A participatory HR-led training programme for employee wellbeing

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Executive Summary

This study addresses the gap in HR-led, culturally contextualised workplace wellbeing interventions, particularly in non-Western settings such as South Africa, where engagement and mental health indicators are significantly below global averages. The authors argue that HR professionals, without clinical expertise, can co-design and deliver effective wellbeing training by integrating evidence-based psychological constructs with employee-driven content selection. The study employed a three-phase qualitative design within a single South African pharmaceutical company: a literature review to identify 25 evidence-based wellbeing constructs, a 4-hour pilot training session with 19 purposively sampled employees, and a focus group discussion (FGD) in which participants voted to prioritise six constructs — relationships, physical health (sleep, nutrition, exercise), mental health (mindfulness, gratitude, optimism), job health (character strengths, job crafting), and meaning in life. These constructs formed the ENGAGE training programme, delivered in a 2-day classroom format. Outcome data measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) are reported in a separate publication. The authors conclude that participatory, bottom-up programme design enhances cultural relevance and employee engagement, offering a scalable model for embedding wellbeing into HRM strategy, particularly in under-researched African organisational contexts.

Key Insights

1. Over half of all global wellbeing intervention studies have been conducted in North America (53.3%) and Europe (34.1%), with South Africa accounting for only 0.2%, highlighting a critical research gap in non-Western workplace contexts.

2. Employees in a South African pharmaceutical company, through participatory voting, prioritised relationships, physical health, mindfulness/gratitude/optimism, character strengths/job crafting, and meaning in life as the most contextually relevant wellbeing constructs — demonstrating that bottom-up co-design can surface culturally specific priorities.

3. Non-clinical HR professionals can feasibly design and deliver structured wellbeing interventions when supported by evidence-based frameworks and participatory design processes, as illustrated by this study and corroborated by Krekel et al.'s (2021) Exploring What Matters RCT.

Practical Takeaways

• Organisations operating in non-Western or African contexts may find that standard Western-derived wellbeing programmes require cultural adaptation; participatory construct-selection processes, such as the FGD voting method used here, represent one documented mechanism for achieving this.

• HR departments can operationalise wellbeing measurement by incorporating instruments such as the WEMWBS alongside engagement and stress indicators, enabling data-driven assessment of programme impact without requiring clinical infrastructure.

Frameworks Mentioned

PERMA — Seligman's (2011) model of flourishing encompassing Positive Emotion, Engagement, Relationships, Meaning, and Accomplishment, used here as a theoretical mechanism underpinning the intervention design.

Job Demands-Resources (JD-R) Model — Bakker and Demerouti's (2007) model explaining how job resources buffer the negative effects of job demands and foster engagement, cited as a psychological mechanism underpinning the intervention.

VIA Character Strengths — Peterson and Seligman's (2004) classification of 24 character strengths contributing to flourishing, incorporated as a construct within the ENGAGE programme.

REACH Model — A structured, step-based forgiveness intervention model referenced by participants during focus group discussions as a practical tool for processing past hurts.

SMART Goals — Not explicitly named in this article — excluded per rules.

Critical Analysis

Strengths: The study is methodologically transparent, with clear documentation of its three-phase qualitative design, ethical approvals, participant demographics, and trustworthiness criteria drawn from Lincoln and Guba (1985). The participatory co-design approach is theoretically justified and addresses a genuine gap in culturally adapted, non-Western workplace wellbeing research. The comparative analysis against four established programmes (ENHANCE, Exploring What Matters, Inspired Life, Happify) provides useful contextualisation. The research is unfunded and declares no conflicts of interest, reducing commercial bias risk. Limitations: The sample is critically small (n=19) and drawn from a single South African pharmaceutical company, making generalisation to other industries, organisational sizes, or African contexts speculative. The qualitative design phase reported here is deliberately separated from the outcome data (WEMWBS results reported in Shekhar et al., 2025), meaning this article cannot independently substantiate effectiveness claims. The absence of a control group and long-term follow-up — acknowledged by the authors — limits causal inference. Participant checking was described as 'informal,' reducing the rigour of member validation. The FGD voting mechanism, while participatory, may reflect social desirability or group conformity biases, particularly given that constructs were pre-selected by researchers from the literature before being presented to employees. The article also contains a section header inconsistency ('Theme 2' is used twice, for physical health and for character strengths/job crafting), suggesting editorial gaps.

Organizational Practice

A South African pharmaceutical company (workforce of 108) served as the implementation site. The HR team coordinated participant logistics and invitations for a voluntary training initiative. A 4-hour pilot session introduced 25 evidence-based wellbeing constructs to 19 employees across multiple departments and demographics. A follow-up focus group discussion using whiteboard documentation and participant voting refined the content into six priority modules. The final ENGAGE programme was delivered in a 2-day classroom format facilitated by HR professionals, without clinical personnel involvement. Direct reports and supervisors were separated to minimise power dynamics.

Strategic Implications

The study's findings suggest a directional shift in HRM toward embedding psychological wellbeing as a core strategic function rather than a peripheral initiative, particularly in Sub-Saharan African contexts where engagement data indicate acute disengagement and stress. The participatory co-design model implies that programme relevance and uptake may be influenced by the degree to which employees contribute to content selection, pointing to tension between standardised, scalable interventions and locally contextualised approaches. The separation of the design phase (this article) from the outcome measurement phase (Shekhar et al., 2025) reflects a modular publication strategy that fragments evidence assessment, a pattern with implications for how practitioners evaluate programme effectiveness from the literature. The documented feasibility of non-clinical HR delivery may have implications for workforce planning and L&D budgeting decisions in organisations without dedicated occupational health resources.

Validation Status: passed
