

Moving From Knowledge to Action in Partnership: A Case Study on Program Adaptation to Support Optimal Aging in the Context of Migration

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Abstract

This case study explored how a researcher–community partnership contributed to program adaptations when implementing person-centered group-based health promotion services to older people who have migrated to Sweden. The study was conducted over 3 years and various data sources were used: focus groups, individual interviews, documents, and archive material. Findings from different data sources and partners' perspectives were triangulated to an overall case description using an iterative process. Adaptations were shaped through a dynamic process, negotiating toward suitable solutions that culminated in actions taken to adapt or inhibit

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adaptations. The negotiations were driven by the interplay within and between three reasons to adapt. The partners' opportunities to influence the negotiation process depended on establishing common ground to shape adaptations. Practical implications are provided on how to move from knowledge to action when implementing person-centered group-based health promotion to support optimal aging in the context of migration.

Keywords

researcher–community partnership, older adults, health promotion, implementation, emigrants and immigrants

Introduction

Health care services worldwide are challenged by population changes such as an aging population and global migration (Karl & Torres, 2016; World Health Organization [WHO], 2015). One such challenge is how to enable access to health care services for people who have migrated (Alizadeh-Khoei, Mathews, & Hossain, 2011; Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013). Yet another challenge is providing evidence-based health promotion services to older people (Löfqvist, Eriksson, Svensson, & Iwarsson, 2012). Health promotion is documented as being important in supporting health in older people and managing their everyday lives (Beswick et al., 2008; Gustafsson, Eklund, et al., 2012a; Huss, Stuck, Rubenstein, Egger, & Clough-Gorr, 2008), here referred to as optimal aging, that is, the capacity to function across different life domains to one's satisfaction despite one's medical conditions (Brummel-Smith, 2007). There are not equal opportunities to age optimally. Being older and having experienced migration may contribute to both social and physical frailty, a diminished ability to respond to stressors (Brothers, Theou, & Rockwood, 2014; Morley et al., 2013). Migration may bring a loss of environmental preconditions for maintaining health, such as deprivation of social network and access to health care services (Alizadeh-Khoei et al., 2011; Bughra, 2004). Older migrants are, therefore, considered an important target group for health promotion. Currently, evaluations of health promotion programs targeting older people aging in the context of migration are sparse (Lood, Häggblom Kronlöf, & Dahlin-Ivanoff, 2015), and studies show that adaptations to such programs are often needed (Liu et al., 2012; Lood, Häggblom Kronlöf, & Dahlin-Ivanoff, 2015). Thus, program adaptation appears to be crucial to support the implementation of evidence-based health promotion programs with the goal to enable older migrants to take advantage of rights and opportunities within health services.

Evidence-based health promotion is defined as professionals' ability to integrate the best available evidence, own expertise, and experiences and preferences of the target group to enable people to take control of and improve their health (Smith, Tang, & Nutbeam, 2006; WHO, 1998). When moving research-based evidence to practice, adaptation might be required to facilitate program implementation and sustainability. One clear motive for such adaptations is to improve the fit between the program and the local context (Damschroder et al., 2009; Graham et al., 2006). In this article, adaptations are defined as activities that customize or tailor original program content and design to current settings and circumstances based on knowledge exchange between health care personnel, a research team, and a steering committee, in the context of moving evidence to practice in a researcher–community partnership (Graham et al., 2006).

Collaboration between researchers and end users of knowledge is a strategy to support the implementation of evidence-based practice (Graham et al., 2006; Walter, Davies, & Nutley, 2003). In the Knowledge to Action (KTA) framework (Graham et al., 2006), a researcher–community partnership is considered to beneficially affect the creation of knowledge to be used in practice. In addition, the partnership influences the process of converting knowledge into action, such as adaptation of evidence to the local context and assessment of barriers for knowledge use to support implementation of program components. In this study, a researcher–community partnership was initiated to reach out with health promotion to older people born in Finland or the Western Balkan region who had migrated to Sweden. The goal was to further develop and implement a group-based health promotion program called “senior meetings” (Dahlin-Ivanoff et al., 2010). Previous evaluations of senior meetings have shown that it can postpone decline in outcomes such as dependence in daily activities, self-rated health, quality of life, and physical activity among community-dwelling native-born people aged ≥ 80 years in Sweden (Behm et al., 2014; Gustafsson, Eklund, et al., 2012a; Gustafsson, Wilhelmson, et al., 2012b; Zidén, Häggbloom Kronlöf, Gustafsson, Lundin-Olsson, & Dahlin-Ivanoff, 2014). However, it is unknown whether the program needs to be adapted when implemented in a context where a high proportion of people are born abroad, and generally have lower socioeconomic status and educational level compared with the target group where the program was developed.

