Discovering the capabilities of ageing persons who are born abroad

Crossing norms, moving health promotion forward

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"All that is gold does not glitter
Not all those who wander are lost
The old that is strong does not wither
Deep roots are not reached by the frost"

J.R.R. Tolkien, *The fellowship of the ring*

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ABSTRACT

To improve the possibilities for the whole population to take control over their health is an important goal for health promotion and public health. Yet, with improved possibilities for international migration and extended life spans, there are more and more people who are considered less capable to reach such a goal. Current normative structures impede upon the possibilities for ageing persons who are born abroad to execute what they consider valuable for their health, and confronting such structures is a critical issue from an ethical perspective, but increasingly also from a public health perspective. Therefore, the overarching aim of this thesis was to explore ethical and empirical points of departure for health promotion in relation to ageing persons who have experienced international migration.

Methods: A mixed-methods approach was applied, combining qualitative and quantitative methods to gather and analyse data from eight randomised controlled trials (study I), 16 health professionals (study II) and 55 ageing persons who had experienced international migration (studies III and IV). The analyses were narrative, descriptive, interpretive and statistical, presenting four distinct stages of the development of a health promotion programme for ageing persons who have migrated to Sweden.

Results: On a comprehensive level, the findings serve as a reminder of the innate dignity of each human being. Focus should lie on solving problems that *actually* exist, instead of solving those that are *believed* to exist. Based on the findings, study I suggest that health promotion programmes should involve

culturally and linguistically modified activities and health information, and that all content should be professionally provided with a person-centred approach. Study II visualises social networks and maintained bonds to the country of birth as both facilitators and barriers for health promotive work, influencing the expectations on health and support over the ageing process. However, interpersonal differences were described as equally important to attend to in order to build up a mutual understanding based on trust and respect. Study III describes meaning of health to ageing persons who are born abroad, and suggest that health promotion programmes should aim to promote the retrospective and prospective process of exercising control over one's life, daily activities, and social commitments. Finally, study IV visualises how health promotion programme feasibility could be improved by pragmatic and flexible approaches, and acknowledgement on how people convert resources for health into actual achievements.

Conclusion: Searching for how to identify, and reach, appropriate health promotion goals in the context of ageing and migration, the major finding is the recognition of the complex and dynamic interplay between personal choices and normative power, leading to a deeper understanding of how to diminish health-care inequities. Moving beyond the norms on what it means to be a capable person, and what is considered a good and healthy life, the capabilities of ageing persons who are born abroad were discovered, leaving negatively charged characteristics of ageing and migration in the foreground. Providing tools to confront, and deal with, normative structures, the findings equip health professionals, decision makers and researchers with possibilities to accept, and embrace the notion of all human beings as persons with capabilities.

Keywords: Emigration and immigration, delivery of health-care, implementation, inequities, health, mixed-methods, person-centredness

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SVENSK SAMMANFATTNING

Avhandlingen handlar om hur ett personcentrerat förhållningssätt till äldre personer som är födda utomlands kan användas för att utmana de normativa strukturer som har skapat ojämlikheter i såväl hälsa som i dagens hälso- och sjukvård. Min målsättning var att utforska hur olika sätt att se på människan påverkar bemötandet av personer med olika åldrar och nationella bakgrunder och hur detta kan användas vid olika hälsofrämjande åtgärder. Mitt syfte var att försöka bidra med en ökad förståelse av hur hälso- och sjukvårdspersonal ska kunna ta hänsyn till de dynamiska processerna åldrande och migration, som handlar om hur människor hanterar olika förändringar i livet och rör sig mellan känslor av tillhörighet och utanförskap.

Att öka möjligheterna för hela befolkningen att ta kontroll över sin hälsa är ett viktigt folkhälsomål. Däremot beskrivs ofta ojämlikheter i hälsa i relation till äldre personer, och i synnerhet i relation till äldre personer som har flyttat till Sverige från ett annat land. Äldre personer som är födda utomlands beskrivs ofta som en grupp som riskerar att uppleva ohälsa genom utanförskap och diskriminering. Det är därför viktigt att utforska hur en fördjupad kunskap om deras förmågor och verkliga möjligheter att använda dem i sitt vardagliga liv kan användas för att öka deras möjligheter att bli sedda och förstådda som de personer de är.

Avhandlingen består av en ramberättelse och fyra delarbeten som syftade till att utveckla ett hälsofrämjande program för äldre personer som har migrerat till Sverige. Resultaten ger en djupare förståelse för hur ojämlika möjligheter att ta kontroll över sin hälsa kan minskas genom att utmana normer som talar om för oss vad hälsa innebär, och vilka människor som uppfattas som kapabla. Hälsofrämjande insatser behöver förstås i relation till vad hälsa innebär för olika personer och vilka hälsorelaterade mål som är viktiga att sträva efter i olika sammanhang.

LIST OF STUDIES

This thesis is based on the following studies, referred to in the text by Roman numerals. All reprints are made with permission from the publishers.

I. Qarin Lood, Greta Häggblom-Kronlöf, Synneve Dahlin-Ivanoff. Health promotion programme design and effectiveness in relation to ageing persons who are culturally and linguistically diverse: a systematic literature review and meta-analysis. *Submitted for publication*

II. Qarin Lood, Synneve Dahlin-Ivanoff, Lisen Dellenborg, Lena Mårtensson. Health-promotion in the context of ageing and migration: A call for person-centred integrated practice. *International Journal of Integrated Care. 2014;14:e004*

III. Qarin Lood, Greta Häggblom-Kronlöf, Lisen Dellenborg. Embraced by the past, hopeful for the future: meaning of health to ageing persons who have migrated from the Western Balkan region to Sweden. *Accepted for publication in Ageing & Society, December 2014*

IV. Qarin Lood, Susanne Gustafsson, Synneve Dahlin-Ivanoff. Bridging barriers to health promotion: a feasibility pilot study of the "Promoting Aging Migrants' Capabilities" study. *Submitted for publication*

CONTENT

ABBREVIATIONS

ADL	Activities of Daily Living
CALD	Culturally And Linguistically Diverse
CERAD	Consortium to Establish a Registry of Alzheimer's Disease
CES-D	Center for Epidemiologic Studies Depression scale
CHAMPS	Community Healthy Activities Program for Seniors questionnaire
CI	Confidence Interval
CSDH	Commission on Social Determinants of Health
ES	Effect Size
FSQ	Functional Status Questionnaire
GDS	Geriatric Depression Scale
GRADE	Grading of Recommendations Assessment, Development and Evaluation
GQL	The Göteborg Quality of Life instrument
HAP-AAS	Human Activity Profile Adjusted Activity Score
LSI-Z	Life Satisfaction Index-Z
Mesh	Medical Subject Headings
MHI-5	Mental Health Index (from SF-36)
MOS	Medical Outcomes Study
NRS	Numeric Rating Scale
OEE	Outcome Expectations for Exercise scale
RCT	Randomised Controlled Trial
SD	Standard Deviation
SEE	Self-Efficacy for Exercise scale
SF-12	RAND Short-Form-12
SF-36	RAND Short-Form-36
SMD	Standardised Mean Difference
SOC-13	Sense of Coherence scale
SPSS	Statistical Packages for Social Sciences
WHO	World Health Organization
YPAS	Yale Physical Activity Survey

DEFINITIONS IN SHORT

Ageing	Unless described otherwise, ageing is defined as being 65 years of age or older, based on the universal retirement age for men and women in Sweden.
Capabilities	The *effective* possibilities a person has to convert functions into the achievement of a desired goal, that is, the personal freedom a person has to be the person he or she wants to be, and live the kind of life he or she has reason to value.
Culturally and linguistically diverse backgrounds	Defined as cultural, linguistic, ethnic or national backgrounds, which are different than the backgrounds of the majority population of the country of residence.
Health	A complex and dynamic process influenced by a variety of predictable and unpredictable integrated aspects, which correspond to the personal, societal and universal demands on each person.
Health promotion	Public health strategies, which aim to improve the possibilities for all people to optimise their functions and take control over their overall health and wellbeing.
Occupation	The daily pursuits of human beings, consciously and purposefully sanctioned within a specific context

PREFACE

I chose to start my doctorate education driven by my belief that all human beings have the innate dignity and rights to live the life they want to live. In my clinical work as an occupational therapist I have however experienced how people are treated differently due to observable or perceived characteristics. My drive to promote each person's innate resources for health has been limited by the demand to solve problems defined by the current health-care organisations, which have constituted the context of my clinical work. Repeatedly I have felt limited by normative structures that contribute to the unjustified differentiation of persons based on stereotypic views and preconceptions of what problems it is that ought to be solved. All of this in combination has provoked me to dig deeper into how to challenge current norms and diminish unjust differences across people in order to improve the situation for people who seek health-care services, as well as the people who work with providing them.

