

Capturing the experience of health among persons aging in a migration context

**Health promotion interventions as means to enable health
and occupations in daily life**

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UNIVERSITY OF GOTHENBURG

Gothenburg 2018

Cover illustration: Nordic walking by Annikki Arola

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ISBN 978-91-7833-105-5 (PRINT)
ISBN 978-91-7833-106-2 (PDF)
<http://hdl.handle.net/2077/56883>

Printed in Gothenburg, Sweden 2018
Printed by BrandFactory

I dedicate this thesis to my parents, a couple of brave immigrants, who chose to migrate and by that shape
a better life and future for the family.

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ABSTRACT

Aim: The overall aim of this thesis was to increase our understanding of health in everyday life among older persons aging in migration, and to evaluate the outcome of a health promotion intervention on sense of coherence, life satisfaction and engagement in activities, which are considered aspects supporting the experience of health in daily life. **Methods:** In this thesis, different methodological approaches were used. Two qualitative studies and two quantitative studies were conducted to fulfill the aim. **Study I:** Qualitative interviews were conducted with sixteen persons, age ≥ 65 , born in Finland and now aging in Sweden as labor immigrants. The analyse had a hermeneutic approach, aiming to obtain deeper descriptions of older Finnish immigrants experiences of health in daily life. **Study II:** Focus group methodology was used to explore healthcare professionals' experiences of health in the context of daily life among older Finnish immigrants in Sweden. Focus group discussions were conducted with 16 professionals, representing different healthcare professions. The analyses was inspired by a qualitative content analyse, in combination with the focus group method described by Kreuger. **Study III and IV** were evaluations of the two armed randomized controlled trial (RCT) emerging from the "Promoting Aging Migrants' Capability project. A total of 131 persons, aged 70 or older living at home, were included in the studies. Participants were independent in activities in daily living and without cognitive impairments. They were assessed at baseline and at follow-ups 6 months and 1- year post intervention. An intention-to-treat analysis was performed by using the following outcome variables: sense of coherence (study III), life satisfaction and engagement in activities of interest (studyIV). **Results:** The overriding meaning of the experience of health was connected to the older person's perception of their capability and the possibilities to use one's capability to manage daily life. This meant that to be able to experience health, the doings in everyday life has to be maintained, even if they have to struggle performing them. Additionally, the interwoven relationship to country of birth and to life in the host country was perceived as a health resource for the participants in the first study (study I). Similar findings emerged in the second study (study II), where professionals perspective of health in daily life could be described in two main categories, which were; "viewing oneself as a capable person" and "striving to maintain own origin". Viewing oneself as a capable person involved a strong belief in the older person's own capability to manage daily life independently. Moreover, the category "striving to maintain own origin" highlighted the importance of maintaining the connectedness to one's origin, including the relationships to compatriots in Sweden. This created a "we-feeling", which was seen as a health resource in daily life (study II). The health-promotion intervention demonstrated a significant difference between the control group and the intervention group regarding the total score of sense of coherence at 6 months follow-up (study III). No significant intervention effect was demonstrated for life satisfaction or engagement in activities of interest. However, at 6 months and 1-year follow-up the odds for maintained or improved life satisfaction was higher for participants in the intervention group compared to

participants in the control group (study IV). **Conclusion:** This thesis has revealed that older persons who have undergone migration do not appear to differ from the majority of similarly-aged older persons in terms of health challenges. The experience of health in everyday life seems to be connected to the persons' perspectives of their own capability, health and aging rather than to the migration background. From an occupational science perspective, this embraces an understanding of how humans are able to create a meaningful life after migration, where the daily life includes parts from the person's life before migrating, in combination with the routines and occupations developed in the host country during resettlement. This confirms the basic concept of occupational science that humans, through their own actions, can shape a manageable and comprehensive daily life despite the changes in context.

Keywords: occupation, health, aging, migration, health promotion, person-centredness

ISBN 978-91-7833-105-5 (PRINT)

ISBN 978-91-7833-106-2 (PDF)

<http://hdl.handle.net/2077/56883>

SAMMANFATTNING PÅ SVENSKA

I framtiden förväntas antalet äldre personer öka och allt fler äldre uppnår en hög ålder. Äldre personer beskrivs ofta som en skör grupp, som är särskilt utsatt för att drabbas av sjukdom, nedsatt aktivitetsförmåga och svårigheter att självständigt klara det dagliga livet. En särskilt utsatt grupp är äldre utlandsfödda personer som nu åldras i Sverige. Undersökningar som har gjorts bland dessa personer tyder på att deras hälsa är sämre i jämförelse med jämnåriga äldre som är födda i Sverige. Med tanke på detta så beskrivs denna grupp av äldre som en särskilt sårbar grupp. Det behövs insatser från samhällets sida för att möjliggöra för äldre personer att kunna upprätthålla hälsa i vardagen. Insatserna ska stödja de äldre personerna att ta i bruk och utnyttja de resurser de har och som de kan använda för att skapa en meningsfull och fungerande vardag och därmed få ett gott liv under sin ålderdom.

Syftet med avhandlingen var att öka vår förståelse av hur hälsa i vardagen upplevs av personer som åldras i ett land som inte är deras födelseland. Syftet var även att utvärdera om ett hälsofrämjande program med ett person-centrerat angreppssätt kan upprätthålla eller förbättra deltagarnas hälsa när hälsa granskas utifrån livskvalitet, deltagande i aktiviteter samt en känsla av sammanhang i vardagen. För att få en uppfattning om vad som bidrar till upplevelse av hälsa i vardagen har vi intervjuat äldre personer från Finland, som nu åldras i Sverige. Vi ville även utreda hur personal inom hälso- och sjukvård, som möter dessa äldre personer i sitt arbete, identifierar faktorer som kan ses som hälsoresurser i vardagen. Sedan utvärderade vi om ett hälsofrämjande program med ett person-centrerat perspektiv kan stödja den äldre personens möjligheter att ta i bruk sina resurser och därigenom stödja hälsa i vardagen.

Resultaten visade att upplevelse av hälsa uppkommer när personen kan utnyttja sin egen förmåga och sina egna resurser i vardagen på ett sätt som möjliggör för dem att utträta de aktiviteter i vardagen som är meningsfulla och nödvändiga. Vardagen blir på det här sättet mer hanterbar. En viktig faktor var att själv få bestämma hur man använder sina resurser och till vad man använde dem. Ett annat viktigt resultat, som stöder upplevelse av hälsa, var att kunna använda sitt modersmål vid kontakter med hälso- och sjukvård. Detta gjorde att situationer i vardagen blev mer begripliga och var lättare att handskas med. Om detta inte var möjligt upplevde de äldre att de då lätt blir utlämnade åt andras godtycke, vilket skulle innebära att de då inte har möjlighet att uttrycka sina egna innersta önsningar och behov. Detta påverkade deras känsla av meningsfullhet i vardagen. En annan viktig faktor som bidrog till upplevelse av hälsa var möjligheterna att kunna upprätthålla kontakterna till sitt hemland; kunna åka dit och hälsa på och delta i de aktiviteter som fanns där. Detta skapade en känsla av tillhörighet, som var en viktig faktor för upplevelse av hälsa i vardagen. Resultaten från det hälsofrämjande programmet antydde att det finns möjligheter att stödja livskvalitet, deltagande i aktiviteter och känsla av sammanhang, vilka alla bidrar till en ökad känsla av hälsa i vardagen. Vi kunde inte påvisa några stora skillnader mellan den grupp som deltog i programmet och den kontrollgrupp som användes som jämförelse. Oavsett detta så var det större chans för deltagarna i programmet att livskvalitet, deltagande i aktivitet med sociala inslag samt känsla av sammanhang skulle upprätthållas eller öka i jämförelse med gruppen som inte deltog i programmet. Orsaken till att det inte statistiskt gick att påvisa skillnaden berodde till stora delar på att antalet deltagare i studien var för lågt.

Sammanfattningsvis kan sägas att hälsa i vardagen handlar om att kunna använda sina egna resurser för att göra de saker i vardagen som har betydelse samt att kunna upprätthålla kontakten till sitt ursprung. Upplevelse av hälsa är kopplat till den egna känslan och möjligheten att kunna skapa en meningsfull vardag. Med tanke på detta så har ett hälsofrämjande program som utgår från ett person-centrerat synsätt möjligheter att stödja personers resurser så att de kan utnyttjas till att skapa en meningsfull vardag även när man åldras utanför sitt hemland.

Resultaten bidrar till att ge en mer nyanserad bild av personer som åldras utanför sitt eget hemland. Tankar kring vad hälsa i vardagen är kan ses vara universella och dessa tankar är relativt lika mellan äldre som åldras i sitt födelseland och äldre som åldras i ett annat land. I vår studie kan denna likhet eventuellt bero på att de äldre personer som deltog i studierna hade bott länge i Sverige. Detta befäster tanken att människor genom sina egna åtaganden och aktiviteter kan skapa sig ett meningsfullt liv i ålderdomen fastän sammanhanget förändras.

TIIVISTELMÄ SUOMEKSI

Ikääntyneiden henkilöiden osuus yhteiskunnassa kasvaa. On oletettava, että heidän toimintakykynsä heikkenee johtuen sairauksista sekä ikääntymisen myötä. Tästä johtuen tämä ryhmä on haavoittuvaisempi kuin muut ryhmät yhteiskunnassa. Erityisen haavoittuvaisia ovat ne ikääntyneet henkilöt, jotka viettävät vanhuuden päivänsä kotimaan ulkopuolella, ns. siirtolaisuudessa. Tutkimustulokset osoittavat, että ikääntyneillä siirtolaisilla on heikompi terveydentila, kuin saman ikäisillä henkilöillä kantaväestössä. Tästä johtuen ryhmä voidaan katsoa olevan erityisen haavoittuvainen.

Tutkimukset osoittavat, että ikääntyneillä henkilöillä on korkea motivaatio pyrkiä ylläpitämään terveyttään ja myös selviytyä arkipäivän toiminnoista mahdollisimman hyvin. Mahdollisuudet jatkaa asumista omassa kodissaan mahdollisimman pitkään on tärkeä osa arkipäiväistä selviytymistä. Ylläpitääkseen terveyttään ikääntyneet henkilöt tarvitsevat tukea ja ohjausta. Yksi keino tähän on terveyttä edistävät toimenpiteet, joita yhteiskunnan terveydenhuolto voi koordinoida. Heidän tehtävä on tukea ikääntyneitä tunnistamaan ja löytämään omat resurssinsa, jonka avulla he voivat toimia paremmin arjessa. Omien resurssien löytämisen myötä arkipäivästä tulee merkityksellisempi ja toimivampi, mikä mahdollistaa hyvän ja laadukkaan elämän.

Tämän tutkimuksen tarkoitus oli selvittää ja lisätä tietämystä siitä mitä terveys arkipäivässä merkitsee ikääntyneille henkilöille, jotka elävät vanhuuttaan ulkomailla. Tavoite oli myös arvioida, jos terveyttä edistävä ohjelma voi tukea ikääntyneitä henkilöitä ottamaan käyttöön omat voimavaransa ja sen myötä ylläpitää tai parantaa elämän laatua, elämän hallintaa sekä osallistumista mielekkääseen toimintaan.

Tässä tutkimuksessa haastattelimme ikääntyneitä suomalaisia henkilöitä, jotka kuvailivat asioita omasta arjesta, jotka tuottavat terveyden ja hyvinvoinnin tunnetta. Halusimme myös hahmottaa mitä voimavaroja ulkopuoliset näkivät ikääntyneiden arjessa, jotka voisivat ylläpitää tai edistää terveyttä. Tätä hahmotusta varten haastateltiin terveydenhuollon eri ammattiryhmiä. Seurasimme myös miten henkilökeskeinen, terveyttä edistävä ohjelma voi tukea ikäihmisten mahdollisuuksia ottaa käyttöön omat voimavaransa ja siten tukea omaa terveyden tunnetta arkipäivässä.

Tulokset osoittivat, että terveyden tunne muodostuu, kun henkilö voi hyödyntää omia kykyjään ja resurssejaan arjessa tavalla, joka luo sujuvuutta

arkeen. Tärkeä osa oli myös, että henkilöllä oli mahdollisuus itse päättää, miten ja mihin omia voimavarojaan käytetään. Tärkeää elämänlaadun ja terveyden kokemisessa, ulkomailla ikääntyessä, oli oman äidinkielen käyttämisen mahdollisuus terveydenhuollon palveluissa. Tämä lisäsi ymmärrettävyyden tunnetta arkipäivässä ja teki tilanteista helpommin käsiteltäviä. Mikäli ei ollut mahdollisuutta käyttää äidinkieltään, jonka avulla ilmaista omia toivomuksia ja tunteita, kehittyi tunne että on kokonaan toisten armoilla. Tämä heikensi arkipäivän merkityksellisyyden tunnetta ja sen kautta heikkeni myös terveyden tunne. Tärkeä osa terveyden ja hyvinvoinnin tunteesta tuli myös siitä, että oli mahdollisuus ylläpitää suhteita kotimaahan; mahdollisuus käydä siellä ja osallistua niihin toimintoihin ja tapahtumiin mitä siellä oli. Tulokset terveyttä edistävästä ohjelmasta näytti, että on mahdollista tukea terveyttä arkipäivässä henkilökeskeisen ohjelman avulla. Heillä, jotka osallistuvat terveyttä edistävään ohjelmaan, oli suurempi todennäköisyys ylläpitää ja parantaa elämänlaatuaan, elämäntilannetta sekä osallistumista toimintoihin verrattuna vertailuryhmään. Eroa ei kuitenkaan voitu osoittaa tilastollisesti, mikä todennäköisesti johtui siitä, että osallistujamäärä tutkimuksessa oli liian pieni.

