were detected about one specific intervention or recommendation for WHP.

The six existing WHP activities for home care employees and its reported effects found in this literature review are:

1. Implementing educational and supportive components → decrease in stress and burnouts
2. WHP that focused on improving their patient's health → higher exchange of employees' health knowledge
3. Increasing employees' health knowledge and skills → improvement of well-being
4. Teaching employees exercises what they can teach their patients and how to motivate them → increased physical activity of employees older than 50
5. Giving access to the gym and organizing health-related classes plus providing motivational counseling → participants who had motivational counseling lost more weight, were less stressed and exercised a bit more per week than participants who did not have motivational counseling

6. Interviews to talk about the impact of a patient's death on employee → support of supervisors had a positive effect and caused fewer burnouts

In most of the reviewed articles, it has been described that home care employees have many health issues and that it is difficult to implement WHP programs because they do not have one workplace but work at patients' homes. Therefore, important challenges have been mentioned. One of them is the fact that WHP is not always focused on how the work environment affects health, specifically for home care employees. In their work, the work environment is always changing. Improving the design by reducing work stressors (such as unsafe environment, no work-life balance and lifting heavy weights) could make the implementation of WHP more effective. This requires more organizational changes. Another challenge is participation rate. The program that consisted of offering a gym, health classes and motivational counseling, suffered low participation rate which was a pitfall. From the article, it is unclear whether those classes and access to the gym were given during working hours. If it was during leisure time, this could be a reason for the low participation rate. A recommendation is to implement wellness services for employees and to motivate them to take care of themselves too. The organizations should pay more attention to increasing health care employees' consciousness about their own health. The issue of low participation rate could also be partly solved by taking another recommendation into account, namely, to both involve patients and employee. Motivation to care more about their own health is bigger if it also helps their patients.

To conclude, different WHP programs or activities have been developed with different challenges and effects. The interventions were most effective when both employees and patients were involved, when employees' knowledge and health skills were increased and when they got motivational counseling. Challenges lie in the low participation rate, not enough research about what is effective for this specific working environment and the fact that home care employees do not have a fixed workplace and may experience work stress, which may need more organizational changes.

### 5.4 Survey preparation based on literature review

The insights of the literature review have been used to inform the survey questions. The questions comprised:

- Whether the manager or team leader recognizes the actual health issues for their home care employees.
- When the organization implements WHP:
    - What kind (and if it was focused on patient's health too)
    - How the participation rate is and how they explain this
    - What the effects are

    - What the age of their employees is and whether that affects the participation rate

- When the organization does not offer WHP, what the reason is and whether this is in line with the results of this literature review.
- What challenges the team leaders and managers see in WHP.

## 6. Survey results

In order to answer the second sub-question: 'Which workplace health promotion programs or activities are currently implemented for home care employees in the Netherlands?', a survey has been conducted. Based on the insights and conclusion of the literature review and on the information retrieved in a meeting with a manager advisor of a home care organization, questions to ask employers of home care organizations have been developed. The procedure can be found in the methods (§3.2) and the entire survey can be found in Appendix B.

### 6.1. Response rate

In total, 93 different organizations were initially invited to participate in this survey on Friday, January 26th 2018. Of these organizations, three organizations indicated not to be eligible for this study. Therefore, the research group consisted of 90 different organizations.

Ten days after the initial invitation, 29 surveys were filled out the survey. To optimize the response, a reminder was sent on a different day: on Monday, February 5th 2018. After the reminder, 29 more people filled out the survey, which made a total of 58 of which seven partly completed the survey. In total, 70 surveys were received back, but twelve of them were empty with no answers. Therefore, a complete case analysis could be performed on a total of 58 surveys. One week after the reminder, the survey was closed down because the answers were needed to decide which organizations to contact for interviews.

It was not mandatory to fill in the organization's name. Still, 40 respondents from 26 different organizations filled in the name of the organization for which they work, and therefore the response rate can be seen as (at least) 28.9 per cent of the invited organizations. Eighteen people filled in the survey anonymously and could theoretically belong to all different organizations, which could increase the response rate to a maximum of 48.9 per cent. All filled-in surveys have been used for analysis, so the percentages and numbers mentioned later on are percentages or numbers of respondents who filled in the survey, and not of organizations. Nineteen people from fifteen different organizations were willing to let their employees participate in interviews, what accounts for 32.8 per cent of all respondents and 16.7 per cent of all organizations. The majority (64.71%) of the respondents who filled in the survey liked to receive a summary of the results with recommendations (Appendix K).

### 6.2 Relationships between variables

From the survey results, different social categories such as cultural background and area of activity have been analyzed separately, to explore relations between social categories and WHP and health. The intersectional framework has been used, by keeping the three questions of Cole (2009) in mind: 1: Who is included within this category? 2: What role does inequality play? 3: Where are the similarities? Those questions were used to find out how those social categories interact and what the differences and the similarities are.

To create a deeper understanding of the results, overview tables have been created and Chi-Square tests have been performed in SPSS to find out whether relationships between different questions and variables exist. In the next part, analyses of the results will be presented in bullet points with supporting figures and found correlations will be explained. The complete SPSS output of the performed Chi-square tests can be found in Appendix F.

### 6.2.1 Organizations with employees with many health issues

First, characteristics of organizations experiencing health issues among the employees will be discussed. In total, 19.64 per cent of the respondents considered the home care employees had many health issues as can be seen in Figure 7.

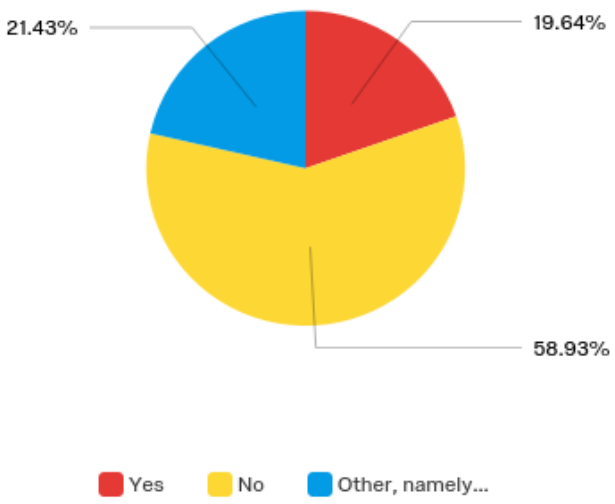


*Figure 7: Percentages of responses on: "The home care employees of my organization have many health issues" (n=56)*

Employees with many health issues cause more worries for employers. From the Chi-Square test between health issues and worries about employees' health, a significant relationship appeared ($\chi^2$ (8) = 18.73, $p$ = .016) (Appendix F). Team leaders of organizations with employees with many health issues had relatively more often worries about employees' health (62.5%) compared to team leaders of organizations with employees with few health issues. Those team leaders had less often worries about the health of the employees (12.5%) In Table 8, the overall results about how many respondents worried about the employees' health can be found.

Table 8

*Percentages and amount of agreement on: "I am worried about the health of the home care employees in my organization"*

| | Percentage responses | Amount of responses |
|---|---|---|
| Disagree | 5.36% | 3 |
| Partly disagree | 8.93% | 5 |
| Neutral | 26.79% | 15 |
| Partly agree | 44.54% | 25 |
| Agree | 14.29% | 8 |

The results from the organizations with employees with many health issues compared to organizations with employees with few health issues showed that:

- The majority (72.73%) provided WHP. Of the organizations with home care employees with few health issues, only 45.45 per cent provided WHP.
- Teaching exercises to empower the employees was chosen more (22.22% compared to 9.68%) by organizations with employees with many health issues (Table 10, p. 43).
- Most of those organizations with employees with considerable health issues were mainly active in urban areas (63.64%).
- The amount of participants in WHP is most often described as low, which is a problem (37.50%) in organizations where home care employees have many health issues. For organizations with employees with few health issues, the most respondents filled in the people who needed it got reached by it. All answers to the question whether many employees participated in WHP programs or activities can be found in Table 13 (p. 47).
- 81.82 per cent had culturally diverse teams. In organizations with employees with few health issues, only 35.48 per cent filled in that cultural diversity existed in the teams.

### 6.2.2 Age-related to health issues

When comparing age, the employees with many health issues are younger than the employees who have a few health issues. From the Chi-Square test between health issues and age, a significant relationship appeared ($\chi^2$ (6) = 22.51, $p$ = .001) (Appendix F). Organizations with employees with an average age between 35 and 45 years old, had relatively more often employees with many health issues (52.9%) compared to organizations with employees with an average age between 45 and 55 years old. Those organizations had more often employees with few health issues (57.1%).

Table 9

*Percentage of the estimated average age of home care employees, divided per (social) category*

| Estimation of average age of home care employees | Total group (n=54) | Organizations with employees with many health issues (n=11) | Organizations with employees with not many health issues (n=31) | WHP provided (n=28) | WHP not provided (n=22) | In rural areas (n=19) | In urban areas (n=14) | In both rural and urban areas (it depends) (n=21) | In teams with cultural diversity (n=27) | In teams with no cultural diversity (n=26) |
|---|---|---|---|---|---|---|---|---|---|---|
| Younger than 25 years old | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Between 25 and younger than 35 years old | 7.41% | 0.00% | 12.90% | 3.57% | 13.64% | 5.26% | 0.00% | 14.29% | 0.00% | 15.38% |
| Between 35 and younger than 45 years old | 31.48% | 81.82% | 19.35% | 28.57% | 40.91% | 15.79% | 71.43% | 19.05% | 37.04% | 26.92% |
| Between 45 and younger than 55 years old | 51.58% | 18.18% | 51.61% | 64.29% | 31.82% | 68.42% | 28.57% | 52.38% | 59.26% | 46.15% |
| Between 55 and younger than 65 years old | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Older than 65 | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| I do not know | 9.26% | 0.00% | 16.13% | 3.57% | 13.64% | 10.53% | 0.00% | 14.29% | 3.70% | 11.54% |

Table 10

*Percentage response to: "What kind of activities or programs is your organization offering to promote health?"*

| What kind of WHP? | Total group (n=66) | Organizations with employees with many health issues (n=18) | Organizations with employees with not many health issues (n=31) | In rural areas (n=15) | In urban areas (n=19) | In both rural and urban areas ("it depends") (n=32) | Teams with cultural diversity (n=45) | Teams with no cultural diversity (n=17) |
|---|---|---|---|---|---|---|---|---|
| Education about health-related topics | 27.27% | 27.78% | 29.03% | 33.33% | 26.32% | 25.00% | 24.44% | 35.29% |
| Activities focused on physical exercises | 18.18% | 11.11% | 19.35% | 13.33% | 15.79% | 21.88% | 13.33% | 23.53% |
| Social activities to improve their well-being | 18.18% | 22.22% | 16.13% | 0.00% | 21.05% | 25.00% | 22.22% | 11.76% |
| Teaching exercises to empower the employees | 12.12% | 22.22% | 9.68% | 20.00% | 15.79% | 6.25% | 11.11% | 17.65% |
| Other, namely… | 12.12% | 11.11% | 12.90% | 26.67% | 5.26% | 9.38% | 13.33% | 11.76% |
| Stress management | 6.06% | 5.56% | 3.32% | 6.67% | 10.53% | 3.13% | 8.89% | 0.00% |
| Quit-smoking programs | 6.06% | 0.00% | 9.68% | 0.00% | 5.26% | 9.38% | 6.67% | 0.00% |

### 6.2.3 Organizations that offer workplace health promotion

In total, 30 respondents (53.57%) filled in that their organization provides WHP (Figure 11).

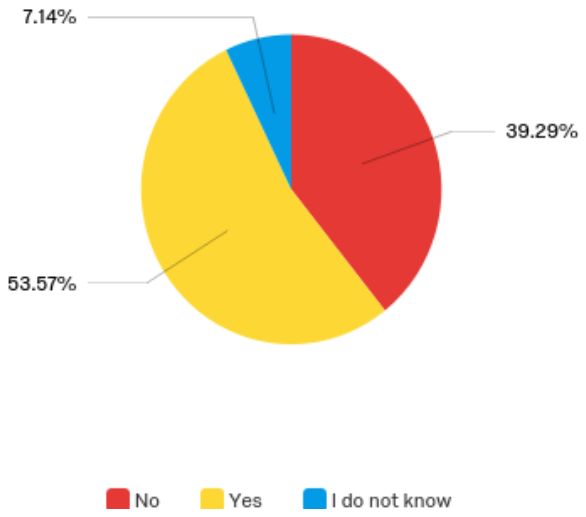


*Figure 11: Percentages of responses on: "Our organization provides activities to promote the health of our home care employees" (n=56)*

Most respondents (65.38%) of the organizations who do not provide WHP, (partly) agreed that their organization should provide it. The organization that does provides WHP, often offer more programs or activities. Sixty-six answers were given on the question of what kind WHP programs or activities they provided, and all suggested answers were chosen. All given answers can be found in Table 10 (p. 43). The most provided WHP programs or activities within home care are:

1. Education about health-related topics (27.27%)

2. Activities focused on physical exercises/social activities to improve their well-being (both 18.18%)

3. Teaching exercises to empower the employees (12.12%)/other, namely... open answer. The open answers were: the presence of a prevention coach, healthy scheduling (maximum 24 hours contracts), providing fruit, stimulate the employees to do sports or relaxing activities and external support for psychological problems.

The least chosen answers were providing quit-smoking programs and stress management.

The average age of the home care employees in the organization who provide WHP was between 45 years old and younger than 55 years old. From the respondents of the organizations who do not provide WHP, the majority filled in that the average age was between 35 years old and younger than 45 years old. A complete overview can be found in Table 9 (p. 42).

Of the organizations that provide WHP, 67.86 per cent had culturally diverse teams. For the organizations that do not provide WHP, this percentage is 34.78 per cent.

### 6.2.4 Role of different cultural backgrounds and/or nationalities

To find out the role of cultural background in WHP and health in general, the organizations with home care teams with employees with different cultural backgrounds have been compared to organizations with no cultural diversity, to explore differences and similarities. Half of the respondents indicated that their teams were culturally diverse (Figure 12).

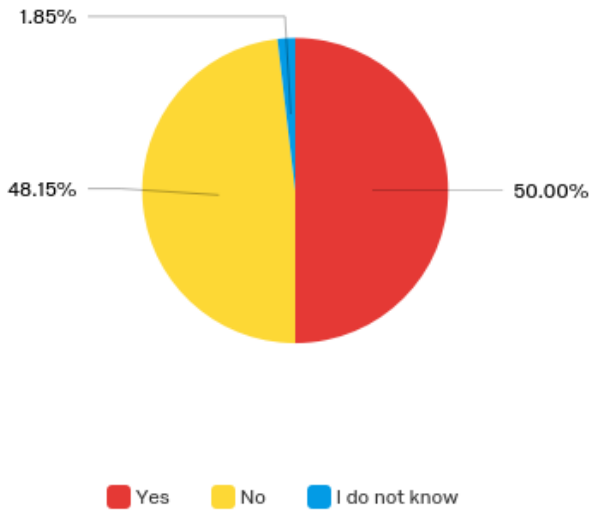


*Figure 12: Percentages of responses on: "Are there employees with different cultural backgrounds and/or nationalities working in the teams?" (n=54)*

The differences and similarities between teams with and without cultural diversity are that:

- Team leaders from culturally diverse teams were more often worried about employees' health (70.37%) compared to 7.69 per cent of organizations with no cultural diversity.
- The organizations with culturally diverse teams were mainly active in urban areas (40.57%), 22.22 per cent in rural areas and the other 37.04 per cent were both in rural as in urban areas active.
- A third of the respondents filled in that the home care employees of their organization had many health issues. For the organizations with no cultural diversity in the teams, 7.69 per cent filled in they had many health issues.

#### 6.2.4.1 Cultural diversity related to workplace health promotion

Organizations with culturally diverse teams also provide more often WHP. The Chi-Square test between culturally diverse teams and providing WHP was marginally significant ($\chi^2$ (4) = 9.33, $p$ = .053) (Appendix F). Organizations with cultural diversity provided relatively more often WHP (67.9%)

compared to organizations with no culturally diverse teams. Those organizations provided relatively less often WHP (28.6%). Furthermore, those organizations more often filled in that they did not know whether they provided WHP (75.0%) compared to organizations with culturally diverse teams (25.0%).

The answers for provided WHP can be found in Table 10 (p. 43). The biggest differences in what kind of WHP activities they provided were:

- Social activities to improve employees' well-being is far more chosen by organizations with cultural diversity within the teams.
- The answer "Teaching exercises to empower the employees" was chosen less by the organizations with employees from different cultural backgrounds.
- Stress management and quit-smoking programs were chosen infrequently, but they were chosen. The organizations with no cultural diversity did not fill in those answers at all.