A number of implementation frameworks advocate monitoring of adaptations during implementation to better understand program outcomes (Damschroder et al., 2009; Glasgow, Vogt, & Boles, 1999; Graham et al., 2006). Previous studies on program adaptations have mainly reported findings on how health promotion programs targeting older migrants are adapted

according to population characteristics such as culture and language (Lood, Häggblom Kronlöf, & Dahlin-Ivanoff, 2015). Studies with an implementation perspective report both advantages and disadvantages of program adaptations. A recent review reported better outcomes for adapted programs compared with programs with high fidelity to the original protocol (Sundell, Beelmann, Hasson, & von Thiele Schwarz, 2015). This result is in line with studies advocating flexible program adaptations and the need to find the right mix between fidelity and adaptations to achieve positive program outcomes (Durlak & DuPre, 2008; van Daele, van Audenhove, Hermans, van den Bergh, & van den Broucke, 2014). Fidelity is often recommended for core components, such as program content and design, which are central to achieving program outcomes (Durlak & DuPre, 2008).

To summarize, it may be important to balance program adaptation and fidelity for core components. To the best of our knowledge, no previous studies have investigated how adaptations of health promotion programs aimed at supporting optimal aging are influenced by a researcher–community partnership and, thus, need to be explored. In addition, knowledge is lacking regarding how adaptations contribute in supporting the implementation of health promotion programs for older people aging in the context of migration. Therefore, *the aim of this study was to explore if, when, why, and how content and design of a health promotion program was adapted in a researcher–community partnership during its implementation.*

Design

An exploratory single-case study was conducted inspired by Yin's methodological recommendations (Yin, 2009). The case was chosen because we could explore adaptations of health promotion targeting people born abroad when moving evidence to practice in a researcher–community partnership. A single-case design was justified because the aim was to study a unique case from a longitudinal perspective (Yin, 2009). The Regional Ethical Review Board approved this study (reference T947-12).

Definition of the Case

The case focuses the process of adapting the original program (Dahlin-Ivanoff et al., 2010) carried out in a researcher–community partnership during the development and implementation of a health promotion program (Gustafsson et al., 2015). The case was studied from the end of 2011 until the end of 2014. It includes both the knowledge creation and the action phase as described in the KTA framework (Graham et al., 2006). In this article, these

phases are further divided and referred to as the exploration phase, program development phase, and intervention phase.

The program targeted independent living persons, aged ≥ 70 years, who had migrated from Finland and the Western Balkan region to Sweden. The researcher–community partnership comprised health care personnel (the operative group), research team members, and a project steering committee. The partners' role was stated in a cooperation agreement and further outlined that the operative group was responsible for recruiting participants and conducting the intervention. The research group was responsible for design and conduct of a randomized controlled trial aimed to evaluate the program, whereas the steering committee was responsible for final protocol approval and reviewing any necessary changes. In addition, reference groups (older people born in Finland or the Western Balkan region) were involved in dialogues about adaptations. Further details of involved partners and their role are provided elsewhere (Gustafsson et al., 2015; Lood, Gustafsson, & Dahlin-Ivanoff, 2015).

Content and Design of the Original Protocol

The health promotion program, that is, the senior meetings, consisted of four weekly small-group sessions (four to six participants) followed by an individual home visit. The group sessions were based on a booklet especially designed for the target group and developed with target group representatives (Dahlin-Ivanoff et al., 2010). The senior meetings were designed to provide an arena for peer learning (Shiner, 1999), and included health information exchanges with an interprofessional team. The team consisted of a physiotherapist, a registered nurse, an occupational therapist, and a social worker. Team professionals were responsible for one session each, and one professional (the group leader) was designated to follow the group throughout the program to provide continuity (Dahlin-Ivanoff et al., 2010). A person-centered approach was implemented by addressing health-promoting actions based on the participants' own life experiences. This approach is founded on the view that all human beings are capable persons and puts emphasis on involving participating persons as active partners who are experts on their own situation (Ekman et al., 2011; Leplege et al., 2007). Shared decision making was applied meaning that all decisions concerning health-promoting activities ought to be taken in partnership between participating persons and the interprofessional team. Thus, both participants and personnel brought their expertise into the senior meetings. For definitions of core components of the original program content and design, see Table 1.