Striving to improve the possibilities for all people to make use of their resources, I aimed to explore how different approaches to health-care encounters could ultimately lead to a more inclusive and just welfare system. A variety of conceptual frameworks are of importance in order to understand the complexity of such an attempt, and I have chosen to delineate some of them. This choice was based on their emerging importance for me to understand the findings I have approached throughout the work of this thesis, and I am painfully aware of the impossibility of being exhaustive. Based on the belief that some words are better than silence, I do however hope that my thesis can provide a road map for how to build bridges instead of walls between people, ultimately leading to a more inclusive society and health-care environment.

INTRODUCTION

Ageing persons who have experienced migration are commonly described as a homogeneous group of people, who run a high risk of developing poor health, and with specific needs that are different from the majority populations' (1). Such descriptions create an idea of dissimilarity, and by consciously or unconsciously contributing to this idea, health professionals, the mass media, and researchers reinforce inequities in different ways. Current norms on what is implicated in capability and health contribute to the creation of inequities and discriminatory behaviours that diminish the possibilities for ageing persons who are born abroad to avail their resources and be acknowledged as persons with capabilities. As described by Sen (2), capabilities refer to the possibility a person has to convert resources, such as physical and psychosocial functioning, into actual achievements that are considered valuable for individual wellbeing (2).

Confronting current norms, which have contributed to unequal opportunities to achieve health and wellbeing, this thesis has an ethical foundation built upon a view of all human beings as capable. Focus lies on what ties human beings together, rather than what differentiates us from each other. However, exploring the capabilities of a group of people categorised as ageing persons who are born abroad, while at the same time acknowledging the unique resources and desideratum of each person proved to be a complex task. Therefore, two intersecting directions of exploration were applied: from an ethical, and inside perspective, the exploration dealt with the ontological complexity of what it means to be a person who is just like anyone else, while at the same time having unique features bound to individual experiences. From an empirical, and outside perspective, the exploration derived from how people are being shaped by environmental aspects, and daily occupations.

Human beings as persons in relation

Bringing to a fore the human need for reciprocity, this thesis builds upon a view of human beings as persons in relation. Philosophical texts have been interpreted and applied in an attempt to explore the intricate and dynamic web of how physical, cognitive, affective and experiential characteristics interact and build up a notion of personhood.

The notion of personhood involves an understanding of human beings as more similar than different, attending to the common feature of what it means to be human. As described by Ricoeur (3), all human beings share the fundamental feature of being capable to achieve what is considered a good life. Buber (4) adds to this understanding an elaboration on dependency, and how it influences us as persons in relation. According to Buber (4), there is no real life without communion, and what constitutes a person is hidden in how we understand and narrate ourselves in relation to other persons. Those philosophical underpinnings allow us to understand human beings as something more than just what they do. Dividing people according to achievements alone tend to categorise us into individuals who are differentiated from each other. Instead, an understanding of human beings as persons in relation implicates a view of man that acknowledges both *what* we are capable of doing and *who* we are.

As persons in relation, we constantly deal with the complexity of simultaneously engaging in a search for an eminent distinction of a genuine self (selfhood), and recognition of what we all share in being persons (sameness). According to Ricoeur (3), selfhood refers to a relatively constant own identity, whereas the notion of sameness involves the universal human feature of being capable of speaking, acting, narrating, taking responsibility and remembering (3). In essence, this deals with how we, as persons, relate to ourselves, each other, and to the world. Accordingly, it is not until we engage in a relation with another human being, and narrate who we truly are, that we can emerge as persons to each other (4). Thus, it seems like the complex task of merging selfhood and sameness into an understanding of who we are as persons lies in the narration.

One of the most fundamental human behaviours is to respond to another person's address, but there is a difference between interacting and authentically engaging in a human encounter (4). The identification of each other as persons is a requirement for experiencing sameness, allowing us to turn our attention towards each other, and engage in authentic relationships even when no previous relation exists. By acknowledging what we have in common as persons, we can communicate with the essential feeling of communion, genuinely listening to what the other person has to say. The notion of sameness allows us to show each other respect by turning our attention towards each other as equal persons, whereas the notion of selfhood allows us to acknowledge each person's very own ways of applying his or her human features of being capable (3).

Environments and personal freedom

Environments encompass a complex web of interrelating aspects that simultaneously influence the opportunities people have to lead the kind of life they want to lead (2, 5). As previously described, all people share the human feature of being capable (3), but environmental aspects might facilitate or constrain the opportunities for people to be acknowledged for their capabilities.

Capabilities can be defined as the *effective* possibilities a person has to achieve a desired goal, because of, or despite, different environmental aspects. In other words; the personal freedom to choose between different options, and to act in line with one's own ideal of a valuable life (2, 6-8). For the aim of this thesis, capability is understood as the successful conversion of resources into the actual achievement of being healthy, and the capability approach as described by Sen (7) was applied to understand how different people answer differently to environmental demands. The successful conversion of resources into actual achievements is equally influenced by personal characteristics (functions), such as physical condition or literacy, and environmental influence, such as public policies, power relations, social norms, infrastructure or institutions. Thus, even when people have similar functions, they are likely to reach different levels and types of achievements due to the different consequences that environmental aspects create in their everyday lives.

People tend to use their resources differently according to the different environmental contexts they find themselves in. Based on their current functions, people make different choices in life, and their capabilities are improved or reduced. Accordingly, exploring capabilities requires us to attend to how different people respond to environmental resources and demands by assessing both which functions a person has, and put them in relation to what contexts that very person is living. This involves evaluations of personal attributes and resources tied to each person, but also how the environment influences the person's possibilities to convert those resources to health.

Objective assessments of function and actual achievements are important when it comes to promote the possibilities for people to be healthy, but it is equally important to address how environmental aspects might influence the possibilities for some people, within certain contexts, to convert their functionings into valuable achievements (2, 7, 8). Coming back to the understanding of the human feature of being capable, it is important to acknowledge, and respect, the

different ideas of what is implicated in capability, and what constitutes a good life across individual persons, communities, and societies. When evaluating health and wellbeing, it is important to attend to *what* a person is capable of, but it is equally important to also address *who* the capable person is, as well as *how* and *why,* he or she chooses to act in different ways in different situations (3).

The occupational nature of human beings

Occupation refers to the daily pursuits of human beings, consciously and purposefully sanctioned within a specific context (9). Involving everything people do to occupy themselves, occupation is central to human existence, and to the development of our innate resources for health (10, 11). When engaging in occupation, people demonstrate how they convert their functions into actual achievements that they have reason to value in their everyday lives (10-12), and many health-related issues can be explained by mismatches between human biology and different occupational possibilities (13).

A person's occupational possibilities and predilections are influenced by their personal capacities for action, an subject to physical, and mental capacities to carry out, monitor and modify different actions in an ideal way within a specific sociocultural context (14, 15). Without environmental availability and support, people might find it hard to participate in a desired occupation, even if all personal capacities necessary are available (16). Occupational possibilities are further influenced by societal norms about who should perform what occupations, with regard to age, ethnicity, socioeconomic status, visible characteristics, occupational role, and objective health status.

Normative definitions of where, how, with which resources, and by whom, different occupations should be performed needs to be confronted in order to promote equal possibilities for all people to engage in occupation (17). The knowledge of the occupational nature of human beings is longstanding, and there is a wide array of literature suggesting how occupations should be applied to promote health and wellbeing (11). However, there are large proportions of the population who currently lack the personal freedom of selecting and engaging in a balanced array of occupations that they consider meaningful and valuable for their health (18). From an occupational perspective, a good life involves engagement in meaningful and culturally relevant activities as a means to be, and become, the person one wants to be, and to feel a sense of belonging to other people (19). It is when we narrate our doings to another person that the

relation between the occupational choices and health can be truly understood. In narrations we relate ourselves to what we do, and put our actions in relation to other persons and contexts (3). Thus, putting normative definitions and preconceptions of occupation into perspective, narratives can provide us with information on the influence daily occupations have on the health of each person within his or her own everyday context.