Yhteenvedon voimme todeta, että terveys arkipäivässä koostuu siitä, että on kykenevä tekemään ne asiat, jotka ovat tarkoituksenmukaisia ja mielekkäitä. Tärkeää on myös että arkipäivässä on tasapaino erilaisten toimintojen välillä. Terveyden tunne on myös vahvasti kytköksissä mahdollisuuteen olla yhteydessä toisten ihmisten kanssa, sekä yhteys omaan alkuperään ja historiaan. Nämä tulokset antavat vivahteikkaamman kuvan ikäihmisistä, jotka viettävät vanhuuttaan ulkomailla. Terveys arkipäivässä koostuu paljolti samoista asioista kuin muilla ikääntyneillä henkilöillä ja terveyden tunnetta ei määrittele pelkästään heidän siirtolaistaustansa. Tämä vahvistaa ajatusta siitä, että ihminen pystyy omien tekojensa ja toimintojen kautta luomaan itselleen merkityksellisen elämän, vaikka joutuu tekemään sen eri ympäristössä kuin hänen alkuperäinen ympäristö. Terveyden tunne on pääasiassa kytkettynä omaan kokemukseen siitä mitä mahdollisuuksia itsellä on luoda merkityksellinen arki. Tämä tarkoittaa että voi käyttää omia voimavaroja arjen askareisiin, joita koetaan tärkeiksi ja välttämättömiksi. Yhteenvedon voimme todeta, että terveyttä edistävällä ohjelmalla voidaan tukea ikäihmisiä ottamaan omat voimavarat käyttöön, mikä mahdollistaa mielekkään arkipäivän, elämän laadun ja osallisuuden. Tämä myös tilanteissa jolloin ikääntyminen tapahtuu oman kotimaan ulkopuolella.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

- I. Arola LA, Dellenborg L, Häggblom Kronlöf G. Occupational perspective of health among persons aging in the context of migration. *J Occup Sci* 2018; 25:65-75.
- II. Arola LA, Mårtensson L, Häggblom Kronlöf G. Viewing oneself as a capable person - experiences of professionals working with older Finnish immigrants. *Scan J Caring Sci* 2016;16. doi: 10.1111/scs.12395.
- III. Arola LA, Barenfeld E, Dahlin-Ivanoff, S, Häggblom Kronlöf G. Distribution and evaluation of sense of coherence among older immigrants before and after a health promotion intervention-Results from the RCT study Promoting Aging Migrants' Capability. (*submitted*)
- IV. Arola LA, Dahlin-Ivanoff, S, Häggblom Kronlöf G. Impact of a person-centred group intervention on life satisfaction and engagement in activities among persons aging in the context of migration. (*accepted for publication in Scan J Occup Ther*)

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ABBREVIATIONS

ADL	Activities of daily living
CG	Control Group
IG	Intervention Group
ITT	Intention-to-treat
LiSAT	Life Satisfaction Assessment
LOCB	Last Observation Carried Backward
LOCF	Last Observation Carried Forward
MCD	Median Change of Deterioration
MMSE	Mini-Mental State Examination
OR	Odds Ratio
PAMC	Promoting Aging Migrants' Capabilities
RCT	Randomized Controlled Trial
SM	Senor Meeting
SOC	Sense of Coherence

1 INTRODUCTION

Life expectancy is expected to increase worldwide, even in Europe, where it is currently the longest. This means that the number of older people will rise in all European countries. The World Health Organization (WHO) has calculated that the number of persons older than 65 years will increase and by 2025 will account for 25% of the total population. It is also assumed that this group of older persons will be healthier than previous generations, but there will also be a larger number of frail elderly (1). It is difficult to anticipate the health status of the future elderly but the assumption is that the need for health care services will increase among them. The increasing number of persons in need of health care services, combined with fewer people of working age, will create a challenge for healthcare providers in society (2).

Research shows that a further challenge will be older persons, who are aging in migration. A report from the Swedish National Board of Health and Welfare (3) states that immigrants evaluate their health status as being bad or very bad three to four times more often than do native born persons of the same age. According to Hjern (4), immigrants are more prone to suffer from mental illness and other non-communicable diseases than are native born persons. Additionally, persons with low sense of coherence (SOC) seem to suffer more from these diseases than do those with a strong sense of coherence (5).

Different explanations have been proposed regarding differences in health status between immigrants and native-born persons, some of them connected to immigrants' previous life styles, low-paid jobs and living in low-status residential areas (3). A further reason evinced is connected to the immigration process with the accompanying language difficulties, displacement and financial challenges, all of which have a negative impact on health status (6, 7). This group of older persons have therefore been identified as being exposed to a double burden of vulnerability; weaker health combined with stress factors connected to migration (8-10).

Health is a difficult concept to define. The most used definition is that proposed by the WHO, namely that health is a state of complete physical, social and mental well-being, not just absence of illness or disease (11). However, in this thesis health is seen from an occupational perspective, which means that a person experiences health when there are opportunities in daily life for doing, being, belonging and becoming (12, 13). Thus health is a subjective experience defined by the person himself and connected to how well he or she consider

that everyday life is meaningful and manageable. Health promotion interventions are all planned activities designed to improve health.

Health promotion interventions have been described as beneficial in supporting health among vulnerable groups (14, 15), especially among older persons (16, 17). It can also be seen as a way to decrease inequalities in health between different groups of older persons in society (18). The aim with health promotion is to empower older persons to create a meaningful everyday life despite frailty or vulnerability due to health related factors. To be able to empower older persons aging in migration to experience health, the starting point should be to focus on the person and his or her actual needs and preferences (18). A health promotion intervention with a person-centred approach makes it possible to empower persons to be experts on their own life situations. A crucial factor is to recognize the person's narrative, which helps professionals to view the world from the person's own perspective (19). Person-centred health promotion is created in partnership between the individual and the professionals providing the intervention (20). Therefore, the key to success in person-centred health promotion is to also utilize professionals' experiences of health promotion work with older immigrants (21, 22).

Research in health promotion aims to improve health promotion practice and so to reduce inequalities in health. Reducing inequalities in health also creates equal opportunities for participation in the community (23). This thesis is a part of a wider study entitled Promoting Aging Migrants' Capabilities (PAMC) (24), which aimed to implement a person-centred approach to health-promotion for older persons aging in migration (25). The health promotion intervention was conducted in the form of 'senior meetings' in partnership between participants and professionals. The intervention was originally developed for native-born older, independent living persons aimed at support them to maintain health in their everyday lives (26). In PAMC the content of intervention was modified to be feasible for older persons with immigrant background (24).

This thesis includes studies aimed at exploring the experience of health in everyday life among older immigrants (I-II). Additionally, it includes studies evaluating the health promotion program implemented in order to identify factors contributing to the experience of health. (III-IV).

1.1 Aging, daily occupations and migration

Daily occupations are often taken for granted and normally give rise to no particular reflection. However, changes in the environment, interruptions to routines, or the need to change ways of doing things serve to raise questions as to how and why certain activities are performed at all. The awareness of the significance of such activities also becomes more acute. Thus changes in the dimension of meaning will also affect the emotional dimension of performing the occupation (27, 28).

The aging process as such entails changes and decreases in people's functioning, which may impair their chances of coping with daily life. The aging continues throughout life. Heritage, environment and lifestyle have an impact on the aging process (29). Successful aging consists of being able to experience good health, have the opportunity to be engaged in daily life and also to have control over one's daily life (30). However, the aging process and decline in functioning may affect individuals' opportunities to manage their daily lives. How a person can manage daily activities depends on both the functional capability the person has and the demands occasioned by the activities and the environment. The environment can either support or hinder persons to perform occupations. If the demands imposed by the environment exceed the individual's competence, this will constitute an obstacle to performance (31). A meaningful daily life also includes the opportunity to continue with those activities which are important on a personal level. However, the aging process with decline of functions may make it impossible to perform occupations in the same way as before. Thus these occupations need to be adapted so as to be feasible in another way or by using assistive devices. Adapting an occupation and the way it is to be performed may have an impact on its meaning. If such impact is negative, the person may choose to abandon the occupation.

Among aging immigrants several of the aspects mentioned above may affect the opportunity to experience health in daily life. Firstly, the context in which the occupations are performed is not the same as the context in the country of birth. A change in context may affect how a person feels about the significance of an occupation. When migrating from one country to another, the context and culture change. Since culture is seen as a dimension which gives meaning to occupations (28, 32), the shift from one cultural context to another may affect their meaning and how they are experienced (28). Persons aging in migration may experience changes in their opportunities to engage in meaningful occupations in everyday life (33). There may be a disruption in daily occupations (34, 35) which may affect the experience of health in daily life.

Additionally, if the environment is such as to preclude occupations formerly a part of the daily routines before migration, this will also have an impact on daily life.

Participation in occupations is also a way for human beings to develop and express their identity (33, 36). Being able to engage in meaningful occupations makes it possible to express one's self, which strengthens the sense of well-being (36). Thus migration may in that sense also threaten a person's chances to show his real identity if there are no opportunities to participate in meaningful occupations. Migration may limit the chances to stay in touch with family and friends left behind, which is also one aspect with a negative impact on health (37). Thus migration may occasion involuntary role changes and role changes as such might lead to a sense of loneliness and boredom (38).

Reflecting on these perspectives, older persons aging as immigrants may have fewer opportunities to engage in meaningful and engaging occupations compared to their native-born age peers. This in turn, may have a negative impact on the person's chances of experiencing health in daily life.

1.2 The occupational perspective of health

An occupational perspective on health highlights the connection between health and engagement in occupations (39). Occupations refers to activities people do in everyday life. The World Federation of Occupational Therapy (WFOT) defines occupations as: "...the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do" (40). The occupations are also recognized and named by the culture in which they are performed (41) and therefore it can be assumed that human occupations are formed by our cultural background.

The relation between occupation and health is connected to dimensions of meaning in occupations (28). The meaning aspect in occupations derives from different dimensions and can be seen to be connected to concepts of doing, being, becoming and belonging (42). The experience of doing, being, becoming and belonging is universal among human beings and an important part of the experience of health in everyday life (28). To be able to experience health, a person should be able to engage in valuable and meaningful occupations in his or her own particular context. The opportunity to use one's capacity enables a person to achieve future goals in life (12, 13). Thus the experience of health is supported when a person can use his capacity in various

types of daily occupations, both routine tasks and more meaningful and engaging occupations.

Engagement in occupations, the doing aspect, contributes to the experience of health, life satisfaction and wellbeing (12, 38, 43). Menec (44) states that the connection between engagement in activities and the experience of health is related to the overall level of engagement in occupations, especially engagement in productive and social activities. An engaging occupation is characterized by a deep emotional aspect. The occupation is performed with passion and perseverance and stands out from other routine activities in daily life. Engaging occupations are also imbued with positive meaning for the person who is engaged in the occupation (38, 45). Additionally, the occupation and engagement have to be self-initiated (46). Thus in a migration context this means that older persons need opportunities to participate in self-initiated occupations which they find meaningful and engaging. Moreover, the occupations should also be named or identified within a group where the person can have a sense of belonging. To have a sense of belonging means that the person has the sense of being affiliated with other persons who are important to him or her (13). This is an important occupational perspective of health and for persons aging in migration, the opportunity to socialize with compatriots and have a sense of belonging can be seen as an important health resource in daily life.

Some research suggests that people with fewer engaging occupations tend to have lower life satisfaction (47) and less sense of meaning in everyday life (48, 49). However, it is important to remember that it is not only the number of occupations which contributes to the experience of health. Instead, it is more about having a balance of different experiences from the occupations, meaning that the occupational repertoire should include both calming occupations and more exciting occupations, which may create a flow experience (50). Thus a balance between different emotional experiences in occupations may have a greater impact on health and life satisfaction than the mere number of occupations. This can be related to the dimension of being as a meaning aspect in occupations, which contributes to the experience of health. With a balance between different occupations, and having time for being, people will have the time to relax and reflect on life and come to terms with themselves. It also creates opportunities to express one's inner thoughts, which enables people to see life as real and authentic (28). The being aspect, with the opportunity to reflect on one's life, is also important when reflecting on the future. This leads to the concept of becoming, which relates to persons thoughts about themselves in the future (13). For persons aging in migration the reflection of oneself in the future can be full of thoughts about what the future will be like:

Is it possible to get the service needed if one's language skills are weak? What will happen if it is no longer possible to manage daily activities independently? (51). Thus the being and becoming aspects of health can have either a positive or a negative impact on health depending on how the environment can enable the person to live a secure and meaningful life without worrying about what is to come.

1.3 The salutogenic perspective on health

Since health can be understood and defined in different ways, the previous section described health from an occupational perspective. Another way to understand health is to focus on how different behaviours in life can be conducive to health and wellbeing. Antonovsky (52) did not see health as an absolute phenomenon. In contrast to the traditional view of health and illness, he did not dichotomize health and illness as opposites (53). Instead, he wanted to highlight and explore underlying factors accounting for why some people experience health in a greater extent than others. Based on this assumption, he developed a theory called salutogenesis that describe this phenomenon. The salutogenic perspective on health sees health as a continuum between total ease (health) and dis-ease (Fig 1). Antonovsky claimed that health is a resource which all human beings have and during the life course human beings experience more or less health. Thus health is seen as a continuum on an axis where health is located somewhere between ease and dis-ease. Every person is always somewhere on this continuum, depending on the circumstances and the context.

