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Physical activity for small- and medium-sized enterprises: what features work in real life? A Delphi study

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Abstract
Regular physical activity is essential for preventing noncommunicable diseases and benefits both employees and organizations. Although small- and medium-sized enterprises (SMEs) employ most of the European workforce, they are often underrepresented in research on workplace health promotion. Most existing evidence from initiatives to promote health-enhancing physical activity (HEPA) focuses on large organizations and lacks insights into feasibility within SMEs. This study aimed to identify real-life HEPA initiatives perceived as most feasible for SMEs and to explore expert consensus on transferable features. We conducted a three-stage hybrid e-Delphi study including a grey literature review, an expert survey, and expert panel discussions, integrating both quantitative scoring and qualitative discussion. Experts independently rated the feasibility of workplace HEPA initiatives and participated in moderated sessions to interpret the findings and identify transferable elements. A total of 714 real-life HEPA initiatives were identified and categorized according to behaviour and intensity. Of these, 390 were evaluated by 17 international experts using predefined criteria, including feasibility by company size. No initiative-level consensus was reached across the WHO European Region. Panellists identified transferable features (most frequently in active-living and exercise/fitness domains) and emphasized adaptability, low-threshold approaches and enterprise size as an indicator. This study contributes a structured analysis of feasible workplace HEPA initiatives for SMEs, using a Delphi-based consensus process. The findings provide guidance for developing practical tools tailored to the needs and capacities of SMEs in the European context.

Introduction

Regular physical activity (PA) is a well-established protective factor against numerous noncommunicable diseases (NCDs), including cardiovascular diseases, type 2 diabetes, and breast and colon cancers [1]. In addition, it supports healthy weight maintenance, improves mental health, delays the onset of dementia, and contributes to better sleep quality, executive function, cognition, and perceived quality of life [2–5]. Despite these benefits, sedentary behaviour remains widespread: four in ten Europeans report sitting for more than 5.5 h daily [6], and over one-third of adults in the 28 European Union (EU) member states were physically inactive in 2020 [7, 8]. Meeting the minimum PA guidelines across the EU could prevent over 10 000 premature deaths annually and avoid 11.5 million new cases of NCDs by 2050, including cardiovascular disease, depression, type 2 diabetes and cancer [8].

PA also positively affects non-health domains, such as productivity (including absenteeism and presenteeism), interpersonal relationships at work, and medical care costs [9–14]. For this reason, workplace health promotion offers potential benefits for employees, organizations, and society [15–17].

In 2018, the World Health Organization (WHO) launched the Global Action Plan for Physical Activity 2030 (GAPPA), promoting PA through a whole-systems approach with 20 policy actions across settings [18]. The workplace is highlighted as a key setting due to its potential reach among working-age adults. Within the EU, small- and medium-sized enterprises (SMEs) represent 63% of employment and generate 52% of economic added value [19]. Thus, SMEs play a critical

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role in supporting the workforce to benefit from health-enhancing physical activity (HEPA) within the workplace.

Systematic reviews on workplace HEPA have so far focused predominantly on the efficacy of interventions delivered in large organizations [20–28], whereas evidence on the implementation, contextual fit and scalability of these initiatives within resource-constrained SMEs remains limited [15, 29, 30]. The unresolved question is therefore not whether real-life HEPA initiatives exist—they do, in considerable numbers—but which of them, or which of their components, are feasible, acceptable and transferable to SMEs across the heterogeneous European context. Engaging SMEs in HEPA initiatives poses challenges overall, primarily attributed to restrictions in both employer and employee time, along with limitations in available resources [31]. Additionally, there is a scarcity of evidence that identifies what HEPA initiatives could be implemented in real-life.

To address this gap, a recent scoping review by Väänänen et al. [32] identified, described and comprehensively summarized 714 real-life HEPA initiatives implemented in workplaces of varying sizes. While this provides a valuable overview, it does not provide insights into the feasibility of these HEPA practices specifically for SMEs.

Objective

This study aims to identify the workplace HEPA initiatives considered most feasible for implementation in SMEs. Evidence from this study can be used to develop a consensus framework for a European Physical Activity Toolkit tailored to this context. To achieve this, we conducted a hybrid Delphi study, an approach combining quantitative and qualitative expert consultation [33, 34]. A hybrid design was suitable here because the research question concerns expert-perceived feasibility across a heterogeneous European context, requires interpretive discussion alongside numerical scoring, and could feasibly be operationalized online with a dispersed expert panel.