Notions of health and health promotion

Health as a concept is elusive and there can be no universally accepted notion of it. However, there have been many attempts to define health, and the World Health Organization's (WHO) (20) definition is one of the most well-known. According to WHO, health is a state of complete physical, social and mental wellbeing, and not only the absence of disease (20). This definition was used as a starting point for understanding health in relation to the work with this thesis, but in order to attend to the dynamic nature of health, and how aspects of relevance for the research subject might be reflected in health conceptions, Bircher's (21) dynamic definition was applied. At large, this definition adheres to WHO's (20) definition, but it also acknowledges how conceptions of health are influenced by different demands in life, and in relation to age, culture and personal responsibility (21). The merger of those two definitions of health resulted in a view of health as a complex and dynamic process influenced by a variety of predictable and unpredictable integrated aspects, which correspond to different personal, societal and universal demands on each person.

Health promotion has been defined as a process to enable individual persons, and communities to increase control over their health (22, 23). It represents a strategy to improve public health, and provides a structure for health professionals to empower people by acknowledging how several environmental factors might influence the health of individual persons (24). Professional and intentional combinations on educational, regulatory, environmental, politic and organisational levels are common strategies for action (25), and there has been a clear focus on how to influence health-related behaviours. Opinions might have shifted in the assignment of responsibility for health, but the notion of personal control and self-sufficiency has been predominant, putting emphasis on individual responsibility for both positive notions of health and health-related problems (26). However, health promotion actions also ought to acknowledge the dynamics of what people do, how they feel about what they do, and how this might influence their perceptions of health in relation to different contexts

(23, 27). Thus, there seems to be a need to redirect resources, from a previous focus on targeting risk factors bound within each person, towards recognition of multiple determinants of health, bound within the dynamic relationship between the person, the environment, and each person's possibilities to perform meaningful and culturally relevant daily activities.

With the aspiration to attend to the dynamism of health, the goal of health promotion is to improve the possibilities for all people to optimise their functions and achieve an overall health and wellbeing across the life span (25, 28). Considering this broad definition, it is however easy to argue that almost all health-care activities could qualify as being health promoting. There is thus an important delineation to make between health promotion and health-care, in the intention of the actions that are being carried out (28). Health promotion deals with how to support health in a broad sense, aiming to *improve* a person's health status and function by encouraging the execution of healthy activities (25, 28, 29). Health-care, on the other hand, traditionally deals with prevention, that is, *maintaining* health by forestalling the onset, or progress, of a predefined symptom or disease, and there is no intent to improve a person's general health status or level of functioning (28, 30).

When targeting ageing persons, health promotion research has for a long time supported the integration of health promotion and prevention (31, 32), and for the purpose of this thesis they are regarded as two ends of a health promotion continuum. It would be counterproductive to exclude the possible benefits of prevention from health promotion actions with ageing persons, and the aim was therefore to develop a health promotion programme with a clear focus on the positive connotations of supporting health, but with the possibilities to also prevent progression of illness, disease, and functional disabilities.

Swedish welfare from an ageing and migration perspective

Sweden has a long-established welfare tradition founded on the basic principles of equality and solidarity. Applying a universal health-care model, the state is responsible for providing services to those in need (33-35), and when people age in Sweden they have equal rights to receive home help services, which might involve household activities, personal and medical care. Home help services are assessed and approved by authorised social workers, and they ought to be based upon each person's needs. However, highly influenced by Kantian ideals of

autonomy (36), the common goal of Swedish care for the elderly has for a long time been to make it possible for all ageing persons to remain living in their homes independently for as long as possible, regardless of what their actual needs and preferences might be. This manifests itself in a general perception of ageing persons as a homogeneous group of people who all have the same needs, and of ageing as a negative experience that ought to be prevented.

In addition to the notion of ageing as a negative experience, there is a wide-ranging preconception of migration as a problem and threat to the Swedish welfare society (1). All people who have migrated to Sweden are entitled to the same formal rights as their native-born counterparts (33-35), but persons who are born abroad are generally confronted with poorer living conditions than their native-born counterparts. Even years after migration they have fewer possibilities to find housing in neighbourhoods with high socio-economic status (37), and they reportedly perceive discrimination and social vulnerability in their contacts with the Swedish society (38, 39).

Ageing persons who are born abroad are often visualised as a group at double, or multiple, jeopardy for poor health, facing both migration- and age-related changes to their life situation and health (40-42). For instance, negative influences on daily activities and health due to loss of social networks and alteration of cultural context (43, 44), or due to physical and cognitive decline (45). Research has put focus on difficulties associated to migration- and age-related losses (42), and visualised ageing persons who are born abroad as a homogeneous group of people with specific health-related needs (1). Indeed, there might be negatively charged characteristics associated with ageing and migration, but different people react and adapt differently to the psychological, social and biological changes that ageing and migration brings (46). Previous and current living conditions and lifestyles, traumatic events in the country of birth, social support, discrimination and Swedish migration and public health policies all influence the capabilities ageing persons who are born abroad have to achieve their desired state of health.

Norms and health-care inequities

Norms involve unspoken rules on what is regarded as common by a certain group of people. By creating an image of what is regarded as neutral or ideal within a specific place or context, normative structures tend to bind people who conform to this norm together, while deviating those who do not (47). Such

categorisations of people involve the identification, definition and delineation of attributes by which people are recognised as ideal or deviant (48). Health-care inequities are founded in such categorisations, which emanate from norms that exclude certain parts of the population, based on visible or perceived characteristics that are associated with discrimination, such as age, migration status, skin colour, linguistic preferences, or ethnicity (49, 50). Thus, health-care inequities concern differences that are systematically deemed as unjust within a certain social context, and as defined by current norms.

In Sweden, current norms on what is considered a good life during old age are highly influenced by an ageing discourse, which describes health in an ageing context as nothing more than adaptation to, and compensation for, inevitable declines of body and mind (51). An ideal ageing person is someone who is not ageing biologically, and who is capable of taking control over his or her life situation and health by being active and productive, youthful, autonomous, and self-fulfilling (52-54). Independence in daily activities are commonly considered to be the true foundation of a healthy and ideal way of life, and therefore considered the ultimate goal of care for elderly people (55). Capability is regarded as being able to find meaning through work and other goal-oriented activities, and norms of a good life involve the independent strive for new experiences (56). Since biological ageing involves deterioration of physical and psychological functions, it might become hard for ageing persons to conform to such norms. Their actions are therefore likely to be considered as less valuable, and they face the risk of being perceived as less capable to take responsibility for their health.

The victimisation of human diversity is even more evident when it comes to ageing persons who are born abroad. There has been an extensive visualisation of persons who are born abroad as a group of people with poorer opportunities of achieving the same health status as the native-born part of the population. Migration is mainly described as a negative experience, and health in the context of migration is most often pronounced in objective and negative terms, by means of physical disabilities and reduced work capacity, or in relation to mental health problems such as anxiety and nervousness (57-62). This all adds up to to a notion of ageing persons who are born abroad as a problematic and less capable group of people, differentiated from the majority population. In contrast, this thesis was built upon the understanding that there is more to the ageing and migration processes than meets the eye, calling for an exploration of the knowledge and competence that different people behold, just because of their different life experiences.

RATIONALE

Health is an essential factor influencing wellbeing and overcoming social disadvantages, which is why challenging health-care inequities are important from a public health as well as from a human rights perspective (49). However, achieving it is an immense task (63), which requires involvement at several levels of health-care organisations at the same time (64). The relationship between power distributions, utilisation of health-care services, and possibilities to achieve health is dynamic and complex, calling for further research to explore why unjust differences with regard to health and health-care access exist.

According to the latest census by Statistics Sweden (65, 66), almost 20% of the Swedish population was older than 65 years of age (universal retirement age in Sweden), and this figure is expected to rise as life expectancy and number of those attaining retirement age increases (65, 66). Additionally, global demographic changes with increased possibilities for international migration leads to an increasing amount of ageing persons who are born abroad. Almost 15% of the Swedish population over 65 years of age are born abroad, and this figure is also expected to rise (65, 66). This surge of ageing persons who are born abroad, in combination with the notion that they have specific needs, is what most decision makers refer to when explaining the specific attention towards this part of the population. However, an increased presence of ageing persons who are born abroad in the health-care system only intensifies challenges that are already there. Some barriers to health-care access can be attributed to the whole population, whereas some are seem to be tied to persons who are born abroad.

In order to diminish health-care inequities in the context of ageing and migration there is a need to explore their underlying aspects. People experience their situation in relation to a multitude of simultaneously interacting dimensions of social identities (e.g. age, gender, visible minority or migration status), contextualised within different systems of power and oppression (67). Therefore, this thesis was written in order to find means for attending to the complexity of different constellations of intersecting identities and roles, as experienced within the broader environmental context people find themselves in. It is part of a larger research project targeting persons from the largest groups of ageing persons who have migrated to Sweden: persons from Finland, Bosnia and Herzegovina, Croatia, Montenegro and Serbia.