Table 13

*Percentage responses on: "Are there many employees participating in those activities or programs?"*

| Many participants? | Percentage responses total group (n=29) | Organizations with employees with many health issues (n=8) | Organizations with employees with not many health issues (n=14) | In rural areas (n=7) | In urban areas (n=8) | In both urban and rural areas (it depends) (n=14) | In teams with cultural diversity (n=19) | In teams with no cultural diversity (n=8) |
|---|---|---|---|---|---|---|---|---|
| No, that is a problem | 24.14% | 37.50% | 7.15% | 14.29% | 37.50% | 21.43% | 21.05% | 37.50% |
| No, but the employees who seemed to need the support, got reached by it | 20.69% | 12.50% | 35.71% | 28.57% | 0.00% | 28.57% | 15.79% | 12.50% |
| Yes, but it would be better if more employees would participate | 17.24% | 25.00% | 14.29% | 0.00% | 25.00% | 21.43% | 21.05% | 12.50% |
| Yes, the majority participates | 17.24% | 12.50% | 28.57% | 28.57% | 25.00% | 7.14% | 21.05% | 12.50% |
| Other, namely… | 17.24% | 12.50% | 14.29% | 28.57% | 12.50% | 14.29% | 15.79% | 25.00% |
| It depends per program | 3.45% | 0.00% | 5.26% | 0.00% | 0.00% | 7.14% | 5.26% | 0.00% |

#### 6.2.4.2 Cultural diversity participation in workplace health promotion

In Table 13 (p. 47) an overview can be found of the participation rate of employees in WHP programs. Culturally diverse organizations often filled in that the majority participates in WHP programs. From the respondents who filled in their teams were not culturally diverse, the majority filled in that low participation rate was a problem.

For the organizations with culturally diverse teams that did not provide WHP, it was asked if they thought their organization should provide this and why they should provide it. Some open answers were:

- The possibility needs to be there, but employees need to be intrinsically motivated
- It is important for an employer to show that you think it is important that the employees are healthy
- As an employer, you are not only responsible for clients but also for the employees and if your employees do not undertake action to stay healthy, it could be a stimulus to do this as a team
- Employees are also responsible, the employer is only a small part
- Absence due to sickness, which will cause less work pressure
- A shared responsibility to keep employees healthy which also creates a positive result for the organization
- Preventing burn-outs and strengthen the body

In organizations with no cultural diversity, responsibility was mentioned more often, that it was a shared responsibility or employees were more responsible for their own health. Furthermore, employability was mentioned as being important, but that it is difficult with no fixed workplace or that even if it would be provided, employees would not have time to participate due to high work pressure.

### 6.2.5 Organizations in rural areas compared to organizations in urban areas

Organizations in rural areas have been compared to organizations in urban areas because they might experience different problems. The respondents were almost equally divided over rural, urban or both urban and rural areas, as can be seen in Figure 14.

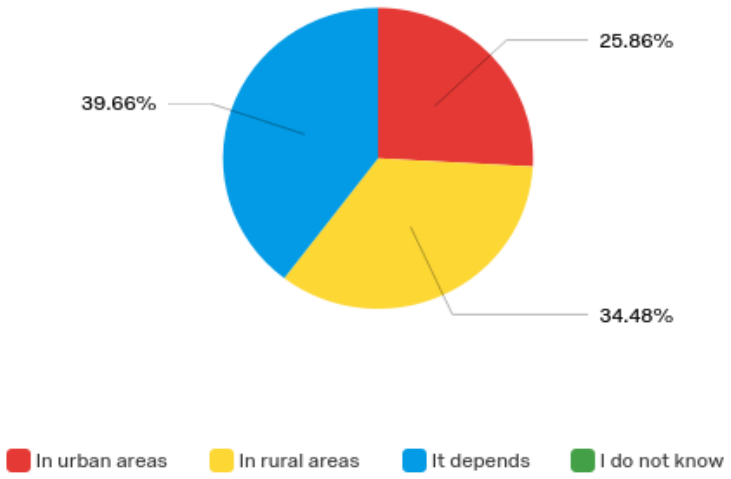


*Figure 14: Answers to the question "Where is your organization mainly active?" (n=58)*

The results, focused on differences and similarities between organizations active in rural and urban areas, are as follows:

- From the respondents working in rural areas, 95 per cent (partly) agreed that health is most important in life and 100 per cent (partly) agreed that they think it is important to focus on their employees' health.
- Twelve respondents (60%) from rural areas did (partly) agree with the statement that they were worried about their employees' health. In urban areas, 71.43 per cent (partly) agreed that they were worried about the health of the home care employees. Among all respondents, this was 58.93 per cent.
- Sixty per cent of the organizations in rural areas worried about the health of the employees. In urban areas, 71.43 per cent (partly) agreed.
- In rural areas, the employees are on average older, namely between 45 and younger than 55 years old. In urban areas, most employees were between 35 and younger than 55 years old (Table 9, p. 42).
- In rural areas, only 31.58 per cent of the organizations had cultural diversity in their teams. In urban areas, this was 60 per cent.

#### 6.2.5.1 Main area of activity related to employees' health issues

Five per cent of the organizations working in rural areas filled in that home care employees of their organization had many health issues. In urban areas, this was 50 per cent. This is a big difference between organizations in rural or urban areas. From the Chi-Square test between the area of activity and health issues, a significant relationship appeared ($\chi^2$ (4) = 12.02, $p$ = .017) (Appendix F). Organizations mainly active in urban areas had relatively more often employees with many health issues (63.6%)

compared to organizations mainly active in rural areas. Those organizations had relatively more often employees with a few health issues (45.5%). Organizations active in both rural and urban areas had also relatively more often employees with a few health issues (39.4%).

#### 6.2.5.2 Workplace health promotion differences based on area of activities

Only 40 per cent of the organizations in rural areas provided WHP. In urban areas, this was 57.14 per cent. Results, focused on what kind of WHP programs or activities, are that:

- In urban areas, social activities to improve well-being were more present than in rural areas (21.05% compared to 0%), and in rural areas, "teaching exercises to empower you employees" was provided more often (Table 10, p. 43).
- In urban areas, 37.50 per cent of the respondents perceived that not many employees participated in WHP, which was a problem. In rural areas, only 14.29 per cent saw this as a problem (Table 13, p. 47).

Respondents who mentioned their organization did not provide WHP were asked whether they agreed they should provide it and why (not). Those explanations were for respondents in rural areas:

- It was difficult because of the fact that employees do not have a fixed workplace
- It would be good to help their employees to get a healthier lifestyle or that it would relax them
- It is a physically heavy job especially if they have to do it until they are 70 years old
- Employees could take initiative and should be motivated to do something about their health
- Sustainable employability is getting more and more important and WHP could help with this
- It is the responsibility of the employees and employers are just a small part of their lives
- It is shared responsibility between employees and employers

In urban areas, different reasons for whether they should provide WHP exist as followed:

- It is a shared responsibility
- Work pressure is high for home care employees and therefore there is no time for WHP
- It would be good to provide because it would decrease the absence due to sickness

An overview of the participation in WHP programs can be found in Table 13 (p. 47). One respondent (14.29%) of the organizations in rural areas filled in that the participation rate was low and that this was a problem. The answer that the majority participated or that the employees who seemed to need the support, got reached by it were given by 57.14 per cent. In urban areas, the participation rate was more

often a problem, or that it would be better if more employees would participate. Only 31.82 per cent filled in that the majority participated or that the employees who seemed to need the support, actually got reached by it.

### 6.2.6 Intersection between rural areas and cultural background

The link between cultural background and rural area has been explored, by intersecting the responses who filled in that the teams are culturally diverse and active in rural areas. To sum up:

- Of all respondents, 10.34 per cent filled in that they were mainly active in rural areas and had employees with different cultural backgrounds and/or nationalities in the teams.
- In urban areas, more cultural diversity exists within home care teams.
- Respondents from culturally diverse organizations in rural areas were more often worried about the home care employees. However, the employees experienced less often health issues.
- Two third of the respondents active in rural areas with cultural diversity filled in their organization provided WHP, while for the total group this number was lower, namely 53.57 per cent.
- From the 33.33 per cent who did not provide WHP, 50 per cent was neutral about whether their organization should provide it and the other 50 per cent agreed that their organization should provide it. Two reasons why they filled this in were:
    - The employer is only a small factor in employees' health, especially for part-time employees
    - It is a shared responsibility, but the improvement of employees' health could also have a positive impact on the organization
- The average age of the employees was between 45 and younger than 55 years old, chosen by 66.67 per cent of the respondents. For the total group, this percentage was slightly lower (51.85%).

None of these organizations were willing to participate in interviews, so more insight could not be obtained.

## 6.3 Brief synopsis of the survey results

The survey gave insight into differences and similarities between social categories and health and WHP. To give a brief synopsis, most relevant results and following insights will be given. First, respondents of organizations who perceive that their employees have many health issues, also significantly worry more about them. Second, organizations with teams with an estimated average age of between 35 and

45 years old have more employees with many health issues compared to organizations with older employees. Older employees seem to experience less often health issues. Third, cultural diversity within teams seems to be related to WHP programs. WHP is more often offered within these organizations compared to organizations without culturally diverse teams. Fourth, organizations mainly active in urban areas, have more often employees with many health issues compared to the organizations situated in rural areas. At last, the most provided WHP activity for home care employees is to provide education about health-related topics. Whether this has an influence on employees' health and whether they feel supported by it have been explored with the interviews. The amount of employees participating in WHP programs seems to be a problem mostly for organizations with employees with a lot of issues and with no cultural diversity.

### 6.4 Conclusion survey

The aim of the survey was to answer the second sub-question: 'Which workplace health promotion programs or activities are currently implemented for home care employees in the Netherlands?'.

All WHP programs and activities for home care employees found in the literature are provided worldwide as well as in the Netherlands as well. In a sequence of importance were mentioned: 1. Provision of education or information about health-related topics, 2. activities focused on physical exercise and social activities to improve their well-being, and 3. quit-smoking and stress-management programs.

Smoking and stress are factors that have a bad influence on health and are more often present in the lives of people with a lower socioeconomic status. From the literature research, stress was often mentioned as a big problem caused by complex problems of people with a lower socioeconomic status. Furthermore, the knowledge synthesis of ZonMW (2016) showed that people with a lower socioeconomic status are more often smokers and prefer quit-smoking programs over other WHP programs. Therefore it could be that employees would prefer quit-smoking programs or stress-management. However, physical inactive lifestyles are also more likely for people with a lower socioeconomic status, so providing physical activities could contribute to making employees more active.

Besides the aim to give a general answer on the second sub-question, intersectionality has been taken into account in the analysis. The main research question concerns the role of cultural background in WHP programs. With the analysis of this survey, different aspects and relations between different questions have been examined. Differences between employees with many health issues and a few health issues, differences between cultural backgrounds, organizations in rural areas and organizations in urban areas and both in urban and rural areas, and the intersection of cultural diversity in rural areas have been explored. This gave more insight into differences and similarities between social categories and what to take into account when preparing and conducting the interviews.

First, a relationship was found between having teams with employees with many health issues and more worries by the team leader about their health. Perceiving that employees have many health issues is related to being worried about employees' health. Differences in answers on the participation of the WHP were found. Respondents from organizations with employees with few health issues filled in that the employees who needed WHP got reached by the programs, which could be an explanation for fewer health issues. Some mentioned that it differed a lot between teams or that it was not more than the employees who worked in nursing homes or compared to other organizations. Others pointed out the words "many", and wrote that it was quite some but not many.

Remarkably, of the respondents who filled in their employees had many health issues, the majority filled in they had employees with different cultural backgrounds and/or nationalities in their teams. People from different cultural backgrounds and/or nationalities, in general, have more health issues (ZonMW, 2016) which is in line with the findings of this study.

Second, a relationship between age and health issues has been found, namely that teams, where the average age is 35 to 45 years old, have more health issues than teams where the average age is 45 to 55 years old. This is in line with the fact younger women more often have burn-outs than older women (CBS, 2018). An opportunity was given to give general comments, and some mentioned that the age differences varied a lot or that they had employees of all ages. Therefore, this question was also interpreted with care.

Third, half of the respondents filled in that their team was culturally diverse. In general, thirteen per cent of all home care employees has a different cultural background or nationality (AZW, 2012). It is unclear how many employees of the teams have a different cultural background or nationality. In organizations with employees with different cultural backgrounds and/or nationalities more health issues exist. The relation between cultural background and health has already been explored in literature and shows that people with different cultural backgrounds and/or nationalities do have more health issues (Singer et al., 2016; ZonMW, 2016). Another explanation for more health issues could be that most teams with different cultural backgrounds and/or nationalities worked for organizations in urban areas, which could be another influence. Organizations in urban areas more often had employees with many health issues compared to organizations in rural areas. WHP programs are more often provided to the culturally diverse team. The implemented programs varied, social activities to improve their well-being are selected more often. Quit-smoking programs and stress management programs have been provided by a minority of organizations with culturally diverse teams, while those programs have not been provided by organizations without cultural diversity. It could be that different preferences exist between teams with cultural diversity and with no cultural diversity, or that different problems exist. As mentioned before, people with a different cultural background could feel excluded and could participate less in society (Singer et al., 2016). Looking at the survey outcomes, this seemed not to be the case. More often

WHP programs were implemented and low participation seemed to be not the biggest issue for culturally diverse teams.

Fourth, rural and urban areas have been compared. As mentioned before, in urban areas, more worries about the health of the home care employees existed compared to organizations active in rural areas. A relationship exists between organizations in urban areas and employees with many health issues. More health issues could be the reason for more provision of WHP. It could be that the worries about home care employees' health play a role or that other sources such as money play a role. The type of WHP programs was different, in rural areas the focus was more on the organizational implementations such as scheduling their employees in a healthy way. In urban areas, social activities to improve well-being and providing activities focused on physical exercise were mentioned more. In urban areas, a low participation rate seems more often a problem compared to rural areas.

Fifth, the intersection between organizations in rural areas and employees with different cultural background and/or nationalities has been analyzed. The group who had employees that were both active in rural areas and included employees with different cultural backgrounds and/or nationalities together formed a minority of respondents. A majority of the selected respondents were worried about employees' health. Living as a minority in the rural area might increase the risk of increased worries. The employees did not have more health issues compared to all respondents, but the organizations did provide more often WHP. The average age of this group was higher compared to respondents in the total sample.

### 6.5 Interview preparation based on survey results

For the interviews, differences and similarities between different groups have been taken into account. Purposive sampling has been used and organizations with a broad variety of features have been selected for interviews. One important topic which has been discussed is participation in WHP. Both in literature and in the survey results it seemed that a low participation rate is often a problem, also in home care organizations of the Netherlands. Most respondents filled in that not many employees participated and that this was a problem. The survey did not give an answer on whether employees with a different cultural background within the teams participate more or less often compared to employees with a Dutch cultural background. An explanation, written in the open answers, was that they have no time to participate because of the high work pressure. Another explanation could be that the provided programs are not in line with employees' needs. The interviews helped to find out the underlying reasons for home care employees to participate or to refuse participation in a program.

## 7. Interview results

### 7.1 Characteristics of the interviewees

In order to give an answer on sub-question 3: 'What are the needs and perspectives of home care employees with different cultural backgrounds on workplace health promotion?', interviews with home care employees have been conducted.

The survey gave access to organizations of which team leaders were willing to collaborate in the next step of the research. Just as mentioned in the methods (§4.3, p. 26-30), fifteen organization offered possibilities to conduct the interviews. In the end, ten interviews have been conducted with ten home care employees from five different organizations.

Two of the organizations had cultural diversity within the home care teams. In e-mails (Appendix E) to those organizations, it was specifically asked if two employees with different cultural backgrounds and/or nationalities could be interviewed. In total, four home care employees with a cultural background and/or nationality different than Dutch have been interviewed. The other six were Dutch, which represents the Dutch nationality perspective to find out differences and similarities between different cultures. One man and nine women have been interviewed. This approximately reflects the male-female ratio within home care: thirteen per cent of home care employees are male (AZW, 2012). Furthermore, age has not been asked beforehand, but it appeared that six of them were younger than 35 years old and the other four were older than 50 years old. As the survey has shown, teams with on average older employees had fewer health issues than younger teams. Underlying reasons have been explored during the interviews.

Organizations in rural areas were less represented in the sampling for interviews: more respondents from organizations in urban areas filled in they were willing to collaborate with interviews. Two organizations active in rural areas were willing to participate. The provision of WHP was less present, but during the interviews, it became clear that some employees perceived this differently and WHP was provided at some of the organizations while it was not filled in.

In order to give an answer on the third sub-question, interviews have been analyzed. First, the main topics of the topic list (Appendix I) will be discussed as follows: provided WHP, needs for WHP, participation in WHP, and health in relation to work. Second, a closer look will be taken at the relation of cultural background in WHP for home care employees. Third, other topics that seemed to be important to home care employees will be discussed. Most interviewees mentioned communication as an important factor, i.e. what could be improved and where they are satisfied with. Furthermore, team collaboration and other suggestions for organizational improvements will be analyzed. After the analysis, a brief synopsis and a conclusion about the interview part will be given.

### 7.2 Insights into employees' perspectives

#### 7.2.1 Existing workplace health promotion programs and activities

In the interviews with home care employees working in organizations where WHP programs were offered, their opinion was asked what they appreciated and what not of the programs.

WHP programs or activities home care employees experienced as positive were:

- Buying a bike via work
- Massages
- Information courses
- Sharing frustrations with colleagues (social support)
- Training:
    - in body posture
    - about aggression (during working time)

Relaxing activities, social support, and educational support showed to be most appreciated by home care employees. Furthermore, the presence of a prevention coach seemed to be an important factor in healthy working. Back or shoulder problems were common, which made the employees more aware of the consequences and how to prevent these. A prevention coach makes employees more aware of their posture and teaches them how to work ergonomically. Employees felt supported by it:

> *R8: "We have prevention coaches so if we encounter a problem (…) then we also just can go to consult like what could we change or improve here. (…) That is very nice."*

A prevention coach could be an option in preventing those problems employees usually first have to experience before they change their posture. More about health issues in relation to work will be explored in §7.2.4.

