

## Report

# CULTURALLY TAILORED GROUP TRAINING TO ENHANCE EQUITY IN HEALTH AMONG MIGRANT WOMEN IN SWEDEN

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## ABSTRACT

**Objectives:** We piloted a culturally tailored, participatory health promotion group intervention and explored the experiences and perceived health at baseline and follow-up of Arabic- and Somali-speaking women migrants in Växjö, South Sweden.

**Methodology:** A mixed methods approach was used to evaluate the experience of this intervention before, directly after and at the 6-month follow-up. Each intervention was 5 weeks long, with a 2-hour session each week, and held by a team of interprofessional clinical staff and a coordinator. The local coordinator

recruited participants from a convenient cohort.

**Results:** The data are from 49 female Arabic- and Somali-speaking participants who were divided into six groups. The participants perceived that their health had improved significantly ( $P < 0.005$ ) directly after the intervention with a moderate effect size ( $d = 0.42$ ). This result was supported by the qualitative evaluation after 6 months, analysed using revised content analysis. The general theme was "Health course with multiple practical impacts", which had two

categories ("Empowerment" and "Changed living habits and new knowledge") and eight subcategories. The study is ongoing and there will be a further comprehensive evaluation. Due to practical aspects, a control group was not used.

**Conclusions:** A culturally tailored, participatory group intervention on the prevention of ill health, on health as a human right and on empowerment in Arabic- and Somali-speaking women has beneficial effects.

**Keywords:** EMPOWERMENT, HEALTH COMMUNICATION TRAINING, HEALTH LITERACY, MIGRANT WOMEN'S HEALTH, MIGRATION, SWEDEN

## INTRODUCTION

According to the Universal Declaration of Human Rights (1), health is a fundamental human right. The World Health Organization defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (2). From this viewpoint, health is seen as a resource for everyday life rather than the purpose of life. As a consequence, primary care needs to be both gender and migrant sensitive (3). Migrant women's ill health, especially mental illness, constitutes a major global public health burden, yet there is a substantial

gap in knowledge and education about this condition. Health is closely related to lifestyle (3). Health promotion, defined as the process of making it possible for people to take control over and improve their health to a large extent (2), includes activities such as psychosocial and health education interventions. These are of great significance as they can tackle the risk factors for and stop progression or even prevent the onset of noncommunicable diseases. In order to be efficient, the strategies need to be tailored to the relevant population and cultural context, and are of significance for making evidence-informed policy recommendations to decrease health inequity in the spirit of the United Nations' 2030 Sustainable Development Agenda (4).



The Swedish Parliament decided in 1975 that Sweden had become a multicultural society (5). At the end of 2014, according to the Swedish Statistics Bureau, foreign-born people made up 20.5% of the population (6). The third most common language in Sweden is Arabic, and the 13th most common is Somali (7). According to the Swedish Migration Agency, the most common reason for immigration during recent years has been to reunite with family already living in Sweden (not taking into account the mass migration experienced during the past year and a half). However, migration may be highly selective, with the so-called healthy migrant effect (8) resulting in migrants being healthier than the population in the target countries with respect to specific diseases. There are manifold factors responsible for the health status of migrants, such as the situation in their home countries and migration history, the situation in the target countries and their cultural background, sense of coherence and coping mechanisms.

According to Silove's theoretical model (9), post-migration stress has a negative impact on the health-related quality of life of newly arrived migrants (10). The Swedish Public Health Report 2009 shows that the prevalence of physical and mental ill health among immigrants is twice that of Swedish-born populations (11). Among migrants, especially refugees, the health of women is poorer than that of men (12). Due to these facts, there has been a call to integrate migration-related health issues with the health-equity framework (13). More research with the aim of empowering migrants to integrate into society is required as our society is characterized by diversity (14). Health empowerment models seem to be the most effective approaches to health education (15, 16). They are viewed as an important part of a comprehensive action that challenges the structural determinants of health, in which health literacy is a significant factor (17). Health literacy is defined as having practical knowledge about bodily functions and signs of dysfunctions, being able to find and understand information about a health condition, and determining how this influences people's actions (15). It has been shown that after an innovative model of culturally tailored health promotion groups for refugee patients in primary care in the United States, these patients had a greater understanding about the importance of preventive health measures, which reduced their perceived illness (depression) (18). We have promising

results from a few case studies in Sweden using this model on groups of newly arrived refugees and immigrant women from countries outside Europe, who had not yet been identified as patients (19–21).