Methods

A hybrid e-Delphi study, combining structured rounds of quantitative and qualitative expert consultation, was conducted in three stages, in line with recommended methodological frameworks for hybrid Delphi designs [33, 34] (Fig. 1). The study was developed and reported according to the *Conducting and Reporting Delphi Studies* (CREDES) guidelines [35] (see Supplementary Material S1, Supplementary Table S1, available as Supplementary data at *EURPUB* online). Ethical approval was not required on the basis that the study involved professional consultation with experts in their professional capacity and did not involve patients, clinical data or vulnerable populations. All participating experts gave informed consent for participation, audio recording of the Stage 3 panel sessions, and use of anonymized verbatim quotations in publications.

Stage 1: scoping review

This stage comprised a grey literature review using a systematic search in Google to identify and elicit key information of real-life workplace HEPA initiatives. The results of this review are published elsewhere [32, 36].

Stage 2: e-Delphi survey (quantitative data)

The 714 collected initiatives [32] were grouped by target behaviour and PA intensity (i.e. *Active living*, *Sitting time or sedentary behaviour*, *Exercise or physical fitness programmes*, *Unclassifiable*). A stratified random sample, with stratification by HEPA category, was distributed to selected experts by email across three sequential waves, accompanied by an online survey (KoboToolbox). Each expert received between nine and 13 initiatives per wave in waves 1 and 2 (covering the full set of 714 initiatives), and 13–19 initiatives in wave 3, in which the 462 initiatives that remained unevaluated after waves 1 and 2 were

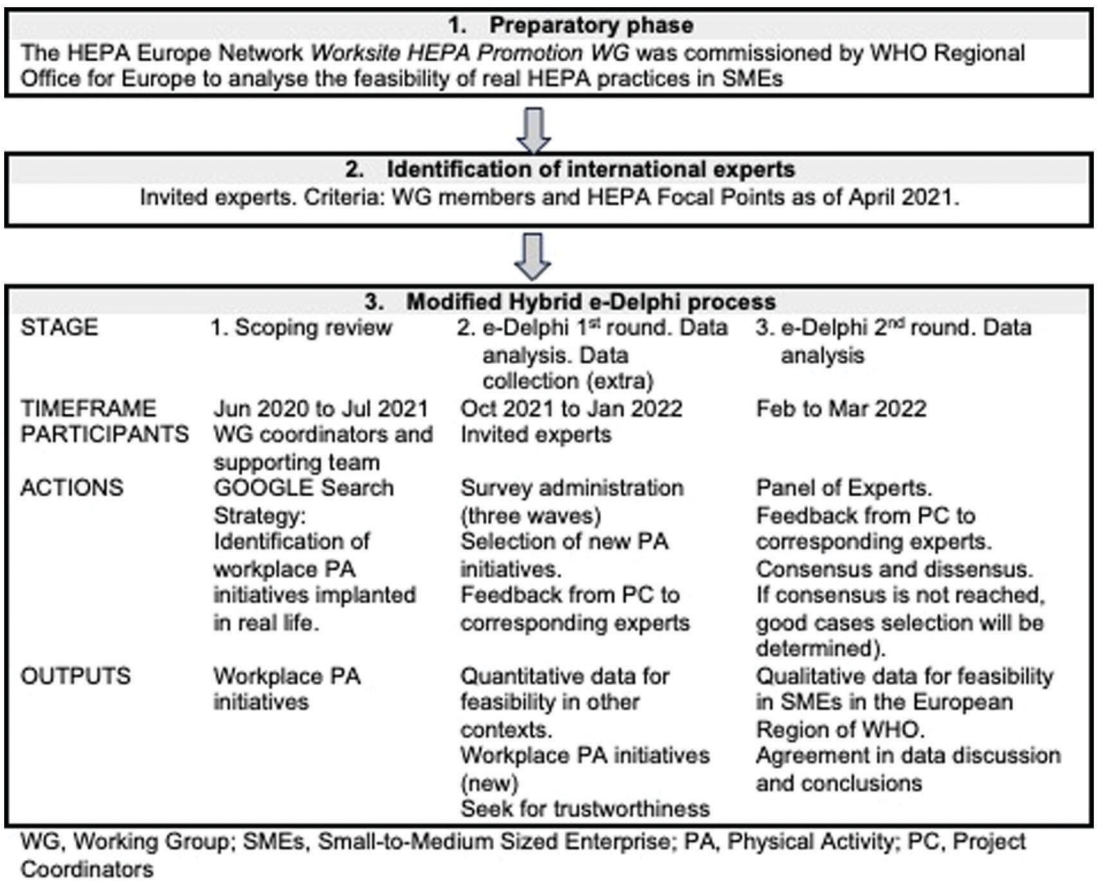

Figure 1. Flow chart to illustrate the three stages of the e-Delphi process design.