Table 1. Overview of adaptations conducted during implementation. The adaptations are presented in relation to core components of the original program and links to subcategories are marked with a footnote. The role of the researcher-community partners and time points for adaptation is specified.

Original definition of core components	Adaptation of content and design	Comment	Time point for adaptation	Partners involved in adaptation
Consists of four group meetings followed by an individual home visit ^a	Held “Senior Meetings” at times when local transportation services is free of charge ^b Held the meetings in different locations nearby the population ^b Offered individual follow-up visits outside the home if requested ^b	Adaptations were preformed to be able to implement development of outreach efforts was identified ^c	Exploration phase	Operative group Research team Reference groups
Target prefrail persons 80 years or older independent of help	Lowered the inclusion age to 70 years or older ^b		Exploration phase	Steering committee
An interprofessional team consisting of RN, SW, OT, and PT held the meetings ^a	Offered translation services ^d Developed team-roles to better balance power ^a Integrated an interpreter in the team when needed ^f	Adaptations were preformed to be able to implement	Exploration Program development and intervention phase	Operative group Research team Interpreter services
Health information is provided in a written booklet and in oral during the meetings ^a	Updated information to context ^{b,d} Added free of charge options to health promotion ^b Added health information concerning stress and psychological health ^d Translated written material ^d Performed language simplification ^d Applied a bilingual approach ^d Offered bilingual audio files ^d	Operative group compromise about language simplifications ^c	Program development phase Intervention phase	Operative group Research team Reference group Steering committee Interpreter services

(continued)

Table 1. (continued)

Original definition of core components	Adaptation of content and design	Comment	Time point for adaptation	Partners involved in adaptation
The booklet is provided in advance and serves as a basis for group discussions ^a	No adaptation made	—	—	—
The meetings are based on participating persons' needs and interests ^a	Clarified the person-centered approach ^e		Exploration Program development and intervention phase	Operative group Reference group Research team Participants
Peer learning The participants share experiences ^a	Developed the role of the group leader ^e Applied new guidelines for group size when interpreter is included in the team ^e Used simultaneous interpretation ^e Offered choices of how to use interpretation services ^e	Adaptations were preformed to be able to implement	Program development Intervention phase	Operative group Reference group Research team Participants
One professional follows the group through all meetings to provide safety and continuity ^a	No adaptation made	—	—	—

Note. RN = registered nurse; SW = social worker; OT = occupational therapist; PT = physiotherapist.

^aMaintaining evidence.

^bCreating opportunities to meet in time and over time.

^cAwaiting adjustments.

^dSafeguarding exchange of health-promoting messages.

^eBalancing partnerships and group dynamics.

^fIntegrating the interpreter into the team.

Table 2. Demographics of the study setting compared to the middle-sized city.

Demographics	Study setting	Middle-sized city
Total population (2013)	49,926	533,271
Born abroad	50%	24%
65 years or older	11%	15%
General educational level ^a	9%	22%
General income level ^b	168,900	230,100

^aUniversity ≥ 3 years among persons aged 65 to 74 years.

^bAverage annual income in (SEK) for persons 65 years and older.

Study Setting

The study was conducted in a low-income suburban district of a middle-sized Swedish city, where 50% of all inhabitants were born abroad. Demographics of the study setting of the specific city are given in Table 2. Influences from the Swedish welfare system of relevance for the program are described elsewhere (Gustafsson et al., 2015). Twelve series of senior meetings were held and a total of 56 people participated.

Recruitment and Data Collection

To explore the case from different perspectives and to triangulate data, several data collection methods were used: focus-group discussions, individual interviews, and review of study documents and archive material. Each of these approaches is described below. Procedural details such as time points for data collection and inclusion criteria are provided in Table 3.