Even if norms seem to distribute power unevenly during health-care encounters, they are not everlasting but in constant change and with the opportunity to exchange. Improving the possibilities for people who currently do not confirm to the norms to vocalise their motivations, needs and desideratum is therefore considered an important step towards more inclusive societies and health-care environments. Consequently, this thesis aimed to challenge current norms on what is considered a good life, and what is implied by being a capable person, and by doing so, improve the possibilities for a larger proportion of the population to achieve their desired state of health.

AIMS

The overarching aim of this thesis was to explore ethical and empirical points of departure for health promotion in relation to ageing persons who have experienced international migration. With the goal of confronting normative structures that contribute to health-care inequities, the intention was to provide knowledge on how to develop a health promotion programme to support an optimal ageing for persons who have migrated to Sweden. More specifically, the aims of the separate studies were:

- To explore the core components of existing health promotion programmes for ageing persons who have culturally and linguistically diverse backgrounds, and to assess the evidence for the programmes' effectiveness (Study I)
- To explore health professionals' experiences of facilitators and barriers for their possibilities to support healthy ageing in the context of migration (study II)
- To deepen the understanding of the meaning of health to ageing persons who have migrated from the Balkan Peninsula to Sweden (Study III)
- To assess the feasibility of a health promotion programme with regard to ageing persons who have migrated to Sweden (Study IV)

METHODS

Study setting

The empirical studies (II, III and IV) were all conducted in the community of a low-income, suburban district of a middle-sized Swedish city. The majority of the population in the suburb live in apartment buildings, and the inhabitants come from over 100 different countries. In general, the proportion of ageing persons is lower than in the greater urban area, but the proportion of persons above 65 years of age who have migrated is high. For more detailed information on the study setting see table I.

Table I. Overview of the demographics of the study setting

Demographics	Suburb (study setting)	Greater urban area
Total population 2013	49 920	533 260
Born abroad 2013	50%	23.5%
65 years or older 2013	10.8%	15.2%
General education level 2012* (university ≥ 3 years)	7%	16.9%
General income level 2011* (SEK)	193 668	286 649

* Latest statistics available

Overall study design and research strategy

Four distinct stages of protocol adaptation were conducted to support the design and implementation of a health promotion programme for ageing persons who have migrated to Sweden: 1) An explorative and mixed-method systematic literature review and meta-analysis was conducted in order to build up a scientific foundation for health promotion. 2) A descriptive focus group study with health professionals aimed to explore facilitators and barriers for health promotion with ageing persons who have migrated to Sweden. 3) An interpretive interview study with ageing persons who have immigrated to Sweden was conducted to collect narratives on the meaning of health to the target group of the health promotion programme under development. 4) An experimental study design was applied to assess the feasibility of a suggested health promotion programme (Figure I).

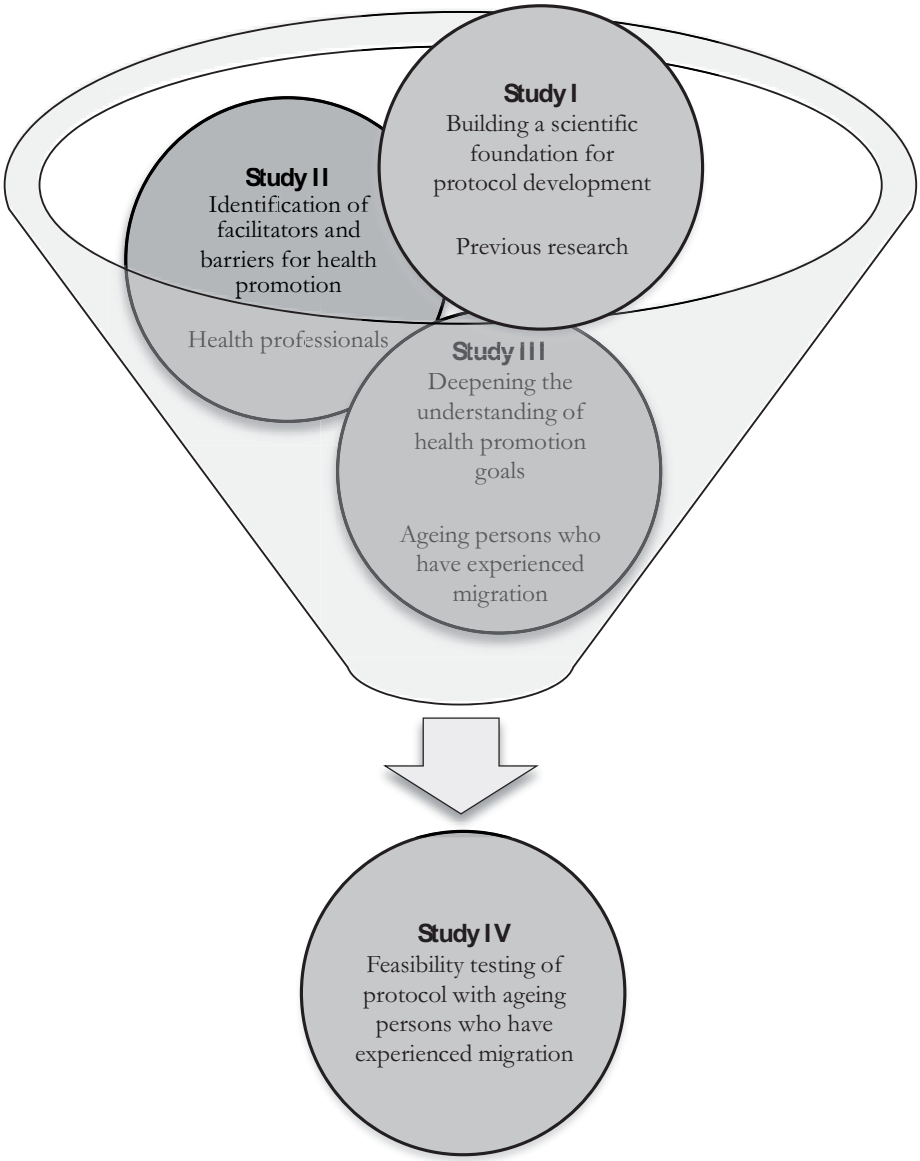

Figure I. Adaptation of a health promotion programme for ageing persons who have migrated to Sweden

Study specific research designs and methods

Understanding the diverse influences of ageing on health, both across and within groups of different social identifications, requires complex theoretical and methodological approaches. Therefore, different designs, methods, analysis procedures and populations were applied to each study in order to ideally suit their particular analytic interests. An overview of those applications to the studies can be found in table II.

Table II. Overview of the methodological approaches and samples

	Study I	**Study II**	**Study III**	**Study IV**
Design	Explorative, mixed-methods	Descriptive	Interpretive	Experimental
Method	Systematic literature review and meta-analysis	Focus group discussions	Narrative interviews	Randomised controlled feasibility trial
Analysis	Narrative analysis and meta-analysis	Long-table approach	Hermeneutic interpretation	Descriptive statistics
Recruitment	Database search	Purposive sampling	Snowball sampling	Consecutive inclusion from a larger RCT
Sample	Eight RCT publications	18 persons: qualified social workers, home help professionals, registered nurses, occupational therapists & physiotherapists	15 persons: ≥65 years of age, migrated from Bosnia and Herzegovina, Croatia, Montenegro and Serbia	40 persons: ≥70 years of age, migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro and Serbia

Systematic literature review and meta-analysis

The study applied Cochrane's (68) updated method guidelines for systematic literature reviews and took on a mixed-methods research approach, combining narrative analysis with meta-analysis and quality of evidence grading.

Data collection and sample

A stepwise database search was conducted in order to identify randomised controlled trial (RCT) publications with ageing persons who have culturally and linguistically diverse backgrounds (for illustration see Figure 1 in study I). Additionally, the RCTs should aim to assess multicomponent health promotion and evaluate results on general, physical or mental health. Publications that aimed to prevent specific health risk behaviours or diseases were excluded. Initially, the aim was to include RCT publications with focus on ageing persons who are born abroad. This did however only render two eligible publications, which is why the inclusion criterion was widened to culturally and linguistically diverse backgrounds, defined as cultural, linguistic, ethnic or national backgrounds differing from the majority population of the country of residence. Following an extensive search, with a variety of search terms and search strategies the final sample consisted of eight RCT publications that were assessed for relevance and quality using established guidelines for evaluation, data extraction (69) and risk of bias (68).