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redistributed to the remaining experts together with six new initiatives suggested by experts (Fig. 2). Each initiative was summarized with a brief description and a link to the source website. The survey collected expert ratings on the perceived feasibility of each initiative for implementation in SMEs across the WHO European Region. It also allowed respondents to suggest additional initiatives (Supplementary Material S2, available as Supplementary data at *EURPUB* online). The survey was piloted with eight experts (38% women) to ensure clarity and usability. These participants (APR, EFT, FV, IDC, IV, SM, SMA, VD) were excluded from the main Delphi round to prevent bias. Experts rated each initiative on a 5-point Likert scale (1-lowest to 5-highest) regarding five positive attributes under their potential value for practice transfer [37] (i) effectiveness: its relevance to health outcomes; (ii) practicality/viability/feasibility: whether an initiative can be used given contextual and environmental constraints such as time, resource availability and practitioner commitment; (iii) adaptability: whether an initiative can be meaningfully modified to meet the needs of different situations; (iv) generalizability: whether it can be transferred to a wider setting; and (v) cost-benefit: the relationship between the resources required and the potential benefits. The total possible score was 25. Additionally, the survey included a multiple-answer question to rate the appropriateness according to a company size (Micro: 1–9 employees, Small: 10–50, Medium: 51–250, Large >250), their likelihood to recommend the initiative to their country/region (on a 10-point Likert scale), and an open question to provide feedback on the survey as a tool.

The survey remained open for 10 weeks. Procedural questions raised by panellists during the survey were answered by the study coordinator using standardized replies, ensuring controlled feedback (Supplementary Material S3, available as Supplementary data at *EURPUB* online); this constitutes the controlled-feedback element of the hybrid Delphi design [33] without anonymous re-rating between waves. Two researchers (EF, VD), who were not involved in survey administration to participants, processed the results and delivered a full report and raw dataset for review (Supplementary Material S4, available as Supplementary data at *EURPUB* online), thereby supporting data trustworthiness (reliability and validity) [34].

Stage 3: panel of experts (qualitative data)

Two virtual expert panels were convened to qualitatively assess which real-life initiatives could serve as good practice examples. Sessions were scheduled online using Doodle (https://doodle.com) and held via Zoom (https://www.zoom.com).

Initiatives were eligible for discussion if they met all of the following criteria: (i) total score ≥20; (ii) no individual attribute scored <4; and (iii) a mean recommendation-to-own-country/region score ≥7 on the 10-point Likert scale. Initiatives were recategorized following a previous classification to ease the discussion [32] and key features were presented to the panel prior to discussion (Fig. 3).

Consensus was defined as full agreement among Stage 3 panellists that a specific initiative could be considered universally feasible for SMEs across the WHO European Region; this strict criterion is justified by the heterogeneity of national, sectoral and organizational contexts. At the feature level, as a fall-back when initiative-level consensus was not reached, agreement on transferable features was confirmed when