To increase knowledge in this field, we explored the strategy of a culturally tailored, evidence-based health promotion intervention in Växjö, a medium-sized town in the south of Sweden. We focused on Arabic- and Somali-speaking migrant groups, which are currently the largest migrant groups in Sweden. The research questions were: (i) how do participants assess their perceived health before, at the end of, and 6 months after the end of the intervention? and (ii) how do participants view their participation in the intervention?

## METHODS

### THE PARTICIPATORY INTERVENTION APPROACH – A SHORT DESCRIPTION

The participatory intervention approach has been described in detail (19–21) and will therefore be presented only briefly here. The intervention was initiated by a health-care centre in one of the more culturally diverse neighbourhoods in Växjö. Initially, a registered district nurse (AH) was employed as a coordinator and a multidisciplinary team was recruited as moderators (physicians, midwives, dental nurse, social workers, police, occupational therapist, therapist, physiotherapist). In order to collect information on the needs and requests from the target group, focus group discussions were held with an Arabic-speaking group and a Somali-speaking group. The pedagogic technique was a participatory approach through an interactive workshop – that is, participants were invited to engage in a dialogue with the moderators and ask questions about health, lifestyle and prevention, which were noted by the coordinator. Each lecture was developed and designed to be simple and clear comprising two hour-long sessions of continuous dialogue and questions on each topic (Box 1). In the middle of each session, there was a short break for some complementary refreshments. Participants were given handouts of the PowerPoint presentations.

**BOX 1. DESCRIPTION OF INTERVENTION**

The intervention comprised a 2-hour session per week for 5 weeks on the following topics:

1. introduction/the Swedish health-care system
2. healthy eating habits/dental care
3. female anatomy and contraception/family planning
4. migration stress-related illness and coping/physical activity
5. social service support for parents and children/domestic violence.

**SETTINGS AND INTERPRETATION**

To support a preventive approach and avoid making the participants feel like patients, the intervention took place in a neutral facility outside the health-care centre. The facility was familiar to the participants and close to where many immigrants live. All presentations were made in Swedish. To ensure that the participants understood what was said, everything was translated by a certified interpreter. The aim

was to use the same interpreter throughout all the meetings. The language alternated between Somali and Arabic for every other health intervention. In order to create a comfortable and familiar atmosphere, the coordinator (AH) was always present. Codes of conduct were also set up to provide a structure to the sessions and minimize disorder (e.g. everything said during the session stays in the room, no visits from others during the session and a closed group to build trust). SE supervised the performance and HL compiled the questionnaires and transcribed the 6-month follow-up (1st follow-up).

All questions raised by the participants during the intervention were collected in order to further improve the course. Some examples from each topic are shown in Table 1.

**INVITED PARTICIPANTS**

Initially, the target group comprised 25–64-year-old immigrant women, who had had a residence permit for a maximum of 5 years. However, some participants who had lived in Sweden longer than 5 years were included as they perceived themselves as newcomers, i.e. departing/arriving several times from/to Sweden. After receiving information from key people on where to find the two target groups, we distributed a written invitation in Arabic and Somali in strategically selected locations where members of the target group gathered for social and educational purposes. The invitation was also distributed at the health-care centre.

**STUDY DESIGN**

To evaluate the intervention, a mixed methods follow-up was used with both qualitative and quantitative questions (How would you describe your health?, How often would you say that you have strength and energy? and How much have aches and pain affected your daily life during the past week?) adapted from earlier studies (19–21), along with a locally written and translated cover letter. The participants answered the questionnaire on three occasions: before the course, at the last session of the course and at a 6-month follow-up.

At the 6-month follow-up, the participants were also invited to discuss their experiences of the course and whether it had had an impact on their life and health. The dialogue was conducted by the coordinator

**TABLE 1. EXAMPLES OF QUESTIONS FROM PARTICIPANTS RELATED TO THE VARIOUS THEMES**

Theme	Question
Swedish health-care system	If I do not speak Swedish well enough, how do I go about calling the health-care centre for an appointment?
Healthy eating habits	Can I develop cancer from not eating healthy?
Dental care	Can my gums disappear if they're bleeding while I brush my teeth?
Physical activity	How can the physiotherapist help to ease the pain?
Stress	Can mental illness affect my memory?
Female anatomy	If I am only allowed to wash my vagina once a day, how do I go about it when I need to pray? I have to be clean then!
Family planning	How can the contraception implant prevent a pregnancy if it is placed in the arm, far away from the uterus?
Social service support for parents and children	When does the social service place children in foster care?
Domestic violence	For how long is a person detained for domestic violence?