Analysis procedure

A narrative analysis (70, 71) was conducted in order to synthesise the data and reach a description of the core components of the evaluated health promotion programmes. The descriptions of the programmes were analysed to identify the overall features, then an iterative process was initiated to categorise them and extract the strongest components, leading to a final of five identified core components.

In order to answer the second part of the aim, which was to evaluate the effectiveness of the health promotion programmes, meta-analysis was conducted on data from publications that were considered sufficiently homogeneous. Results were pooled and standardised mean differences were calculated for continuous variables using a random-effect model. Finally, the quality of evidence for the results was assessed based on the grading recommendations by the GRADE working group (72).

Focus group discussions

In study II, focus group discussions (73-75) were conducted to generate qualitative data on health professionals' experiences of facilitators and barriers for supporting healthy ageing. This method is founded on social constructivism (76), with the basic assumptions that participants influence each other in group interaction and challenge different points of view in order to construct new knowledge.

Recruitment and sample

The participants were recruited by purposeful sampling (77), and in total, 18 health professionals with experience of working with ageing persons who have migrated to Sweden were recruited. Meeting the requirement of sample heterogeneity, the participants had different length of work experience (3-21 years), work place, gender (15 females, 3 men) and national backgrounds. To also ensure homogeneity, the professionals were divided into four focus groups according to their professional field: 1) registered occupational therapists and physiotherapists 2) registered nurses 3) qualified social workers 4) home help professionals (for more information on participants' demographical characteristics see table 1, Study II).

Data collection and analysis procedure

A topic guide was developed, covering question areas on the professionals' experiences and reasoning on their possibilities to promote healthy ageing in their work with persons who are born abroad. Each focus group discussion was recorded digitally and listened to directly after it had been conducted in order to get an immediate impression and further develop the topic guide for the forthcoming discussions.

All recorded material was transcribed verbatim and then continuously re-read and listened to throughout the analysis procedure. Based on the method described by Krueger and Casey (75) the analysis took on a descriptive long-table approach involving a cutting and pasting of transcribed data in order to identify themes and categories that answered to the aim of the study. Sections were spread out and sorted into preliminary categories, which were discussed between the authors and qualitative formulations were reached by comparing the authors' interpretation of condensed data with the raw data.

Narrative interviews

In study III an interpretive design with narrative interviews was employed in order to deepen the understanding of the meaning of health in the context of ageing and migration. With the intention to develop an intersubjective understanding of the studied phenomena, the interpretation of the collected data took on a hermeneutic approach inspired by Ricoeur (78, 79).

Recruitment and sample

Fifteen persons who were 65 years of age or older and had migrated to Sweden from Bosnia and Herzegovina, Croatia, Montenegro or Serbia were recruited using snowball technique (80). The majority of the participants had come to Sweden due to the war o the Balkan Peninsula in the 1990's and they had all been living in Sweden for more than 10 years. None of the participants spoke Swedish on a daily basis, but more than half had been working in Sweden before retirement. Nine of the participants rated their health as good, the remaining participants rated their health as following: good (n=2), very good (n=2), poor (n=1) and pending between good and poor (n=1).

Data collection and analysis procedure

Two research assistants were responsible for conducting the interviews in the participants' mother tongue since this was considered as the most appropriate way to ensure a trustful relationship between the interviewer and participant. A topic guide on health, ageing, everyday life and meaningfulness in life was used for all interviews.

Through a dialectal movement between explanation and understanding (78, 79), interpretive themes were constructed from clues in the text. Those themes were repeatedly confronted with previous literature and the authors' pre-understandings, which meant that they were rejected or expanded until four final themes were reached. Throughout the interpretation, contact was kept with both interviewers to ensure critical reading and achieve cultural translations of expressions and proverbs.

Feasibility study

An evidence-based health promotion programme (original protocol) (81) was adapted and assessed for feasibility by applying an explorative randomised controlled design and descriptive feasibility approach. Participants were randomised to a health promotion programme or an inert control group.

Original protocol

The original protocol (81) was three-armed, with two intervention arms and an inert control group. An operative team consisting of a registered nurse, a registered physiotherapist, a registered occupational therapist and a qualified social worker administered both intervention arms. The first intervention arm comprised four senior meetings held on a weekly basis, and one individual follow-up home visit. All participants received a booklet (83) with health information in order to form a basis for the senior meetings. The second study arm consisted of one individual preventive home visit, and those participants did not receive the booklet. The control group did not receive any intervention but was assessed during the baseline and follow-up interviews, and participants who reported urgent needs were referred to appropriate health-care services.

Adapted protocol

The adapted protocol excluded the second intervention arm since it has been proven inferior to the senior meeting intervention arm (84, 85). A new operative team consisting of the same professions (but different persons) was recruited and reference group meetings between this team, people representing the target groups, and the research leaders were held to improve the acceptability and feasibility of the adapted programme. All adaptations were made in relation to those meetings, and with regard to findings from the previous study of this thesis. The adaptations involved a greater focus on the person-centred approach (3, 86, 87), with an establishing of partnerships with participants during both design and implementation of the programme to ensure that the health promotion goals were set up in concordance. An additional adaptation was a bilingual approach, with all information material being translated to the participants' mother tongues, and the participants could choose which language they preferred the senior meeting to be conducted in. The control group followed the original protocol.

Recruitment and sample

Forty persons, 70 years of age or older, and had migrated to Sweden were recruited: 20 from Finland, and 20 from any out of four countries on the Balkan Peninsula (Bosnia and Herzegovina, Croatia, Montenegro, Serbia). Following discussions with reference groups for the target population and the operative group, the age criterion of 65 years applied in study II was considered too young, which is why the age criterion for study IV was set at age 70 years and older. Additionally, the participants should be independent of other persons in activities of daily living (ADL). Persons who showed signs of impaired cognition, assessed with Mini Mental State Examination (MMSE) (82), were excluded from the study due to ethical reasons and referred to appropriate health-care services.

All eligible persons received an information letter by post. The letter was followed by a telephone call, and persons who did not have registered telephone numbers received a second letter with contact details to the operative group, urging interested persons to take contact when possible. The included participants were between 71 and 85 years of age, the majority had lived in Sweden for more than 21 years, had come to Sweden work or to find a safe refuge from war, and lived alone. The self-rated Swedish proficiency level was higher among the participants from Finland than the participants from the countries on the Balkan Peninsula. For more information see table 2 in Study IV.

Data collection, outcome measures and analysis procedure

Research assistants were introduced and trained in how to administer the study questionnaire, and they collected all demographic and baseline data in the participants' preferred language and on their choice of location. Following the interview, the participants were randomly allocated to either health promotion programme or control, by randomly selecting an opaque envelope provided by the research assistant.

The primary outcome measure was sum of activities managed independently, measured by the ADL-staircase (88, 89), which is a Swedish instrument developed to measure independence of another person in the following ten ADL items: feeding, continence, transferring, going to the toilet, dressing, bathing, cooking, transportation, grocery shopping and cleaning. For the aim of this study 'continence' was excluded since it was not considered an activity. Independence was defined as not being directly or indirectly dependent on another person in the activity, meaning that the person should be able to perform the activity when

alone. The instrument has been tested for validity and reliability in relation to ageing persons (90, 91). Secondary outcome measures were: *risk for depression, fear of falls, frailty, life satisfaction, loneliness, self-rated health, sense of coherence, symptoms* and *participation in leisure activities.*

The analysis was explorative and descriptive, with focus on feasibility goals on recruitment, retention rates, study questionnaire administration and data variability of collected data at baseline. Participants were divided with regard to region of origin (Finland/Balkan Peninsula) only when specific differences were identified.

Ethical considerations

The ethical considerations of relevance for this thesis mostly concern the different means of viewing and measuring others, and how this can be put in relation to how we view ourselves. Research with persons who find themselves in the context of ageing and migration can thus be regarded as a mirror of our view of mankind, and our view of ourselves.

The underlying values and principles of health equity are deeply rooted in internationally recognised ethical and human right principles (98), and research on health and health-care inequities puts focus on how to improve all human beings' opportunities to lead the kind of life they have reason to value. There is however a risk, that the participants or other ageing persons who are born abroad might feel stigmatised by the division of people with regard to chronological age and national backgrounds. Therefore, this thesis aimed to confront common descriptions of ageing persons who are born, which might lead to stereotypic views of those persons being different, as being 'strangers' with ageing- or migration specific needs. The intent was to recognise and acknowledge the underlying power dynamics associated with different personal and environmental determinants of health, and the intersections among them.