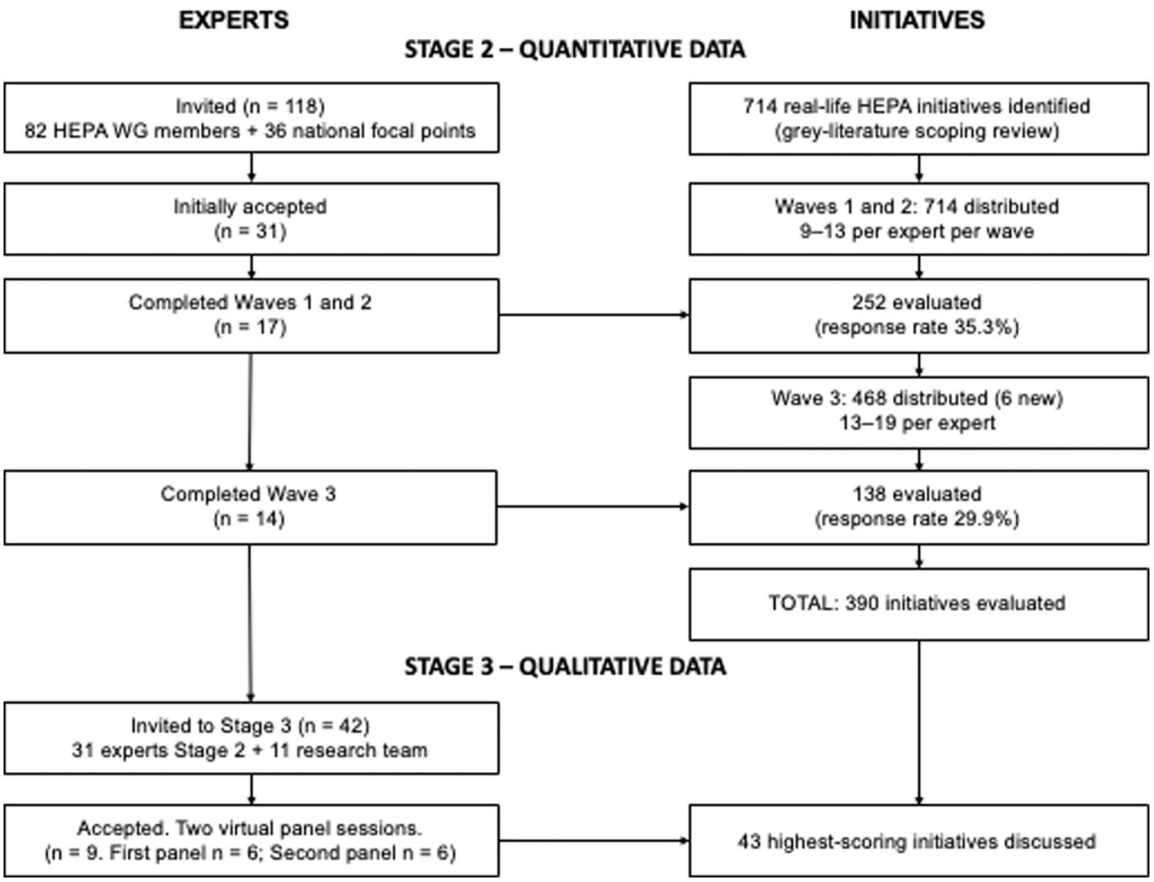

Figure 2. Number of analysed interventions and number of experts. Stage 2: 31 experts volunteered to participate and each received from 9 to 13 initiatives to evaluate in 2 waves of distribution. It resulted in the evaluation of 252 initiatives. Unanalysed initiatives and others that were suggested to undergo evaluation were then distributed in a third wave to the remaining experts (3 dropped out), each expert received between 13 and 19 initiatives to evaluate and provided evaluation for 138 initiatives. The 3 waves collected the evaluation of 390 initiatives. Stage 3: 9 experts participated, three of them in both panels.

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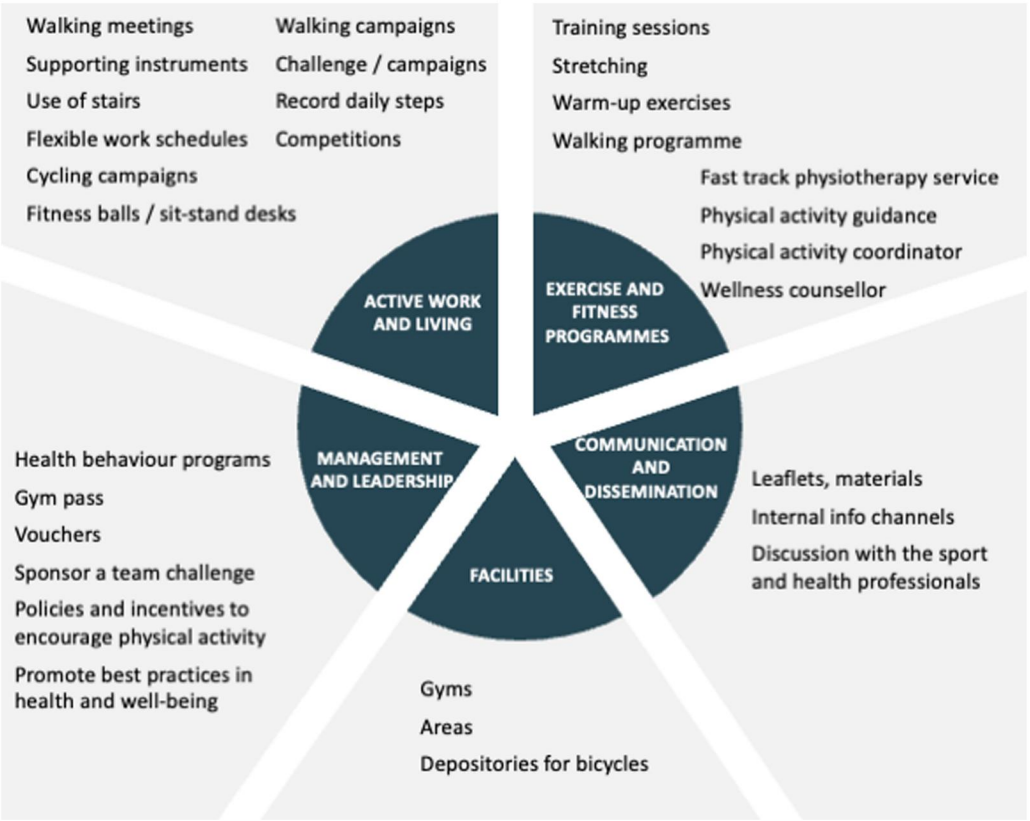