Focus groups. Two focus groups were held to obtain a collective view of adaptations (Dahlin-Ivanoff & Hultberg, 2006). Eleven people involved in the implementation of the program were recruited for participation. One focus group consisted of six research team members and the other comprised personnel in the operative group and project assistants ($n = 5$) working in the community. Each focus group lasted for 1.5 hr and was moderated by the first author, who also recorded discussions and transcribed verbatim. A question guide was used (Table 3).

Individual interviews. Interviews were held with representatives from the operative group, the research team, and the project steering committee. The participants were purposefully sampled due to their ability to explore different perspectives of adaptations. Participant inclusion criteria were conducting

Table 3. Overview of the procedure for data collection and analysis presented per data source.

Inclusion criteria and data collection	Focus-group discussions	Individual interviews	Documents
Representatives from research group (FG1) or personnel (FG2)	Representatives from research group (FG1) or personnel (FG2)	Representatives from research group, personnel, or steering committee	Documents concerning descriptions of performed adaptations or adaptation decisions were included
Time point for data collection	June 2013	September 2013 to December 2014	2011-2013
Informants (n)/amount of data materials	FG1; n = 6 FG2; n = 5	n = 9	Eight protocols from the steering committee (30 pages) (years 2011-2013) Two documents with process notes from the operative group (130 pages) (years 2012-2013) Year report 2012 One memory note 2011 One project plan
Question guide	Five open-ended questions Probes	Seven open-ended questions Probes	Not relevant
Question areas	<ul style="list-style-type: none"> How would you describe what is central in the content and design of senior meetings? How are you reasoning about the need to adapt the program to the context in which implementation occurs? How would you describe the main adaptations during implementation? Have you actively worked to encourage and/or inhibit adaptations? If so, can you explain how? How do you view the role of each research-community partner in program adaptations? 	<ul style="list-style-type: none"> Reasons for adaptations or nonadaptations Experiences working in a partnership Experiences of adaptations in relation to program core components Experiences performing adaptations during the implementation 	Not relevant

(continued)

Table 3. (continued)

	Focus-group discussions	Individual interviews	Documents
Performed steps in the initial analysis	<p>Focus-group analysis</p> <ul style="list-style-type: none">• Preliminary themes were identified representing the sense of the whole material• Discussions in raw data were marked• The discussions were sorted into the preliminary themes• Descriptions of the themes were written using raw data	<p>Content analysis</p> <p>Meaning units were marked, condensed, and thereafter given a code according to its latent content</p>	
Role in the integrated analysis	Primary data source	Primary data source	Data triangulation

program adaptations or being involved in decisions regarding program adaptations. Of 10 people who were recruited, nine agreed to be interviewed. Three participants represented two organizational perspectives because of dual roles in program implementation. Thus, perspectives from the operative group ($n = 4$), the research team ($n = 4$), and the project steering committee ($n = 4$) were covered. The first author conducted the interviews. A question guide developed from the focus-group discussions was used (Table 3). The interviews lasted between 53 and 88 min (median = 69 min) and were transcribed verbatim by the first author.

Document review. Archive material and documents regarding adaptations, such as protocols and process notes covering the time span 2011 to 2014 were identified. Thirteen documents were included (Table 3).

Data Analysis

The study's explorative design meant that a case description was built up through an iterative analysis performed in two steps: (a) initial analysis of primary data sources and (b) pattern matching involving category development. The first step analyzed focus groups according to Krueger and Casey (2009) and the individual interviews using content analysis (Graneheim & Lundman, 2004). Focus-group analysis and content analysis were initiated by reading transcriptions and listening to the recordings. Details regarding the process of coding are provided in Table 3. The initial analysis resulted in descriptions representing preliminary themes from the focus groups and codes from the individual interviews.

The second step involved an overarching integrating analysis performed by pattern matching (Yin, 2009). Descriptions of preliminary themes from the focus-group analysis and codes identified in the individual interviews were compared, synthesized, and further developed. Those representing the same pattern were sorted into categories or subcategories. The category development was an iterative process supported from multiple data sources and perspectives. The role of each data source in the integrated analysis is provided in Table 3. Focus groups, individual interviews, archive material, documents, and protocols were used to triangulate data in the categories. The triangulation served to converge data in line with Yin (2009), meaning that each category was supported by at least two data sources. In addition, it was used to identify divergence of perspectives into the case description (Curtin & Fossey, 2007; Stake, 1995). Furthermore, researcher triangulation was used as categories and subcategories were developed in cooperation between the first and third author (Curtin & Fossey, 2007). NVivo 10 was used to

structure data and to facilitate triangulation. Member checking (Curtin & Fossey, 2007) was done by sharing the interpretations of the final results with participants who validated the results.