Even if analyses of health-care inequities require categorisation to some extent in order to highlight the complexity of the phenomena, they should never aim to make generalisations based on homogenisation and classification. For the ease of writing this thesis, persons who are 65 years of age or older, with other national backgrounds than Swedish, are described, somewhat categorically, as ageing persons who are born abroad. Every attempt has however been made to

acknowledge both the differences and similarities that exist across all human beings, regardless of migration experience, cultural and linguistic backgrounds, biological ageing, gender or living conditions. Consequently, the interpretations and analyses took a stance in an intersectionality understanding (67) of how multiple within-group categorisations intersect and simultaneously influence the different meanings, and experiences of health to different persons.

The risk of stigmatisation was carefully considered in relation to the importance of illuminating differences, not between people, but with regard to the opportunities different people have to take control over their health and live a meaningful life. A selective concern for persons who have previously been visualised as disadvantaged when it comes to health and health-care access, was therefore not considered to be stigmatising, but as an attempt to give them voice and reduce discrimination in view of the opportunities for all persons to be healthy.

From a methodological perspective, the linguistic differences between the participants and researchers involved ethical issues of how to communicate information in a both comprehensible and effective way. All written information regarding the study was therefore translated into the participants' mother tongues, provided to those persons who did not feel linguistically safe with information in Swedish. As such, information on each study's prerequisites and how the results will be reported were made avail to all participants. They were also ensured of confidentiality by means that all data referring to their identities would be unidentifiable in the reports.

With regard to the specific studies, the ethical considerations in study I regarded the reporting of previous research in an unbiased and honest way, and required no formal ethical approval. Study II, and III and IV on the other hand required approval by the Regional Ethical Review Board in Gothenburg, which was received before any data collection begun (Reference numbers 821-11 and 001-12), and all study protocols conformed to the principles of the Declaration of Helsinki (99). Study IV, raised some additional ethical concerns with a risk of participants experiencing questions as tiresome or challenging. This risk was estimated as small, compared to the benefits of receiving information and regular assessments of one's health status. Additionally, all evaluators were be observant on signs of fatigue, and ceased the evaluation for continuation another day if the participants expressed this wish.

FINDINGS

For the aim of this thesis, ethical and empirical foundations for health promotion in the context of ageing and migration were explored, and a health promotion programme was adapted accordingly. On a comprehensive level, the findings deepen the understanding on how to improve the possibilities for health in the context of ageing and migration. By crossing norms, the capabilities of ageing persons who are born abroad can be discovered, and suggestions for how to design and implement health promotion programmes accordingly are provided.

In study I, the state of health promotion intervention research with ageing persons who have culturally and linguistically diverse backgrounds was summarised on a global level. Highlighting five core components of previous health promotion programmes, the findings provide a scientific foundation for decision-making with regard to health promotion programme design. The findings call for a multidimensional approach; combining different types of activities with health information, and with cultural and linguistic adaptions to all content. Additionally, the findings propose that health promotion should be provided by qualified health professionals, and with a person-centred approach. A meta-analysis of the statistical results from five RCTs identified statistically significant and clinically relevant effects in favour for health promotion on depression, mental and physical health and vitality, but the scientific foundation for those effects is limited. The insufficiency of published RCTs raised some serious concern, and especially with regard to the lack of data on ageing persons who have experienced migration. Thus, the findings urged the following studies of this thesis to focus upon how to improve the accessibility and quality of health promotion in an ageing and migration context.

Exploring how the findings from study I could be applied in a Swedish migration context, health professionals were invited to participate in focus groups to discuss their experiences of how the health of ageing persons who are born abroad could be promoted. The major finding from this study (study II) was that there is no single intervention that fits all persons, and that health promotion programmes ought to emanate from how each person narrates his or her desideratum in relation to the health professional. Thus, putting a focus upon collaboration and continuity of care, the findings strengthened the call for

a professional and person-centred approach as visualised in study I. What study II added with regard to the implementation of a health promotion programme for ageing persons who have experienced migration, was the visualisation of how the migration process might influence the provision of the programme. Loss of social networks, maintained bonds to the country of birth, linguistic skills and expectations of health and support over the ageing process were discussed in relation to health promotion for ageing persons who are born abroad. However, although emanating from migration specific facilitators and barriers, the discussions encircled the complexity of how different aspects can function as both facilitators and barriers for health-care access and health promotion for any person regardless of migration experience. Expressing an ambiguity on what is related to migration and what is related to other influencing aspects, the professionals highlighted the importance of acknowledging the heterogeneity of persons.

Underwired by the call for a person-centred and integrated approach to health promotion acknowledged in study I and II, the aim of the next study of this thesis was to explore another key issue of the implementation process, the subjective meaning of health to the ageing persons themselves. Uncovering hidden meanings of health, narratives from ageing persons who have migrated to Sweden described meaning of health as a retrospective and prospective process of exercising control over one's life, daily activities and social commitments. This process was in turn interpreted as the ability to influence one's health by executing what is expected and desired, and by being able to articulate whom you really are. Additionally, the participants associated health with the creation of a feeling of home, and feelings of affinity in the places and spaces they find themselves in. Integrating physical and psychosocial origins of health, the participants described how they strived to feel capable by means of physical control over their bodies, and mental control over their daily activities and social commitments.

Closing the loop, the findings of study IV provide a road map on how to implement feasible and effective health promotion programmes in an ageing and migration context. A linguistically adapted, person-centred and multidimensional approach to health promotion was implemented with ageing persons who have migrated to Sweden. The major finding was the call for a pragmatic and flexible design, with a selection of recruitment techniques to choose from, and with consideration given to all participants' possibilities to express their desideratum. Structural and linguistic barriers to reaching out to potential participants are

visualised, suggesting responsiveness to each person's linguistic and health promotive preferences by attending to each person's current capabilities. The high retention rates suggest that the participants found the programme satisfactory, but there were some concerns raised with regard to the study questionnaire. Many participants withdrew their consent to participate immediately after the baseline interview, calling for a need to further develop study questionnaires with regard to the target groups.

In summary, the present findings add to the scientific landscape an image of how ageing persons who are abroad can release themselves from current norms, turning their life experiences into health and hope for the future. If health-care organisations facilitate a person-centred capability approach, which takes a stand against normative structures, solutions can be created in concordance, and the notion of ageing persons who have experienced migration as a vulnerable group of people with limited possibilities to exercise their human capabilities, can be challenged.

DISCUSSION

Born from a concern of what is included in normative evaluations of health, this thesis resulted in a visualisation on how to cross current norms in order to move health promotion forward. With emphasis on how to recognise and acknowledge each person's application of the basic human feature of being capable, the findings provide a deeper understanding of how to promote the opportunities for ageing persons who are born abroad to achieve their desired state of health. Exploring what has previously been lacking in health-related research with this part of the population, a person-centred capability approach to health promotion is suggested as a means to diminish health and health-care inequities.

Guided by a philosophical footing on what it means to be a person in relation (3, 4), a person-centred approach involves an ethical point of departure for human encounters, in the view of human beings as more similar than different. The capability approach on the other hand, deals with the differences across people; with regard to the opportunities we have to achieve what we, upon reflection, consider valuable to our health (2, 7). By combining the ethics of person-centredness, with the capability approach as a framework for action on inequities, a person-centred capability approach was used in the suggested health promotion programme in order to acknowledge both the sameness and otherness of people, and deal with the complexity of challenging one's own, and other people's preconceptions.

As described previously, normative structures have led to negative perceptions of ageing and migration status (52-54). Additionally, linguistic, cultural and structural barriers have led researchers to turn their heads away from inequities that they know exist, and persons who have culturally and linguistically diverse backgrounds have been excluded from research due to practical or financial reasons (100). Consequently, there is a lack of knowledge with regard to the capabilities for health in the context of ageing and migration, and actions to diminish health and health-care inequities have predominantly been guided by preconceptions based on norms. Health-care services generally emanate from objective measures of poor health, and perceptions of people's capabilities as defined by current norms. This approach to health-care subsidies differentiation of people, and as visualised in the present findings, it is not sufficient for the discovery and promotion of capabilities beyond the norms. The present thesis

therefore confronted current health-care approaches, and the findings suggest an approach, which could be used for health promotion in the context of ageing and migration. With specific attention towards the design of a health promotion programme with, and for, ageing persons who have migrated to Sweden, the exploration led to deep reflections and a challenging of the current preoccupation of objective manifestations of health and disease.