Figure 3. Features of HEPA initiatives. Selected features were classified according to five dimensions related to individual or organizational level [38].

≥80% of panellists rated the feature 4 or 5 on a 5-point Likert scale [39]. Panel discussions were held on 24 February and 17 March 2022.

Participants

Eight academics with experience in HEPA initiatives in practice conducted the scoping review (Stage 1). For the e-Delphi survey (Stage 2), a convenience sample of 118 experts was invited, including 82 members of the Worksite HEPA Promotion Working Group from 26 countries (academics and practitioners) and 36 national HEPA focal points (policy-makers). Experts involved in Stage 1 were excluded. All participants who confirmed participation were invited to join the expert panel (Stage 3), unless they withdrew.

Data analysis

The collected quantitative data were transformed and coded using SPSS v. 22.0 (SPSS Inc., Armonk, NY). Descriptive statistics including frequencies, mean values, and standard deviations were applied. Stage 3 panel sessions were moderated by the study coordinator and transcribed. Transcripts were read by the research team to identify recurring topics raised by the panellists; these were used to interpret patterns in the Stage 2 ratings and were illustrated in the Results by verbatim quotations. The five-domain feature framework presented in Fig. 3 was predefined from the prior categorization in our scoping review [32] and refined through the Stage 3 panel discussion; the specific features within each domain were extracted inductively from the panel discussions and from the highest-scoring initiatives identified in Stage 2.

Data availability

All data supporting this study are available online as Supplementary Materials S1–S9, available as Supplementary data at *EURPUB* online and in online repositories [36, 40].

Results

Stage 1: scoping review

The grey literature search initially identified 756 workplace HEPA initiatives. After removing duplicates and incomplete records, 714 initiatives were retained for analysis [36]. A categorization of focus area according to target behaviour and intensity of PA resulted in: 223 initiatives (29.5%) focused on *Exercise or physical fitness programmes*; 202 (26.7%) on *Active living*—from *Active living of at least moderate-intensity activity*, *Active living or light-intensity activity* and *Active living or light-intensity activity and sitting*; 104 (13.6%) on *Sitting time or sedentary behaviour*—from *Sitting time or sedentary behaviour* and *Sitting time or sedentary behaviour and active living*; and 185 (24.5%) were considered not applicable or unclassifiable.

Stage 2: Delphi survey

Of the 31 experts who initially accepted to participate, 17 completed the survey (54.8%, 10 women) (Supplementary Material S5, Supplementary Table S2, available as Supplementary data at *EURPUB* online). Most respondents worked in academia/research ($n = 11$), with professional backgrounds in health disciplines ($n = 13$), physical activity ($n = 10$), and, to a lesser extent, industrial design engineering ($n = 1$) or unknown ($n = 1$). The sample included experts from 11 countries, ten of which were in Europe and one in the Caribbean Region. Seven experts (41.1%) had professional experience in the private sector. Invited country representatives from Finland, Germany, Hungary, Italy, Slovenia and Turkey did not participate.

Three sequential waves of initiative evaluations were conducted (Fig. 2); the wave-by-wave allocation procedure is described in Methods, Stage 2. Across the waves, 252 initiatives were evaluated, equivalent to a 35.3% response rate. The third wave included the 462 remaining unevaluated initiatives along with six new ones suggested by experts, and led to the evaluation of 138 additional initiatives, with

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a response rate of 29.9%. In total, 390 initiatives were evaluated. The focus area of the unevaluated initiatives at the first two waves, which were distributed again and finally evaluated on the third wave were similar (from 33.2% for *Exercise or physical fitness programmes* to 35.6% for *Sitting time or sedentary behaviour*).