Results

The analysis showed that adaptations of program content and design were performed during program implementation. The adaptations took place during the exploration phase, program development phase, and intervention phase, and involved different partners. We first present the process explaining how and why adaptations were performed in the researcher–community partnership. Thereafter, details of adapted content and design compared with the original protocol, time points for adaptations, and involved partners are provided (Table 1).

Negotiating Toward Suitable Solutions

The analysis showed that adaptations performed in a researcher–community partnership can be explained by a dynamic process, *negotiating toward suitable solutions*, that is, shaping the design and content into adaptations that were considered to work and be acceptable for involved partners. The degree of acceptance for what was perceived as a suitable solution differed between the partners and during implementation. Three reasons explaining adaptations were identified: to meet needs and resources in the target group, to defend core components, and to advocate evaluability. The negotiations were found to be driven by how the interplay within and between these three reasons for adaptations were influenced by the researcher–community partnership. The partners could support and inhibit adaptations based on their views of how content and design should be shaped to be a suitable solution.

Negotiating toward suitable solutions is underpinned by four categories. These include one category concerning prerequisites for negotiation—*establishing a common ground to shape adaptations*—and three categories concerning why and how the researcher–community partnership influenced what was seen as suitable solutions—*striving to meet needs and resources in the target group*, *defending core components*, and *advocating evaluability*. The negotiations about suitable solutions resulted in actions taken to adapt or inhibit adaptations. The contribution from each category and subcategory to the case description is provided in Figure 1, whereas the link between subcategories and conducted adaptations is presented in Table 1.

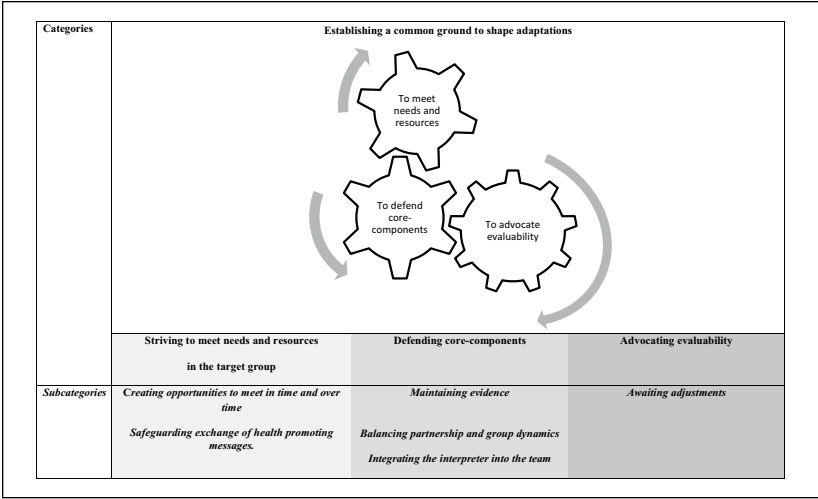


Figure 1. An overview of categories and sub-categories explaining the course of events that underpin the dynamic process; negotiating toward suitable solutions.

Establishing a Common Ground to Shape Adaptations

Establishing a common ground to shape adaptations means creating prerequisites for involved partners to bring their own perspectives and competence into the negotiations toward suitable solutions. This was an ongoing process that consisted of actions that approached different partners’ perspectives of what was considered a suitable solution. The prerequisites of having a common ground to negotiate varied during program implementation. These prerequisites were formed by both the regulations stated in the cooperation agreement and by the conditions created to establish a meeting between involved partners’ perspectives. Meeting referred to seeing each other and having contact on a regular basis. In addition, it referred to reaching mutual understanding and feeling able to cooperate.