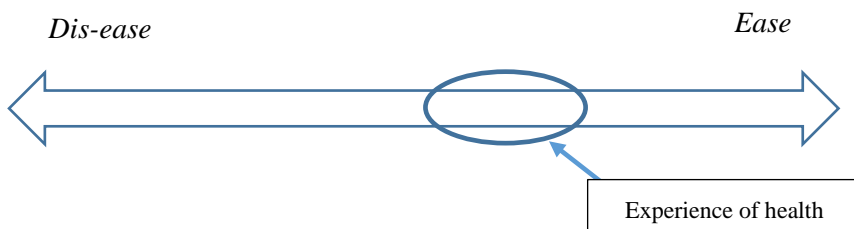


Figure 1: The continuum of health as described by Antonovsky (2005)

The theory highlights factors conducive to health in contrast to the traditional, pathogenic view, which predominantly seeks to discover the causes of illness. To focus on factors conducive to health can be seen as consisting of different

coping strategies used to move towards the health pole on the ease/dis-ease continuum, i.e. towards salutogenesis. Antonovsky defined health as:

‘a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that (1) the stimuli deriving from one’s internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges worthy of investment and engagement’. (54), p19).

The concepts of Sense of Coherence (SOC) and General Resistance Resources (GRR) are the main components of the salutogenetic perspective on health. (52, 53). SOC and GRR explain how health is affected but also provide guidance on how health can be maintained and promoted. The Sense of Coherence refers to a person’s ability to understand his or her life situation and to have the capacity to use available resources as means to be able to move towards the health pole (55).

The concept of SOC includes three parts, which promote a strong SOC: comprehensibility, manageability and meaningfulness. Comprehensibility relates to a belief that things happen in a predictable way and a person has the ability to understand the challenges encountered in everyday life. Manageability means that a person has confidence in the availability of resources to support coping in challenging situations. It is related to personal skills but also to external support and resources which can be used to manage daily life.

Meaningfulness means that a person finds life interesting, and that it gives satisfaction and the motivation to cope with situations in daily life. The person is also convinced that there is a good reason or purpose to live. A strong SOC is a result of both psychological and social factors and of a person’s cultural context. The person’s life experience and narrative are also factors affecting SOC (53, 56). A strong SOC can reduce the impact of stress on physiological functions (57) and can therefore be seen as health promoting factor. It can also be promoted by available resources in the environment and also by experiences in everyday life. Antonovsky called these resources Generalized Resistance Resources GRRs; they may be internal resources (physical, cognitive, emotional) or external resources (sociocultural context) (55).

The aging process can be a stressor undermining the GRR and may consequently also weaken the SOC. If the decline in health or social support and networks appears faster than the older person can cope, the impact on the

SOC may be negative (57, 58). For older persons aging in migration there may be several factors affecting the SOC. According to Slootjes (59), comprehensibility in daily life may be affected by the differences in sociocultural norms and symbols. This may affect the person's possibilities to interpret and understand the expectations from the environment. Additionally, there may be contradictions regarding the expectations of compatriots and native-born persons (59). Slootjes also states that manageability may be affected by the fact that the person with immigrant background belongs to a minority group. Belonging to a minority group may imply limited possibilities to use all the resources the person has. In this situation there may be an imbalance between the resources the person has and his or her opportunities to use the resources, causing these opportunities to be underused. On the other hand, there may also be an overload, meaning that the expectations and demands from the environment exceed what the person can manage, thereby having a negative impact on the person's ability to manage the situation and so also on the opportunities to lead a meaningful daily life. The meaning aspect may also be affected by limited opportunities to participate in decision-making in important social situations (59), thereby constituting an additional stressor likely to impact on the persons health and well-being.

1.4 Capability as a health resource

This study uses the capability approach to point out that older persons aging in migration have at their disposal capabilities to maintain health and create a meaningful everyday life. Viewing human beings as capable persons means seeing them as having resources to manage their lives (60). Capability as a concept focuses on how persons can use their capabilities to create valuable and meaningful lives. The concept includes two main constructs, functioning and capability. The construct functioning in the capability approach is the visible proof of a person using his capability, and also the goal for conducted actions (61, 62). Capability refers to the real opportunities a person has to be what he wants to be. It also includes the person's real opportunities for doing the things he values and chooses to do. Capabilities occur on different levels, organizational level (policy), community level (healthcare organizations and community) and individual level (individual competence, resistance skills). The individual level of capability is the person's individual characteristics, such as genetic predisposition, physical and mental health and lifestyle which allow the person to make use of his capability. Healthcare organization in society can be seen as a capability factor on community level. The role of the healthcare organization is to create structures and environments enabling people to convert their resources into desired functions (61). Thus, health promotion interventions can be seen as a capability factor on community level.

An important aspect in the capability approach is the person's free will, meaning that two persons with the same capability may choose to use their capabilities in two different ways, or choose to not use them at all (62, 63). A capable person therefore has the freedom to choose which actions enable him to reach important and meaningful personal goals in life (60). The aspect of free will in the capability approach has similarities with theories within occupational science and occupational therapy. The core for participating in occupations derives from the personal causation, which refers to the motivation for performing an occupation (38). The personal freedom to choose what one wants to do is closely connected to the person's motivation to act. Additionally, seen from an occupational perspective, functionings can be seen as the occupations, which the person choose to perform and participate in and which he deems significant.

According to Robeyns and Sen (62, 63), a person's possibilities to reach the desired goals, with his motivation and free will, depends on what kind of means or goods he has access to. A person uses these means to perform the desired actions. The relation between the means and the goals for actions is influenced by three types of conversion factors: personal, social and environmental (62, 63). The personal factors are the individual's skills and body functions, such as physical functions, cognitive capacity, gender. Examples of social conversion factors are social norms in society, discriminating actions and gender roles. The environment conversion factors may include the physical surroundings or geographic environment but also the social environment, including significant others and significant groups of persons. So, a prerequisite for a persons to be able fulfill life goals is that the circumstances in the environment are such that enable the persons to use their capabilities. If the environment do not allow the persons to use their capabilities, the capability will break down (64). One step in supporting the capability among older persons aging in migration is to enable them to identify the resources they have. Additionally, it is crucial to create environments where it is possible for them to use the capability and also to support the person to start using their capabilities. This creates more equal opportunities for persons to focus on occupations, which are meaningful and important and by that support the experience of health in daily life.

1.5 Health promotion with person-centred approach

Health promotion is about empowering people participating in health promotion interventions, with the aim to maintain or improve their health and wellbeing (65). Health promotion can be seen as a form of supportive environment which enables persons to utilize their capability. The traditional way to develop support and services within healthcare usually has a deficit perspective, where the focus is on decline and illness instead of health resources. This approach has been criticized by Morgan & Ziglio (66), who argue that there is a need for research concerned with seeking evidence departing from the perspective of health resources.

To enable health and a meaningful everyday life for persons aging in migration entails encountering person in their specific contexts. This means that it is their occupations, values and interests in daily life which guide the intervention. Additionally, this can be seen as a way to empower these old persons and to enable them to build daily lives which they appreciate (67). Thus a person-centred approach is preferable when planning health promotion interventions for older immigrants (25). The aim of person-centred health promotion is to enable and empower persons to utilize their capabilities (68). Seen from an occupational perspective, this means enabling participation in occupations they want and need to do and which create meaning in everyday life (27). The starting point is then the older persons themselves, with their individual experiences, diversities, identities and potentials (6, 12, 69). Moreover, it is important to recognize that different persons may have different needs caused by the aging process (70). Different persons may also have different goals in everyday life. Thus, the support needed will then differ depending on the participants in the intervention.

Health promotion interventions with a person-centred approach are built up by an interaction between the recipients of the service and the professionals providing it (25). The central issue is the encounters between the person and the professionals. Here the focus is on the person's life tasks, valuable occupations and the individual's different roles in daily life (68). A person-centred approach in health promotion strives to create a relation in which there is opportunity for an authentic dialogue (71) between the person and the health care professionals. This can be seen as a relationship or as a partnership, which creates mutual respect for the person's life situation, volition and self-esteem (19). The partnership is based on co-operation and on a dialogue where the person is respected as an equivalent partner in the situation. Professionals' role is to support and enable the person to make autonomous decisions based on the

dialogue. In this way, the intervention will be capability-focused (72). The person's active involvement is key to the whole intervention process (73). The relation, dialogue and partnership open up opportunities to jointly identify the person's health resources and capabilities. These can then be used to empower the person to utilize the capability and so maintain and improve health and support a meaningful everyday life.

Evidence about health promotion with a person-centred approach, based on the occupational perspective and the salutogenic perspective, opens up possibilities to identify and focus on health resources which the older person can utilize to experience health and wellbeing in the migration context. Additionally, this kind of health promotion also creates opportunities to identify those factors constituting possible obstacles or barriers to the experience of health in daily life. Thus, the person-centred approach enables a shift and a movement from the problem-oriented perspective on health towards a perspective where the focus is on health resources among older persons themselves. Taking this perspective on health supports older persons aging in migration to move towards positive health along the ease/dis-ease continuum (74). Moreover, it enables older persons to build a meaningful everyday lives where it is possible to experience doing, being, belonging and becoming (12, 13).

2 RATIONALE

Maintaining health in old age is both a challenge and a goal for individuals and for society. Research has shown that older persons with immigrant backgrounds are frail due to poorer health status than their native-born peers (4, 6). Frailty and the immigration process reportedly represent a double burden for older immigrants (9), which jeopardizes the experience of health. Health in everyday life is closely connected to opportunities to engage in meaningful occupations (13) and a sense of meaning in life is a key determinant for experiencing health (28, 53). In the context of migration, the perspective on health and health resources among older persons is essential.

The rationale for this thesis is based on the assumption that it is of vital importance to understand and broaden the view of health from an occupational perspective among older persons living in the context of migration. By doing so, it gives guidance on how to empower older persons to create a meaningful, comprehensive and manageable life in migration context. It may also create a more nuanced picture of health among older persons aging in migration, in contrast to descriptions where this group of older persons are viewed as passive victims of their past (75).

This thesis takes an occupational and salutogenic approach to describing health and health resources. An occupational and salutogenic perspective on health offers an opportunity to develop health promotion interventions where the focus is on the resources the person has, i.e. on the person's capability. To be able to do so, it is crucial to place the person at the very core of the health promotion and therefore a person-centred approach is preferred.

Health promotion interventions need to be evidence-based (66). To be able to create person-centred and evidence-based interventions, both qualitative and quantitative approaches were used in this thesis. The qualitative approach was used to capture older person's experience of health and the challenges and barriers likely to be detrimental to health in daily life. Additionally, a quantitative approach was used to evaluate the impact of health promotion interventions on the sense of coherence, life satisfaction and engagement in activities, all aspects which have been identified as being supportive factors for the experience of health in daily life (12, 38, 43, 53, 76). This will contribute to develop an occupational and salutogenic health promotion where the persons and their resources are the core and able to act as experts on their respective life situations. Additionally, this will also contribute to the health

promotion field by taking a capability and resource oriented view instead of a perspective where the focus is on decline and illness.

3 AIMS

The overall aim of this thesis was to increase our understanding of health in everyday life among older persons aging in migration, and to evaluate the outcome of a health promotion intervention on sense of coherence, life satisfaction and engagement in activities, which are considered aspects supporting the experience of health in daily life.

The specific aims for the studies were:

- To explore how older persons from Finland who are aging in Sweden experienced health from an occupational perspective. (Study I).
- To explore healthcare professionals' perception of health in context of daily life among older immigrants (Study II).
- To describe the distribution of SOC and its components among older persons aging in the context of migration and to evaluate whether a health promotion intervention with a person-centered approach could influence SOC 6 months and 1 year post intervention (Study III).
- To analyze the effects of a person-centred health promotion intervention on life satisfaction and engagement in activities among older immigrants aging in Sweden (Study IV).

4 PARTICIPANTS AND METHODS

4.1 Overall study design

In this thesis, different methodological approaches were used. Two qualitative studies and two quantitative studies were conducted to fulfill the aims of the thesis (Table I). Study I took a hermeneutic approach aiming at developing understanding the reality or the lived world of the research participants (77), in order to obtain deeper descriptions of 16 older Finnish immigrants' experiences of health in daily life. Study II was a focus group study based on four focus group discussions with healthcare professionals aiming at gaining a collective understanding of health professionals' experiences of health in the context of daily life among older Finnish immigrants. Studies III and IV were two armed randomized controlled trials (RCT) emerging from a project entitled "Promoting Aging Migrants' Capability" (PAMC) (24) evaluating the effect of the intervention program senior meetings 6 months and 1 year post intervention. In addition, study III had a cross sectional design aiming to describe the distribution of the sense of coherence and its components among older persons aging in migration. Participants in the intervention studies were independently living older persons 70 years or older who had migrated to Sweden from Finland and the Balkan Peninsula (an overview of the study design approaches is presented in Table I). The regional Ethical Review Board approved the study (Reg. no.: 821-11) and the trial was registered at ClinicalTrials.gov (NCT01841853).