WHP programs or activities that home care employees experienced as not useful were:

- Discussing problems in a big group
- Discount on a gym membership of one specific fitness center

Discussing problems seems to be not always useful for everyone because: or it would happen just on normal working days or it would be shared but no further action would be taken. One perspective was that it did not work because people do not change and that in a women's world, people always talk behind each other's back. The usefulness of social support and talking about problems seems to be

personal preferences as well because some, but not all, perceive it as useful to share experiences and improve work atmosphere by talking about problems.

Sports as a form of WHP was often discussed. Most interviewees separated doing sports from their work and were not in need of WHP in form of sports. Two organizations did provide a discount on a gym membership, but it was not a preferred option: the interviewees did not make use of this. Their practical reasons were that discount was only on a particular fitness center in one location and they were not living nearby. Other reasons were that they preferred doing sports on their own or with friends. However, in working places, where it was not provided, employees were positive about doing sports via work because sports are expensive. Another argument was that it would improve fitness of them and of colleagues and it would improve the team bonding. Ideas for which kind of sports and other suggestions will be discussed in the next paragraph.

### 7.2.2 Suggestions for workplace health promotion

Extra courses in private time were not always appreciated. However, some employees proposed different ideas. Support in health was appreciated by most home care employees, but it should be tailored and fit personal preferences. Their needs or suggestions for WHP programs or activities were related to physical activities, food, mental health and work-related health, such as:

- Assertiveness training
- Discount on fitness center of own choice
- Swimming/yoga lessons/running clinics for team
- Team building activities
- Massages
- Support in health
- Providing fruit
- Social support
- Test employees more often on specific tasks
- Courses in working ergonomically

Bigger topics that home care employees see as valuable could be identified. Stimulation of a healthy lifestyle and provision of physical activities by offering financial support, support from both colleagues and team leaders and more training in home care actions were mentioned. Specific ideas for stimulating physical activities exist. Besides physical activities, training and tests on specific tasks were needed more. Arguments were that their education was a long time ago or that insecurity about rare tasks played

a role. Having a conversation with employees about their specific needs to increase knowledge, could help to develop courses that are perceived as useful. Social support by organizing social activities was mentioned as crucial too. Employees who experienced their team as a close team liked to do social activities with them. In organizations where this was less offered, employees often had the feeling that the connection with their colleagues was less strong. The connection could be improved by organizing more social activities, which could have a positive influence on work atmosphere, job satisfaction and well-being.

Questions about the resistance of specific workplace health promotion programs or activities were asked as well. Not all employees had a need for:

- Extra courses in their own time
- Doing sports together
- Stress management courses
- Social activities (would be nice but not necessary)

It appeared that private time was an important factor that influenced the need for certain WHP programs or activities. Problems in maintaining a work-life balance and personnel shortage were mentioned because these factors often increased the amount of work and feelings of work pressure. In those cases, having free time and be free to choose what to do with that time seemed to be essential. When courses would be provided during working time or when the employees would not feel work pressure, time seems to be less important.

The needs for WHP differ per person and per organization and could vary. For example, it appeared that employees seemed not to have the urgent need to do sports with colleagues, but it was perceived as something which could be fun. Where WHP is not provided, it is often perceived as something extra which could be good but has not always a priority. What most employees do feel as necessary is the presence of a prevention coach. Working ergonomically is connected to health and is therefore important to pay attention to.

#### 7.2.3 Participation in workplace health promotion

The underlying reasons for whether employees participated or would participate in WHP activities have been explored.

In one organization, the whole team participated in everything the organization offered, for example discussing improvements, massages or team activities. Sometimes it was conducted in their private time. It was a close team in which team members cooperated well and the activities were fun, which might have added to the participation rate. In other organizations with other WHP programs or activities, not

many employees participated. Not realizing it was offered or no time to participate were used arguments. One mentioned that the organization should communicate better about the existence of it and promote it because otherwise there is no point in providing it. However, it was appreciated that the organization provided it to show their interests in employees' health. The option to buy a bicycle via work to use during work or in spare time was appreciated.

Another organization provided physical activities for the whole organization instead of for the teams. This was an important reason for not participating. If it would be provided for smaller groups, it would be more likely for the employee to participate. However, some employees still did not see the necessity of doing sports. Different perceptions of being active exist. Walking a lot during their workday was perceived sometimes as being active, while another perspective was that their job was physically demanding which made it more necessary to do sports and stay active in their private time. Personal perspectives seem to play an important role in the need to participate in WHP programs or activities as well.

Employees working in an organization where no WHP programs or activities were offered, often brought up social activities that are organized either by themselves or by the organization. It seemed that most employees of the team were joining. However, some preferred to do activities with friends or family, outside of work. This seems to be a personal preference or related to how they perceived the team collaboration. Team collaboration will be further examined in §7.2.7.

Different opinions exist: some thought it could be fun to do sports with colleagues or their team, others would not participate in such activities. Some would participate in any WHP program or activity if it would be provided, while others had no need for it and if they would have the need, they would tell it to their team leader or they would take action themselves. Furthermore, one never thought about WHP programs or activities and one would only participate in leisure time when it was useful. Time seems to be an important factor. Coming back to work to follow extra courses was not attractive. Most of them spend more time at clients' homes than at the office. It was not preferred to spend more time at the organization than needed. For example, someone explained that if it was not obliged, she would not participate:

> *R1: "Because I just take my own time so no I cannot imagine a course or anything (...) of what I'm thinking well I would really come back to participate."*

Time was mentioned often in the context of work schedules and shifts. Most employees worked 24 hours a week, scheduled over the week. They have the feeling they are already too often at work:

> *R2: "I need to work 24 hours and the routes are not that long so I am already here seven days a week, well, I do not need to follow a course to become healthier".*

Besides time, workplace showed to be an important factor as well in need for WHP. Some of the organizations were established in a flat for older people where home care could be provided. This appeared to improve support of colleagues, team leaders and participation in WHP activities. It could be that own time is perceived differently by the different employees: coming back to work for extra activities takes more effort and seemed to decrease leisure time while being at work doing extra activities is not perceived as a decrease in leisure time.

However, when the organization would focus on employees' health or show interest in it was appreciated, but perhaps not as a WHP program or activity. Support from the organization by paying attention to employees' health seemed to play a big role and could have an influence on well-being:

> *I: "But do you think that the organization should pay more attention to employees' health?*
>
> *R1: Ehm… yes, in the end I think they should, I mean it is not only for the employees themselves but in the end also for their (…) interest that they take care of their employees and just be there and also just lend a sympathetic ear, and do something with it afterwards, (…) because, sometimes well then they hear you but then, in the end, nothing happens with it."*

Team leaders who do not take action seem to cause frustration by employees. More ideas were suggested about what could be improved, and most of it was not directly about WHP but could lead to improved health and well-being in the long run. Later on, those ideas will be explored. First, health in relation to work will be discussed.

### 7.2.4 Health in relation to work

Being healthy was perceived as very important for performing in their job. Health was defined as having no issues, feeling good, no stress, and no complaints. Being healthy is important for their clients as well:

> *R3: "Yes because if you are not healthy you cannot take care of others."*

Self-care seems important, there was no disagreement on this point. However, personal health situation was not always perceived in the same way: health issues were sometimes mentioned later on while they first stated they were healthy. Furthermore, colleagues with health issues were discussed more often, own complaints got less attention. Back and neck complaints by putting on stockings seemed to be the biggest struggle. Often this was not perceived as a health issue:

> *R1: "I need to say I do not have any complaints, but, sometimes I do have, especially if I have worked too much that I think "ouch, my shoulder", you know."*

Health and work are interrelated, especially in health care jobs such as home care. Caring as a profession sometimes leads to neglecting self-care:

> *R1: "That I also just need to take care of myself more, I care a lot for others that I forget to care for myself."*

However, this also seems to be personal, caring for others is not always above everything. When clients demand to do tasks what is harmful to the body, some employees refuse it or call colleagues for help.

Besides tension between self-care and caring for others, the division of shifts and personnel shortage have been mentioned as big problems. Personnel shortage is a national problem (UWV, 2018). The tension between fulfilling shifts and own health exists and personal differences exist in how to cope with it. Fulfilling shifts was often mentioned as a priority, even though it could lead to poor health. A dilemma appeared: working extra or choosing for own health? It is not always perceived as a choice:

> *R1: "Yes actually it is also said "hey, you need to think about yourself" but yeah, shifts need to be fulfilled as well."*

Low autonomy could play a role. However, a division of shifts was not always a problem. In those teams that cooperated and knew each other well, also privately, dividing shifts went easily. Having the feeling that the division of shifts was done equally and all colleagues had to work extra was also an important factor. However, the consequences of working too much are well-known, as those two quotes illustrate:

> *R4: "No sometimes I think no, next time I will choose for myself, because I also need rest, because if I will work too much for example, and I will get sick or overtired then yes they also have to solve shifts."*

And:

> *R2: "It [work] should not be at the expense of our body."*

Furthermore, different views existed on the physical aspect of home care work, some of them emphasized that home care was physically demanding. A link with previous experiences could be identified: employees who had worked in a hospital or nursing home before they worked in home care did not experience home care as heavy work with high pressure. On the contrary, those employees who always worked in home care often experienced work pressure. Moreover, the amount of work pressure differed per organization. Some organizations did not cope with personnel shortage. In those organizations, employees had enough time per clients and no high work pressure was experienced. The attitude of the employees seemed to play a role in this perception of work pressure as well:

> *R3: "It does not affect me but I also think, it is how your attitude is and on which moments."*

For employees who experience work pressure, changing the attitude could decrease the feeling of high work pressure. Hiring more personnel would be appreciated, just as less pressure from the organization and less rushing. Another argument to emphasize why rushing is not good was low sickness absenteeism:

> *R2: "And again if someone is almost never sick and then be all over it, (…) it was not nice."*

It seems that being sick is not easily accepted by home care employees.

Health issues because of work seemed to be often related to having a bad body posture during work or high stress levels. Therefore, courses about how to change this were experienced positively. Most employees were aware that having a bad posture while doing home care tasks could cause shoulder or back complaints. However, time played an important factor of having a bad posture. When experiencing time pressure, employees did their tasks quickly without paying attention to their posture. More focus on their postures is needed by themselves. Age seemed to play a role in this. For younger employees, the need to change a bad posture seemed less urgent. Older employees agreed with this when they were young but are more aware of the consequences of perpetuating a bad posture. Awareness of the limits of your body appeared to grow with age:

> *R10: "Most colleagues are already 40, 50 (…). You make more use of tools, when you're older maybe you think sooner: "oh my body", and when you're younger, I also did not have that before that you think like oh well (…) we will lift that quickly, you know, like that (…) but you just should not do that."*

Not using the tools while they are present was a reason for causing bad posture for younger employees. Furthermore, clients are responsible for purchasing the tools what occasionally is problematic. Sometimes, convincing the clients to purchase tools was difficult. Mostly in organizations active in rural areas, employees faced problems with clients who did not buy the needed tools. Money seemed to play a critical role in this.

Except for those problems and health issues, job satisfaction seemed to be high. Especially social contact with clients was appreciated by the employees. The importance to care for other people was mentioned: because of the increase of older people who need to stay at home and because they want to be taken care of the same way when they are in need for care.

Needs for WHP programs and activities, participation in it and health in relation to work were topics coming from the topic list. The role of cultural background within those discussed topics was explored as well and will be discussed in the next paragraph.

### 7.2.5 Role of cultural background and/or nationality

Four interviewees had a cultural background different from Dutch. Two of them were participating in WHP programs and would like to join every other thing the organization might provide in the feature. In one organization, the team leader indicated that they did not provide WHP. However, employees perceived this differently. A massage and a possibility to talk with colleagues about problems were offered WHP activities.

Low participation rate seemed not to be a problem within the organization:

> *R3: "I always like it (…) one day they had someone who gave massages to us (…) had to be in your own time then, (…) but I believe everyone here participated. (…) They also organized something (…) what*

*made you have conversations with each other (…) and all irritations (…) were let all out. (…) and you communicated about it."*

Personal preferences and character appeared to play an important role:

*R3: I think you know if it is only work (…) I also like it to participate, do something else. (…) Yes, I am not a person who says "oh no, I'm not interested in that". You know, I think it is also just fun to do things together."*

The workshops about sharing experiences and frustrations with colleagues were not always seen as useful. The group was close, which created an open atmosphere where employees already talked about their problems with each other. However, if problems between colleagues would exist, it could still be a big step to share this in a big group for some employees:

*R4: "But I don't think that even if there would be things, that anyone would say it easily because it is, of course, a whole group so that is quite difficult. (…) I, personally, if I for example really had something I would not… I would not do that."*

Personality seems to be the biggest influence on whether employees would participate. Furthermore, it seems that a close team leads more often to participation in WHP activities.

Physical activity as WHP idea was appreciated, with concerns about colleagues' health as a reason:

*R3: "You work a lot and well (…) I would like it you know, if you could do sports, via work. (…) we have to walk a lot right, and I think that doing sports is really a thing that is really good, some colleagues are quite overweight."*

For the other organization with two employees with different cultural backgrounds, it was also indicated that no WHP was offered. Nevertheless, it became clear that some physical activities were provided, for example, clinics or running together. However, those activities were organized for the whole organization and not per team. This was an important argument for not participating in those activities. Other reasons why participation was often refused, were preferences for activities with friends and no need to see colleagues outside work.

Not participating in physical activities implied to be based on personal preferences as well:

*R6: "No I prefer to do sports on my own." And R5: "I don't even have a gym membership."*

Work-life balance seemed to play a role here, that doing activities with colleagues interfered with personal life:

*R5: "If I would like that, an anti-stress or mindfulness or something*

*[Laughing]*

*R5: then I would just do that with friends or my sister instead of with colleagues, which is a bit more distant."*

However, doing sports together was perceived as fun and it would be appreciated when the organization would provide yoga or aqua spinning classes. This could be interpreted as that no urgent need for WHP existed, but if it would be provided, it could have a positive influence on (team) work.

It does not seem that cultural background and/or nationality plays a visible role in whether employees participate in WHP programs focused on physical activities. The reasons for whether employees (would) participate in WHP were quite similar for interviewees with a Dutch background as interviewees with a different cultural background. It seemed more to be based on personal preferences, whether someone liked to do sports or not. Most interviewees would not like to do sports with colleagues and saw it separated from work. One concrete example was by a person with a Dutch cultural background who wanted to have freedom in choosing to do sports:

*R1: "Eh… well maybe also because I see doing sports separated from work- I just don't think about (…) that it is linked with work I think, but if I want to do sports then I arrange that, where I want and what or why so I do not (…) link it to work."*

Furthermore, in two organizations with no cultural diversity, discount on a gym membership was given, but no one of the interviewees made use of that. Awareness and time seemed to be factors in the consideration of participating:

*I: "Yes and [team leader] had indicated that your organization provides fitness for employees?*

*R1: I've read that once yes*

*[Laughing]*

*I: (…) do you make use of it?*

*R1: No, no, I don't make use of it. (…) I don't have any time for that (…) and actually, I never realized it."*

Looking at those differences and similarities, it seems that participation in WHP is mostly depending on individual features and organizational structure rather than on cultural background. Employees from different cultural backgrounds and/or nationalities seemed to be open to WHP activities and programs what resulted in participating in provided WHP activities. Of the interviewees with a Dutch cultural background, doing sports alone or with friends was more preferred than doing sports with colleagues. Furthermore, coming back to work to follow extra courses or to get a healthier lifestyle seemed not to be a preference for most employees with a Dutch cultural background. Work-life balance seemed to be important to most employees. Participating in social activities implied to be a personal preference as well: some participated with everything or wanted that more activities were organized to create team bonding or just for fun, others did not have the need to see colleagues in their free time.

All in all, different perspectives on the provided WHP and need for WHP existed. Personal preference, organizational structure, and team support played a role in those different perspectives. Cultural background seemed to be of less importance. However, some of the interviewees with a cultural background different from Dutch participated in every WHP activity offered by the organization and would like to participate in any other program. It seems that character and personal preferences play a role, irrespective of their cultural background. As explained in the literature (Singer et al., 2016), a different cultural background leads often to exclusion and less participation. This seems not the case within home care: character and team seemed to be more important. With a close team, employees seem to participate more often in WHP programs and arguments about whether needs for WHP existed were similar.

Besides the topic list topics, some other topics seemed to be important to home care employees and will be discussed in the next paragraphs.

### 7.2.6 Communication

Communication seemed to be important to home care employees and appeared to be a substantial factor for job satisfaction:

> *R3: "It is really nice working here. (…)*
>
> *I: And what is the main reason for that?*
>
> *R3: (…) I think mainly because of mutual communication."*

However, not in all organizations communication was perceived in a similar way. Often, employees would like to see improvements in communication among employees and between the employees and employers or other parties. Honesty and open communication seemed to be most valuable to create a better work atmosphere as those two examples below show, which could lead to an improved well-being:

> *R2: "Well I think we should communicate much more. Or yes that is very important, communication is very important, both negative and positive."*

And:

> *R10: "Yes, maybe be more honest, saying things to each other sooner and not behind their back."*

Being on the same page within the organization appeared to be important. This example shows in other jobs within health care, the same problems have been experienced and is not related to organizations. Improvements in communication could improve the work environment:

> *R6: Communication I think. But that is something separated from health. (…) but communication, communicate more about certain things, not that (…) the one team says something and the other teams*

*say something completely different. That has to be in line and that is what I miss here I think but that has always been in health care. (…) Yes among the teams, among the supervisors, everything in line."*

As mentioned before, home care employees have low autonomy which means they have not a say in many decisions within their work. Home care employees did not see this always as a problem, because they did not know in what kind of decisions they should be involved. However, sometimes it was perceived as if the organization did not do anything with employees' suggestions or comments when their opinion was asked. Most frustrations were about when the organization acted not in line with employees' wishes or needs. Furthermore, sometimes it was unclear who the contact person was when employees had issues or questions, due to changing team leaders or organizational changes. A conversation between employer and employee about employees' needs could increase collaboration, which could be useful in times of personnel shortage and health issues.