Now I can see that it’s a joint effort. In the beginning I didn’t feel it was a joint effort, but that it rather felt like there was research on the one side and practical application on the other side. (Individual interview, operative group)

The process of establishing a common ground to shape adaptations ranged from being in two separate “worlds” in which the partners did not meet to experience conditions for cooperation where joint solutions could emerge. This was characterized by the experience of a power imbalance between the

partners, and a lack of understanding of one another's situation and views of adaptations. Working together on an operative level, sharing a common language, and countering the perception of hierarchy between the research team and personnel contributed to establishing a common ground to shape adaptations. The steering committee fulfilled a balancing role.

Striving to Meet Needs and Resources in the Target Group

One of three reasons to adapt program content and design was to meet the needs and resources of the target group, that is, to strive to make program content and design compatible with the target populations' capabilities to access valuable health promotion services. To provide easy access to health promotion services was a shared goal of all researcher–community partners. Initially, focus was on cultural adaptations and assumed needs and rights of the target group based on previous experiences and literature. By taking on a person-centered approach, the exploration of experiences from reference groups, participants in senior meetings, qualitative background research, and experiences of conducting senior meetings complemented this view by identifying resources within the target group. The negotiations resulted in actions to meet needs and resources, described in the two subcategories: *creating opportunities to meet in time and over time* and *safeguarding exchange of health-promoting messages*.

Creating opportunities to meet in time and over time. Opportunities were created that enabled participants and personnel to come together in the same physical space during the program. In addition, opportunities were created to build trust to establish sustainable relations between participants and health care personnel (Table 1). One example of adaptation connected to this subcategory was the lowering of the age for participation from 80 (original protocol) to 70 years old. This was done to meet the need of access to health-promoting services before the onset of dependence in daily activities. Adaptations were also performed to bridge barriers related to identified socioeconomic resources that could hinder either participation in the group sessions or ability to proceed with health promotion activities after the program.

Just the fact that we have these meetings when it's free, so that they get free travel on the public transport. Because it's . . . Finances control so much and that we always offer them opportunities that don't cost anything, to exercise, to social gatherings. We always present alternatives that don't cost anything [in the written material]. (Individual interview, operative group)

Safeguarding exchange of health-promoting messages. Adaptations were conducted to safeguard exchange of health-promoting messages in relation to linguistic, health-related, and educational needs and resources among the target population, for example, to protect the target group's right to receive, understand, and communicate health information. One such adaptation was the development of how health-promoting messages were exchanged relative to language skills, functional ability, and previous experience. Interpretation services were offered and this support was adapted according to group preferences. In addition, health information from the booklet was provided on audiotape for people who could not read due to functional decline or illiteracy.

We have some sort of bilingualism as those who don't fully understand Swedish must be able to feel that they can use the level of Swedish that they know, and that they can feel proud of. I think this is such an issue, and it also arose from the reference groups and it felt as if it was the right decision to make, to approach the participants this way. (Individual interview, research team)

Defending Core Components

The second of three reasons to adapt program content and design was to defend core components, that is, striving to implement program content and design that are considered to be central to achieving program outcomes. Defending core components included both a resistance and openness to adaptation. The actual approach to applying the core components in practice could vary between the research team and personnel. This was because the research team and personnel could, over time, have opposing views on how to apply the core components. The negotiation resulted in actions taken to defend core components as described in three subcategories: *maintaining evidence*, *balancing partnership and group dynamics*, and *integrating the interpreter into the team*.

Maintaining evidence means preserving or clarifying content and design from the original protocol (see Table 1). The following components were preserved: targeting independent people living in ordinary housing, administering group-based meetings with a person-centered approach, providing health information both written and orally, and exchanging health information with an interprofessional team commencing with the booklet. In addition, the offered dose of the program was kept unadapted.

When I say that the core remains, I mean that we are an inter-professional working group; four professions, a group leader, with five or six participants.