Table 1. Overview of the study design approaches

	Study I	Study II	Study III	Study IV
<i>Design</i>	Explorative	Explorative	Experimental and descriptive	Experimental
<i>Sample</i>	Persons (n=16) aging in Sweden born in Finland, ≥ 65 years of age	Health care professionals (n=16), social workers, occupational therapist, physiotherapist, nurses, home help professionals	Immigrants 70 year or older from Finland and Western Balkan (n=131)	Immigrants 70 year or older from Finland and Western Balkan (n=131)
<i>Data collection method</i>	Individual interviews	Focus group discussions	Questionnaire and assessment	Questionnaire and assessment
<i>Data analysis</i>	Interpretative hermeneutic	Qualitative content analysis	Chi square Odds ratio	Chi square Odds ratio

4.2 Study setting

The setting for all studies was a suburban district in a middle-sized town in Sweden with an overall low income level and a large proportion of older immigrants (Table II). The majority of the inhabitants lived in rented apartments and approximately half of them had experienced migration. Most immigrants over the age of 65 had their origins in the Western Balkans and Finland.

Table II: Demographic characteristics of participants at baseline

	Control n = 75 (%)	Intervention n = 56 (%)	Total n = 131 (%)
Age range (mean, SD)	70-84 (74.2 SD 3.4)	70-82 (74.0, SD 3,4)	70-84 (74.1, SD 3,4)
Male, n (%)	29 (52)	37 (49)	66 (50)
Living alone, n (%)	32 (43)	31 (51)	63 (48)
Type of housing			
<i>Tenant</i>	38 (51)	30 (54)	68 (52)
<i>Owner of apartment</i>	17 (23)	9 (16)	26 (20)
<i>Owner of house</i>	19 (25)	16 (28)	35 (27)
<i>Other</i>	1 (1)	1 (2)	2 (1,5)
Education, n (%)			
<i>Tertiary education^a</i>	12 (16)	8 (14)	20 (16)
<i>Low education^b</i>	13 (18)	15 (27)	28 (22)
Migrated from, n (%)			
<i>Balkan Peninsula</i>	38 (51)	22 (39)	60 (46)
<i>Finland</i>	37 (49)	34 (61)	71 (54)
Years lived in Sweden, n (%)			
≥21 years	63 (84)	51 (91)	114 (87)
Reason for migration, n (%)			
<i>Labor</i>	20 (27)	27 (50)	47 (37)
<i>Refugee</i>	17 (23)	9 (17)	26 (20)
<i>Family</i>	9 (12)	7 (13)	16 (13)
<i>Other</i>	27 (37)	11 (20)	38 (30)
Good self-rated ability to speak Swedish in contact with authorities, n (%)	66 (88)	51 (91)	117 (89)

^a Tertiary education (≥3 years) ^b Low education /elementary school or no education

4.3 Explorative study design

4.3.1 Individual interviews with hermeneutic approach (Study I)

Study I had a qualitative interpretive design with a hermeneutic approach. “Hermeneutic” is the scientific subjective interpretation of texts with the aim of developing and deepen the understanding of a phenomenon in the reality or the lived world of the research participants (77).

Participants and recruitment

Sixteen persons, who had migrated from Finland were recruited from members of a Finnish Association in a middle-sized town in western Sweden. Snowball

sampling (78) was additionally used to recruit more participants. Inclusion criteria were age ≥ 65 years, living in ordinary housing, no diagnosis of memory loss. The majority of the participants had come to Sweden as labour migrants and had been living in Sweden ≥ 40 years. Some of the participants had a working knowledge of Swedish, but despite this, they chose to conduct their interviews in Finnish. Participants' self-reported health revealed that the majority of the participants evaluated their health as being good ($n=7$) or satisfactory ($n=6$).

Data collection and analysis process

The present author was responsible for conducting all the interviews. Sixteen one-on-one interviews were conducted at a place selected by the participant: own home or the premises of one of the Finnish associations. The interviews were conducted in the language the participants preferred, Finnish or Swedish. This was considered the most appropriate way to ensure a trusting relationship between the interviewer and participants. It also gave participants the opportunity to express themselves in greater detail during the interview by being able to choose the language they felt most comfortable with. Qualitative semi-structured interviews were used for all interviews to reach richer descriptions of participants' experiences of health in daily life. To create a context for the data each interview was re-written into narratives (79). The narratives were written in the first person, which facilitated the personal understanding of participants' life worlds. The hermeneutic understanding of the phenomena was produced through systematic interpretation processes. After an extensive comparison of the narratives and critical reflection sessions between the three researchers involved, different patterns emerged from the narratives. In line with the hermeneutic approach, the formulation of comprehensive themes was then tested against the totality of the text for the themes to reach a level of coherence that captured the meaning of the text.

4.3.2 Focus group methodology (Study II)

A focus group method was used to explore different professionals' views on and experiences of what contributes to the experience of health in daily life among immigrants from Finland. This method involves group discussions among participants generating the data used in the analysis. Group interaction is an important part of this method (80-82). The focus group process aims to encourage participants to express not only what they think, but why they think

in a certain way. The collective nature of focus groups can also empower participants and validate their views and experiences.

Participants and recruitment

Participants were recruited by convenience sampling (83) through managers in primary and municipal care units. In total, 16 professionals participated in four focus groups: home help professionals (n = 5), registered occupational therapists and physiotherapists (n = 4), nurses (n = 4) and social workers (n = 3). Participants in the focus groups were heterogeneous in terms of age, length of work experience, and different professions and nationalities. They were homogeneous in their respective groups because all participants belonged to the same profession, and all were involved in the care and rehabilitation of older persons from Finland.

Data collection and analysis process

The focus group discussions were conducted at the professionals' workplaces, during their ordinary working day. Each focus group met once for up to two hours. Key questions were formulated in advance to structure the discussion. The questions were related to different aspects of health in the context of daily life among older Finnish immigrants; the person's activity in seeking help when a health problem arose, issues regarding language problems, motivating issues for the older immigrants to participate in health promotion and cultural influences on their views of healthcare services. The focus group discussions were led by two researchers, one in the role of moderator and the other of observer. The moderator's task was to pose questions to develop the discussion while the observer took notes during the session.

The qualitative data analysis used was inspired by the framework of analysis developed by Graneheim (84) and Krueger (85) in order to analyse the large and complex nature of focus groups discussions. The most suitable unit of analysis is data, which are large enough to be considered as a whole and which can be kept in mind as a context for meaning (84, 86)

All sessions were audio-recorded and transcribed verbatim. The analysis was performed in Swedish. In the first step of the analysis the audio-recordings were listened to several times. Thereafter, sections of the discussion relevant to the research topic were identified and sorted into different themes. The working material was kept in the form of raw data to enhance the

understanding of the contextual meaning. Categories were established on the basis of the raw data, which constructed descriptive statements synthesizing, abstracting and conceptualizing the data. The last step was to summarize the categorized raw data, combined with an interpretative step that aimed to provide understanding.

4.4 Experimental study design: Promoting Aging Migrants Capabilities (Study III & IV)

Promoting Aging Migrants' Capability (PAMC) (24) was a two-armed randomized controlled trial aiming to evaluate the health promotion intervention as regards the sense of coherence (Study III), life satisfaction and engagement in activities (Study IV) at 6 month and 1 year follow-ups. In addition, study III had a cross sectional design aiming to describe the distribution/prevalence of sense of coherence and its components among older persons aging in migration.

Participants

Participants were independently living older persons 70 years or older who had migrated to Sweden from Finland and the Balkan Peninsula, including Bosnia–Herzegovina, Croatia, Montenegro and Serbia. The inclusion criteria were as follows: independent of others' help in activities of daily living, as measured by the ADL staircase (87, 88), and living in ordinary housing in an urban district. The exclusion criterion was impaired cognition. Individuals scoring less than 80% on administered items from the Mini-Mental State Examination (MMSE) (89) at baseline were excluded and referred to the appropriate health care services.

Recruitment

Participant recruitment comprised three hierarchical waves. In the first step, participants were randomly selected from official registers in one suburban district of a medium-sized town in Sweden. As the target inclusion rate was not achieved in the first wave, a second sampling wave was conducted. This step used the same procedure as in the first wave but used official registers from another suburban area with similar demographics. Additionally, snowball sampling (78) was used as a third step to recruit more participants from the

target groups. The study protocol (24) contains additional information about the recruitment process as presented in Figure 2.

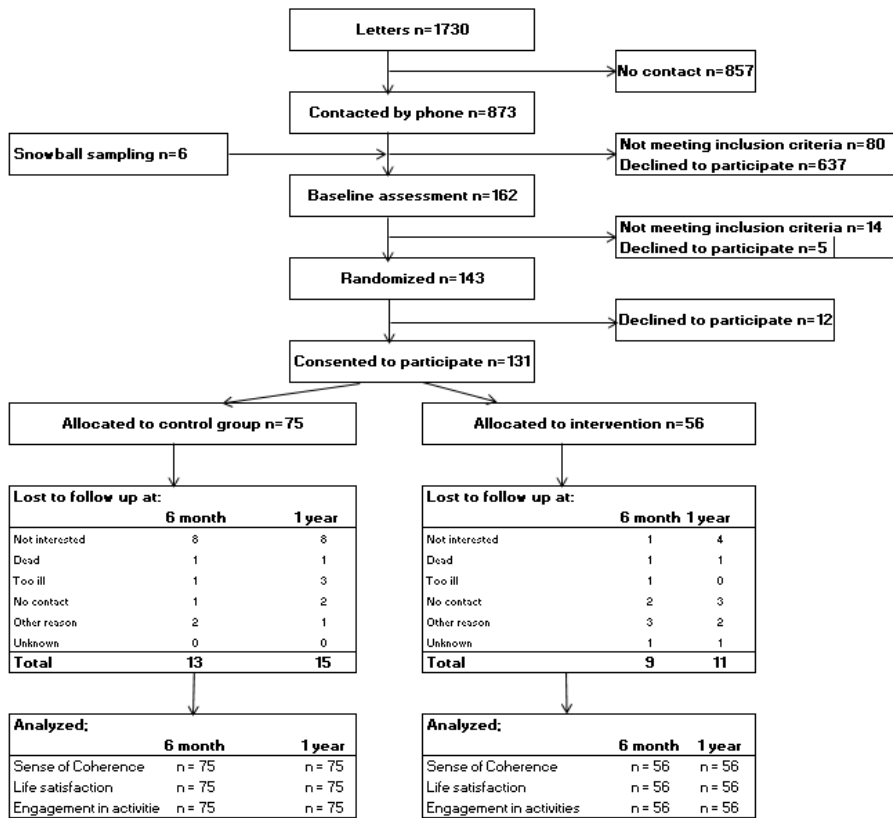


Figure 2: The flow of participants through Promoting Aging Migrants' capabilities study and the reasons for declining participation at 6 months and 1 year follow-ups

In total, 131 persons fulfilled the inclusion criteria and consented to participate; 88 participants were allocated in the first wave, 37 participants in the second wave and six participants in the third wave. The study protocol contains details of the study setting (24).

Data were collected during 2012–2016. Members of the interdisciplinary team or a research assistant trained in the specific assessments conducted the assessments at baseline. The research assistants conducted the follow-up assessments at 6 months and 1 year post-intervention.

4.4.1 Intervention

Senior group meetings with one follow-up home visit

The intervention consisted of four group meetings, named senior meetings (SM), held over a period of four weeks. Additionally, the participants were offered a follow-up home visit two to three weeks after the last SM. Separate SMs were held for both language groups, Finnish and Serbo-Croatian. A booklet delivered in advance was used as a trigger to open up reflections about general challenges related to aging and health in daily life. The booklet was translated into both languages and was also available as a CD. The study protocol contains detailed information about the content of the booklet and the professionals in charge for the interventions (24). A person-centred approach (19) was used, with the intention to promote a shift of power from the group leader to the participants in order to facilitate the partnership between the participants in the senior meetings but also between the participants and the professionals. During the meetings the participants was encouraged to narrate who they are and describe how they perceived their capability in daily life. These narrations stimulated the group discussion, exchange of experiences and peer-learning between the participants (90). A bilingual approach was used, meaning that participants chose their preferred language of communication: Moreover, an interpreter was available if needed. The follow-up home visits were conducted by one of the professionals who had conducted the SM. These follow-up visits gave the participants the opportunity to pose any individual questions that had occurred to them since the last meeting.

Control group

Participants in the control group (CG) had access to ordinary health care services, which they could contact as they wished. At baseline or follow-up participants were given information about where to access health care if they required it urgently.

4.4.2 Outcomes

Sense of coherence

The 13-item form of the Orientation to Life Questionnaire was used to assess sense of coherence (53). The SOC questionnaire consists of three interrelated components: five items connected to comprehensibility (e.g., “do you have the feeling that you are in an unfamiliar situation and don’t know what to do?”), four items connected to manageability (e.g., “how often do you have feelings that you’re not sure you can keep under control?”), and four items connected to meaningfulness (e.g., “how often do you have the feeling that there’s little meaning in the things you do in your daily life?”).

Life satisfaction

Life satisfaction was measured using the validated Life Satisfaction Assessment LiSat-11 (91). The LiSat-11 focuses on important life domains, such as financial and vocational situation, self-care management, contact with family and friends and global life satisfaction. Participants are asked to respond to each item by estimating their level of satisfaction, scored on a 6-point scale from 1 (very dissatisfied) to 6 (very satisfied). In this thesis, items on sexual life (item 6), family life (item 8) and partner relations (item 9) were excluded, leaving eight items. This exclusion was based on previous experiences indicating that these items would be too sensitive for the target study population (92).