### 7.2.7 Team collaboration

Related to communication, although a bit more specified, is team collaboration. Collaboration with colleagues was valued as important by employees as well. Even though in some organizations employees could start working from home, they still preferred to discuss both work-related and not work-related topics with colleagues. Feeling supported by each other seems to be the main reason for job satisfaction. Home care employees who worked all in the same flat seemed to have more contact because it is easier to meet up:

*R3: "Yes that is just really nice (…) you come together for a moment to drink a cup of coffee (…) is immediately fun and you almost forget you are working you know."*

Employees working in the neighborhood have less opportunity to do this, but still, most employees perceived their team as being close. Contact with colleagues is essential, for support in work but also in private life. It also appeared to be an important reason to not change jobs:

*R7: "I do not want to miss my colleagues, I have a really good connection with them. "*

The fear for changing contact with colleagues due to technology exists: that meeting with colleagues would be not necessary anymore. However, until so far, they still had to come to the office before doing their shifts where they could share their stories and could get advice from colleagues. Not all teams were close, for example, because many students were working within the team or because they had just started working for the organization. These employees would appreciate if more focus lied on team building, to see each other in a different way than just in work setting, which would improve team collaboration. However, different perspectives exist on seeing colleagues outside work. One perspective is that keeping work and private life separated is important, while another perspective is that it could be good to increase team bonding and that it was fun. Social activities, team building or clinics were examples of what seemed to be accepted to do as a team. Doing sports was often seen as something private. However, this

depended on personal preferences. Besides collaboration on team level, some suggestions for improvements on organizational level were given. Examples of suggestions for organizational improvement will be given in next paragraph.

#### 7.2.8 Suggestions for organizational improvements related to health

Home care employees' suggestions for organizational improvements, which could have a positive effect on their health, were:

- Creating work schedule together (take employees' work-life balance into account)
- Repeating or practicing rare actions more often
- Give time for recovery
- The possibility of further education (e.g. prevention coach course)
- Provide courses about how to work ergonomically to new employees
- Focus on team-building
- Empathize with specific situations (e.g. health issues)

Scheduling appeared to be an important topic as well. Sometimes it was about personnel shortage and difficulties in scheduling and fulfilling all shifts. Other times it was more about how the scheduling was done and whether it took employees' work-life balance into account. Flexibility of the job and changing schedules was a known given for employees, but it was not appreciated when external people did the scheduling without taking personal preferences into account. Ideas for how it could be better was to create the working schedule together so you could discuss in person why you prefer certain shifts. Besides scheduling, the job was not always perceived as challenging and more education or more responsibility and tasks would be appreciated by some employees. The feeling of being limited by the organization occurred when they could not follow the wanted education or had to leave the organization when they wanted a "higher" job.

These mentioned ideas for improvement seemed to be not heard by the organization or were not shared by the employees. Having low autonomy within home care could play a role in this.

### 7.3 Brief synopsis of the interview results

Personnel shortage leads to worries about work-life balance and tensions between own health and fulfilling shifts. Most employees appreciate it when the organization focuses on employees' health, but only focusing on it is not enough: the organization should also take action in this as well. For example, when employees are sick, they want to feel supported by the organization. Feeling rushed by the

employers to work again might make them experience more pressure to work when they are not ready yet. This could lead to more absence due to sickness in the longer term.

When the organization provides WHP, it should be more promoted to create awareness of the possibilities. Lack of participation could occur because employees do not now WHP is provided. Furthermore, WHP in own time will get more participants when:

- Employees think it is useful
- Employees who have a fixed workplace
- Employees have a close team

Promoting physical exercise is often done by organizations. Employees do not always make use of it because work and sports are often seen as separated. However, ideas about what could work were:

- Offering clinics or specific sports lessons for one home care team could increase team bonding and could be fun
- Offering discount to any gym stimulates some employees to do sports, however, employees who are not athletic will still not make use of it

Home care employees seem to appreciate social activities the most, an idea for WHP could be to focus on team building what could improve work atmosphere and well-being. Some of the employees are in need of more practice and training on specific rare topics to feel less unsure, which could be good for well-being.

A bad posture may contribute to health issues e.g. shoulder or back pain. Focusing on posture could be good for employees' health and could be promoted by:

- Providing a short course to new colleagues about how to work ergonomically
- Providing a short course to employees to remind them of how to work ergonomically
- The presence of a prevention coach: important to employees
- Promoting the use of tools to prevent employees from having a bad posture

The cultural background did not seem to play a big role in WHP participation and needs. Employees with a different cultural background than Dutch seemed to be a bit more open to WHP programs. However, personal preferences and organizational structure seemed to be more important in employees' perspective on needs for WHP.

What seemed to be important to all interviewees was communication, between team leaders and employees and among employees, to create a good work environment. Improvement in communication could help to reach this. To sum up:

- Knowing who employees' contact person is could lead to fewer frustrations of employees
- Employees want to get the feeling of being heard by team leaders, which could be improved by receiving feedback on their input
- Employees seem to know what they want: as an employer, asking them what their needs are could lead to less struggle
- Sharing stories with colleagues about what they are up against seems to be valued

### 7.4 Conclusion interviews

In order to give an answer on the third sub-question: 'What are the needs and perspectives of home care employees with different cultural backgrounds on workplace health promotion?', ten interviews with home care employees have been conducted. Four interviewees had a cultural background and/or nationality different than Dutch, the six others represented Dutch culture and nationality.

The interviews gave insight into perspectives of different home care employees on WHP. The different perspectives seemed to be mainly based on personal features and organizational structure: cultural background seemed to be a less big influence. Every individual had different perspectives on WHP and some opinions were shared by employees with different cultural backgrounds. Some participated in everything with all their colleagues, others did not have the need to do health-related activities at work in their own time. Especially about physical activities different opinions existed: some thought it would be good for team bonding and to become fit, while others did not have the need because they did not like doing sports or they preferred to do sports on their own. For employees with a Dutch cultural background, this was similar: perspectives on participating in doing sports together with colleagues seemed to be based on personal preferences for how to do sports. Keeping a work-life balance and seeing sports separated from work were mentioned often as a reason.

In organizations where WHPs were not provided, most interviewees seemed to have the need for social activities and courses about how to work ergonomically to feel more secure. Some interviewees did not have a need for WHP in their own time. Workplace and time seemed to play a role in participation. Coming back to work to follow courses to improve employees' health seemed no priority. What did seem to be a priority for employees was hiring more personnel and improving the communication among the teams and between the teams and the team leaders. Most employees thought better communication could lead to fewer conflicts, less stress, and fewer health issues. It seems that communication played a big role in how employees experienced absent colleagues and work pressure, just as their willingness to

divide open shifts. Improved communication could lead to more involvement of employees, which could have a positive impact on employees' willingness to take initiative in sharing their needs.

## 8. Overall conclusion

The main question of this thesis is: 'What is the role of cultural background in workplace health promotion for home care employees in the Netherlands?'. To answer this overarching question, different perspectives on WHP have been explored, guided by three sub-questions and using three different methods.

First, the literature review showed that WHP programs for home care employees mostly focuses on physical activities and educational support. Participation in WHP was often a problem for home care employees because they do not have a fixed workplace. Second, the survey showed how home care teams with cultural diversity were offered more often WHP programs or activities than teams without cultural diversity. Lack of participation in those programs seemed to be an issue for most home care organizations. Most of the team leaders or managers from organizations that did not provide WHP stressed that employees' health was a shared responsibility for both organization and the employees, but that it is important to maintain employees healthy for sustainable employability. Third, the interviews demonstrated employees' perspectives. Both survey and interview results showed that cultural background seemingly did not lead to inequality in accessing WHP. The need for WHP differed between interviewees, but cultural background did not seem to play a role in this. Personal features played a bigger role: sometimes WHP seemed to interfere with work-life balance, and sometimes it was perceived as an opportunity to improve team collaboration. Furthermore, the organizational structure seemed to be of importance: employees working in a fixed environment were more willing to participate in WHP. It did appear that (the absence of) WHP was no priority for employees. Bigger problems were identified: personnel shortage was often mentioned as a factor causing health issues, especially because of the need for employees to work extra shifts. Lastly, communication was often mentioned as something that could be improved. Most employees would appreciate better communication with their team leaders, director or team, in order to have fewer misunderstandings, more support, and fewer frustrations. Most employees were of the opinion that improved communication would lead to more job satisfaction and an increase in well-being, which could lead to less absence due to sickness.

# 9. Discussion

## 9.1 Discussion results

The aim of this explorative research is to create an image of the current situation of home care employees' health issues and provided WHP programs and activities.

From the employers' perspective, organizations with and without cultural diversity show different needs for WHP programs. Stress-management and quit-smoking programs were more often provided in culturally diverse teams. However, the employees' perceived the programs as unnecessary. The needs of employees might not be in line with the perspectives of employers, which seems to be reflected in the low participation rate.

In both urban and rural areas, personnel shortage is a problem, which is responsible for higher work pressure and more health issues. However, the survey showed that employees of organizations that are mainly active in urban areas experienced health issues more often while having more resources to provide WHP activities and programs. In general, people living in urban areas have more health issues than those living in rural areas (Verheij et al., 1998). Underlying reasons for the health inequality as a result of differences in the area of activity have not been found. Although no evidence is found in the current study, possible explanations are that in urban areas there might be more stress and higher work pressure or the living environment (of both clients and employees) might be unhealthier.

Besides area of activity, age seems to play a role in health perception. Teams with younger employees experienced more health issues compared to teams with older employees. From the interviews, it appeared that older employees made use of home care tools to support them, while younger employees did not see the urgency. Additionally, a possible explanation is that people between 35 and 45 years have more difficulty to maintain a work-life balance (Richert-Kaźmierska & Stankiewicz, 2016). Haar, Russo, Suñe, and Ollier-Malaterre (2014) emphasize the importance of a work-life balance for people's well-being and productivity. A perceived balance between work and life has a positive influence on mental and physical health and therefore, not being able to maintain a work-life balance could be a factor that affects employees' health.

In literature (ZonMW, 2016; Bertens & Van Kesteren, 2011) was found out that people with a lower socioeconomic status experience more health issues and are less willing to participate in WHP. This seems to be in line with the perspective of home care employees. They do not experience extra courses in their private time as a priority unless the courses are perceived as useful and related to their job.

This research focused on people with a lower socioeconomic status. However, this assumption was made based on the educational level and profession of home care employees. A socioeconomic status is based on more factors, which were unknown during the research. Moreover, health differences within the group of people with a lower socioeconomic status exist as well. Research does not usually explore the

role of individual features or employees' cultural background in relation to socioeconomic differences in health. In addition, people with a lower socioeconomic status who migrated to the Netherlands and who experience language and culture barriers are an extra vulnerable group (ZonMW, 2016). Intercultural communication could play a role in communication difficulties at the workplace. Conflicts between team members in culturally diverse teams might occur due to different perspectives (Brett, 2018). This could be an explanation for the higher amount of health issues in culturally diverse home care teams. However, intercultural communication could yield benefits, if the focus is on team collaboration and individual competence. A possibility is that organizations provide training in intercultural communication in order to create better understanding among their employees. Better understanding could have a positive effect on employees' perspective on team collaboration and job satisfaction (Brett, 2018).

This research shows that personal features have a big influence on employees' needs and perspectives. The experiences of work pressure and health issues are personal as well. Deeper understanding of the occurrence of differences within the same target group is obtained using the intersectional framework. Home care employees with a different cultural background are seen as a minority intersecting with a lower socioeconomic status. Furthermore, most home care employees are women, which are a minority as well. The intersection of those features might be a reason for the high amount of health issues for home care employees. In this research is found that a cultural background different from Dutch is related to more health issues but does not seem to be a barrier in participating in WHP.

The improvement of collaboration and communication between employer and employee is important to increase social support, which in turn could promote a quick recovery (ZonMW, 2016). In the traditional view of WHP, activities mostly target individual behavior, and organizational aspects, such as communication, are much less taken into consideration (Van Berkel et al., 2014). However, a broader definition of health at work and a healthy workplace includes collaboration between employees and managers by focusing on health and well-being improvement in the psychosocial work environment (Burton & World Health Organization, 2010). This broader definition would plea for including organizational aspects such as improving communication as a WHP activity. In line with that broader definition of health at work, in this thesis, health and well-being are considered interconnected and improvement of communication could increase well-being. Therefore, improvement in collaboration and communication fits within WHP.

### 9.2 Methodological reflections

The mixed-method approach has led to more insights into the different perspectives on WHP and the health issues of home care employees. The literature review helped to develop relevant questions for the survey and the survey showed the perspectives of team leaders and managers while the interviews gave insight into employees' perspectives. Without the interviews or the survey, differences and similarities

between perspectives would have remained unknown. The inclusion of the perspectives of home care employees on WHP has helped to understand their preferences. This may facilitate the development of effective programs or activities (Nöhammer et al., 2013) and could increase the participation rate. Some deeper reflections focusing on each separated method will be described in the next paragraphs.

### 9.2.1 Literature review

Only a PubMed search has been used, which is a limitation. More online databases could have been used to search relevant literature, for example, PsychInfo. In further research, other sources could be used, however, PubMed is the most obvious database for health research related to work. The goal of the literature review was to explore existing WHP programs for home care employees. It gave enough input to develop the survey and seemed to connect well with practice.

### 9.2.2 Survey

A first pitfall of the survey was that more than one team leader or manager within one organization was able to fill out the survey. Therefore, the results do not represent 58 different organizations but 58 different home care teams. This could give a distorted image of reality. Team leaders are able to make choices regarding the implementation of WHP to some extent but are not responsible for organizational implementations. More research could be done by focusing on an organizational level and taking the directors' perspectives into account.

Second, the results could be biased if only people who are very engaged with the topic filled out the survey. Surveys frequently have this selection bias pitfall and therefore it might not be a coherent overview of employers' perspectives on employees' health issues and WHP. However, the results showed many different opinions with various perspectives on WHP and health.

The Likert scale used in the survey may have contributed to less nuance in the responses. By using a 5-point scale, people are less likely to fill out the extremes and more often give socially desirable answers. However, this scale has been chosen because people are more willing to fill out the survey when limited options are given (Bouranta, Chitiris & Paravantis, 2009). The Likert scale was only used to get an indication of the employer's opinion and to create a lower threshold for respondents to fill out the survey.

Social desirability might have played a role in the survey results. The survey contained questions about the importance of employees' health and the employers' responsibility regarding the health of employees. However, possibilities to clarify the answers were provided and some respondents made use of it in order to show nuances. Respondents were able to fill out the survey anonymously, which decreases the chance of giving socially desirable answers.

A further limitation is a difficulty to ensure complete objectivity in the survey. The survey was developed with the aim to be objective without steering respondents' opinion in a certain direction. Five

different people checked the survey and the e-mail for the organizations in order to eliminate possible ambiguous terms.

Lastly, some questions in the survey might have been interpreted differently by different respondents. For example, the question of if the home care employees of their organization had many health issues, 'many' was not defined. The answers were based on respondents' perception and interpretation, which could have influenced the results. However, the survey was designed to get an indication of the situation, not to get the exact number of employees with health issues.

### 9.2.3 Interviews

One limitation of the interview could be the use of the purposive sampling method. The organizations were chosen based on the researcher's own insights in the various institutions and based on willingness to collaborate. Some organizations canceled the interviews because of absence due to sickness, which led to increased work pressure on the remaining employees. More interviews could have been conducted in order to represent a broader group of home care employees, including the organizations for which health issues seem to be a bigger problem. Nevertheless, the in-depth interviews with home care employees made clear that different perspectives between team leaders and employees exist.

Another limitation is the background of the interviewer, including culture, gender, and socioeconomic status. This might have played a role in which information was retrieved, as it offered a specific social context. Interviewers need to be aware of power relations and dominant perspectives (Verdonk et al., 2010). The interviews were conducted at the organizations where the employees worked. In this way, the location was a more familiar environment for the interviewees than for the interviewer, which may have promoted a feeling of equality and mutual respect.

Social desirability might have played a role in responses to health and the organization because the interviewees were asked by the team leaders or managers to participate in the interviews. During the interviews, it seemed that the interviewees communicated openly and honestly about sensitive topics showing both positive and negative perspectives. Therefore, the consequences are considered to be limited.

The ideas for WHP given by the interviewees might have been affected by the examples mentioned by the interviewer. The examples were given as a starting point for interviewees, but sometimes interviewees seemed to stay close to those examples. However, most of the interviewees came up with their own different ideas.

When conducting interviews, interpretation always plays a role. However, it has been aspired to overcome this barrier by re-listening to the recorded interviews, transcribing them and reading the transcriptions several times. In this way, an effort has been made to interpret the results in a way the interviewees meant it.