We have a material that in different ways, depending on how much you want to study as a participant, can help to arouse reflection and discussion within the group. (Individual interview, operative group)

Balancing partnerships and group dynamics means that personnel created solutions to achieve a power balance during the group sessions, thereby enabling peer learning and a person-centered approach. The balance concerned the relationship between participants and personnel and between participants. It also referred to achieving balance between serving participants at the individual level as well as in a group (Table 1). One adaptation concerned a role distribution between the group leader and the personnel in the interprofessional team. The group leader was attributed a more active role and become responsible for supporting the group process during the senior meetings. One personnel describes this new role as a facilitator for implementing the person-centered approach,

We are only experts that take a step back to meet the needs of the participants, but I feel the group leader is the one who creates conditions for person-centered approach. It would be interesting to try it without a group leader, but I don't believe that we would get as far during our meetings, or that we would be able to catch the group in the same way. (Individual interview, operative group)

Integrating the interpreter into the team entailed creating space for an interpreter in group processes during the senior meetings. This was an additional adaptation required to enable the implementation of core components such as peer learning and a person-centered approach when offering interpretation services. Integrating the interpreter into the team required extending the group leaders' role to create prerequisites for interpretation. This included keeping the interpreter updated on group processes, positioning the interpreter to facilitate group dynamics, and mediating the participants' preferred interpretation methods. Simultaneous interpretation was used to bridge identified implementation barriers;

Should we achieve some sort of group dynamic—this is really the whole basis of the entire intervention. You break the dynamic completely if the interpreter interrupts and strangulates a discussion. In order to create the conditions to work with the group and base more group dynamics as a tool it was necessary to have a simultaneous interpreter or someone who could skillfully smooth over or help with language issues, for example. (Individual interview, research team)

Advocating Evaluability

A third identified reason to adapt program content and design was to advocate evaluability, that is, solutions considered otherwise suitable for meeting the needs and resources of the target population were argued against in the negotiations, if they were considered to hinder the production of new research evidence. The research team had the leading role in advocating evaluability, but the personnel were also using it as an argument for accepting researchers' proposals in the negotiations. The negotiation resulted in actions taken toward suitable solutions to advocate evaluability described in the following subcategory, *awaiting adjustments*.

Awaiting adjustments refers to inhibiting actions to adapt where the negotiations resulted in decisions that postponed the implementation of identified suitable solutions to protect evaluability. Such identified solutions include outreach visits to better meet the target population in time and over time.

Yes, we felt the need to get out and hold meetings for seniors in the various different clubs and associations, for example, for them to see what we do and for us to be able to spread the word. However we can't do this [right now] as it would contaminate the data. (Individual interview, operative group)

Results Discussion

The present study explored whether, when, why, and how content and design of a health promotion program was implemented and adapted in a researcher–community partnership. The results showed that adaptations in the process of translating knowledge to action were made, and could be explained by a dynamic process, *negotiating toward suitable solutions*.

To our knowledge, this is the first study to demonstrate how and why a researcher–community partnership contributes to program adaptations that support optimal aging in the context of migration. The study's findings illustrated how using a researcher–community partnership as an implementation strategy contributed to inhibiting and encouraging adaptations. Involved partners were found to strive to meet the needs and resources of the target group, defend core components in the implemented program, and advocate for the program's evaluability for the sake of research. Identified reasons and actions explain why and how the program's content and design were shaped through ongoing *negotiations toward suitable solutions*. These reasons and actions were central for the adaptations to be considered to work and to be acceptable from different partners' perspectives. The identified reasons have

been demonstrated as important also in previous research (Chen, Reid, Parker, & Pillemer, 2013; Damschroder et al., 2009; Durlak & DuPre, 2008; Liu et al., 2012; Viswanathan et al., 2004). Similar to previous studies, our results underline the fact that adaptations should be performed according to the target group's needs (Damschroder et al., 2009; Liu et al., 2012), and that implementation of program core components should be supported (Chen et al., 2013; Damschroder et al., 2009; Durlak & DuPre, 2008). *Advocating evaluability* as a reason to inhibit adaptations has similarities with findings in a previous study (Viswanathan et al., 2004), which demonstrated that researchers must balance methodological rigor with responsiveness to the community. Our result was further underlined by findings showing the importance of monitoring outcomes in praxis and that researchers are often involved as partners in aging community projects due to their expertise in evaluation (Giunta & Lori Thomas, 2015). However, we found no previous studies demonstrating the interplay within and between reasons to adapt or inhibit adaptations and how they actually influence program content and design (Figure 1), which our study adds to the current knowledge base.