Engagement in activities of interest

A questionnaire was used to assess engagement in 17 activities categorized into four domains: *solitary-sedentary activities*, such as watching TV, following the news, reading a book or completing a crossword puzzle; *solitary-active activities*, such as gymnastics, gardening or walking; *social-cultural activities*, such as going to the cinema or concerts or visiting a museum; and *social-friendship activities*, such as visiting friends, travelling and association membership activities (93, 94). Participation in these activities was rated on a 3-point scale: 1 (yes, often/regularly), 2 (yes, sometimes) and 3 (never). The response alternatives were then dichotomized into 1 (yes, often/regularly and yes, sometimes) and 0 (never).

4.4.3 Sample size, random allocation and blinding

A power calculation was performed based on one of the secondary outcome measures of the PAMC study (24) the Berg Balance Scale. To reach a power of 80%, a significance level of $\alpha = 0.05$ was needed and to detect a difference of $\geq 15\%$ between the groups, each study arm required a sample of 65 participants. The random allocation was stratified to enroll equal numbers of people from Finland and from any of the other four countries selected in the Balkan Peninsula: Bosnia–Herzegovina, Croatia, Montenegro and Serbia. After the baseline assessment, participants were randomly assigned to the intervention group (IG) to the control group (CG) using opaque, sealed envelopes. A researcher not involved in the enrolment or the intervention organized the randomization, which was performed after baseline assessment. To enable blinding of the assessments at baseline and follow-up, different individuals conducted the assessments (24).

Statistical analyses

Descriptive and inferential statistics were used to compare the control group (CG) and the intervention group (IG) and for analysis of change over time from baseline to 6 months and from baseline to 1 year follow-up. To ensure that the results were as comprehensive as possible, analyses were conducted according to the intention-to-treat principle, which required that all participants were analysed in the group to which they were randomly allocated (95). This means that missing data at follow-ups was replaced. For sense of coherence and engagement in activities the last observed carried forward, LOCF (96) was used, assuming that sense of coherence and engagement in activities are stable over time. If it was not possible to use LOCF, the replacement of missing values was made by using last observation carried backwards (LOCB) for each participant. If neither LOCF nor LOCB were feasible, the median score for the group was used to replace missing data. For life satisfaction missing data were replaced using median change of deterioration (MCD), assuming that life satisfaction is expected to deteriorate over time owing to normal aging.

For sense of coherence, several analysis was performed. First, we made a cross-section at baseline of the distribution of SOC scores and the three SOC components, i.e, comprehensibility, manageability and meaningfulness. Second, a longitudinal analyse was made of changes over time in total score on SOC and the three components. Additionally, an analyse was made to

evaluate movements between the different levels of SOC during the intervention. The participants were dichotomized to maintained/improved score or non-maintained from baseline to respective follow-up. The numbers of participants who had maintained or improved their scores were calculated. To test differences in proportions of participants who maintained/improved their scores at follow-ups, an overall chi square test was performed. Thereafter odds ratios (ORs) were calculated.

To be able to describe movement between different levels of SOC, the scores were divided into quartiles, scores; 13-63 indicate low level of SOC, scores 64-79 indicate medium level of SOC and scores 80-91 indicate high level of SOC (97). A comparison of the levels of SOC was then made between participants in CG and IG by calculating how many persons had improved, been maintained or had deteriorated regarding their level of SOC. Here the focus was not on the scores per se; instead, the movement between the different levels of SOC is described; from low to medium or to high level of SOC or vice versa. A chi square test was conducted to test the movements between levels in SOC among the participants in both groups and odds ratios (OR) were calculated.

All tests were two-sided with significance level of $p \leq 0.05$. Data were analysed using SPSS version 24 (IBM Corp., Armonk, NY, 2009).

5 ETHICAL CONSIDERATIONS

The regional Ethical Review Board approved the studies (821-11 and T947-12). The main focus in this thesis is to explore the experience of health among older persons aging in migration and if a health promotion intervention with a person-centred approach could be used to maintain or improve their opportunities to achieve health. To choose a specific group on the basis of ethnicity can be considered stigmatizing. However, this research can be seen as a good intention aiming to create better conditions for an exposed group to maintain health in everyday life. Additionally, the information gathered from the studies, and which is summarized in this thesis, may draw a more diverse picture of older persons aging in migration. By highlighting their resources and the importance of being able to conduct meaningful occupations, there may be more similarities than differences compared to native-born age peers. In this way the older persons are seen as having needs which are similar to those of others, not as persons with specific needs due to their immigrant background. This fulfills the requirement of both occupational justice and health justice for this group of older persons.

However, since the thesis focuses on older persons with immigrant background there are several ethical issues to consider. The first issue concerns language. To be able to overcome language difficulties and misunderstandings, the material used was given to participants in both Swedish and the participants' native language. The participants then had a real opportunity to have all the information about what it meant to participate in the research project. The translated material was also a way to enable participation in a research project for those who did not speak the mainstream language. The language issue has been raised as one main reason for the exclusion of people of foreign origin from research projects (98). The assessments at baseline and follow-ups were also made in the participants' native language, or in Swedish if the person so wished. When participants chose to use their native language the assessments were conducted by speaker of that same language. The senior meetings were conducted in a mixture of languages, Swedish, the participants' native language or a combination of both. An interpreter was also available if needed. These actions created situations in the senior meetings, which guaranteed that the participants could obtain the information and be able to participate in group discussions on equal terms.

Some of the assessment methods used in the studies was based on interviews where the participants were asked to evaluate and rate their physical and psychological health. Some of the questions may have appeared sensitive and

might also give rise to strong feelings. To meet these situations, some extra time was reserved for the interviews so that it was possible to discuss and respond to such feelings. The same approach was used during the senior meetings. Additionally, if other health related issues arose, and if the person was in need of healthcare, a contact to healthcare service was established.

6 RESULTS

This chapter presents the contribution of each study to the thesis as a whole, with a summary of the main results; detailed results are presented in Studies I – IV.

6.1 Results of Study I

The results in study I illustrate how older persons experience health in everyday life. The overriding meaning of the experience of health was connected to their opportunities to cope in daily life. An important aspect of the experience of health was connected to persons' perceptions of their capabilities used to perform occupations, deemed necessary and meaningful. The participants described that it was of great importance for the participants to "*Push and force to keep on doing*" in daily life. This meant that the sense of health in daily life entails persevering with activities even if it is a struggle.

Additionally, the relationship to the country of origin and life in the host country could also be seen as a health resource for the participants. The experience of health was supported when the two contexts, country of origin and host country were reconciled. This created an experience of being at home in both places, which was described in the theme "*Belonging to and longing for two places called home*" (study I). This could be also seen in the themes related to language issues. The theme "*Language of heart*" described the importance of being able to express oneself in a way that revealed and imparted one's inner thoughts to others. The language was important in connections to others, such as compatriots and connections to family left behind. The theme "*Connection to origin*" revealed the importance of being able to remain in touch with friends and family back home. This created a sense of security, continuity in life and a sense of belonging, which can be seen as a health resource connected to the occupational perspective of health. To have a sense of belonging was also important for of the participants' identities. It was obvious that the connections to the country of birth strengthened their identities and created feelings of knowing where they come from, where they have their roots. This can be seen as a part of their narrative and of a person having a sense of continuity in his or her narrative. It also gives strength to manage daily life. However, belonging was seen as a dual issue, since they also had the feeling of belonging in the host country, which was a more continuous support in daily life and thereby contributed to the experience of health.

An important issue, when trying to understand the experience of health, was related to the sense of belonging among compatriots in the host country. *“Togetherness with compatriots”* describes the importance of having the opportunity to participate in occupations together with like-minded persons and to share a common background and a common language.

Factors detrimental to the experience of health included a fear of the future. The fear consisted of thoughts regarding how the future in daily life would be if the person could no longer cope independently with daily life. *“Imaging aging in future daily life”* and *“Language of heart”* describes the uncertainty the older persons experienced when thinking about aging far from home as immigrants. There was concern about the future that was largely linked to anxiety about not being understood, not being able to express occupational needs and not to be seen as the person you are. This fear was mostly connected to situations where persons imagined themselves being in need of healthcare services and dependent on professionals who did not speak their *“language of heart”*.

6.2 Results of Study II

Health promotion interventions are conducted by professionals within healthcare. Study II contributes to the overall aim by describing how professionals reason regarding health resources and factors impeding health among older immigrants.

The results show that healthcare professionals respect the older person and are keen to understand how to enable a good everyday life despite decline caused by the aging process. Professionals respect older person’s capabilities which they want to use to manage daily life. The results also highlight how professionals respect and perceive the importance in being able to continue as independently as possible. In the category *“Viewing oneself as a capable person”* professionals describe how important it seems to be for the older persons to be able to cope with daily activities independently without help from others.

Professionals also described difficult situations caused by the persons’ enormous desire for independence. The subcategories *“Keeping up appearances”* and *“Battle of wills”* described situations when the person can no longer cope independently with daily life. The professionals described these situations as difficult to handle since they might well lead to conflicts between the person and the professionals. According to the professionals, older persons reject the help offered as long as possible. Professionals felt compelled to argue

with the person and try to convince him or her to use the support offered. These situations were frustrating for the professionals and caused a sense of vulnerability since they could not relieve the suffering they saw.

A strong health resource which professionals identified among the older persons was their desire to keep up with the contacts in the country of birth. “*Striving to maintain own origin*” concerns their wish and aspiration to continue to keep up contacts and also to continue to perform occupations familiar from the country of birth. Another issue identified by the professionals as a health resource was the older person’s contacts with compatriots in Sweden, in whom the elderly persons seemed to have more faith regarding health issues and health care services than professionals or health care organizations gained.

6.3 Results from experimental study design: Promoting Aging Migrants Capabilities

Sense of coherence

The results in study III describes a cross-section at baseline of the sense of coherence among older persons aging in migration, see table III. There were no significant differences regarding the distribution of sense of coherence between the two groups.

Table III: Cross section at baseline of the distribution of SOC scores and the three components of SOC, mean (SD), median, n (%).

	Control n = 75	Intervention n=56	<i>p</i>	Total n=131
SOC total score				
mean(SD)	71,5 (12,7)	68,9 (11,0)	0,255	70,4 (12,0)
median	74,5	70,0		73,0
n (%)	62 (83%)	42 (75%)		104 (74%)
Meaningfulness				
mean (SD)	22,3 (4,2)	21,3 (3,8)	0,207	21,9 (4,1)
median	22,0	22,0		22,0
n (%)	65 (87%)	43 (77%)		108 (82%)
Comprehensibility				
mean (SD)	27,3 (6,0)	26,7 (5,0)	0,397	27,2 (5,6)
median	29,0	27,5		28,0
n (%)	63 (84%)	44 (79%)		107 (82%)
Manageability				
mean (SD)	21,8 (2,8)	20,7 (3,2)	0,210	21,3 (4,5)
median	23,0	22,0		22,0
n (%)	64 (85%)	44 (79%)		108 (82%)

After the health promotion intervention a significant difference was apparent between the control group and the intervention group regarding total SOC score at 6 months follow-up, $p=0.038$ (OR: 2,23 CI: 1,05-4,77) (Table IV). There was also an improvement in all the separate components of the SOC so that participants in the intervention group were more likely to have maintained or strengthen scores for all three components. An interesting result is the component manageability at 6 month follow-up, where the odds for a strengthen manageability was in favour for the intervention group, OR: 1,96 ; CI (0.94 to 4.11). However, this improvement was not visible anymore at 1 year follow-up.

Table IV: Maintenance or improvement of total SOC scores and the scores of the three components at 6 month and 1-year post-intervention: n (%), odds ratio (OR), 95% confidence interval (CI), and p-values.

	Control group n (%) OR	Intervention group n (%) OR(95%CI)	p- value
6-months			
Total SOC	43(57) 1.00	42 (75) 2.23 (1.05 to 4.77)	0.038
Meaningfulness	50 (67) 1.00	42 (75) 1.50 (0.69 to 3.25)	0.303
Comprehensibility	44 (59) 1.00	38 (68) 1.49 (0.72 to 3.07)	0.283
Manageability	42 (56) 1.00	40 (71) 1.96 (0.94 to 4.11)	0.073
1-year			
Total SOC	47 (63) 1.00	32 (57) 0.79 (0.39 to 1.61)	0.523
Meaningfulness	49 (65) 1.00	37 (66) 1.03 (0.50 to 2.14)	0.930
Comprehensibility	45 (60) 1.00	28 (50) 0.67(0.33 to 1.34)	0.255
Manageability	47 (63) 1.00	32 (57) 0.79 (0.39 to 1.61)	0.523

The results also suggest a minor movement between the different levels of SOC (Table V). Compared with the control group, more participants in the intervention group exhibited an increase in SOC level from baseline to the 6 month follow-up, OR: 1,74; CI (0,75-4,05), although the findings was not significant. At 1 year, SOC levels returned to baseline levels in the intervention group.