Regarding evaluation effort, seven experts (41.1%) assessed 30 or more initiatives, another seven (41.1%) evaluated between 10 and 29, and three (17.8%) assessed only one. The majority of responses originated from Northern Europe (40.3%) and came from academia/research (71.3%), with most experts not having direct experience in the private sector (65.9%). These proportions aligned with the initial expert profile, as shown in Supplementary Material S5, Supplementary Table S2, available as Supplementary data at *EURPUB* online. See Supplementary Material S6, available as Supplementary data at *EURPUB* online for complete data on distribution and results.

Most initiatives (81.8%) were evaluated with the help of Supplementary Information available on the linked websites. However, in 49.2% of cases, the quality of this information was considered poor. In many instances, the provided links were broken or not available (see Table 1 and Supplementary Material S7, available as Supplementary data at *EURPUB* online).

The lowest-rated feature across all initiatives was Cost-benefit, with 41.8% of responses rating it as 2-bad or 1-very bad. This was followed by Effectiveness (34.9%) and Practicability/Viability/Feasibility (32.5%). Conversely, Generalizability and Adaptability received the most favourable evaluations, with 71.9% and 71.3% of initiatives respectively being scored as 3-good, 4-quite good, or 5-very good. In terms of content categorization, 34.8% of initiatives were perceived to target *Exercise or physical fitness programmes*, whereas only 8.8% focused on *Sitting time or sedentary behaviour*. Regarding feasibility by enterprise size, 76.2% were considered somehow feasible for medium-sized enterprises and 68.2% for small ones. Only 13.8% were deemed suitable exclusively for large enterprises, 4.1% for micro enterprises, and 4.4% were not considered feasible for either small or medium-sized companies. The average recommendation score for implementing the initiative in the respondent's own country or region was 6.13 (SD ±3.085), on a 10-point scale.

Nineteen participants provided feedback on the survey tool itself. Several concerns were raised regarding the limited information available to evaluate the initiatives ($n = 11$), the presence of broken links ($n = 2$), and the use of closed-ended response formats ($n = 4$). However, seven respondents considered the tool helpful to obtain a general overview and encourage broad participation. Additional feedback was also sent directly to the study coordinator (see Supplementary Material S8, available as Supplementary data at *EURPUB* online).

Stage 3: panel of experts

Of the 42 experts invited to this final stage, nine participated in two scheduled online sessions. Although survey results were shared beforehand, the group agreed during the first meeting that the amount of information was too large to analyse effectively in one session. Therefore, a second meeting was convened to specifically discuss the highest-scoring initiatives (Supplementary Material S5, Supplementary Table S2, available as Supplementary data at *EURPUB* online). As one participant noted, 'you would send us the PDF files, so that we have

Table 1. Summary of initiative evaluations by category, score, and feasibility ($n = 390$)

Variable	Value	Frequency (*n*)	Percentage (%)	Notes
Focus of interventions				Multiple answers
	Exercise & fitness	193	34.8	
	Active living	173	31.2	
	No specific focus	139	25.1	
	Sitting	49	8.8	
Attribute scores				
	Effectiveness (1–5)	–	–	Mean score: 3.14
	Feasibility (1–5)	–	–	Mean score: 3.10
	Adaptability (1–5)	–	–	Mean score: 3.28
	Generalizability (1–5)	–	–	Mean score: 3.29
	Cost–benefit (1–5)	–	–	Mean score: 2.89
Feasibility by company size				
	Micro (1–9 employees)	233	59.7	Multiple answers
	Small (10–50)	266	68.2	
	Medium (51–250)	297	76.1	
	Large (>250)	316	81.0	
Transferability to own country/region (1-low to 10-high)				Mean: 6.13; *SD* ±3.085
	1	63	16.2	
	2	20	5.1	
	3	10	2.6	
	4	19	4.9	
	5	25	6.4	
	6	40	10.3	
	7	51	13.1	
	8	57	14.6	
	9	48	12.3	
	10	57	14.6	
Link verification				
	Checked	319	81.8	
	Not checked	71	18.2	
Link issues				
	Broken link	25	6.4	
	Link not provided	20	5.1	
	Could not open	9	2.3	
	Other language	3	0.8	
Quality of website information				
	Low	157	40.3	
	Medium	85	21.8	
	High	77	19.7	

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them available, because we cannot at this meeting online look at those' (Expert_2).

Before the first meeting, the 43 initiatives that met the inclusion criteria were presented to the panel before discussion. The initiatives were recategorized to be consistent with a previous classification system [32], with 20 (46.5%) classified as *Active work and living*, 10 (23.3%) as *Exercise and fitness programmes*, seven (16.3%) as *Management and leadership*, three (6.9%) as *Communication and dissemination*, and three (6.9%) as *Facilities*.