### 9.3 Ethical reflection

In WHP, the ethical question arose how much an organization can promote employees' health and how much it is the employees' own responsibility (ZonMW, 2016). According to Robroek, Van de Vathorst, Hilhorst, and Burdorf (2012), between 21 and 26 per cent of the employees perceive WHP as interfering with their health and privacy. Coercion could play a role in the resistance of participating (Van Berkel et al., 2014). In this study, the employees often perceived participation in WHP programs or activities as voluntary. Employees still make the choice whether they participate or not, and did not seem to feel the pressure from employers or colleagues. However, when organizations provided physical activities, employees showed some resistance. WHP activities regarding education and training were often perceived as more useful. This is in line with the findings of Van Berkel et al. (2014), that coercion is perceived when the organization is involved in private life rather than work life. In this research, employees did not seem to feel forced by their employers to participate in WHP. The participation rate often seemed to be low and even though employees appreciated the attention from employers on health and of WHP, it was not always in line with their needs.

The power relation between employer and employee seemed also to play a role, which is in line with previous research (Van Berkel et al., 2014). To start with, employees stressed out the tension between taking on extra shifts and prioritizing their own health and well-being, and the role of the employer in this. On the one hand, employees experienced pressure from the employers when extra shifts needed to be fulfilled while on the other hand, employers emphasized that employees' needed to take care of themselves and not work too much. However, it seemed that employees still had the feeling of freedom of choice when taking on extra shifts. Most employees would prioritize themselves if they experienced health issues or too much stress.

In addition, the employer-employee relationship plays a role in communication. Employees wish to see improvement in communication with both colleagues and employers. Most frustrations were regarding employers who listened to the employees but did not take action afterward. Employees have low autonomy and employers are the decision makers. Because of this inequality and dependency, it is difficult to improve this communication. However, most employees indicate that involvement in decision making was not desired on many levels, but when their opinion was asked, action or feedback would be appreciated.

### 9.4 Further research

This research mainly focused on differences and similarities between home care employees with a Dutch cultural background and a different cultural background. The cultural background did not seem to play a big role in participation in and needs for WHP. However, this was based on four interviews with employees with a cultural background other than Dutch. The perspectives seemed to be as different between those four employees as between the employees with a Dutch background. Further research

could focus on specific cultural backgrounds to find out differences and similarities between cultures to find out whether barriers to participation in WHP programs exist between other cultural backgrounds. An option could be to conduct interviews with focus groups, based on similar cultural backgrounds. This way, underlying values, and norms might become identified, which could be used in creating WHP activities.

This research shows that home care employees do not have an urgent need for WHP. Improving communication between the employee and the employer seems to have priority. Using effective communication between both parties could take away much stress and many worries. Further research in communication improvement is warranted. Evaluating dialogues between colleagues could be an option in order to find the most effective ways to improve communication. Furthermore, the role of the relationship between employer and employee could be explored focusing on (in)effective communication and how this promotes or hampers health improvement.

### 9.5 Practical implications

The insights of this research could be used in real life settings in order to improve home care employees' health and WHP programs and activities. First, employees prefer educational support and social activities. Both social and educational activities could contribute to more mutual support. Educational support could exist of training in specific tasks or education about certain topics based on employees' preferences. Social activities should have a focus on team building to improve team collaboration, especially for teams that do not organize that kind of activities themselves. Second, team collaboration and communication could be improved by setting up dialogues between colleagues or conversations in small groups. Topics might be frustrations and uncertainties within the home care profession or on private problems. In this way, insights into personal features and cultural differences and the different perspectives can be explored, which may improve the working environment and prevent conflicts.

Too much pressure on fulfilling extra shifts could lead to tension and/or health issues. Improving team collaboration could contribute to an easier division of shifts. In line with this, communication could be improved as well. In practice, a contact person for employees could be created with whom ideas and problems can be discussed. Employees do not have the need for much involvement in decision-making processes except for scheduling. Employees' needs should be taken into account while creating a work schedule. External scheduling does not seem to be appreciated. A suggestion for the improvement of communication is that when employees' perspectives are asked, feedback is appreciated in order to inform the employees how their input will be used. Otherwise, they might still feel excluded and ignored. This could lead to more frustrations, which affects job satisfaction. Open and honest communication is highly valued and could lead to improved well-being and health.

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## Appendix

### Appendix A: Letter to home care organizations

**Subject line: Gezondheid Thuiszorgpersoneel Enquête**

Geachte leidinggevende/directie,

Er is tegenwoordig steeds meer aandacht voor de gezondheidsproblemen van thuiszorgpersoneel. Voor mijn Masterscriptie aan de Wageningen University & Research doe ik onderzoek naar gezondheidsbevordering op de werkplek. Graag wil ik met uw medewerking onderzoek doen naar wat er aan de gezondheid van thuiszorgteams gedaan wordt.

WAT IS HET?
Een enquête met 17 (grotendeels) meerkeuzevragen. Het invullen kost u niet meer dan 5 minuten en is anoniem. De enquête gaat over de gezondheid van thuiszorgpersoneel in uw organisatie en over gezondheidsbevordering op de werkplek.

VOOR WIE?
Manager of teamleider van uw organisatie. Bent u dit niet? Dan zou ik het heel fijn vinden als u deze e-mail naar de juiste persoon door kunt sturen!

WAT KRIJGT U ERVOOR TERUG?
Indien u meedoet aan dit onderzoek zult u in maart de resultaten van het onderzoek ontvangen.
Dit zal een overzicht zijn van wat voor gezondheidsbevordering op de werkplek er door thuiszorgorganisaties uitgevoerd worden. De antwoorden zullen niet te herleiden zijn naar uw organisatie, het is dus volledig anoniem.

VOOR WANNEER IN TE VULLEN?
Graag zo snel mogelijk, maar het liefst binnen twee weken. De resultaten van de enquête zullen gebruikt worden voor het volgende gedeelte van dit onderzoek.

Klik hieronder voor de enquête:
https://wur.az1.qualtrics.com/jfe/form/SV_3gahzOLfPMoy2c5

WAT HIERNA?
Om het onderzoek compleet te maken worden er interviews afgenomen bij Verzorgenden IG, Helpende Zorg en Welzijn of Zorghulpen die in de thuiszorg werken. Als dit bij uw organisatie zou kunnen, laat dan graag contactinformatie achter aan het einde van de enquête. Als u dit liever niet

heeft, wordt het invullen van de enquête al heel erg gewaardeerd en draagt u al een groot deel bij aan het onderzoek.

De uitkomst van deze enquête en de interviews zal input zijn voor aanbevelingen, met als doel om de gezondheid van thuiszorgpersoneel te waarborgen of te verbeteren.

Hopelijk vindt u dit onderzoek relevant en wilt u meewerken!

Alvast heel erg bedankt,

Met vriendelijke groet,

Susanne Conradi
Master student Communication, Health & Life Sciences aan Wageningen University & Research
E: susanne.conradi@wur.nls
T: 0651985516

**Appendix B: Survey**

## Enquête Gezondheid Thuiszorgpersoneel

Bedankt dat u wilt meedoen!

Met het invullen van deze enquête gaat u akkoord dat de ingevulde gegevens gebruikt zullen worden, uitsluitend voor dit onderzoek. De doelen van dit onderzoek staan in de informatiemail. De gegevens zullen vertrouwelijk worden behandeld. Al uw gegevens blijven anoniem en zijn niet herleidbaar. Meedoen is geheel vrijwillig en u kunt op elk moment beslissen om te stoppen.

Door te klikken op "Volgende" gaat u hiermee akkoord.

Page Break

1

Wat is uw functie binnen de thuiszorgorganisatie?

- Manager
- Teamleider
- Anders, namelijk...

2

Hoeveel mensen werken er voor uw organisatie?

- 0-10
- 11-25
- 26-50
- 51-75
- meer dan 75

3

Waar is uw organisatie voornamelijk actief?

- In de stad
- Buiten de stad (in dorpen en landelijke gebieden)
- Dit verschilt
- Weet ik niet

Page Break

In hoeverre bent u het eens met de volgende stellingen?

4

Gezondheid vind ik het belangrijkste in het leven

| Oneens | Enigszins oneens | Neutraal | Enigszins eens | Eens |
|---|---|---|---|---|
| | | | | |

5

Ik vind het belangrijk om me bezig te houden met de gezondheid van het thuiszorgpersoneel

| Oneens | Enigszins oneens | Neutraal | Enigszins eens | Eens |
|---|---|---|---|---|
| | | | | |

6

Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie

| Oneens | Enigszins oneens | Neutraal | Enigszins eens | Eens |
|---|---|---|---|---|
| | | | | |

Page Break

7

Het is mijn taak om me bezig te houden met de gezondheid van het thuiszorgpersoneel

- Ja
- Nee
- Anders, namelijk...

8

Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen

- Ja
- Nee
- Anders, namelijk...

Page Break

Er is steeds meer aandacht voor 'Gezondheidsbevordering op de werkplek'. Dit houdt in dat er inspanningen worden gedaan om de gezondheid van de medewerkers te bevorderen. Programma's en activiteiten worden ontwikkeld speciaal voor de medewerkers met als doel om hun gezondheid te verbeteren. Deze programma's of activiteiten kunnen variëren van het hebben van een fitnessruimte tot lessen geven over gezond gedrag. De volgende vragen gaan over gezondheidsbevordering binnen uw organisatie.

9

Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren

- Nee
- Ja

- Weet ik niet

Condition: Ja Is Selected. Skip To: Wat voor activiteiten of programma's ....

10

Mijn organisatie zou activiteiten moeten aanbieden om de gezondheid van de werknemers te verbeteren

| Oneens | Enigszins oneens | Neutraal | Enigszins eens | Eens |
|---|---|---|---|---|
| | | | | |

11

Kunt u de belangrijkste redenen geven waarom u dit vindt?

Display This Question:

If Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren Ja Is Selected

10

Wat voor activiteiten of programma's wordt er op uw werk aangeboden om de gezondheid te verbeteren?

- Stress management
- Activiteiten gefocust op lichamelijke beweging
- Stoppen met rokenprogramma's
- Lessen of informatie verstrekken over onderwerpen gerelateerd aan gezondheid
- Oefeningen leren aan werknemers om ze sterker te maken
- Sociale activiteiten om hun welzijn te verbeteren
- Anders, namelijk...

Display This Question:

If Wat voor activiteiten of programma's wordt er op uw werk aangeboden om de gezondheid te verbeteren? Stress management Is Displayed

11

Zijn er veel mensen van het thuiszorgpersoneel die meedoen aan deze activiteiten of programma's?

- Ja, de meerderheid doet mee
- Ja, maar het zou beter zijn als er meer mensen meededen
- Nee, dat is een probleem
- Nee, maar de mensen die het nodig hebben worden er wel mee bereikt

- Dit verschilt per programma (graag toelichten)
- Anders, namelijk...

Page Break

Nog enkele vragen over de achtergrond van uw personeel werkzaam in de thuiszorgteams van uw organisatie

12

Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie?

- Onder de 25 jaar
- Tussen de 25 en jonger dan 35 jaar
- Tussen de 35 en jonger dan 45 jaar
- Tussen de 45 en jonger dan 55 jaar
- Tussen de 55 en jonger dan 65 jaar
- 65 jaar en ouder
- Weet ik niet

13

Werken er mensen met verschillende nationaliteiten en/of culturen in de teams?

- Ja
- Nee
- Weet ik niet

14

Is er nog iets anders wat u kwijt wilt? Dit mag zowel over de inhoud als over de enquête zelf gaan.

Page Break

Voor het beste resultaat van dit onderzoek wordt er na de uitkomst van de enquête thuiszorgpersoneel gezocht waarbij interviews kunnen worden afgenomen. Op die manier verkrijgen we meer inzicht in hun beeld van hun gezondheid en gezondheidsbevordering op het werk. Er zal vertrouwelijk worden omgegaan met de uitkomsten van de interviews.

De uitkomst van deze enquête en de interviews zal input zijn voor aanbevelingen, met als doel om de gezondheid van thuiszorgpersoneel te verbeteren waar nodig.

Graag zou ik willen vragen of u mij kunt helpen met dit vervolgonderdeel van het onderzoek, zodat de resultaten voor iedereen nog relevanter worden!

15

Zou ik uw organisatie in dit geval voor deze interviews mogen contacteren?

- Ja, op het e-mailadres en/of telefoonnummer:
- Nee

16

Wat is de naam van de organisatie waar u voor werkt? (Dit antwoord wordt niet gebruikt voor het onderzoek, maar maakt het makkelijker om u te contacteren)

17

Zou u de resultaten van het onderzoek willen ontvangen?

- Ja, op het e-mailadres:
- Nee, bedankt

## Appendix C: Reminder letter to home care organizations

**Subject line: Herinnering Gezondheid Thuiszorgpersoneel Enquête**

Geachte leidinggevende/directie,

Hierbij wil ik u herinneren aan de enquête waarvoor ik u heb uitgenodigd, over gezondheidsproblemen van thuiszorgpersoneel. Ik hoop dat u alsnog een paar minuten van uw tijd kunt vrijmaken om de vragen te beantwoorden.

Voor mijn Masterscriptie aan de Wageningen University & Research doe ik onderzoek naar gezondheidsbevordering op de werkplek. Graag wil ik met uw medewerking onderzoek doen naar wat er aan de gezondheid van thuiszorgteams gedaan wordt.

WAT IS HET?

Een enquête met 17 (grotendeels) meerkeuzevragen. Het invullen kost u niet meer dan 5 minuten en is anoniem. De enquête gaat over de gezondheid van thuiszorgpersoneel in uw organisatie en over gezondheidsbevordering op de werkplek.

VOOR WIE?

Manager of teamleider van uw organisatie. Bent u dit niet? Dan zou ik het heel fijn vinden als u deze e-mail naar de juiste persoon door kunt sturen!

WAT KRIJGT U ERVOOR TERUG?

Indien u meedoet aan dit onderzoek zult u in maart de resultaten van het onderzoek ontvangen. Dit zal een overzicht zijn van wat voor gezondheidsbevordering op de werkplek er door thuiszorgorganisaties uitgevoerd worden. De antwoorden zullen niet te herleiden zijn naar uw organisatie, het is dus volledig anoniem.

VOOR WANNEER IN TE VULLEN?

Graag zo snel mogelijk, maar het liefst binnen één week. De resultaten van de enquête zullen gebruikt worden voor het volgende gedeelte van dit onderzoek.

Klik hieronder voor de enquête:

https://wur.az1.qualtrics.com/jfe/form/SV_3gahzOLfPMoy2c5

WAT HIERNA?

Om het onderzoek compleet te maken worden er interviews afgenomen bij Verzorgenden IG, Helpende Zorg en Welzijn of Zorghulpen die in de thuiszorg werken. Als dit bij uw organisatie zou kunnen, laat

dan graag contactinformatie achter aan het einde van de enquête. Als u dit liever niet heeft, wordt het invullen van de enquête al heel erg gewaardeerd en draagt u al een groot deel bij aan het onderzoek.

De uitkomst van deze enquête en de interviews zal input zijn voor aanbevelingen, met als doel om de gezondheid van thuiszorgpersoneel te waarborgen of te verbeteren.

Hopelijk vindt u dit onderzoek relevant en wilt u meewerken!

Alvast heel erg bedankt,

Met vriendelijke groet,

Susanne Conradi
Master student Communication, Health & Life Sciences aan Wageningen University & Research
E: susanne.conradi@wur.nl
T: 0651985516

## Appendix D: Table Sampling

Table

*Original Sampling Organizations for Interviews*

| Sample number | City/Rural area | Size of the organization | Workplace health promotion | Cultural diversity |
|---|---|---|---|---|
| 1 | City | >75 employees | Yes | Yes |
| 2 | City | <75 employees | No | Yes |
| 3 | Rural | >75 employees | No | No |
| 4 | Rural | <75 employees | Yes | No |
| 5 | It depends | >75 employees | ? | Yes |
| 6 | It depends | <75 employees | Yes | No |

**Appendix E: Example e-mail interview**

Beste teamleider,

Heel hartelijk bedankt voor het invullen van de enquête over Gezondheid Thuiszorgpersoneel!

U heeft aangegeven dat u open staat om het onderzoek verder te helpen door interviews af te laten nemen. Ik zou erg graag interviews willen houden met thuiszorgmedewerkers (Verzorgenden IG, Helpende Zorg en Welzijn of Zorghulpen) van uw organisatie.

Het liefste zou ik 2 medewerkers apart willen interviewen. Ik ben geïnteresseerd in het perspectief van mensen met verschillende achtergronden. U heeft aangegeven dat er mensen met verschillende nationaliteiten en/of culturen in de thuiszorgteams werken.
Zou het mogelijk zijn dat ik twee personen met beide verschillende nationaliteiten en/of culturele achtergronden apart van elkaar zou kunnen interviewen?

De interviewperiode is vanaf 26 februari tot 12 maart. Zou er daartussen een geschikte dag voor uw medewerkers zitten? Het liefst zou ik beide interviews op dezelfde dag doen in verband met reistijd. De interviews zullen allebei ongeveer een uur duren.

Graag hoor ik van u wanneer het het beste uitkomt. Ik ben qua tijdstip flexibel maar moet wel uit Wageningen komen, dus het liefst tussen 10:30 uur en 18:00 uur.
Bij vragen kunt u mij altijd bereiken op dit e-mailadres (susanne.conradi@wur.nl) of telefoonnummer: 0651985516.