Table V: Comparison of changes in SOC levels between control group and intervention group 6-months and 1-year post-intervention: n (%), odds ratio (OR), 95% confidence interval (CI), and p-value

	Control n =75 n (%) OR	Intervention n=56 n (%) OR (95% CI)	<i>p</i>
SOC level baseline – 6-month			
Strengthened SOC	13 (17) 1,00	15 (27) 1.74 (0.75-4.05)	0.195
Maintained SOC	48 (64) 1,00	31 (55) 0.70 (0.34-1.41)	0.318
Deteriorated SOC	14 (19) 1,00	10 (18) 0,95 (0.39-2.32)	0.906
SOC level 6-month-12-month			
Strengthened SOC	13 (17) 1.00	4 (7) 0.37 (0.11-1.19)	0.096
Maintained SOC	49 (65) 1.00	39 (70) 1.22 (0.58-2.56)	0.604
Deteriorated SOC	13 (17) 1.00	13 (23) 1.44 (0.61-3.41)	0.405
SOC level baseline-12-month			
Strengthened SOC	12 (16) 1.00	10 (18) 1.14 (0.45-2.87)	0.779
Maintained SOC	50 (67) 1.00	31 (55) 0.62 (0.30-1.26)	0.189
Deteriorated SOC	13 (17) 1.00	15 (27) 1.74 (0.75-4.05)	0.195

Life satisfaction

At 6 month follow-up, positive change could be seen in life satisfaction even if the changes were not significant (Table VI). The odds ratio was higher for participants in the intervention group regarding maintenance or improvement

of life satisfaction, especially in areas related to activities and social relationships. Even at 1 year follow-up the odds was higher for participants in the intervention group to have maintained or improved their life satisfaction compared with the control group.

Table VI: Proportion (%), odds ratio (OR), 95% confidence interval (CI), and p-value for maintenance or improvement of life satisfaction at 6 month and 1 year follow-up between control group and intervention group

Outcome measure	6 month follow-up			1-year follow-up		
	Control n = 75 n (%) OR	Intervention n = 56 n (%) OR (CI)	p	Control n = 75 n (%) OR	Intervention n = 56 n (%) OR (CI)	p
Life as a whole	52 (69) 1,00	34 (61) 0,68 (0,33-1,41)	0,305	48 (64) 1,00	35 (63) 0,94 (0,46-1,92)	0,860
Vocational situation	48 (64) 1,00	41 (73) 1,54 (0,72-3,28)	0,265	41 (55) 1,00	37 (66) 1,61 (0,79-3,30)	0,190
Financial situation	50 (67) 1,00	39 (70) 1,15 (0,54-2,42)	0,718	50 (67) 1,00	35 (63) 0,83 (0,40-1,72)	0,621
Leisure	47 (63) 1,00	32 (57) 0,79 (0,39-1,61)	0,523	43 (57) 1,00	33 (59) 1,07 (0,53-2,15)	0,855
Contact with friends	49 (65) 1,00	39 (70) 1,22 (0,58-2,56)	0,604	45 (60) 1,00	40 (71) 1,67 (0,79-3,50)	0,177
Ability to manage self-care	41 (55) 1,00	33 (59) 1,19 (0,59-2,40)	0,627	36 (48) 1,00	25 (45) 0,87 (0,44-1,75)	0,703
Physical health	43 (57) 1,00	22 (54) 0,86 (0,43-1,72)	0,668	48 (64) 1,00	30 (54) 0,65 (0,32-1,31)	0,230
Psychological health	40 (53) 1,00	35 (63) 1,17 (0,58-2,39)	0,657	39 (52) 1,00	35 (63) 1,54 (0,76-3,12)	0,281

Engagement in activities of interest

Regarding engagement in activities, even if there was no significant difference between the groups at 6 month follow-up, it was possible to see that participants in the intervention group had higher odds for improvement in engagement in activities. Activities connected to friends and social situations had higher odds of being improved than among participants in the control group (Table VII)

Table VII: Proportion (%), odds ratio (OR), 95% confidence interval (CI), and p-value for maintenance or improvement of engagement in activities of interest at 6 month and 1 year follow-up between control group and intervention group.

Outcome measure	Control n = 75 n (%) OR	Intervention n = 56 n (%) OR (CI)	<i>p</i>	Control n = 75 n (%) OR	Intervention n = 56 n (%) OR (CI)	<i>p</i>
Some/any activity of interest	49 (65) 1,00	43 (77) 1,76 (0,80-3,84)	0,158	51 (68) 1,00	36 (64) 0,85 (0,41-1,76)	0,656
Solitary-sedentary activities	70 (93) 1,00	49 (88) 0,50 (0,15-1,67)	0,259	65 (87) 1,00	51 (91) 1,57 (0,50-4,88)	0,436
Solitary-active activities	55 (73) 1,00	42 (75) 1,09 (0,49-2,41)	0,830	56 (75) 1,00	41 (73) 0,93 (0,42-2,04)	0,851
Social-cultural activities	61 (81) 1,00	49 (88) 1,61 (0,60-4,29)	0,344	54 (72) 1,00	43 (77) 1,29 (0,58-2,86)	0,537
Social-friendship activities	60 (80) 1,00	47 (84) 1,31 (0,53-3,24)	0,566	60 (80) 1,00	44 (79) 0,92 (0,39-2,15)	0,842

This is in line with the results for life satisfaction, where the parts dealing with social relationships were improved among participants in the intervention group. Thus, engagement in activities connected to social aspects favoured participants in the intervention group 6 months post intervention. However, at 1-year follow-up there was no significant difference between the groups on any of the variables. The odds ratio for maintained or improved engagement in activities among participants in the intervention group had returned to the baseline level and in some cases even lower.

7 DISCUSSION

The findings from this thesis contribute to gaining a more profound understanding of what contributes to the experience of health among older persons aging in migration. The findings also include the results from a health promotion intervention intended to support older persons to experience health from the perspective of life satisfaction, sense of coherence and engagement in activities of interest. The findings reveal that experience of health among older migrants include the opportunity to manage in daily life by performing meaningful occupations deemed necessary and desirable (study I) and being able to accomplish these without too much outside help (study II). The experience of health was reinforced by a sense of belonging with family and relatives in the country of origin and with compatriots in host country (studies I & II). The health promotion intervention with a person-centred approach had some positive impact on the participants' sense of coherence and life satisfaction, while no effect was visible regarding participation in activities of interest (Studies III & IV).

7.1 Experience of health in everyday life

An understanding of what contributes to the experience of health among older persons is connected to the perspective of being able to manage occupations in daily life deemed necessary and meaningful. This serves to impart a sense of mastery and reinforces the person's experience of health. The participants described the importance of this by expressing that they have to "*Push and force to keep on doing*" (study I). This was a way of maintaining health and delaying the decline in capability. The participants talked about this as a "*life blood*". The sense of having control over one's daily life, and be capable of doing the activities expected and desired, was a way to fight against aging and the gap it would create between what they wanted to do and what they actually could do (99). The importance of being able to manage daily occupations by themselves was also apparent in the category "*Viewing oneself as a capable person*" (study II), which describes the professionals' views of what health consists of among this elderly group. According to the professionals, there was a strong motivation among the participants to keep up the appearance of being a capable person in control of his or her daily life. This way of creating a sense of health through occupations is consistent with theories describing how doing is the foundation of health and living (13). It can also be related to findings from other studies related to healthy aging among native-born older persons, where health consists of having motivation for and being able of doing things in everyday life and to be able to adjust one's doings to the demands of daily

life (100, 101). Thus, the findings reveal a picture, where the participants were able to perform occupations, which were important for them and so to strengthen their experience of health. This in contrast to research suggesting that migration may disrupt older people's chances of continuing to participate in meaningful occupations (34).

Health in daily life was also supported by a sense of belonging (13). The connections to life in the country of origin and to life in the host country created a context where the person had a sense of belonging to a specific group (studies I & II). When these two contexts were interwoven, the experience of health was strengthened. This interwoven life was related to family left behind and the life in host country. Connections with family left behind were maintained by travelling to the country of origin where they joined family members in shared activities and visited places where they had been in their youth. These activities with family and friends created a sense of safety and a sense of still being a part of the life left behind. This can be compared to studies describing the importance of older immigrants having a place for the "real me" (99). Moreover, the participants also had a sense of a place for the real me in the host country. This was shaped by the activities they engaged in with compatriots. The importance of being a part of a group with the same preferences as oneself reinforced the experience of health. Palo-Stoller claims that this 'knowing each other in advance' creates a basis for fellowship (102) thereby strengthening the sense of belonging as a meaningful aspect of a sense of health. According to Krause (56) it is important for older persons to maintain social relations with those to whom they are emotionally attached and this affords emotional support in the form of empathy, caring and trust. Moreover, Krause claims that social relationships and social support can influence the creation of meaning in life. The interaction with significant others makes it possible to discuss, reflect and clarify issues with others which might otherwise be unclear.

However, the findings also revealed another picture, which can be seen as the other side of the coin, and which may detract the sense of health among older immigrants. The subcategory "*Battle of wills*" (study II) relates to the participants' opportunities make decisions regarding their daily lives and how to maintain their health. The findings indicated that there is a discrepancy between the views of healthcare professionals and those of the participants related to when and what kind of healthcare services the participants would need. Lundberg (103) highlight the importance for professionals to have an understanding of the values and decisions which the older person makes. Otherwise there may be a risk that the professionals will objectify the person and not respect the person as a person (72).

This objectifying and misunderstanding of the participants' view of health in daily life may be the explanation for the fear of the future which the participants experienced. This fear of the future may be associated with the perspective of becoming. The concept of becoming includes the person's thoughts of how the future will be (13). The participants were apprehensive about the future; should they no longer be able to perform the important occupations anymore due to aging process and decline in functions? In other words, if they did not have the capability needed to cope with daily life without support from others. They expressed this as "*being at the mercy of others*" (study I), which reveals the feeling of being unable to take care of oneself and especially being unable to express one's needs and wishes regarding personal matters in daily life. To become dependent on others in the future, and not be able to express one's thoughts and needs, created a picture of the future which the participants experienced it as no longer being seen as a person. The findings indicate that the participants tried to protect themselves against showing their vulnerability to others by trying to "*keep up appearances*" (study II) as long as possible. This meant that the participants did not want to show that there was a decline in their capability affecting their chances of managing daily occupations. Instead, the participants created alternative ways of doing things. Previous research confirm that older persons tries to keep up with their occupations by creating alternative ways of performing the occupations (104). Consequently, these perspectives and experiences of health in daily life are not specific to older persons aging in migration but rather suggest a scenario where aging is experienced similarly regardless of the ethnic background.

However, the findings revealed some specific aspects which is important to highlight when it comes to persons aging in migration. The findings revealed that the language aspect had an essential impact on the experience of health among the participants. The worry about the future was connected to language in relation to worries over how meaningful occupations would be affected when aging in a country other than the country of birth. It was of great importance for the participants to be able to use their native language in different situations in daily life, especially when communicating about health-related matters with healthcare professionals. The participants spoke of this as having the opportunity to use "*the language of heart*" (study I) when communicating one's wishes and needs. Language is also the means for being able to interpret signs and symbols in an environment (105), which is a prerequisite for being able to perceive situations as comprehensible. The participants described that language was important in the sense that it made it possible for them to express themselves, to be able to reveal their spirituality. Spirituality concerns the experience of the being human and finding meaning

in daily occupations (106). Additionally, language is essential in relations with others when shaping meaning in one's doings in everyday life (36). To be forced to use a foreign language when communicating about daily life with healthcare providers creates feelings of uncertainty (107) which may impair the experience of health. Thus, experience of health in daily life is supported when a person can express himself using his native language and so being able to reveal his true self.

7.2 Outcome of health promotion intervention

The purpose of Studies III and IV was to ascertain if the health promotion intervention could maintain or improve the older person's sense of coherence, life satisfaction and engagement in occupations. All these aspects have been identified as supporting experience of health in daily life (12, 38, 43, 53, 76).

Sense of coherence

The cross-section made at baseline (study III) showed that mean SOC score was comparable to that of older persons in Sweden (108). This finding contradicts earlier findings that migration may undermine all components of the SOC, comprehensibility, manageability and meaningfulness (59). One explanation for this may be the duration of the stay in the host country. The participants had been living in the host country for decades and this may affect how a person feels about immigration and how they have been able to build up a meaningful daily life in a new context (109). After living many years as an immigrant the participants may have felt capable of acculturation and had time to adapt to the new culture (110). This creates opportunities to comprehend the daily life, including the occupations the person needs and wants to perform. Thus, when health is defined from the salutogenic perspective the experience of health in everyday life consists of how the person can manage daily life in the actual context so that it is comprehensive and manageable and so also more meaningful (52).

The longitudinal evaluation of the sense of coherence (study III) 6 months after the intervention showed that there were differences in level of SOC between the intervention group and the control group. One important and distinctive difference was related to manageability. The manageability component of the SOC relates to the resources that a person possesses which can be used to meet challenges in daily life, in other words, the person's capability (62, 63). A heightened sense of manageability is of concrete relevance to health and wellbeing in daily life because it corresponds to the perception that one has the resources needed to manage daily life. Thus this indicates that the intervention

with a person-centred approach enhanced manageability and capability by providing participants with new ideas and strategies for dealing with challenges in daily life, including those posed by the aging process. According to Antonovsky (53) a high sense of manageability is reflected in the perception that a person has agency, which means that the person has confidence in being able to manage different situations in daily life.