Despite the focused discussions, no consensus was reached regarding which initiatives could be considered most feasible across the WHO European Region, which includes 53 countries. Experts highlighted key concerns, including the lack of specificity to SMEs, scarce objective data on effectiveness, insufficient resources in small companies to implement complex initiatives, and limitations in occupational health capacity. As one expert commented, 'many of these projects or reports [initiatives] didn't really focus specifically on the small and medium sized enterprises' (Expert_2), while another noted that 'quite a few of the interventions [initiatives] that you've identified are from very big organizations … they're not going to be relevant to SMEs' (Expert_3). Others pointed out structural barriers: 'if you are a SME and you don't have occupational safety personnel … you can't have this type of initiative.' (Expert_4).

Still, the experts agreed on the importance of raising awareness on HEPA promotion and providing simple, adaptable tools. One participant remarked that the toolkit should 'present something that is easy to go with … maybe not at the work site itself, but … to follow the general PA Guidelines' (Expert_2), while another added that 'the toolkit should contain … practical things … you go through the toolbox you say oh I identify with this typology of SME … it brings you tools that you can apply very easily' (Expert_5). Finally, concerns were expressed about variability in scoring among experts, which made it difficult to treat the evaluations as a reliable ranking of feasibility. As the coordinator explained,

> '[Coord_1]: we distributed the 700 interventions between the experts and, of course, not everybody evaluated all… your best evaluation scored 23 …and … it was not taught [as a top scored initiative].
> [Expert_2]: So that is a weakness, because I'm a very strict person. There [as top scored initiatives] are three of my projects [initiatives] that I evaluated among the 27 but not my stars [to be the best].'

Despite these limitations, the group agreed that the ideas and approaches behind the initiatives (Fig. 3) were useful and could serve as a foundation for dissemination and practice transfer. Full quotations and Supporting Material are included in Supplementary Material S9, available as Supplementary data at *EURPUB* online.

Discussion

The aim of this study was to identify workplace HEPA initiatives perceived as most feasible for SMEs. Among the 390 real-life initiatives evaluated, none met the criteria to be considered universally feasible across the heterogeneous SME context of the WHO European Region. The panel discussion therefore turned to recurring components and identified several underlying features (Fig. 3) considered potentially useful and inspirational for SMEs. The substantive contribution lies at this feature level, informing the future co-design of a European HEPA Toolkit for SMEs. This work builds on a series of two studies resulting in a WHO publication of a selection of initiatives for SMEs [38] and a deeper analysis of appropriate categorization of potentially transferable initiatives to SMEs [32]. In the first study, a scoping review [32], 714 real-life initiatives targeting the organizational and/or individual level, were classified into five categories for implementation approach after grouping responses from a previous categorization on HEPA: *Active work and living*, *Exercise and fitness programmes, Management and leadership, Communication and dissemination, and Facilities*. Although these initiatives were implemented in real-life settings and may have been considered feasible by the organizations that developed them, this does not imply universal feasibility—particularly not for SMEs. To address this question, a hybrid e-Delphi study was conducted. A panel of 17 international experts, with balanced gender representation (54.8% women), provided feedback across three stages. Experts did not evaluate all initiatives, but a representative sample was distributed across five HEPA categories of *Active living of at least moderate-intensity, Active living or light intensity activity, Active living or light intensity activity and sitting, Exercise or physical fitness programmes* and *Sitting time/sedentary behaviour*. Existing research suggests that successful workplace HEPA initiatives are typically comprehensive and multicomponent [15–29], and our results show that initiatives perceived as feasible for SMEs were present across all five categories [32].

Interestingly, experts most often identified the collected initiatives as focused mostly on *Exercise or physical fitness programmes* (34.8%) and least on *Sitting time or sedentary behaviour* (8.8%) (Table 1). This distribution across HEPA categories differs from the one identified in the previous scoping review [32], in which 48% of initiatives coincide in this categorization. Moreover, among the 43 initiatives rated most feasible, all five HEPA categories were represented. These included interventions targeting both the individual level—such as *Active work and living* ($n = 20$; 48.5%) and *Exercise and fitness programmes* ($n = 10$; 23.3%)—and the organizational level, including *Management and leadership* ($n = 7$; 16.3%), *Communication and dissemination* ($n = 3$; 6.9%), and *Facilities* ($n = 3$; 6.9%). The proportional representation, and therefore representativeness, of these categories mirrors that of the original dataset of 714 initiatives which most were on either *Active work and living* (38%), or *Exercise and physical fitness programmes* (33%) and the rest were in smaller portions (between 7% and 12%).