Strengthened by the capability approach as a means to address health and health-care inequities (2, 6, 7), the findings visualise how health-care approaches should emanate from the effective possibilities a person has to achieve health (capabilities), instead of focusing on the objective measures of functions and achievements. By aiming to discover each person's capabilities for health, the suggested health promotion programme could promote the opportunities for ageing persons who are born abroad to undertake the activities they have reason to value, and become the kind of persons they want to be. However, a person-centred approach to health promotion does not involve a predefined goal, and is therefore more challenging than prevention of specific diseases, which aims to remove the causes of certain symptoms. With its open-ended agenda, the suggested health promotion programme does not pre-specify what exactly it is that ought to be promoted. Consequently, it might be deemed unfeasible and difficult to implement within the current welfare system, which is strongly founded in the objective tradition of modern medicine. Even if the findings visualised the programme as feasible with regard to the target population (study IV), the normative adhesive of current health-care organisations makes implementation of person-centred approaches an epistemological challenge, and a conflict of ideas (101).

The knowledge and understanding on what is implicated in a person-centred approach is still premature. Even if person-centredness has become a buzzword among researchers, health professionals, and decision-makers around the world, there is little consensus on its actual meaning (102, 103). Concept analyses of person-centredness (104) and person-centred care (105), describe how the concepts person-centred, patient-centred and client-centred have been used interchangeably, suggesting that they all refer to the same intent of health-care delivery, i.e. to put focus on the person seeking care. Based on the present findings, put in relation to previous research (101, 102, 106, 107), and philosophical literature (3, 4), I do however argue for something more than a shift of focus from the illness or disease towards the person.

Preconceptions and stereotypic views of ageing persons who are born abroad influence their possibilities to receive support based on their actual resources, needs and desideratum. External decision makers generally predefine the higher purposes of health-care services, and capabilities beyond the norms are neither recognised, nor acknowledged. Ultimately, this leads to a reduction of people who seek health-care to being tasks, and people who work as health professionals to being functions. Thus, even if the argumentation of semantics might seem trivial, the there is a crucial difference between how people are approached as persons or not. When people are approached as patients or clients, there is a risk for putting an inappropriate focus upon the health-related impediments they currently experience. And when people are approached as elderly immigrants, they are defined by visible or perceived characteristics associated with stereotypic views of ageing and migration. In contrast, the suggested health promotion programme allows for an acknowledgement of all human beings as persons, defined according to their capabilities.

Contrasting the notion of ageing persons who are born abroad as a group of people at double jeopardy for poor health (40-42), the present findings describe health in the context of migration as a prevalent and continuous movement between here and there, us and them, past and present (study III). Additionally, the adapted health promotion programme provides tools for how to dissolve the normative adhesion, which undermines the inappropriate focus on poor health in the context of ageing and migration. Functions and achievements were put in relation to environmental influences, and barriers were explored from both inside and outside perspectives.

Although plausible that characteristics associated with migration need to be recognised when targeting health promotion towards ageing persons who have culturally and linguistically diverse backgrounds (study I), the findings from study II and III visualise how those characteristics should not be given primacy. Health statuses vary across different groups of people, and personal, occupational, and environmental aspects constantly influence different people's perceptions of health in unpredictable ways (study II). Therefore, the suggested health promotion programme (study IV) challenges the current welfare system's focus upon functions and achievements (108, 109), and the bridging of health-care barriers from a purely organisational perspective. Descriptions of barriers to health-care commonly emanate from the perspective of health-care organisations and professionals, instead of focusing on what each person is currently able of and in need for (110). The understanding of what barriers to health and health-

care access ageing persons who are born abroad actually experience is still vague, as is the understanding of what it is that ought to be evaluated and achieved. Much time and resources are distributed in order to bridge linguistic and cultural barriers, but as visualised in study II, and III, barriers are also a result of socioeconomic aspects and the heterogeneity of persons. Additionally, the findings describe how resources need to be availed in order to design health-care interventions, which correspond to the personal freedom of choice for both participants and providers.

The suggested person-centred capability approach means that all people involved in a health-care encounter should acknowledge who the other person is, how he or she is able to function with the resources he or she has to dispose, and only *then* decide what to do. As described in previous research (111-113), most health-care organisations are however based on assumptions that objective measures of disease are superior to subjective experiences of health, giving primacy to professional knowledge on how to limit biomedical pathologies (111-113). Challenging such assumptions, the present findings acknowledge how all parties of a health-care encounter have important roles and a shared responsibility to acknowledge each other's capabilities, and health-care organisations need to be adapted accordingly. Health-care organisations need to promote the engagement in conversations built on mutual respect, and each person who is in need for health-care services should have the personal freedom to explore and choose between different options, as well as broaching their experiences and ideas with health professionals. What is considered important from a health equity perspective is that all people should have the same freedom to choose between different activities and lifestyles they consider valuable in order to live the kind of life they want to live, and become the persons they want to be. Only when a person has freedom to choose between different lifestyles, he or she can choose to act on those freedoms in line with his or her own ideal of a valuable life.

In summary, the present findings provide a road map for how to implement an approach, which could attend to both collective and individual needs, and combine personal and professional resources. The findings can be interpreted as prerequisites for a person-centred capability approach to ageing persons who are born abroad, giving primacy to personal narratives. Visible characteristics are left in the foreground as parts of the context, and the knowledge rendered could be used to improve the precision of health promotion and other health-care services. The findings from study I provide a scientific foundation for

health promotion on a collective level, and visualise the knowledge gap with regard to the capabilities of ageing persons who are born abroad. Study II and III aimed to fill this gap by digging deeper into what might *actually* facilitate or hinder the implementation of a health promotion programme, instead of attending to perceived needs. Contributing to health and health-care equity, previous conceptions of ageing persons who are born abroad as a vulnerable group of people are described as counterproductive with regard to health and health promotion, and the assessment of health promotion feasibility in study IV provide key lessons for how to discover, and promote capabilities, which reach beyond current norms.

Methodological conundrums

This thesis' exploration of how a health promotion programme could be developed in the context of ageing and migration highlights the importance of daring to speak about what is initially perceived as being difficult. Given the scientific scarcity, the strategic road map for the research conduct of this thesis was explorative in order to identify and define the research problem. Different approaches were applied in order to ideally suit each study's particular analytic interests. However, all methodological choices were made in relation to the overarching aim, which guided the whole research process.

To point out some people as different involves dangerous consequences for individual persons as well as the society as a whole, but categorising and targeting specific parts of the population is per definition what research is all about. Without categorisations it would be impossible to deal with the complexity of the human nature, and without being specific enough, there is no means of conducting high quality research. Since this thesis was designed to act as a prospective road map for health promotion practice in an ageing and increasingly diverse society, categorisations were made, but with careful consideration in order to be able to explore and reflect upon different people's capabilities and ways of perceiving health and health promotion.

The aim of the thesis required a distanciation from reductionist approaches and individually held preconceptions, and in order to address the multifaceted process of health promotion accordingly, the methodological choices were based on an integration of designs and methods. A hybrid and integrated approach to mixed-methods research was applied, with qualitative and quantitative findings informing later data collection processes. This allowed for an increased depth of

understanding, as well as an improved reliability and validity of the findings. The data collection involved multiple data sources and analytic techniques, sanctioning an integration of qualitative and quantitative findings. Findings were used to triangulate each other, to improve the validity and to inform the forthcoming derivation and analysis of data. What emerged was a complex picture of how the findings are situated within different contexts, and in relation to different health-care policies. The methodological approach applied thus answered questions with regard to what works and for whom, in relation to different circumstances.

The purpose with synthesising qualitative and quantitative findings was to create a solid research design to aid the construction of knowledge on perceived health promotion needs in order to improve the appropriateness, and feasibility of health promotion programmes. Working with several key principles, such as transparency, rigor, user involvement, and triangulation, the methods chosen were considerately integrated to complement each other. The integration of methods is however not without controversy and methodological conundrums. Due to epistemological differences, echoes of paradigm wars deem quantitative and qualitative research paradigms as incommensurable (114). However, there are paradigm stances to adopt in order to allow for a mix of methods, and for the aim of this thesis, a complementary strengths stance was applied. The mixed-methods design aimed to reduce each method's weaknesses, that is: the quantitative limitations with regard to depth of understanding, and the restricted possibilities and appropriateness of generalising qualitative findings (115). All questions of relevance to health-care provision can never be attended to, but by contrasting, and supplementing the requirements of strictly quantitative analyses, the findings of this thesis provide a more comprehensive perspective. Structures associated with different contexts, procedures and composition of health promotion programmes were explored and quantitative findings were strengthened by qualitative in order to explore hidden meanings and processes.