(AH) and the evaluation resource (HL) according to a semistructured interview guide. The conversation was mainly translated by an interpreter who was present on site and once with the aid of an interpreter over the phone.

## DATA ANALYSIS

Quantitative data acquired from the three evaluations were analysed through descriptive statistics using SPSS version 22.0 for Windows. This analysis included calculating mean values and standard deviations for all Likert items included. We used Spearman's analysis to identify the strength of associations between ranked (nonparametric) questions. Paired samples *t*-testing and a binominal distribution for exact significance test were performed to determine whether the participants showed changes in their perceived health at group level directly after the health course. Effect sizes (Cohen's *d*) were calculated to verify any improvement: an effect size of 0.2 was assumed to be small, 0.5 to be average and >0.8 to be large. Only *P* values of less than 0.05 are reported in the results. Sociodemographic characteristics and lifestyle questions were described by means, standard deviations and frequencies.

An inductive approach was used for the qualitative data because this is advisable when previous knowledge is lacking, which was the case in our study (22). The qualitative data was analysed through a manifest content analysis (23) as the study relied on an interpreter for translation of communication, and analysing the latent content would therefore be questionable (24).

The interviews were recorded with the consent of the participants. These were transcribed by the evaluation resource (HL) and independently scored by the coordinator (AH). The participants' answers to the questions and the narratives from the group interview at the 6-month follow-up were summarized in notes taken by the evaluation resource (HL) and independently scored by the coordinator (AH). They then discussed the coded material and arrived at content categories and themes.

## ETHICAL CONSIDERATIONS

The study was approved by the regional ethical committee in Linköping (Dnr 2014/502-31).

# RESULTS

## PARTICIPANTS AND DROPOUTS

The main challenge of the health intervention was recruiting participants. In the six interventions conducted in the ongoing project thus far, the response rate was 87.5%; 49 women completed the course. A few people applied but failed to show up and seven participants started but did not complete the course. The drop-outs (seven participants) were not included in a drop-out analysis as the number was too small to analyse. As the quantitative data analysis from the 2nd follow-up is ongoing, these results are not included. Of the 49 individuals completing the course, 39 answered both the baseline and 1st follow-up questionnaires; therefore, the quantitative analysis is limited to these 39 individuals.

The group represented 11 different countries of origin, of which Somalia, Syria and Iraq were the most common. The majority were married women with children. As Table 2 indicates, both educational background and working experience varied among the participants, with working experience predominantly in the fields of sales, restaurant, economics and teaching.

**TABLE 2. SOCIODEMOGRAPHIC DESCRIPTION OF THE GROUP**

	Mean (SD)	Min-Max
Age	38.18 (8.73)	20-53
Number of children	3.23 (1.24)	1-6
Years in school	9.33 (4.270)	1-16
Working years before arrival in Sweden	7.67 (8.015)	0-25
Years in Sweden	4.70 (2.22)	1-12
SD: standard deviation.		

The main reasons for coming to Sweden were to escape war or other difficulties in the home country (63%) or to reunite with family already living in Sweden (in the latter case, they are given permission to stay).

## PERCEIVED HEALTH

The number of participants who experienced a lot of pain decreased between the baseline and 1st follow-up. The same positive trend was observed in participants' experiences of strength and energy; however, the

improvement was not significant, as shown in Table 3. When studying the participants' self-perceived health, the results showed a positive development among the participants: the difference was significant ( $t = -2.994$ ,  $df = 37$ ,  $P < 0.005$ ) with a medium effect 0.42 (Cohen's  $d$ ).

**TABLE 3. PERCEIVED HEALTH AMONG PARTICIPANTS BEFORE (BASELINE) AND AFTER (FOLLOW-UP 1) THE HEALTH COURSE**

	Baseline mean (SD) (n=39)	Follow-up 1 mean (SD) (n=39)	Gain	Cohen's d
How would you describe your health? (Poor-Excellent)	3.59 (1.069)	4.00 (0.383)	0.41	0.42
How often would you say that that you have strength and energy? (Never-Always)	3.72 (0.999)	3.82 (0.721)	0.10	0.11
How much have aches and pain affected your daily life during the last week? (Very much-Not at all)	3.50 (1.133)	3.64 (0.903)	0.14	0.13

There are strong correlations among the three questions at baseline and a rather strong correlation at the 1st follow-up (Table 4).