In afwachting van uw antwoord,
Met vriendelijke groeten,

Susanne Conradi
Masterstudent Communication, Health & Life Sciences
Wageningen University & Research

## Appendix F: SPSS output Chi-Square tests

### Output Health issues and worries

**Case Processing Summary**

| | Cases | | | | | |
|---|---|---|---|---|---|---|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 56 | 96.6% | 2 | 3.4% | 58 | 100.0% |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Oneens | | | | | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 0[a, b] | | | | | |
| | | Expected Count | .6 | | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 0.0% | | | | | |
| | Nee | Count | 2[a, b] | | | | | |
| | | Expected Count | 1.8 | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 66.7% | | | | | |
| | Anders, namelijk... | Count | 1[a] | | | | | |
| | | Expected Count | .6 | | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 33.3% | | | | | |
| Total | | Count | 3 | | | | | |
| | | Expected Count | 3.0 | | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | | | | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | | | | |
|---|---|---|---|---|---|---|---|
| | | | Enigszins oneens | | | | |
| Het thuiszorgpersoneel van mijn | Ja | Count | 0[a, b] | | | | |
| | | Expected Count | 1.0 | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| organisatie heeft veel gezondheidsproblemen - Selected Choice | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 0.0% | | | | |
| | Nee | Count | 5[b] | | | | |
| | | Expected Count | 2.9 | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | | | | |
| | Anders, namelijk... | Count | 0[a] | | | | |
| | | Expected Count | 1.1 | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 0.0% | | | | |
| Total | | Count | 5 | | | | |
| | | Expected Count | 5.0 | | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | | | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | | | |
|---|---|---|---|---|---|---|
| | | | Neutraal | | | |
| Het thuiszorgpersoneel van mijn organisatie | Ja | Count | 0[b] | | | |
| | | Expected Count | 2.9 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| heeft veel gezondheidsproblemen - Selected Choice | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 0.0% | | | |
| | Nee | Count | 11[a, b] | | | |
| | | Expected Count | 8.8 | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 73.3% | | | |
| | Anders, namelijk... | Count | 4[a] | | | |
| | | Expected Count | 3.2 | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 26.7% | | | |
| Total | | Count | 15 | | | |
| | | Expected Count | 15.0 | | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | | |
|---|---|---|---|---|---|
| | | | Enigszins eens | | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 6[a, b] | | |
| | | Expected Count | 4.9 | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 24.0% | | |
| | Nee | Count | 14[a, b] | | |
| | | Expected Count | 14.7 | | |

| | | | | | |
|---|---|---|---|---|---|
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 56.0% | | |
| | Anders, namelijk... | Count | 5[a] | | |
| | | Expected Count | 5.4 | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 20.0% | | |
| Total | | Count | 25 | | |
| | | Expected Count | 25.0 | | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | |
|---|---|---|---|---|
| | | | Eens | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 5[a] | |
| | | Expected Count | 1.6 | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 62.5% | |
| | Nee | Count | 1[a] | |
| | | Expected Count | 4.7 | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 12.5% | |
| | Anders, namelijk... | Count | 2[a] | |
| | | Expected Count | 1.7 | |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 25.0% | |

| | | | |
|---|---|---|---|
| Total | Count | 8 | |
| | Expected Count | 8.0 | |
| | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie Crosstabulation**

| | | | Total |
|---|---|---|---|
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 11 |
| | | Expected Count | 11.0 |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 19.6% |
| | Nee | Count | 33 |
| | | Expected Count | 33.0 |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 58.9% |
| | Anders, namelijk... | Count | 12 |
| | | Expected Count | 12.0 |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 21.4% |
| Total | | Count | 56 |
| | | Expected Count | 56.0 |
| | | % within Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie | 100.0% |

Each subscript letter denotes a subset of Ik maak me zorgen over de gezondheid van het thuiszorgpersoneel van mijn organisatie categories whose column proportions do not differ significantly from each other at the .05 level.

**Chi-Square Tests**

| | Value | df | Asymp. Sig. (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 18.726[a] | 8 | .016 |

| | | | |
|---|---|---|---|
| Likelihood Ratio | 22.603 | 8 | .004 |
| Linear-by-Linear Association | 1.363 | 1 | .243 |
| N of Valid Cases | 56 | | |

a. 12 cells (80.0%) have expected count less than 5. The minimum expected count is .59.

## Output Health issues and age

**Case Processing Summary**

| | Cases | | | | | |
|---|---|---|---|---|---|---|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 54 | 93.1% | 4 | 6.9% | 58 | 100.0% |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? Crosstabulation**

| | | | Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | | | | |
|---|---|---|---|---|---|---|---|
| | | | Tussen de 25 en jonger dan 35 jaar | | | | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 0[a, b] | | | | |
| | | Expected Count | .8 | | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 0.0% | | | | |
| | Nee | Count | 4[a] | | | | |
| | | Expected Count | 2.3 | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | | | | |
| | Anders, namelijk... | Count | $0_a$ | | | | |
| | | Expected Count | .9 | | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 0.0% | | | | |
| Total | | Count | 4 | | | | |
| | | Expected Count | 4.0 | | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | | | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? Crosstabulation**

| | | | Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | | | |
|---|---|---|---|---|---|---|
| | | | Tussen de 35 en jonger dan 45 jaar | | | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | $9_b$ | | | |
| | | Expected Count | 3.5 | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 52.9% | | | |
| | Nee | Count | $6_a$ | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Expected Count | 9.8 | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 35.3% | | | |
| | Anders, namelijk... | Count | 2[a] | | | |
| | | Expected Count | 3.8 | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 11.8% | | | |
| Total | | Count | 17 | | | |
| | | Expected Count | 17.0 | | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? Crosstabulation**

| | | | Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | | |
|---|---|---|---|---|---|
| | | | Tussen de 45 en jonger dan 55 jaar | | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 2[a] | | |
| | | Expected Count | 5.7 | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 7.1% | | |
| | Nee | Count | 16[a] | | |
| | | Expected Count | 16.1 | | |

| | | | | | |
|---|---|---|---|---|---|
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 57.1% | | |
| | Anders, namelijk... | Count | 10[a] | | |
| | | Expected Count | 6.2 | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 35.7% | | |
| Total | | Count | 28 | | |
| | | Expected Count | 28.0 | | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? Crosstabulation**

| | | | Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | |
|---|---|---|---|---|
| | | | Weet ik niet | |
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 0[a, b] | |
| | | Expected Count | 1.0 | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 0.0% | |
| | Nee | Count | 5[a] | |
| | | Expected Count | 2.9 | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | |
| | Anders, namelijk... | Count | 0[a] | |
| | | Expected Count | 1.1 | |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 0.0% | |

| | | | |
|---|---|---|---|
| Total | Count | 5 | |
| | Expected Count | 5.0 | |
| | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% | |

**Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice * Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? Crosstabulation**

| | | | Total |
|---|---|---|---|
| Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | Ja | Count | 11 |
| | | Expected Count | 11.0 |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 20.4% |
| | Nee | Count | 31 |
| | | Expected Count | 31.0 |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 57.4% |
| | Anders, namelijk... | Count | 12 |
| | | Expected Count | 12.0 |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 22.2% |
| Total | | Count | 54 |
| | | Expected Count | 54.0 |
| | | % within Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? | 100.0% |

Each subscript letter denotes a subset of Wat is ongeveer de gemiddelde leeftijd van het thuiszorgpersoneel in uw organisatie? categories whose column proportions do not differ significantly from each other at the .05 level.

**Chi-Square Tests**

| | Value | df | Asymptotic Significance (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 22.514[a] | 6 | .001 |

| | | | |
|---|---|---|---|
| Likelihood Ratio | 23.950 | 6 | .001 |
| Linear-by-Linear Association | .684 | 1 | .408 |
| N of Valid Cases | 54 | | |

a. 8 cells (66.7%) have expected count less than 5. The minimum expected count is .81.

## Output Cultural diversity and WHP

**Case Processing Summary**

| | Cases | | | | | |
|---|---|---|---|---|---|---|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Werken er mensen met verschillende nationaliteiten en/of culturen in de teams? * Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 54 | 93.1% | 4 | 6.9% | 58 | 100.0% |

**Werken er mensen met verschillende nationaliteiten en/of culturen in de teams? * Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren Crosstabulation**

| | | | Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | | | |
|---|---|---|---|---|---|---|
| | | | Nee | Ja | | |
| Werken er mensen met verschillende nationaliteiten en/of culturen in de teams? | Ja | Count | $7_a$ | $19_b$ | | |
| | | Expected Count | 11.0 | 14.0 | | |
| | | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 31.8% | 67.9% | | |
| | Nee | Count | $15_a$ | $8_b$ | | |
| | | Expected Count | 10.6 | 13.5 | | |
| | | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 68.2% | 28.6% | | |
| | Weet ik niet | Count | $0_a$ | $1_a$ | | |
| | | Expected Count | .4 | .5 | | |

| | | | | | |
|---|---|---|---|---|---|
| | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 0.0% | 3.6% | | |
| Total | Count | 22 | 28 | | |
| | Expected Count | 22.0 | 28.0 | | |
| | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 100.0% | 100.0% | | |

**Werken er mensen met verschillende nationaliteiten en/of culturen in de teams? * Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren Crosstabulation**

| | | | Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | |
|---|---|---|---|---|
| | | | Weet ik niet | Total |
| Werken er mensen met verschillende nationaliteiten en/of culturen in de teams? | Ja | Count | 1[a, b] | 27 |
| | | Expected Count | 2.0 | 27.0 |
| | | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 25.0% | 50.0% |
| | Nee | Count | 3[a, b] | 26 |
| | | Expected Count | 1.9 | 26.0 |
| | | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 75.0% | 48.1% |
| | Weet ik niet | Count | 0[a] | 1 |
| | | Expected Count | .1 | 1.0 |
| | | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 0.0% | 1.9% |
| Total | | Count | 4 | 54 |
| | | Expected Count | 4.0 | 54.0 |

| | | | |
|---|---|---|---|
| | % within Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren | 100.0% | 100.0% |

Each subscript letter denotes a subset of Onze organisatie biedt activiteiten aan om de gezondheid van onze werknemers te verbeteren categories whose column proportions do not differ significantly from each other at the .05 level.

**Chi-Square Tests**

| | Value | df | Asymp. Sig. (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 9.330[a] | 4 | .053 |
| Likelihood Ratio | 9.950 | 4 | .041 |
| Linear-by-Linear Association | 1.217 | 1 | .270 |
| N of Valid Cases | 54 | | |

a. 5 cells (55.6%) have expected count less than 5. The minimum expected count is .07.

## Output Area of activity and health issues

**Case Processing Summary**

| | Cases | | | | | |
|---|---|---|---|---|---|---|
| | Valid | | Missing | | Total | |
| | N | Percent | N | Percent | N | Percent |
| Waar is uw organisatie voornamelijk actief? * Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 56 | 96.6% | 2 | 3.4% | 58 | 100.0% |

**Waar is uw organisatie voornamelijk actief? * Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice Crosstabulation**

| | | | Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | | | |
|---|---|---|---|---|---|---|
| | | | Ja | | | |
| Waar is uw organisatie | In de stad | Count | 7[a] | | | |
| | | Expected Count | 2.8 | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| voornamelijk actief? | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 63.6% | | | |
| | Buiten de stad (in dorpen en landelijke gebieden) | Count | 1[a] | | | |
| | | Expected Count | 3.9 | | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 9.1% | | | |
| | Dit verschilt | Count | 3[a] | | | |
| | | Expected Count | 4.3 | | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 27.3% | | | |
| Total | | Count | 11 | | | |
| | | Expected Count | 11.0 | | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 100.0% | | | |

**Waar is uw organisatie voornamelijk actief? * Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice Crosstabulation**

| | | | Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | | |
|---|---|---|---|---|---|
| | | | Nee | | |
| | In de stad | Count | 5[b] | | |

| | | | | | |
|---|---|---|---|---|---|
| Waar is uw organisatie voornamelijk actief? | | Expected Count | 8.3 | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 15.2% | | |
| | Buiten de stad (in dorpen en landelijke gebieden) | Count | 15[a] | | |
| | | Expected Count | 11.8 | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 45.5% | | |
| | Dit verschilt | Count | 13[a] | | |
| | | Expected Count | 13.0 | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 39.4% | | |
| Total | | Count | 33 | | |
| | | Expected Count | 33.0 | | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 100.0% | | |

**Waar is uw organisatie voornamelijk actief? * Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice Crosstabulation**

| | | | Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | |
|---|---|---|---|---|
| | | | Anders, namelijk... | |
| Waar is uw organisatie voornamelijk actief? | In de stad | Count | 2[a, b] | |
| | | Expected Count | 3.0 | |

| | | | | |
|---|---|---|---|---|
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 16.7% | |
| | Buiten de stad (in dorpen en landelijke gebieden) | Count | 4[a] | |
| | | Expected Count | 4.3 | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 33.3% | |
| | Dit verschilt | Count | 6[a] | |
| | | Expected Count | 4.7 | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 50.0% | |
| Total | | Count | 12 | |
| | | Expected Count | 12.0 | |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 100.0% | |

**Waar is uw organisatie voornamelijk actief? * Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice Crosstabulation**

| | | | Total |
|---|---|---|---|
| Waar is uw organisatie voornamelijk actief? | In de stad | Count | 14 |
| | | Expected Count | 14.0 |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 25.0% |
| | Buiten de stad (in dorpen en landelijke gebieden) | Count | 20 |
| | | Expected Count | 20.0 |
| | | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 35.7% |
| | Dit verschilt | Count | 22 |

| | | |
|---|---|---|
| | Expected Count | 22.0 |
| | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 39.3% |
| Total | Count | 56 |
| | Expected Count | 56.0 |
| | % within Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice | 100.0% |

Each subscript letter denotes a subset of Het thuiszorgpersoneel van mijn organisatie heeft veel gezondheidsproblemen - Selected Choice categories whose column proportions do not differ significantly from each other at the .05 level.

**Chi-Square Tests**

| | Value | df | Asymp. Sig. (2-sided) |
|---|---|---|---|
| Pearson Chi-Square | 12.015[a] | 4 | .017 |
| Likelihood Ratio | 11.173 | 4 | .025 |
| Linear-by-Linear Association | 2.900 | 1 | .089 |
| N of Valid Cases | 56 | | |

a. 6 cells (66.7%) have expected count less than 5. The minimum expected count is 2.75.

## Appendix G: Interview preparation introduction talk

Heel erg fijn dat u er bent, bedankt dat u tijd kon maken! (Algemene vragen stellen)

Ik zal eerst even uitleggen waar mijn onderzoek over gaat.

Ik heb eerst een enquête gehouden over de gezondheid van thuiszorgpersoneel. Teamleiders en managers hebben dat ingevuld, ook over wat ze doen om de gezondheid te verbeteren.

Nu ben ik geïnteresseerd in wat het thuiszorgpersoneel hier zelf van vindt. Ik wil u graag interviewen omdat ik benieuwd ben naar hoe u (als medewerker in de thuiszorg) kijkt naar gezondheidsbevordering op de werkplek. Gezondheidsbevordering op de werkplek houdt in dat er aandacht wordt besteed aan de gezondheid van medewerkers. Door activiteiten aan te bieden willen de werkgevers de gezondheid van medewerkers verbeteren. Deze activiteiten of programma's zijn bijvoorbeeld gezondheidslessen geven, sporten aanbieden of helpen bij het stoppen met roken.

Het interview zal ongeveer een uur duren en ik zou het graag op willen nemen met een voice-recorder en mijn mobiel. Deze opnames zullen eerst uitgewerkt worden en worden daarna verwijderd. De uitwerking wordt geanalyseerd en delen hiervan worden in mijn verslag gebruikt. De gegevens worden anoniem verwerkt: uw naam of de organisatie worden niet genoemd.

Heeft u vragen?

Hier is een formulier. Dit gaat over dat u het goed vindt dat het wordt opgenomen en dat u meedoet aan het onderzoek. Zou u dit formulier willen ondertekenen?

**Appendix H: Informed consent**

# TOESTEMMINGSFORMULIER (informed consent)

## Betreft: onderzoek gezondheidsbevordering voor thuiszorgpersoneel

- Ik ben op de hoogte van waarom dit onderzoek wordt uitgevoerd.
- Ik ben op de hoogte van hoe dit onderzoek wordt uitgevoerd.

- Ik kan op elk moment stoppen met dit onderzoek.
- De gegevens worden anoniem verwerkt.
- Mijn naam en organisatie worden niet genoemd.

- Ik geef toestemming om het interview op te laten nemen.
- De geluidsopname wordt alleen gebruikt voor dit onderzoek.
- De geluidsopname wordt verwijderd na het uittypen.

- Ik doe geheel vrijwillig mee aan dit onderzoek.
- De uitkomsten van dit interview mogen gebruikt worden in een verslag.

Handtekening: ……...……

Naam: ……

Datum:……

– – – – – – – – – – – – – – – – – – – – – – – –

Keuze:

Graag zou ik de resultaten willen ontvangen:

☐ Samenvatting ☐ Hele verslag

E-mailadres:……..……..

Onderzoeker:

- Ik heb verteld waar dit onderzoek over gaat.
- Ik heb verteld waarom dit onderzoek wordt uitgevoerd.
- Ik heb verteld hoe dit onderzoek wordt uitgevoerd.

Graag beantwoord ik alle verdere vragen.