The evaluation at 1 year follow-up showed that effect on SOC did not last and there was no difference between the groups (study III). The effect for the intervention group regarding manageability, which was visible after 6 months, had decreased. Compared with the control group the odds for maintenance of manageability actually decreased. This raises the question whether the intervention, with support from compatriots, was so empowering that everyday life seemed more manageable? When the participants no longer had regular meetings with compatriots, it was difficult to keep up the motivation for maintaining manageability in daily life. This explanation may be supported by the findings in the explorative studies (studies I & II), which revealed the great importance of contacts with compatriots, especially when it comes to listening and trusting information about health related issues. Older persons aging in migration seem to rely on compatriots for information more than relying on information from healthcare professionals alone (study II).

One interesting aspect in the results was that it was possible to see a minor movement in levels of SOC in the intervention group (study III). Salutogenic theory (53) holds that the SOC is generally stable, but there may be some minor fluctuations depending on the circumstances. In most cases, however, the SOC level returns to its main habitual level. This was also the case among the participants in the intervention group. There were minor movements between the levels for participants in the intervention group but the SOC level returned to its pre-intervention level. This indicates that while health promotion interventions may temporarily affect the SOC, more regular interventions may be necessary to maintain SOC. The main issue here is to create encounters with older person in ways that enable them to continue to experience their situation as comprehensible, manageable and meaningful (53). Thus, regarding persons in old age, where the aging process causes regular changes in functions, more long-lasting and regular encounters with the older person may be necessary to ensure the person's opportunities to maintain health.

Life satisfaction and engagement in activities of interest

The results concerning life satisfaction (study IV) showed that at 1-year follow-up the intervention group had higher odds for maintaining life satisfaction than did the control group. The difference was visible in items measuring social relationships, activities and psychological wellbeing. These outcomes are interrelated with the occupational perspective of health. To be able to engage in pleasant activities and to have a sense of belonging through social contacts was an important health resource giving older persons psychological wellbeing. Thus an occupational view of health (13) may be a strong explanatory factor for experience health in daily life when aging in migration. Additionally, since it was the social aspect of life satisfaction, which maintained, this may be related to the capability approach (62, 63) where life satisfaction is supported when the person can use these social contacts as conversion factors for one's capability and experience of health.

The short duration (6 month) of the effect on participants' engagement in activities of interest (study IV) showed that the odds for being engaged in activities were higher among participants in the intervention group. However, this pattern did not persist until 1 year follow-up. Instead, it was apparent that participants in the intervention group had changed their activity repertoire 1-year post intervention to include activities which were feasible in the home environment. Consequently activities necessitating the person to leave home or activities entailing physical effort had diminished. The reason for this change in activity repertoire may be that the aging process per se had caused decline in the person's capability. When aging, it is inescapable to consider the physical decline in body functions (111). However, the important question here concerns how the decrease in number of activities affects the overall experience of health in daily life. Considering this from an occupational perspective, it may be more valuable to be able to participate in those occupations, which afford life satisfaction and support the person's sense of belonging and balance in daily life instead of having several activities which takes energy from the important and meaningful activities. Additionally, when relating the results of engagement in activities, it is difficult to say if these activities listed on the checklist fulfilled the definition of being engaging to the persons concerned. If they did not find the activities engaging in the sense of being emotionally absorbing and performed with passion (45) perhaps the decreased number of activities did not affect the overall experience of health in a negative manner.

Another possible explanation for this change in number of activities may be related to having balance in the occupations engaged in. Seen from an

occupational perspective, it means that such a decrease in number of activities may create opportunities for simply being. Having one's occupations in balance leaves time for relaxation and for organizing daily life (13). Since the results indicated that the participants in the intervention group had reduced their range of activities (study IV) it may be that the intervention had made the older persons aware of the importance of balance. Too many activities may be too challenging and to keep up the balance they prioritize participation in activities which offer relaxation together with friends in a social context. It is difficult to say if this is the case, but it may be since the content of the intervention included a theme about how to cope with daily life (24). In this light the intervention may have raised awareness of the importance of having a balance of occupations in daily life, as one aspect of promoting health.

Regarding manageability, the diminished number of activities may have created a more manageable situation in daily life, which supported an overall sense of coherence. Additionally, when the aging process influences and restricts one's capability to perform occupations as one once did, it may serve to reduce the significance of such occupations. If the person is unable to manage the occupations or if it takes too much energy, the meaningfulness in the situations may disappear. In that way it has a negative impact on the overall experience of health. It may be that the health promotion intervention also raised awareness of how the aging process affects the body and the participants were realistic about their diminished capability. In this situation, the persons utilized their free will to act (62, 63), and use the remaining capability in a way they personally preferred. The occupations they wanted to perform were more related to social aspects and mastery of daily life than the number of activities performed. Thus experiencing health in daily life when aging entails life satisfaction, including one's free will to use the capability as desired. The same applies to older persons aging in migration.

7.3 Health promotion intervention with a person-centred approach

The person-centred approach here departs from the older persons and their living situations. The person-centred approach includes using the older person's narrative as a way to explore the person's personal needs, wishes and resources. In the intervention studies (studies III & IV), a person-centred approach was used (24, 25).

The findings in the explorative studies (studies I & II) support the intention to use person-centred approach in health promotion. Person-centredness creates

a context where the participants ponder together how to manage health in daily life when aging. To be able to discuss and ponder these issues with persons in a similar situation, in this case having similar experiences of migration, created situations engendering trust and willingness to participate in group discussions. Trust in compatriot creates a sense of safety and emotional support (study I) which stimulates and empowers the person to discuss health and how to maintain health in daily life. Is it likely that the person-centred frame of reference used in this intervention program could empower participants to utilize their capability and also to guide them how to manage daily life. This has been shown in other studies, where participants described that the health promotion intervention provided means to seek information about health related issues and also to guide others in similar questions (112).

The results of the intervention studies (studies III and IV) indicate that it was possible to support and enable the older person to maintain a sense of coherence and life satisfaction in daily life and by doing so, also to maintain a positive experience of health. The interventions took the form of group meetings, thereby creating encounters where participants and professionals discussed and raised awareness about health related issues. This served to enable the participants to acknowledge themselves as capable persons with abilities to act in daily life (112). This is also in concur with the aim for a salutogenic approach to health promotion (53, 66). The health promotion program should be shaped so that encounters within the program result in the feeling that life can be predictable, that there is a balance, and that everyday life is meaningful.

Considering this, a health promotion intervention with a person-centred approach, such as PAMC, may be a good way to implement health promotion interventions for older persons aging in migration. The structure for the content was based on an earlier evidence-based health promotion intervention with native born older persons (113) and then modified for older persons aging in migration. In this way both the homogeneity (older persons and health) and heterogeneity (different backgrounds and issues contributing to safety and trust) are recognized. Additionally, the approach of having participants who trust each other create a good platform for peer-learning, which has been shown to be an important part of a person-centred group intervention (112). Even though older immigrants may have experiences of health in daily life similar to those of their native-born peers, health promotion interventions with a person-centred approach have the advantage of considering each person's narrative and life situation including the trust these older persons have in each other.

However, the findings indicate that there may be an obstacle to the implementation of the person-centred approach related to the service providers. Healthcare professionals, as representatives of service providers, had difficulties in finding a balance between their own perspective on the service and the view of the participants, regarding their service needs (study II). In situations when the older person's health had deteriorated in such way that independent living was no longer an option, it was difficult for the professionals to still respect the older person's wish to perform occupations in his own way. These situations caused conflicts between the person and the professionals. The professionals could, to some extent, recognize the importance of self-determination and older person's reluctance to expose their vulnerability to outsiders. Despite this, the healthcare professionals still wanted the older person to accept the support offered. Frailty and the subsequent support needed was defined from the professionals' perspective, without considering the older immigrants' self-determination and view of their health status. According to Ekman (114) the person-centred approach stresses the importance of initiating partnership with the patient. This is done by listening to the person's narrative and so coming to realize which issues are of importance for the person in daily life and the context where he or she lives. Shared decision-making creates the opportunity to build up a partnership between the professionals and the person. Through discussions it is possible to create a common understanding of the situation and based on a common understanding find solutions in line with the needs and wishes of the person concerned. In health promotion, the way in which service providers perceive the person-centred approach has to do with how professionals understand the value and ethical implications of the approach. The ethical implications have to do with the core in person-centred approach, which means having respect for the person and recognizing the individual experiences and previous life events. Additionally, it is about enabling the person to utilize his or her capability so that everyday life is satisfactory despite decline in health status (67).

7.4 Methodological considerations

This thesis applies different research approaches to achieve its objective. The main point was to choose the approach and method which would be optimal for the purpose envisaged. This means that it is the aim of the research, which should determine the choice of a specific design (115). In this way the results can enrich and improve understanding of the phenomena being studied and also promote new ideas based around them (116).

The aim of the thesis was to explore and learn more about the health of aging migrants, and a qualitative approach was deemed the most appropriate method to gather data. Additionally, since the aim was also to evaluate a health promotion intervention with a view to accumulating evidence for a person-centred health promotion, a quantitative approach was considered to be more suitable. The qualitative approach made it possible to explore health from a subjective perspective (Studies I-II) while the quantitative approach made it possible to generalize the results to a wider context (Studies III-IV). By using both qualitative and quantitative approaches the research design captures the strengths of both.

7.4.1 Sampling procedure and analysis of qualitative data

Qualitative interviews were used to explore the participants' experiences of health in daily life. Individual interviews make it possible to create a more profound understanding of how the person experiences a situation (79), in this case how older persons experience health in daily life. To elicit the experiences of professionals regarding health resources in daily life among older immigrants, focus group discussion was deemed as an appropriate method. The strength in focus group discussions is that it enables the researcher to gain an understanding of how a specific group of people perceive their reality related to a specific topic or situation (81).

In qualitative research, the quality of the results is related to trustworthiness, which includes credibility, dependability and confirmability, while the quality of the research with a quantitative approach is related to the validity and reliability. Credibility is about how well the results represent the reality as perceived by the participants (117). The selection of participants was based on the participants' experiences of the research topic. The individual interviews (study I) were conducted with older persons from Finland, who had migrated decades ago, while the participants in the focus groups (study II) were selected on the basis of their experience of working with older persons from Finland. Participants consisted solely of those who could contribute to the topic of the research by articulating their own experiences. In this respect, the participants could contribute rich information, which provided the studies with perspectives on health in everyday life among aging immigrants that are both broad and profound. Thus it can be assumed that the credibility of the study is satisfactory (117).

Another way to strengthen the credibility was to make the situations as relaxing and comfortable as possible. Therefore the individual interviews were

conducted in places of the participants' own choosing. Additionally, the participants could decide which language should be used during the interview. The focus group discussions were conducted at the professionals' workplaces. To avoid disturbance, the focus group venue was a meeting room at their workplaces. These arrangements created trustful situations, which contributed to gathering in-depth and representative information. The familiar environment and calm atmosphere supported open-minded, nuanced interviews and discussions. Furthermore, at the end of each interview and focus group session the content of the interview and discussions was summarized, giving the participants the opportunity to respond to the summary and correct details possibly not matching the reality.

A possible limitation in the qualitative studies may be that the experiences explored concerned only persons from Finland, and professionals working with Finnish immigrants, not the group of older persons from the Balkan Peninsula. However, other studies have been conducted with the same approach, including participants from the Balkan Peninsula and professionals working with this group of older persons. Those studies show similar findings (99, 118). Thus in this respect the results should not be biased due to focusing on only one group. Instead, it strengthens the hypothesis that the experience of health may be more of a universal experience than merely dependent on ethnic background. However, to strengthen this hypothesis, more research is needed with participants with other cultural backgrounds and different migration history, such as older persons who migrate in old age.

Credibility in qualitative research is also connected to how well the categories and themes cover the data. The analyses in Studies I and II were qualitative. In study I the analysis was inspired by a hermeneutic approach. Hermeneutics is the science of interpreting texts with the aim to develop an understanding of the reality or the lived world among those involved in the research (77). A hermeneutic approach made it possible to explore the intersubjective meaning of health in daily life among the participants. This opened up channels for a more profound understanding of the experience of health among older persons aging in migration. The experience, as described by the participants, can be seen as consisting of individual pieces and these pieces together were contextualized into a larger picture of the phenomenon of health in everyday life. The analysis in study II was inspired by qualitative content analysis, focusing on the latent dimension in the material (84, 86). To ensure credibility in this way of analysing focus group discussion, the crucial point was to keep in mind that it is the discussion and interaction between the group members which is the core of the discussion, not participants' single and individual statements (81, 85). Therefore, during the analysis process, the focus was not

on statements from individual group members; instead it was crucial to see in the material that the content reflected the result of the discussion and interaction between participants in the focus group. In this way the results reflected a broader and more profound understanding resulting from the common discussion in each focus group.

The individual interviews and focus group discussions were conducted within a limited time. The researchers in charge of data gathering were experienced in interviewing (study I) and the moderator for the focus groups was experienced in leading focus group discussions (study II). Furthermore, all material was transcribed within a short period of time after the sessions. All these aspects can be seen to contribute to the dependability of the results. Several researchers were involved in all parts of the analysis and held a continuous discussion about the analyse and the interpretation of the emerging findings, which ensured the credibility of the study.

7.4.2 Sampling procedure and analysis of quantitative data

The aim was also to evaluate the effect of the health promotion intervention on sense of coherence, life satisfaction and engagement in activities. We therefore conducted a randomized controlled trial with a longitudinal design. Randomized controlled trials (RCT) are considered as being the gold standard of trials and high confidence is placed in studies with RCT design (119). Moreover, longitudinal studies are important in health research (120) and they can contribute to develop evidence-based health promotion interventions.