Regarding sleeping habits, the group showed a positive tendency towards sleeping more hours, and having fewer and less frequent nightmares after the intervention.

## NARRATIVE INTERVIEWS AT THE 1ST FOLLOW-UP

Twenty-three persons participated in the group dialogue at the 6-month follow-up and until now. The attendance was as expected and gives saturation in the qualitative analysis, i.e. no new information emerged during the interviews (23). The qualitative analysis

**TABLE 5. GENERAL THEME, CATEGORIES AND SUB-CATEGORIES FROM SIX-MONTH FOLLOW-UP INTERVIEWS**

General Theme	Categories	Sub-categories
Health course with multiple practical impact	Empowerment	Improved health and confidence
		Practicing the language
		Social benefits
		Becoming ambassadors
	Changed living habits and new knowledge	Eating habits
		Physical activity
		Female body
		The parental role

**TABLE 4. CORRELATIONS BETWEEN QUESTIONS ON PERCEIVED HEALTH, STRENGTH/ENERGY AND PAIN AT BASELINE MEASUREMENT AND THE 1ST FOLLOW-UP<sup>a,b</sup>**

Questions	Baseline			1st Follow-up		
	1	2	3	1	2	3
1. How would you describe your health?	-	-	-	0.524**	-	-
2. How often would you say that you have strength and energy?	0.764**	0.617**	-	-	0.373*	-
3. How much have aches and pain affected your daily life during the past week?	0.578**	-	-	-	-	0.468**

\*: Correlation is significant at the 0.05 level; \*\*: correlation is significant at the 0.01 level.

<sup>a</sup> n = 39.

<sup>b</sup> Spearman's two-tailed correlation test.

resulted in one general theme, “Health course with multiple practical impacts”, two categories and eight subcategories, as presented in Table 5.

## EMPOWERMENT

### Improved health and confidence

Participants stated that the health intervention was important for immigrants in several ways. They expressed how they received a lot of new knowledge, which improved their health and resulted in a better quality of life. They also felt more confident in making healthy choices and taking care of their own health after the course.

*I have been here more than 6 years and I had not received this information earlier that I've received through the health course, when it comes to food and the body, when it comes to health. I learnt a lot that I did not know before.*

A commonly expressed opinion in the groups was that the intervention was too short and they wanted additional sessions to learn more. The participants wished the intervention to continue in order to reach as many immigrants as possible.

### Practising the language

Participants felt that the health course not only improved their knowledge on health but also provided a great opportunity for them to practise Swedish and expand their vocabulary in the field of migration and health. Some participants also used the handouts to pass on the information as these were written in Swedish, and provided an opportunity to practise the language.

### Social benefits

Another important point expressed by the women was the increased social interaction due to the health intervention. They made friends and engaged in other activities together. The participants expressed their gratitude towards the moderators who showed interest in them and treated them with great respect and kindness.

### Becoming ambassadors

The women shared the new and useful knowledge with friends, relatives and fellow students during Swedish lessons. They found the handouts very useful for informing others. It was sometimes a challenge to influence their children and husbands to improve their eating habits; however, with perseverance, they managed to get their message through.

*I sat down with the family in the living room and showed them all the handouts and I said, “If you want better health you should do like this.” And then I asked, “Do you want better health?” “Of course we want better health,” they said. So we have changed the eating habits. It was difficult in the beginning but now everyone is used to it.*

## CHANGED LIVING HABITS AND NEW KNOWLEDGE

### Eating habits

The habit that most participants changed was their eating habits. They talked about how their view on daily meals had changed; for example, they started eating breakfast. Another piece of advice several participants followed was the plate model (i.e. half of the plate consists of vegetables, a quarter of carbohydrates and a quarter of protein). Eating more vegetables, drinking-water instead of juice or coca cola and using whole-grain bread and pasta instead of white flour products were other examples: “My children didn't like vegetables but now they eat and they have got used to it.” The women also affirmed that they had lost weight due to their new habits. The intake of sugar was considerably reduced; for example, they were eating less cakes and candy. This was not only because of the risk of gaining weight but also related to improved dental health. They were now very conscious about brushing their teeth after eating sweets.

### Physical activity

Prior to the health intervention, some participants were physically active only when they went from one place to another, while others said that they never exercised in any way. After the health intervention, some started to walk instead of taking the bus or walked as a form of exercise. Some of the health

benefits they described were a sharper mind, not feeling as tired as they did previously when they were physically active, sleeping better and resolution of earlier back pain: “Before, I went by bus. However, now I can walk far without feeling the effort.”