Handtekening: ……

Naam: ……

Datum: ……...……

**Appendix I: Topic list**

| Topics | Voorbeeldvragen |
|---|---|
| Werk (algemeen) | • Wat is uw functie?<br>• Hoe lang werkt u in de thuiszorg (en hier)?<br>• Hoe ziet een normale werkdag eruit? (Kunt u eens vertellen van het begin van de dag tot het einde?)<br>• Wat vind u het leukste of interessantste aan uw beroep? |
| Gezondheid (algemeen) | • Wat betekent gezondheid voor u?<br>• Wat heeft volgens u invloed op gezondheid? |
| Gezondheid in relatie tot werk | • Hoe belangrijk is gezond zijn in uw werk?<br>• - Waarom?<br>• Heeft u gezondheidsproblemen waarvan u denkt dat ze door uw werk komen? |
| Gezondheidsbevordering op de werkplek (als dit wordt aangeboden) | • Wat doet de manager/teamleider voor de gezondheid van het personeel?<br>• Wat vindt u daarvan?<br>• - Welke dingen vindt u er goed aan?<br>• - Welke dingen vindt u er slecht aan?<br>• Vanuit uw organisatie is gezegd dat ze … aanbieden. Doet u hier aan mee?<br>• - Waarom? Waarom past dit (niet) bij je?<br>• - Wanneer zou u wel meedoen?<br>• Wat zou u willen dat uw organisatie aan zou bieden?<br>• - Waarom?<br>• Waar zou u niet aan meedoen?<br>• - Waarom? Waarom past dit niet bij je? |

| | |
|---|---|
| Gezondheidsbevordering op de werkplek (als dit niet wordt aangeboden) | • Wat zou u ervan vinden als uw werk dingen zou aanbieden om uw gezondheid te verbeteren? (Voorbeelden zijn anti-roken programma's, stress management of gezondheidslessen.)<br>• Zou u hieraan meedoen?<br>• - Waarom?<br>• Wat zou u willen dat uw organisatie aan zou bieden?<br>• - Waarom?<br>• Waar zou u niet aan willen meedoen?<br>• - Waarom? |

## Appendix J: Theme codes + descriptive codes

An overview table of all descriptive and theme codes can be requested by sending an e-mail to: susanneconradi@hotmail.com

*Table: Codes theme 'Age'*

| Codes |
|---|
| age matters for employability |
| age of employees |
| difficult to find young women for small contracts |
| flat for older people |
| less conscious about posture when you're younger |
| more flexible because of older age |
| nice that organization takes age into account |
| old but independent |
| old generation of new clients do not like a man in home care |
| old people in home care |
| older employees |
| older people nicest of home care |
| oldest people |
| think about not contaminate older people |
| using more often tools because of age |
| working alone not possible at this age |

*Table: Codes theme 'Need for improvement'*

| Code |
|---|
| annoying when they change routes without discussion |
| organization should change communication |
| communication could improve |
| high council says different things than employees |
| more communication, on the same page |
| need: deeper understanding from team leader |
| need: point of contact |
| organization should listen and act |
| organization should listen to employees |
| organization should talk with employees about their needs |
| different team leaders bad influence on team |
| organization should change |
| always things to improve |
| annoying to don't know schedule |
| annoying to train new colleagues all the time |
| asked for flex pool, took a long time |
| back issues not taken into account when buying cars |
| being more honest with each other |
| can't keep it up |
| concerns in team about schedule |

create schedule together would be a relief
different expectation than reality
difficult no other solution than calling police
external scheduling, individual needs for work-life balance not taken into account
hard to find employees
insecure about certain actions, nicer when training is more often
knowing each other outside work would be better
mad about new cars without consultation
manager should take responsibility
many things need to improve
more men in team would be better
more promotion/attention needed
need for more attention for uniforms
need for more attention to repeating tests
need for more employees
need for prevention coaches
need: discount on all gyms
nice if practices would be repeated more often
not healthy scheduling
not on the same page always problem in care
or don't provide or promote WHP
organization acts differently than they say
organization could provide swimming/yoga
organization needs to support us
organization should ensure that employees do sports
organization should focus on team building
organization should give time for recovery
organization should improve
organization should not act as if employees have a say
organization should provide sports WHP
organization should support health
organization should take action, not wait
organization should take care of their employees
rare action, need for training
reading in situations
resistance
smaller groups would be nicer
sometimes difficult to divide the extra work
sports would be good (e.g. overweight)
still difficult to say it in the group
sufficient staff would solve all problems
synthetic uniform
tension between own health and fulfilling shifts
too many clients
too much on long term
unsatisfied clients because of different employees every day

want: further education for prevention coach
wasted energy
would be good to provide course to new colleagues
would be nice to have dinner
would participate when it was only with the team
would participate when it was with all teams from team leader

*Table: Codes theme 'Change'*

| **Code** |
|---|
| annoying when they change routes without discussion |
| organization should change communication |
| different team leaders bad influence on team |
| organization should change |
| behavioral change because of positive conversation |
| change in contact with colleagues (technology) |
| conversation with planners about why change of routes |
| a total new schedule |
| behavioral change |
| behavioral change: eating healthy, exercising |
| better situation because of changed attitude |
| change from nursing home to home care |
| change of job |
| different job |
| different list |
| different scheduling approaches |
| different team leaders |
| every house is different |
| every week adjusted schedule |
| fewer tasks because they live independently |
| increasement of work pressure |
| less heavy compared to nursing home |
| less own people because of holidays |
| less pressure because of behavioral change |
| new colleagues |
| new schedules |
| no change because of people's characters |
| people have difficulties with organizational change |
| recently flex pool |
| recently started to provide WHP |
| two teams became one |

*Table: Codes theme 'Communication'*

| **Code** |
|---|
| annoying when they change routes without discussion |
| organization should change communication |
| behavioral change because of positive conversation |
| change in contact with colleagues (technology) |

conversation with planners about why change of routes
communication could improve
high council says different things than employees
more communication, on the same page
need: deeper understanding from team leader
need: point of contact
organization should listen and act
organization should listen to employees
organization should talk with employees about their needs
all on the same page
always miscommunication with family members
avoid communication
colleagues giving each other tips
communication always a problem in a women's world
communication is important
communication is not okay
contact with colleagues
contact with people
contact with team leader
contacting manager
conversations with colleagues about irritations
couldn't communicate with patients
courses about talking with each other not successful
discuss with each other
e-mail address for questions for prevention coaches
e-mail when not making enough hours
expressing towards colleagues
frustrated to get no response from direction
good communication
good contact between colleagues
good working because of mutual communication
less contact colleagues
listening to each other is most important
meetings to discuss
mention it early
mention it to direction, working on it
miscommunication and complaints
need to talk about it during meeting
negative conversation with manager
nice possibility to talk with prevention coach about improvement
nice to talk with clients
no communication
no contact with colleagues outside work
no contact with team leader
no point of contact
no talking

| |
|---|
| no time to talk |
| normally voices are being heard |
| not a good relation with manager |
| not always time for talking |
| not much contact with direction |
| not sharing with a big group |
| organization calls to ask when you can work again |
| organization listens, no action |
| personally no difficult communication |
| possible to talk with colleagues about work/private |
| quote contact colleagues |
| talk about problems with manager |
| talk with team leader |
| talking about work |
| talking with colleagues about work/other |
| time to talk with clients |

*Table: Codes theme 'Health behavior'*

| **Code** |
|---|
| behavioral change |
| behavioral change: eating healthy, exercising |
| need: discount on all gyms |
| organization should ensure that employees do sports |
| sports would be good (e.g. overweight) |
| tension between own health and fulfilling shifts |
| less conscious about posture when you're younger |
| think about not contaminate older people |
| advice to be more physical active |
| attention for tools due to neck complaints colleagues |
| being aware of posture |
| being careful with yourself and residents |
| being conscious about posture |
| being healthy is not having issues |
| bicycle plan |
| bike to stay fit |
| biking a lot |
| biking good for health |
| combining sports, work and household tasks |
| critical about own health |
| did not realize WHP fitness was option |
| disciplined for going to the gym |
| doing all shifts not good for health |
| doing sports 6 times a week |
| doing sports not good for body |
| doing sports to become stronger |
| doing sports when you want |

don't allow myself to be sick
don't smoke
don't want to do sports with team
eating has influence on health
eating healthy, exercising a lot
everything has influence on health
example bad posture and health issues
finding a way to be physically active without harming the body
fitness center of own choice
fitness for employees
focus on more hygienic
goal to get rid of medication
going to the gym to exercise alone
gym membership WHP
happily never had a burn-out
hard work results in health issues
having a good home situation is important for health and work
health issues because of weight
health partly own responsibility
healthy life style
heavy physical activities
important to stay active
important to stay healthy
life style and no stress factors for health
like doing sports
might like to do sports with colleague
never heard anyone about WHP fitness
nice to do sports via work
no gym membership
no need to sport together
not active work
not participating in fitness because of location
not participating in fitness WHP because of money
not sporty
own choice to sport with colleagues
own decision to continue working
pain is own fault, not using tools
physically demanding tasks
prefer to do sports alone
relaxed in gym
relaxing is good for health
responsible for own health
scooter faster, worse for health
self-care
self-protection
sleep has influence on health

| |
|---|
| sometimes no energy for doing sports |
| sporting with husband |
| take shoulder pain into account |
| trying to be aware of posture |
| using tools for better posture |
| using tools for own protection |
| using tools to work healthy |
| walking a lot |
| weak back, knows how to handle |
| weight loss |
| working ergonomically |
| working while being sick |
| working while not feeling ready |
| worldview and life style |
| would be funny to do sports with colleagues |
| would not participate in sports WHP |

*Table: Codes theme 'Health issues'*

| **Code** |
|---|
| attention for tools due to neck complaints colleagues |
| doing all shifts not good for health |
| doing sports not good for body |
| example bad posture and health issues |
| hard work results in health issues |
| health issues because of weight |
| pain is own fault, not using tools |
| take shoulder pain into account |
| working while being sick |
| back issues not taken into account when buying cars |
| back issues colleagues |
| complaints when working a long time in care |
| complications |
| complications surgery |
| didn't want to and couldn't work due to neck hernia |
| family health issues |
| flue period |
| health issues |
| health issues colleague |
| health issues influences work |
| impact on back |
| last week absent due to sickness, not with a cold |
| lots of work because of sickness |
| mental consequences surgery neck hernia |
| mentally heavy work |
| neck and back issues |
| nerve pain after surgery neck hernia |
| never sick, not nice to be rushed |
| no good posture |
| no health issues |
| no health issues because of work |

| |
|---|
| no physical complaints |
| not going to work when feeling sick |
| not many sick colleagues |
| not often absent due to sickness |
| one year absent due to sickness |
| pain during work |
| pain in shoulder |
| pain in shoulders |
| physical constraints |
| shoulder pain due to compression stockings |
| shoulder pain due to work |
| sick |
| sick colleagues |
| surgery |
| tearing apart mentally |
| undesirable neck hernia |
| weak back |
| work more when people are sick |

*Table: Codes theme 'Health meaning'*

| **Code** |
|---|
| being healthy is not having issues |
| everything has influence on health |
| having a good home situation is important for health and work |
| life style and no stress factors for health |
| definition health |
| e.g. physically healthy but mentally not |
| health is big |
| health is different for everyone |
| health is feeling good |
| health is going well at home |
| health is important |
| health is private and own decision |
| health means a lot |
| if you're not healthy you can't care for others |
| many aspects influence health |
| meaning health |
| mental health, physical health, so many aspects |
| stress is important factor |
| very important to be healthy for work |
| very important to relax |

*Table: Codes theme 'Tools'*

| **Code** |
|---|
| attention for tools due to neck complaints colleagues |
| pain is own fault, not using tools |
| using tools for better posture |
| using tools for own protection |
| using tools to work healthy |
| using more often tools because of age |

| |
|---|
| clients don't want to buy tool |
| clients don't want to buy tool because of money |
| enough tools |
| explaining why tools are needed |
| home care can't take own tools |
| not all clients like tool |
| presence of tools |
| request for tools |
| requesting hoist in case you're alone |
| showing compression stockings tool |
| tool doesn't work for all clients |
| tools for compression stockings |
| tools for no back pain |
| tools important |
| tools in nursing home |
| using tools |

*Table: Codes theme 'Money'*

| **Code** |
|---|
| clients don't want to buy tool because of money |
| not participating in fitness WHP because of money |
| cheaper uniforms |
| downside, care is money |
| e.g. discount on sports because it is expensive |
| expensive to rent an office |
| financial difficult times for foundation |
| no money |
| no prevention coaches because of financial issues |
| not sure if organization would pay for WHP |
| role of money in choosing organization |
| scheduling based on most money |

*Table: Codes theme 'Organization'*

| **Code** |
|---|
| financial difficult times for foundation |
| not sure if organization would pay for WHP |
| role of money in choosing organization |
| organization should ensure that employees do sports |
| annoying when they change routes without discussion |
| organization should change communication |
| high council says different things than employees |
| organization should listen and act |
| organization should listen to employees |
| organization should talk with employees about their needs |
| contacting manager |
| frustrated to get no response from direction |
| mention it to direction, working on it |
| negative conversation with manager |
| not a good relation with manager |
| not much contact with direction |

organization calls to ask when you can work again
organization listens, no action
talk about problems with manager
organization should change
people have difficulties with organizational change
two teams became one
always things to improve
asked for flex pool, took a long time
manager should take responsibility
organization acts different than they say
organization could provide swimming/yoga
organization needs to support us
organization should focus on team building
organization should give time for recovery
organization should improve
organization should not act as if employees have a say
organization should provide sports WHP
organization should support health
organization should take action, not wait
organization should take care of their employees
nice that organization takes age into account
all organizations have some issues
app on phone is useful
bad organization
basic schedule
big organization
bought a bike via work
car from organization
compared to other organizations
division of shifts
don't know whether organization provides WHP
employees feel rushed to work again
employees fired
foundation asks a lot from their employees
foundation doesn't see how heavy work is
good attention for self-care
good enough to stay at organization
manager often present
manager responsible for health in work
managers left
more time compared to other organizations
nice organization
not leaving organization
organization can't find personnel
organization did not call to ask how it was going
organization does not provide WHP
organization feels like community
organization handled wrong
organization has other priorities
organization has to accept
organization is right place
organization motivates employees to go by bike
organization offers a lot
organization one goal

| |
|---|
| organization pays attention to employees |
| organization provides physical activities |
| organization provides well |
| organization rushes employees |
| personnel shortage |
| personnel shortage problem for foundation |
| planning |
| planning is difficult |
| pressure from organization |
| pressure leads to resistance employees |
| pressure on division of work |
| protocols |
| remote team leader |
| reorganization |
| showing interest |
| support manager |
| take preferences employees into account for scheduling |
| thought of changing job because of direction |
| tips from organization |
| try to make routes in a small area |
| unique to have an office |
| want more experience in other organizations |
| wanted to do nursing but limited by organization |

*Table: Codes theme 'Personnel shortage'*

| **Code** |
|---|
| organization can't find personnel |
| personnel shortage |
| personnel shortage problem for foundation |
| hard to find employees |
| need for more employees |
| sufficient staff would solve all problems |
| colleagues leaving |
| empty flex pool |
| experienced personnel shortage |
| hiring employees |
| in need of personnel |
| long term personnel shortage |
| new colleagues leaving |
| no personnel shortage |
| personnel shortage in whole of the Netherlands |

*Table: Codes theme 'Work pressure'*

| **Code** |
|---|
| employees feel rushed to work again |
| foundation asks a lot of their employees |
| pressure from organization |
| pressure leads to resistance employees |
| pressure on division of work |
| doing all shifts not good for health |

| |
|---|
| increasement of work pressure |
| less pressure because of behavioral change |
| can't keep it up |
| balance load and load ability |
| being busy is better than being bored |
| choose work over yourself |
| desire for less work pressure |
| experiencing work pressure |
| no work pressure |
| no work pressure compared to hospital |
| no work pressure, depends on attitude and moments |
| not extreme work pressure |
| very high work pressure |
| work pressure |

*Table: Codes theme 'Taking action'*

| **Code** |
|---|
| mention it to direction, working on it |
| organization should take action, not wait |
| mention it early |
| act fast |
| action good for residents and employees |
| action when needed |
| approach help |
| immediately action |
| solving problems yourself |
| take action myself |

*Table: Codes theme 'Team collaboration'*

| **Code** |
|---|
| all employees together |
| all on the same page |
| call colleagues for help |
| change in contact with colleagues (technology) |
| close team |
| colleagues giving each other tips |
| colleagues help each other |
| contact with colleagues |
| conversations with colleagues about irritations |
| don't like to do clinic with colleagues |
| don't want to do sports with team |
| drinking coffee is fun, forget it's work |
| efficiency |
| everyone worked extra |
| explanation different teams |
| expressing towards colleagues |
| finding a solution together |
| good connection with colleagues |
| good contact between colleagues |
| good for team connection |
| good team |

important to keep team together
independent team
involved, helping colleagues
knowing colleagues
less contact colleagues
lots of students in team, less connection
more men in team would be better
nice team
offer help to colleagues
organization should focus on team building
organizing team activity
possible to talk with colleagues about work/private
quote contact colleagues
real team feeling
responsibility self-managing team
self organizing dinners
self organizing things
self-managing team
self-regulating
self-scheduling
small team
social aspect with colleagues
sometimes difficult to divide the extra work
support from colleagues
taking weakest person into account
talking with colleagues about work/other
team activities
team activities are fun, not work-related
team activities for employees
team activity in own time
team knows each other well also private life
try to eat with colleagues
two teams became one
unrest in team
working together
would participate when it was only with the team
would participate when it was with all teams from team leader