The findings in studies III and IV with the quantitative approach revealed a significant difference between the control group and the intervention group on one occasion regarding the total SOC score at 6 months follow-up. No significant difference was found for either life satisfaction or engagement in activities. Therefore, some limitations should be kept in mind when interpreting the validity and reliability of the results.

Several reasons for the lack of significant differences in the results can be discussed. Firstly, the main reason was difficulties in the recruitment process, leading to low number of participants. Despite conducting three recruitment waves, we failed to recruit 65 participants in each study arm which was required to reach power. In addition, there were a higher withdrawal among participants in the intervention group.

There are several possible explanations for these recruitment difficulties. One is a distrust of health care providers among older persons with an immigrant background. This has been found in qualitative studies on health perceptions in older persons aging in the context of migration (21). Another possible reason for the recruitment difficulties is the participants' age. The age limit was set at 70 years or older, which was probably too low. This cut-off was based on earlier research indicating that older immigrants have poorer health than their native-born age peers (3, 4). Other similar studies conducted with native-born older people have used an age limit of 80 years or older (92) and have reported significant results for life satisfaction. The lower age limit may have meant that participants were reasonably healthy with no frailty. Therefore, they probably did not yet see any need to participate in health promotion interventions. Secondly, the non-significant results may have been caused by the imbalance in the number of participants in the control group and intervention group. During the random allocation process more participants in the intervention group declined to participate than in the control group. However, the groups were similar in demographic characteristics and in that sense there were no confounding factors, which might have influenced the outcome of the intervention (121). A third reason for the non-significant findings may be connected to the assessment tools used. The tool for assessing engagement in activities of interest was a non-standardized tool, inspired by other studies regarding engagement in activities (93, 94). This tool may not be sensitive enough when it comes to measuring change over time. The tool used to measure life satisfaction, LiSAT-11 (91) is a validated instrument and the results can be considered valid. This is also the case with the 13-item Orientation to Life Questionnaire (53). Finally, the non-significant results may have been influenced by the fact that the control group was also assessed at follow-ups, possibly creating a Hawthorne effect where the participants change their natural behaviour just because they are participating in a study (122)

The small number of participants, in combination with dropout, may also have affected the internal validity of the results. However, a drop-out analysis in the PAMC showed that there were no significant differences between the groups regarding drop-out and the groups were still similar regarding socio-demographic characteristics, which can be seen as supporting internal validity. Nevertheless, the dropout rate was 17% at 6 month follow-up and 20% at 1 year follow-up (123). This dropout rate has to be considered as a possible bias (120).

To minimize the consequences of dropout, the analyses were based on the intention-to-treat principle (ITT). This means that all those who were randomized to control group and intervention group were included in the

analysis and analysed within the group to which they were randomized (95). Using the ITT approach made it possible to keep the sample size at same level as it was at randomization. This is important when trying to avoid diminishing the power but also to minimize confounding factors between the two groups (121, 124). This can be seen as pragmatic approach and can be considered as a way to reflect a situation in clinical practice where clients are unlikely to complete the intervention offered (121). To be able to generate a balance according to missing data at baseline and the follow-ups, missing data had to be imputed. Different imputation methods were used. In study III the assumption was that the sense of coherence is stable over time (53). Therefore we used the last observed carried forward (LOCF) method (96) as our first choice. If LOCF was not possible, we replaced missing values using the last observation carried backwards (LOCB) method for each participant. If neither LOCF nor LOCB were possible, we replaced the missing data with the median score for the group. In study IV, the median change of deterioration (MCD) was used for those lost to follow-up. The assumption was that older people's health deteriorates due to aging, which may be one reason for older people not attending follow-ups (125). Different imputation methods might have produced different results, but it is important to note that there is no universal imputation method that guarantees the most accurate results (126).

The high drop-out rate also affects the generalizability of the results. However, the study was implemented in an area in which most inhabitants are immigrants and socio-demographic characteristics of the groups were similar. The external validity can therefore be regarded as satisfactory. However, the results should be interpreted with caution owing to several difficulties with enrolment and dropout, which led to a lack of power. Further research is needed to achieve adequate power in a person-centred health promotion intervention targeting aging immigrants. Future research should focus on how to overcome problems with the recruitment of older immigrants.

8 CONCLUSION AND CLINICAL IMPLICATIONS

In conclusion, this thesis has revealed that older persons who have undergone migration do not appear to differ from the majority of similar-aged older persons in terms of health challenges. The experience of health in everyday life seems to be connected to the persons' perspectives of their own capability, health and aging rather than connected to the migration background. The health of persons aging in the context of migration should be viewed holistically; i.e., people are inextricably involved with their social surroundings, which encompass their past and present. This represents an awareness of the importance of recognizing a person's capability and also their narrative. From an occupational science perspective, this embraces an understanding of how humans are able to create a meaningful life after migration where the daily life includes parts from the person's life before migrating, in combination with the routines and occupations developed in the host country during resettlement. This confirms the basic concept of occupational science that humans, through their own actions, can shape their daily life despite changes in their context. Thus, it is possible to create a meaningful life even as an immigrant in that the context of migration does not have to be a negative influence on their experience of health.

Additionally, this thesis reveals that the demands are complex when developing health promotion interventions for older immigrants. Several aspects have to be considered, including: healthcare organizations with professionals, the immigration context and the persons' themselves. The results reveal the importance of recognizing the heterogeneity of health context among older immigrants. Health in the context of daily life is dynamic and complex and older persons' needs have to be recognized on a personal level, which means to be recognized as a person, with an individual narrative, instead of a being just another patient in a crowd. Consequently, a person-centred approach should be used when providing health promotion interventions for home dwelling older immigrants. Professionals' competence in creating encounters, where the affirmation of the persons' capability is acknowledged, is a key component prior to a health promotion intervention.

The findings in this thesis indicates that there are challenges related to implementation of health promotion interventions for older persons born abroad. The findings may be applicable to other older persons aging in the context of migration. However, heterogeneity in the group of persons aging in migration must be taken into consideration. It is inappropriate to assume that

this occupational perspective of health is the same as the way in which older immigrants experience health. Older persons with different immigration backgrounds and reasons for immigration may experience health in daily life differently. So, an important implication for practice, is to view the concept of health from the perspective of the individual person. This is especially important when it comes to persons whose capability may be decreased. Even if the findings did not show any significant differences, the odds nevertheless indicated that the intervention could support health when health is seen from an occupational and salutogenic perspective. Viewing health from these perspectives in clinical practice opens up the possibilities to enable and support health in everyday life from a person-centred perspective. A group-based and person-centred approach can encourage older person's to identify their capabilities thus maintaining and supporting their health in everyday life. This implies that the starting point for health promotion interventions should be shifted to a perspective that supports a person-centred approach.

9 FUTURE RESEARCH

This thesis contributed to what is known about how older immigrants experience health in daily life. Additionally, the thesis explores the effects of a health promotion intervention with a person-centred approach and how it may support health in daily life. However, further studies with larger numbers of participants and with a longer intervention period are needed to be able to detect the effectiveness of the group intervention with a person-centred approach.

The participants included in this thesis evaluated their health as good or fairly good. The fact that several of the outcome measures appeared to identify no effect suggests that the age of the participants may have been too low. Therefore, further research could focus on age groups which are older than the group in this research. In that way it would be possible to capture the group of pre-frail or frail older immigrants. Additionally, since the main problem with the design and evaluation of the intervention was difficulties with recruitment, one crucial task is to explore the reasons for the unwillingness to participate among older persons aging in migration.

One issue which emerged in the findings was that the main reason for dropout from the intervention was lack of interest in participating. Therefore further research is needed to learn more about health promotion interventions where the content is based even more on the wishes, needs and expectations among the participants. In this way the person-centred approach would be more visible and fulfil the essence of person-centred health promotion. This could be done by starting the senior meetings with discussions in the group to elicit what kind of thoughts the participants have about health promotion as a way to support health in daily life. This might serve to generate new themes for the content of the senior meetings and so increase the motivation for participation. Additionally, the motivation for participation could also be increased by conducting qualitative studies to ascertain the experiences of those who participated. This could be a way to reveal how the participants perceive the person-centred approach, including their reflections on what person-centredness is, seen from their perspective. The intervention was implemented in the form of meetings among older people for group discussions. In the qualitative studies, the doing aspect was strongly connected to the experience of health in daily life. Therefore, more research could focus on developing the senior meeting by combining group discussions with a doing aspect. Participation in activities together with others, as a part of the intervention, could support health and broaden the participants' occupational repertoire.

TACK

Jag vill rikta mitt varma och uppriktiga tack till de som bidragit till att jag kunnat både genomföra och slutföra det arbete som här nu avslutas. Först av allt, ett stort tack till de deltagare som gav av sin tid när jag åkte runt och intervjuade er. Utan er hjälp skulle denna avhandling inta ha kunnat förverkligas.

Greta Häggblom-Kronlöf, min huvudhandledare. Under denna process har jag fått ta del av din kunskap och kompetens. Därutöver vill jag tacka dig för den mjukhet, mänsklighet, empati och förståelse som du visat när du handlett, det finns inte ord som tillräckligt kan beskriva det. Du har varit min trygga hamn samtidigt som du inte har tvekat en sekund att slänga mig tillbaka i sjön, med riktningen mot nästa kobbe! Dina diskreta deadlines har gjort att jag har lyckats komma i mål. Tack Greta!

Synneve Dahlin-Ivanoff, min bihandledare. Jag vill tacka dig för att du med mjukhet och empati lotsat mig vidare här på slutrakan. Jag har under den tiden upptäckt vilken klok och kompetent person du är. Din konstruktiva kritik, som alltid varit relevant och saklig, har gjort att jag utvecklats inom forskningen. Att ha fått den ynnesten att ha dig som bihandledare har betytt mycket för mig och gjort mig säkrare i det som jag hållit på med.

Lena Mårtensson, min första medförfattare. Tack för ditt tålamod i början av min resa. Ditt sätt att handleda genom att "tvinga" mig att tänka själv och komma fram med det som fanns där inne var många gånger svårt men du lyckades alltid få mig vidare i mina tankar, tack!

Lisen Dellenborg, Tack för att jag fått fara med dig uti dina enorma reflektioner, där jag fick en känsla av att här har jag aldrig tidigare varit! Känslan efter de handledningarna var verkligen upplyftande, en bättre kick kunde man inte få någonstans. Så ett stort tack, Lisen.

Emmelie Barenfeld, den lycka jag kände när du föreslog att du kunde hoppa med i båten och vara min medförfattare går inte att beskriva. Tack för ditt tålamod med mig och SPSS...Du hjälpte mig att få ihop det sista som krävdes till vår artikel. Men utöver detta, tack även för det viktiga referensstöd jag fått av dig. Du är kunnig, insatt, strukturerad och framför allt empatisk, beredd att alltid ställa upp, lyssna och hjälpa. Emmelie, jag kunde inte ha gjort det här i denna takt utan din hjälp!

Ett stort tack vill jag även rikta till *Centret för person-centrerad vård, GPCC*. Att delta i GPCC har fördjupat och öppnat nya dörrar till insikter om personcentrering och dess betydelse. Utöver det har det ekonomiska stödet varit av stor betydelse för genomförandet av detta doktorandprojekt.

Tack även till SWEAH, *Nationella Forskarskolan om Åldrande och Hälsa*, för ekonomiskt understöd men även för de tillfällen till referensstöd som en doktorand på distans kan behöva. Jag har fått flera nya kontakter inom åldrandeforskningen som jag inte skulle ha fått utan deltagande i aktiviteter anordnade av SWEAH. Ett stort tack även till *AGECAP* för möjligheten att få fördjupa mig i kapabilitets begrepp och se relevansen i förhållande till personer som åldras i migration.

Yrkehögskolan Arcada, tack för den flexibilitet som visats när forskning skulle kombineras med ordinarie arbete.

Till mina *kollegor* på Arcada. Det har betytt mycket för mig att känna ert stöd under dessa år. Ett speciellt tack till *Ira*, du har varit mitt stöd och lyckats sätta perspektiv på saker och ting när man är mitt uppe i det, tack för dina goda råd och din vänskap.

Till *Jennie*, you helped me find my spirit!

Denice, väninna och kollega, tack för de underbara och energigivande samtalen om ditt och datt. Tack även för de filosofiska diskussioner vi haft när våra hjärnhalvor har mötts! Våra diskussioner och ditt stöd har alltid gett mig styrka att fortsätta.

Kirsti, min allra käraste syster, tack för att du finns! Du har gett mig tak över huvudet och mat i magen så att jag inte blev "helt utmärglad"! Du har gett mig ett hem att landa i, delat mina glädjestunder, tröstat och uppmuntrat när det har varit jobbigt. Din filosofiska kommentar att "är du nu på trappavsatsen..." har alltid fått mig att sätta saker i relation till helheten.

Min allra käraste familj, det bästa jag har! Tack för att ni haft tålamod med mig. Tack till mina två underbara döttrar *Heidi och Katja*, som hållit mig till verkligheten: vad är relevant? Är det att sitta vid datorn eller göra lasagne när barnen med familj kommer på besök? Tack för att ni finns!

Lopuksi, *Kauko* minun elämäni rakkaus, kiitos että olet jaksanut kestää minua tämän prosessin aikana. Olet kestänyt minun ikuista opiskelua ja antanut minun kasvaa ja kehittyä. Kiitos, rakastan sinua ikuisesti!

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