A summary of the experience of developing a protocol for a health promotion programme with ageing persons who are born abroad reveals the process of construction as equally important as the resulting scheme for health promotion. The aim was to enable the sharing, and making sense of multiple sources of knowledge, building bridges to aid communication between different groups of people. As described by previous cross-cultural studies (116-118), and qualitative methodology literature (119, 120), language differences may yield consequences for both interpersonal communication, and interpretation of collected data since

language is the common tool for expressing meaning. However, giving words to experiences is a complex process, not accessible for all people. Linguistic understanding of words is central in all phases of research, and linguistic differences between researchers and participants might threaten the validity of qualitative research. Therefore, certain methodological choices were made in the studies that are included in this thesis, with bilingual research assistants and triangulation of interpreted data.

Implications for practice

From a health professional perspective, the aim with this thesis was to inspire, and provide knowledge that could aid the creation of sustainable solutions on how health can be promoted in a society with an increased survival rate and improved possibilities for international migration. Providing a framework to guide execution and evaluation of health promotion initiatives, the findings provide some statements on what health professionals, researchers and decision makers could do to contribute to a more inclusive health-care environment.

Health professionals and health-care organisations are not immune to normative influences. In fact, they might even add to the construction of inequities by co-creating a normative adhesion, which reinforces power asymmetries, and influences what words are being used and by whom (121). Persons who seek health-care, and ageing persons who are born abroad, are two groups of people that are commonly categorised as being in an inferior position, with poor capabilities to achieve a desired state of health. As a response, the suggested person-centred approach confronted health-care structures, which give health professionals the power to undertake the role of an expert who determines to what degree the patient is allowed to participate.

Health professionals may face the risk of engaging themselves in rather superior behaviours as a result of the normative adhesive of health-care organisations (121). Limited by normative structures, we might conform to a view of human beings as individuals who are differentiated from each other. In contrast, a person-centred approach acknowledges the inherent reciprocity of human development. A person is, per definition, dependent on other persons and human interaction, and all persons share a common ground in being human. As visualised in the present findings, it is thus of importance to reflect upon how we conceptualise human beings, and recognise what is important to each person by genuinely listening to his or her narrative.

Promotion of health in the context of ageing and migration requires a confrontation of stereotypic views of ageing and migration. By visualising ageing persons who are born abroad as persons with capabilities, the findings could be used to identify a pathway to the *real* aspirations, motivations, and health-care needs of this part of the population. Current health-care organisations are commonly too system-centred and driven by norms, which contribute to health-care inequities. Sandman and Munthe (122) have described how this might influence health professionals to apply predefined standards of what ought to be the goal of a health-care encounter, and what information needs to be sought (122). Such standards are commonly founded in relation to the health professional's clinical experience, and preferably also to evidence-based practice. Considering the lack of knowledge on the health of ageing persons who are born abroad, this poses serious threats to the precision of health-care services. Health professionals' preconceptions are given primacy, and normative categorisations of people guide the direction of the health-care process. The suggested person-centred capability approach instead allows people engage in more equal health-care encounters, and acknowledge each other as persons with capabilities.

Reflecting further on the findings, the key to change is to confront the power privileges of health professionals, and dare to cross norms that the society and health-care organisations bear. As health professionals, we might be tempted to hide behind a professional role as certain behaviours might feel justified when taking on the role of a health professional who is guided by the organisational structure of his or her workplace, as well as by policies, laws and regulations. Entering an encounter as a person in relation to another person could in contrast be perceived as threatening and challenging, and result in professional uncertainty when not being able to decide the direction of the health-care encounter in beforehand. Yet, it is exactly this unsecurity that I would like to point ot as the core of a person-centred approach. By showing our own vulnerability to the other person, that person could be strengthened to show his or her vulnerability to us. Only then can power be more equally distributed, and health professionals and the persons who seek health-care can engage in a human encounter built on mutual respect.

In essence, person-centredness is concerned with human interaction and how we, as persons, relate to each other. Thus, in order to fully integrate a person-centred approach into the current health-care system, there is a need to

confront the egocentric view of mankind, which has been dominating the Swedish welfare system for a long time. As visualised in study III, all persons have their very own life stories, but it is not until we identify ourselves by narrating who we are and what we are capable of doing to another person that we can emerge as a person with capabilities. Consequently, person-centredness does not concern a shift of focus, or power, from the health professional to the person who is seeking care, but to the interpersonal action, that is, where the true power of human capability lies.

Previous research has put emphasis on the need for health professionals to recognise and respond to what cultural values and health-related beliefs persons who are born abroad behold (123). Cultural competence has been used to safeguard the quality of health-care for culturally diverse populations, described by Betancourt et al. (124) as an understanding of social and cultural influences on health beliefs and behaviours. Yet, even if cultural factors might have an impact upon norms on how to behave in a certain situation, and shape how human beings experience health and illness (125, 126), there is a risk with the idea of cultural competency to put focus on the differences across people based on their cultural backgrounds (110). As suggested in this thesis, a person-centred approach, with focus upon what connects people together as persons, is more likely to contribute to health equity, and health-care with high quality as perceived by person who are born abroad. This statement is supported by Dellenborg et al. (127), who describe the need for health professionals to understand human beings as being both similar and different in order to avoid stereotypic understandings of people with different cultural backgrounds than their own. However, Dellenborg et al. (127) also poses the question if a person-centred approach could acknowledge a person's sociocultural context. In the light of the present findings, this notion of person-centredness as a means to put focus on individual's taken out of their context, is interpreted as a result of current norms that put high value in autonomy and individuality. Hence, this notion needs to be crossed in order to adhere to the complexity of being a person in relation.

CONCLUSION

Bringing to a fore the universality and dynamism of human capability, the findings of this thesis challenge the common notion of ageing persons who are born abroad as a group of people with poor possibilities to take control over their health. Each study provides knowledge that has previously been lacking, gradually building up a potential foundation for how to design and implement health promotion programmes together with, and for, ageing persons who are born abroad. To target the ageing and migration processes with the aim to prevent them seems to be inadequate if we are to diminish health-care inequities, and the major finding is the recognition of the complex and dynamic interplay between personal choices and normative power, leading to a deeper understanding of what the actual threats to public health and welfare are. Moving beyond the norms on what it means to be a capable person, and what is considered a good and healthy life, the capabilities of ageing persons who are born abroad were discovered, leaving negatively charged characteristics of ageing and migration in the foreground. The findings suggest a person-centred capability approach to health promotion in order to allow for this discovery, strengthening each person's possibilities to be healthy within a living context. Tools to confront, and deal with, normative structures that have contributed to discriminatory behaviour and health-care inequities are provided, equipping health professionals, decision makers and researchers with possibilities to accept, and embrace the notion of all human beings as persons with capabilities.

FUTURE PERSPECTIVES

This thesis could be used as a foundation for further development of health-care services with ageing persons who have previously been excluded from health-care intervention research due to linguistic and cultural barriers. The findings provide knowledge on how a representative selection of how persons who are born abroad and health professionals experience their situations and possibilities, but there is always a need to put research findings in context. Even if a road map for how to apply a person-centred capability approach to health promotion is suggested, no standardised guidelines can be provided on how to move from knowledge to action in a broader context. The findings fill the knowledge gap to some extent, but the overall findings leave some questions open with regard to how human capability could actually be used to reduce health and health-care inequities. Believing in the power of the ageing population, a suggestion for future research is therefore to explore how to move health promotion even further by developing health-care policies that can build sustainable solutions and cross the borders that have been built between people.

The findings provide a foundation for future research, encouraging researchers to engage in research with people across all ages, cultural and linguistic backgrounds. Exclusion of ageing persons who are born abroad from research, and underwire negative norms, which diminishes the opportunities for all people to achieve a desired state of health. The call for a fully integrated person-centred capability approach to cross norms and move health promotion forward could be answered by research on what might facilitate or hinder the implementation of such an approach at all levels of health-care.

The findings further call for a need to reassure that health promotion programmes are feasible for both providers and participants. They also need to be perceived as valuable and purposeful for the target groups with regard how they can achieve a desired state of health. Previous work against discrimination in the health-care system has mainly been done in relation to professionals' preconceptions, and stereotypic views of different groups of people. Therefore, future research should aim to highlight the importance of bridging barriers that emanate from the experiences of both ageing persons who are born abroad, and health professionals.

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