*Table: Codes theme 'Work-life balance'*

| **Code** |
|---|
| combining sports, work and household tasks |
| external scheduling, individual needs for work-life balance not taken into account |
| extra work is a choice |
| no work-life balance |
| seeing work and sports separated |
| take preferences employees into account for scheduling |
| work influences private life |
| work more |
| work more when people are sick |
| working less |
| working less to care for children |
| working too much to follow extra courses |

| |
|---|
| work-life balance |
| work-life balance important |
| work-life combination |

*Table: Codes theme 'Workplace health promotion idea'*

| **Code** |
|---|
| organization should focus on team building |
| arranging trainings |
| assertiveness training |
| bicycle plan |
| bought a bike via work |
| courses about talking with each other not successful |
| discount on gym |
| doing sports when you want |
| e.g. discount on sports because it is expensive |
| example courses |
| fitness center of own choice |
| gym membership WHP |
| ideas for WHP |
| information course |
| insecure about certain actions, nicer when training are more often |
| intended to give clinical lessons about posture |
| interesting courses |
| massage is always nice |
| massages WHP |
| might like to do sports with colleague |
| more promotion/attention needed |
| need more attention to repeating tests |
| need: discount on all gyms |
| never suggest WHP idea |
| nice if practices would be repeated more often |
| nice to do sports via work |
| no craft club |
| no ideas WHP |
| no need for extra courses in own time |
| no need for support in health |
| no need to sport together |
| no WHP against stress |
| or don't provide or promote WHP |
| organization could provide swimming/yoga |
| organization should ensure that employees do sports |
| organization should provide sports WHP |
| organization should support health |
| provided a lot trainings |
| provided courses how to bend/lift |
| providing clinical lessons |
| providing fruit would be a nice extra |
| quote for WHP |
| rare action, need for training |
| smaller groups would be nicer |
| social activities would be nice but not necessary |
| sports would be good (e.g. overweight) |

| |
|---|
| take course to keep up to date |
| test employees on tasks |
| training during work time about aggression |
| training in posture |
| would be funny to do sports with colleagues |
| would be good to provide course to new colleagues |
| WHP in own time only if it's useful |

*Table: Codes theme 'Workplace health promotion participation'*

| **Code** |
|---|
| bought a bike via work |
| might like to do sports with colleague |
| nice to do sports via work |
| no need to sport together |
| quote for WHP |
| seeing work and sports separated |
| working too much to follow extra courses |
| don't like to do clinic with colleagues |
| don't want to do sports with team |
| would participate when it was only with the team |
| would participate when it was with all teams from team leader |
| always participating |
| could be fun with colleagues, not with whole organization |
| did not participate because of school |
| did not realize WHP fitness was option |
| don't know whether organization provides WHP |
| everyone participated in own time |
| most employees participate in social activities |
| never heard anyone about WHP fitness |
| never thought about WHP |
| no need for WHP |
| no participation in what trainings provided |
| no role of culture in WHP |
| not always participate in team activities |
| not participating in fitness because of location |
| not participating in fitness WHP because of money |
| not sure if organization would pay for WHP |
| not willing to not participate |
| organization does not provide WHP |
| own choice to sport with colleagues |
| participating is fun |
| prefer doing courses with friends/family instead of colleagues |
| prefer doing something with friends |
| prefer to do sports alone |
| recently started to provide WHP |
| unsure about need for WHP |
| would not participate in sports WHP |
| would participate |

*Table: Codes theme 'Physical exercise'*

| **Code** |
|---|

bought a bike via work
might like to do sports with colleague
nice to do sports via work
no need to sport together
seeing work and sports separated
don't like to do clinic with colleagues
don't want to do sports with team
own choice to sport with colleagues
prefer to do sports alone
would not participate in sports WHP
discount on gym
doing sports when you want
e.g. discount on sports because it is expensive
gym membership WHP
need: discount on all gyms
organization should ensure that employees do sports
organization should provide sports WHP
sports would be good (e.g. overweight)
would be funny to do sports with colleagues
combining sports, work and household tasks
advice to be more physical active
bike to stay fit
biking a lot
biking good for health
disciplined for going to the gym
doing sports 6 times a week
doing sports not good for body
doing sports to become stronger
eating healthy, exercising a lot
finding a way to be physically active without harming the body
go by bike
goal to get rid of medication
going to the gym to exercise alone
important to stay active
like doing sports
many of the team go by bike
move, don't sit
no gym membership
no time to go by bike
not active work
not far biking
not sporty
organization motivates employees to go by bike
organization provides physical activities
relaxed in gym
sometimes no energy for doing sports
sporting with husband
transport preference
using car
using car because of distance
walking a lot

*Table: Codes theme 'Support'*

| Code |
| --- |
| no need for support in health |
| organization should support health |
| call colleagues for help |
| colleagues giving each other tips |
| colleagues help each other |
| conversations with colleagues about irritations |
| finding a solution together |
| good connection with colleagues |
| good contact between colleagues |
| involved, helping colleagues |
| offer help to colleagues |
| possible to talk with colleagues about work/private |
| social aspect with colleagues |
| support from colleagues |
| talking with colleagues about work/other |
| always someone present |
| always willing to help other teams |
| app on phone is useful |
| approach help |
| call police to assist lifting |
| discuss with each other |
| get accepted |
| health support |
| help from team leader |
| indicate when need help |
| need: deeper understanding from team leader |
| need: point of contact |
| nice possibility to talk with prevention coach about improvement |
| nice to do together |
| no contact with colleagues outside work |
| no contact with team leader |
| no point of contact |
| not encumbered |
| organization feels like community |
| organization needs to support us |
| organization pays attention to employees |
| possibility to call |
| showing interest |
| social |
| support each other |
| support from wife |
| support manager |
| talk about problems with manager |
| talk with team leader |
| talking about work |
| team leaders try their best |
| tips from organization |
| using tools for better posture |
| using tools for own protection |
| using tools to work healthy |
| when help needed, it is given |

*Table: Codes theme 'Prevention coach'*

| Code |
|---|
| nice possibility to talk with prevention coach about improvement |
| advice from prevention coach |
| e-mail address for questions for prevention coaches |
| followed prevention coach course |
| need for prevention coaches |
| no prevention coaches because of financial issues |
| prevention coach |
| prevention coach course |
| prevention coach course gives good feeling |
| prevention coach course led to consciousness about posture |
| prevention coach showed how to put on compression stockings |
| prevention coaches to take care |
| want: further education for prevention coach |

*Table: Codes theme 'Contact with clients'*

| Code |
|---|
| being strict to clients |
| can't provide care to clients |
| care declined because of non-compliant clients |
| client who didn't want a man to come anymore |
| clients are always different |
| clients don't want to buy tool |
| clients don't want to buy tool because of money |
| clients' own environment |
| clients think it's not nice |
| complaining clients |
| complaining clients for employees of employment agency |
| complaining clients when being late |
| don't accept everything clients demand |
| getting a connection with clients |
| getting to know clients |
| good connection with clients is important |
| independency of clients |
| maintain contact |
| more time for clients |
| nice to cheer up clients |
| nice to talk with clients |
| not all clients like tool |
| old generation of new clients do not like a man in home care |
| protected by clients |
| taking over from clients |
| task to convince clients |
| teaching clients how to do things |
| time to talk with clients |
| unsatisfied clients because of different employees every day |
| work to work for clients |
| working with clients is nicest |

*Table: Codes theme 'Task home care'*

| Code |
|---|
| task to convince clients |
| teaching clients how to do things |
| combining sports, work and household tasks |
| test employees on tasks |
| compression stockings physically demanding |
| e-mail when not making enough hours |
| heaviest is compression stockings |
| heavy physical work |
| heavy work: showering |
| fewer tasks because they live independently |
| most basic care |
| no heavy care people |
| no heavy health care |
| not interested in basic care |
| not used to put on compression stockings |
| nursing actions nice |
| people falling, how to handle when they're heavy |
| physically demanding tasks |
| shoulder pain due to compression stockings |
| showing compression stockings tool |
| task |
| tasks during work |
| tasks during work: basic care |
| too much tasks |
| tools for compression stockings |
| varied work and tasks |
| when people fall, inclined to lift |

*Table: Codes theme 'Opinion about work'*

| Code |
|---|
| task to convince clients |
| no heavy health care |
| not interested in basic care |
| nursing actions nice |
| too much tasks |
| varied work and tasks |
| good connection with clients is important |
| nice to cheer up clients |
| nice to talk with clients |
| work to work for clients |
| working with clients is nicest |
| nice possibility to talk with prevention coach about improvement |
| need for prevention coaches |
| prevention coach course gives good feeling |
| want: further education for prevention coach |
| organization should support health |
| social aspect with colleagues |
| app on phone is useful |
| need: deeper understanding from team leader |

need: point of contact
nice to do together
organization feels like community
organization needs to support us
team leaders try their best
using tools for better posture
using tools for own protection
using tools to work healthy
when help needed, it is given
nice to do sports via work
need: discount on all gyms
organization should ensure that employees do sports
organization should provide sports WHP
no time to go by bike
not active work
working too much to follow extra courses
organization should focus on team building
need more attention to repeating tests
nice if practices would be repeated more often
no need for extra courses in own time
rare action, need for training
would be good to provide course to new colleagues
extra work is a choice
important to keep team together
more men in team would be better
nice team
real team feeling
sometimes difficult to divide the extra work
team activities are fun, not work-related
annoying to don't know schedule
annoying to train new colleagues all the time
annoying when they change routes without discussion
appreciated work
basic care physically heavy
being busy is better than being bored
busiest in the morning
busiest in the morning and evening
busy because people stay at home
can't keep it up
caring for others
caring for people and their appreciation
challenge yourself
cheerful and cozy with the residents
choose for home care because of freedom
choose for myself
communication always a problem in a women's world
continue working because at home is also busy
constraints of working at people's houses
create schedule together would be a relief
desire for less work pressure
did not want to work 24 hours
different team leaders bad influence on team
don't like formal
don't want to work somewhere else

employees feel rushed to work again
enough time
enough tools
experienced personnel shortage
experiencing work pressure
foundation asks a lot of their employees
foundation doesn't see how heavy work is
fun is important
fun parts most present
good enough to stay at organization
good working because of mutual communication
happy with work
health issues influences work
high council says different things than employees
home care can't take own tools
hope team leader stays
important no physical complaints
important to be thoughtful with medication
important to do nice things together
important to feel good
important to get space to get better
important to get to know each other outside work
important to have a full shift
important to not have a bad posture you repeat
important to work in uniform
increasement of work pressure
intention to stay
less heavy compared to nursing home
love complex care
love the job
luxury to choose to work
manager should take responsibility
mean something for people
mixed feelings
more time compared to other organizations
need extensive work
need for holiday
need for more attention for uniforms
need for more employees
need to feel good at work
need to talk about it during meeting
nice in-between solution
nice organization
nice that organization takes age into account
nice to be at people's home
nice to work alone
nice work
no more guidance needed
no need for control function
no need for different job
no one wants to work in care
no time to talk
no work pressure
no work pressure compared to hospital

no work pressure, depends on attitude and moments
not enough space at home
not extreme work pressure
not impersonal compared to hospital
not interested in bodies
not leaving organization
not missing anything
not on the same page always problem in care
not physical heavy work
nursing actions less physically heavy
nursing homes heavier work
old uniform was better
older people nicest of home care
organization acts differently than they say
organization handled wrong
organization is right place
organization provides well
organization rushes employees
organization should change
organization should change communication
organization should give time for recovery
organization should improve
organization should listen and act
organization should listen to employees
organization should not act as if employees have a say
organization should take action, not wait
organization should take care of their employees
organization should talk with employees about their needs
pain is own fault, not using tools
paying attention to posture is most important
people most important
poignant situations
pressure leads to resistance employees
responsible work
safety
satisfaction is important
shoulder pain may be because of work
so nice that everyone is different
social aspect of work
social conversation
spoiled clients
sufficient staff would solve all problems
too many clients
too much on long term
varied work is nice
varied work, always different
very high work pressure
very important to be healthy for work
want more experience in other organizations
wanted to do nursing but limited by organization
wants to stay working within health care
when there is time, take time
work not responsible for health
working day is good

## Appendix K: Recommendations for home care organizations

**Resultaten onderzoek gezondheidsbevordering voor thuiszorgpersoneel**

Op basis van literatuur, enquêtes en interviews zijn de verschillende perspectieven van werkgevers en thuiszorgpersoneel onderzocht. Uit de literatuur bleek dat gezondheidsbevordering op de werkplek voor thuiszorgperosneel een positief effect kan hebben op werktevredenheid en vermindering in ziekteverzuim en ziektekosten. De grootste uitdaging is dat thuiszorgpersoneel geen vaste werkomgeving heeft. Daardoor is het lastig om activiteiten te organiseren waarbij het laagdrempelig is om deel te nemen. Het lage aantal deelnemers aan die activiteiten is dan ook het grootste probleem.

Uit de enquêtes bleek dat de helft van de organisaties die het ingevuld heeft gezondheidsbevorderende activiteiten aanbiedt aan het thuiszorgpersoneel. In stedelijke gebieden komen meer gezondheidsproblemen, terwijl er wel vaker gezondheidsbevorderende activiteiten worden aangeboden. In culureel diverse teams zijn ook meer gezondheidsproblemen dan in teams zonder culturele diversiteit. Bij de gezondheidsbevorderende activiteiten bleek dat het lage aantal deelnemers vaak een probleem is.

Gezondheidsproblemen van personeel en het bevorderen van gezondheid werd vaak gezien als gedeelde verantwoordelijkheid van zowel de werkgever als het personeel. Verder werd het gezien als belangrijk om de gezondheid van het personeel te verbeteren, vooral met oog op duurzame inzetbaarheid.

Er zijn interviews afgenomen bij 10 verschillende thuiszorgmedewerkers bij vijf verschillende organisaties. Uit deze interviews kwam naar voren dat het personeel het waardeert als de organisatie aandacht aan hun gezondheid besteedt, maar dat het niet alleen bij aandacht moet blijven. Vaak waren ze niet op de hoogte van de opties die de organisatie aanbood of sloot het niet aan bij de behoeftes. Lichamelijke activiteiten werden vaak gezien als belangrijk, maar niet iets wat gelinkt werd aan het werk. Als het op het werk aangeboden werd, werd het vaak gezien als een leuke extra. Het personeel lijkt behoefte te hebben aan meer trainingen en educatie. Sommige handelingen komen niet vaak voor en daar voelt het personeel zich soms onzeker over. Ook training in houding met behulp van een ergocoach is iets wat het meeste personeel nodig leek te hebben of waar ze het meeste aan hadden. Verder worden sociale activiteiten om het welzijn te verbeteren gewaardeerd. Goede samenwerking binnen het team heeft invloed op werktevredenheid en welzijn. In sommige organisaties neemt het personeel zelf initiatief, in anderen waar de teambonding beter kan is het lastiger dit op te zetten. De organisatie zou hierbij kunnen ondersteunen door teambuilding activiteiten te organiseren.

In de organisaties waarbij het personeel deelnam aan alle activiteiten leek het meestal aan de werkomgeving te liggen. In organisaties met gebouwen waarbij thuiszorg wordt verleend bleken de gezondheidsbevorderende activiteiten niet gezien te worden als iets extra’s in eigen tijd, maar als een onderdeel van de werkdag. In andere organisaties is dit lastiger omdat het personeel individueel in de wijk werkt. Naar kantoor komen om deel te nemen aan gezondheidsbevorderende activiteiten krijgt geen

prioriteit. Verder speelt werkdruk een rol in de deelname. Het personeel dat hoge werkdruk ervaarde ziet vaak gezondheidsbevordering niet als prioriteit.

Wat wel als een groot probleem gezien wordt is personeelstekort. Het meeste personeel ziet dit als grootste oorzaak voor de gezondheidsproblemen. Personeel gaf aan dat ze de druk om extra diensten op te lossen moeilijk vinden, helemaal als het mogelijk ten koste van hun eigen gezondheid gaat. Ook bij ziekte ervaart het personeel druk om direct weer aan het werk te gaan, ook als ze er niet klaar voor zijn. Op lange termijn zou dit een nadelig effect kunnen hebben.

Naast het bespreken van gezondheid en gezondheidsbevordering opperde veel personeel dat de communicatie binnen het bedrijf verbeterd kon worden, of dat de werksfeer goed was door goede communicatie. Dit lijkt dus een belangrijk onderwerp waar veel winst te behalen valt worden.

**Aanbevelingen**

- Trainingen aanbieden op basis van de behoeftes van het personeel
- Een ergocoach inzetten om de houding van het personeel te verbeteren
- Teambuilding activiteiten organiseren, vooral in de teams die zelf niets organiseren
- Lichamelijke activiteiten stimuleren:
    - Clinics geven aan één team (kleinschalig in plaats van op organisatieniveau)
    - Iedereen korting geven op een sportschool naar keuze
- Het personeel voelt zich vaak niet gehoord of niet serieus genomen: ga in dialoog en bespreek problemen of frustraties
- Als er naar inspraak van het personeel gevraagd wordt is het belangrijk om deze inspraak ook daadwerkelijk mee te nemen
- Communicatie verbeteren:
    - Maak alles bespreekbaar
    - Vraag het personeel waar ze behoefte aan hebben op het gebied van gezondheid, communicatie of educatieve ondersteuning
    - Laat het personeel met elkaar praten in kleine groepjes
    - Wees duidelijk in wie het aanspreekpunt is voor het personeel
    - Probeer het personeel niet te forceren om te werken als ze ziek zijn, dit werkt op den duur averechts