### Female body

The female body was one topic of discussion that the participants found very important and wanted to learn more about. As most of the women were practising Muslims, and had to wash themselves five times a day before praying, vaginal hygiene was a topic that engaged many. One participant said that she had stopped using medicine for vaginal hygiene and she felt it was very good for her. Several of the women had been giving birth to a child every, or every other, year and therefore family planning was another important subject they wanted to learn more about.

*I went to the midwife and said I want to rest, I want to sleep. Give me some advice. What can I use? The midwife was totally shocked. “What has happened? You usually don’t want to use those things!” But now, the 17th of this month, I’m going to put that contraceptive implant in.*

A sensitive discussion issue was virginity. The women came from cultural contexts where it is important to bleed after the first sexual intercourse. They found it very difficult to receive facts about the female anatomy that contradicted what they had learnt before.

The participants wanted more information about the female body and pregnancy; and how they as parents could inform and talk to their daughters about menstruation. In their home countries, they got support from their own mothers or other female relatives but here they were on their own when dealing with such issues.

### The parental role

The women felt that they needed a lot of information about bringing up children in Sweden, as there are different laws here than those they were used to. For example, it is forbidden to use corporal punishment on children in Sweden, and this clashes with a cultural belief that children do not learn without corporal punishment. A fear was also expressed concerning the

social workers’ authority to separate children from their parents. An inaccurate perception was that social workers could place their children in foster care if the parents put up boundaries that upset the children: “We meet with a social worker. But we need more knowledge. About what they do and what the police do. They should tell us more about it. Many do not know!”

## DISCUSSION

The aim of this study was to explore self-perceived health among female participants before a culturally tailored health intervention and at two follow-up interactions. The results indicate a significant improvement in perceived health directly after the intervention, with a medium effect size, which is in line with other Swedish interventions (19–21). The approach of group dialogues generated a group dynamic that resulted in peer recommendations; it may therefore be more effective than individual dialogues (19–21).

The study highlights two main findings: the women felt empowered and improved their living habits after the health intervention. The women described how the health course inspired them to make changes in their lifestyle. Increased physical activity and healthier eating habits were prominent changes among the women in the group. They also described how they felt the effect and reward of better health almost immediately, which made it easier for them to establish a new habit. As they felt inspired to spread the message about the importance of healthy living habits, they became ambassadors of a preventive perspective. This is important in the long run, as teaching children at an early age about healthy living habits (e.g. preventing obesity in a child) increases the chances of them maintaining these habits in adult life, which could have a positive effect on public health in general (25). It is also empowering for the women themselves to feel that they can contribute something important to the health of their family and friends.

Participants expressed a wish to continue the learning process. They said that they felt empowered in both their ability to learn and to actively make healthier decisions related to their living habits. This made them more confident of taking care of their own health.

This outcome is supported by earlier studies (19–21). The health intervention turned out to have a positive effect on the participants' health literacy (15), as they expressed an improved ability to communicate on their own when talking to a doctor or other health staff.

With the benefits connected to improved health among the women, the health course model itself brought little strain on the health-care system as it was managed with limited resources. Beyond the knowledge gained in health, the health intervention also gave the participants the opportunity to practise the Swedish language. Thus, the intervention not only had a direct impact at the individual level but is also likely to have a positive effect on the society at large, as good health and successful integration are strongly connected (2).

All topics were appreciated and considered important by the participants; however, two topics attracted greater attention than the others and brought about lively discussions. These were knowledge about the female body and increased understanding of social service support. Cultural differences and concepts were strong within these areas and it was important to encounter these perceptions with facts in a respectful way. This finding underlines the importance of providing a culturally tailored participatory intervention for each target group.

A methodological limitation of this ongoing study is the small size of the intervention group, and the limited amount of material produced. A limitation was the insecurity among the women in filling in the questionnaires, which could have affected the data. Further, it is not possible to confirm the health improvement, that is, that the medium-size effect on perceived health is solely the outcome of the health course. For practical reasons, there was no control group in this study (but the participants were their own controls via pre-/post-intervention measurements). However, the mixed methods approach ensures data validity, which strengthens the observation that the health course contributed to participants' changed living habits. A report from the Health Evidence Network and the WHO regional Office for Europe has examined the cultural contexts of health and the use of narrative research in the health sector (26).

## CONCLUSIONS

A culturally tailored participatory group intervention on the prevention of ill health, on health as a human right and on empowerment for Arabic- and Somali-speaking women has implications for better health.

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