Despite the identification of promising initiatives, no consensus was reached on which could be considered universally feasible for implementation in SMEs. One of the key challenges was the lack of detailed quantitative information in the grey literature, including on participant numbers, target population characteristics (e.g. participants that may benefit the most due to sedentary behaviour or insufficiently physically active), or outcome evaluation (e.g. effectiveness). Consequently, the expert panel was unable to suggest any initiative in itself to be included in a European HEPA Toolkit for SMEs. Nonetheless, several features underlying the initiatives were considered potentially useful and inspirational for SMEs, as shown in Fig. 3 [32]. Experts agreed that these elements could support the development of tools that help SMEs take action aligned with their capacities and constraints.

The main strength of this study is the analysis of real-life workplace HEPA initiatives. The screening by the experts resulted in a list of features that are put forward as feasible for SMEs to work on. This identifies expert-perceived features that may inform future SME-tailored tools, rather than establishing what is empirically feasible for SMEs in general. SMEs are heterogeneous: micro, small and medium-sized enterprises differ substantially in resources, occupational-health infrastructure, managerial capacity, work organization and ability to implement workplace health promotion. Drawing on the panel discussions and on the company-size feasibility ratings collected in Stage 2 (Table 1, in which 76.1% of evaluated initiatives were considered feasible for medium-sized enterprises, 68.2% for small, and 59.7% for micro enterprises), the feature-level findings can be tentatively mapped onto SME size. Low-threshold features that may be feasible for many micro and small enterprises include walking meetings, stair-use prompts, active breaks, step-count recording and challenges, walking and cycling campaigns, flexible work schedules, simple internal communication materials, and low-cost environmental supports such as bicycle storage. More resource-intensive features more realistic for medium-sized or better-resourced enterprises include onsite gyms, fast-track physiotherapy services, wellness counsellors, dedicated physical-activity coordinators, and structured policy instruments and incentive schemes (Fig. 3). This

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mapping is informed by expert perception in Stage 2 and by Stage 3 panel discussions; it is not a substitute for empirical evaluation in actual SME settings, which is required before any feature is adopted as a recommended practice. As no consensus was reached on which initiatives are transferrable for all SMEs, this confirms that a tailor-made approach is necessary when rolling out a workplace PA initiative.

A central validity limitation of this study is the absence of SME end-user involvement. Feasibility in SMEs is shaped by managerial capacity, work organization, employee participation, occupational-health infrastructure, sector and resource constraints; the present panel evaluated feasibility as perceived by predominantly academic public-health experts, not as experienced by SME owners, managers, employees or occupational-health practitioners. The findings should therefore be interpreted as expert-informed inputs to a future co-design process with these stakeholders. Moreover, the geographic distribution of experts was limited; none of the respondents were based in the eastern or south-eastern part of the WHO European Region. In addition, most experts worked in academia or research (71.3%) and a majority had no direct experience in the private sector (65.9%). A further methodological limitation is the lightweight nature of our qualitative analysis. A more formal qualitative protocol (e.g. multi-coder thematic analysis with software-assisted coding) is recommended for any future co-design phase involving SME end-users.

Ultimately, since SMEs do not have the same resources as large companies, it is crucial that they receive clear, practical, and hands-on information. This can help lower the threshold for taking action while ensuring that any effort made results in meaningful and high-quality outcomes.

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Author contributions

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Supplementary data

Supplementary data are available at *EURPUB* online.

Conflict of interest

None declared.

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Data availability

The data underlying this article are available in Zenodo, at https://doi.org/10.14787288 [40], and in EURPUB online at https://academic.oup.com/eurpub/article/32/Supplement_1/i22/6676129#381324552 [36].

Key points

- This study identifies expert-perceived transferable features, rather than a consensus-based set of initiatives, that may inform the future co-design of a European HEPA Toolkit tailored to SMEs.
- A hybrid e-Delphi method involving 17 international experts was used to evaluate 390 initiatives collected from grey literature across Europe.
- Initiatives categorized as *Active living* or *Exercise and physical fitness programmes* were most frequently rated as feasible for SMEs.
- There is a general lack of implementation data and SME-specific evaluation metrics limited the identification of best practices.
- Experts agreed that SMEs require simple, flexible tools supported by clear, actionable information to facilitate adoption and impact.

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