Another unique contribution from our study was demonstrating how a researcher–community partnership influenced program adaptations during both the knowledge creation and action phase as described in the KTA framework (Graham et al., 2006). Previous studies on program adaptations, and reasons for adaptations concerning older people (with or without migration experiences), have mainly focused on either knowledge creation or the action phase. For example, one randomized controlled trial has briefly described adaptations conducted for a program to better fit older migrants before implementation and reasons for these (Reijneveld, Westhoff, & Hopman-Rock, 2003). In addition, major types of adaptations and reasons for adaptations when implementing evidence-based chronic disease prevention programs have been demonstrated (Carvalho et al., 2013). Outcomes of an adaptation process that aimed to make intervention more culturally sensitive have also been reported (Jackson et al., 2000). Furthermore, there are guidelines on how to adapt evidence-based interventions to new populations or how to culturally adapt them to support implementation (Chen et al., 2013; Liu et al., 2012; Wingood & Diclemente, 2008). However, the primary focus of previous studies did not longitudinally explore how adaptations are shaped by the interplay between knowledge creation and actions taken to support implementation. Our study contributes by presenting six actions that support or inhibit adaptations and how these were shaped over time as a result of the partners' negotiations.

The results of this study emphasize the importance of making health-promoting interventions available to people aging in the context of migration, which is in line with the findings of previous research (Alizadeh-Khoei et al.,

2011; Lood, Hägglöf, & Dahlin-Ivanoff, 2015; Rechel et al., 2013). However, fewer adaptations than expected were conducted. The final adaptations not only were migration specific but also due to age-related decline and socioeconomic status. In addition, the adaptations were shaped to take advantage of the older persons' resources. This might be explained by the use of a person-centered approach, as it advocates integration of target group expertise on experienced needs and resources in program development (Ekman et al., 2011). The advantage of a person-centered approach was evident in the category *striving to meet the needs and resources* of the target population. It showed that the first adaptations, cultural and linguistic, were shaped by the research-community partners' skills, knowledge, and experiences. In person-centered dialogues with reference groups of older persons and program participants, the need to adapt content toward each participating person's innate resources was successively recognized. Thus, in line with previous research (Lood, 2015), our result showed that a person-centered approach helped to counteract stereotypes of the target groups needs by discovering capabilities of older persons aging in the context of migration.

Working in a researcher–community partnership to develop services is advocated in the literature (Chen et al., 2013; Liu et al., 2012). Such partnerships involve ongoing negotiations and are most effective when end users, that is, decision makers and health care professionals, are included at all stages of the process (Walter et al., 2003). Our study's findings not only are consistent with these assumptions but also demonstrated that integrating different partner's perspectives into negotiations required support. Similar to our results, previous research (Wallerstein & Duran, 2010) has described challenging factors in partnerships between researchers and communities, such as incompatible language between partners and the privileging of academic knowledge regarding what counts as evidence. The category *establishing a common ground to shape adaptations* showed that creating prerequisites for involved partners to bring their own specialized perspectives and competence to negotiations was an ongoing process. Thus, our results also acknowledge how such challenges were faced by building on facilitating circumstances such as working together on an operative level. In addition, sharing a common language between researchers and health care personnel allowed to take advantage of different partners' perspectives. Thus, our findings contribute with experiences of how to bridge previously described challenges of working in partnership to improve health equity (Wallerstein & Duran, 2010).

The category *defending core components* is consistent with findings that the quality and trust of research evidence can affect the success or failure of implementation (Damschroder et al., 2009; Rycroft-Malone, 2004). Identified actions within this category showed that the researcher–community partnership

inhibited adaptations of the original protocol (*maintaining evidence*). However, adaptations were supported to allow implementation of a person-centered approach or peer learning (*balancing partnerships and group dynamics* and *integrating an interpreter into the team*). These actions reinforced the concept that these two program core components were central in achieving program outcomes. Consequently, adaptations were performed so that peer learning and a person-centered approach could be implemented in the senior meetings. Thus, our results contribute with practical examples of how adaptations can be performed to provide person-centered bilingual group meetings that support optimal aging. Implications for how to shape adaptations according to the target population's resources and needs are proposed, especially for bridging language barriers between personnel and participants during senior meetings.

Methodological Considerations and Limitations

The case study approach inspired by Yin's (2009) method was considered useful because adaptations could be studied during program implementation in the context in which it occurred. The results should be interpreted and understood on the basis of the context in which they were developed with regard to the targeted group, the socioeconomic status, and the educational level in the studied setting. The studied context can also be understood from other perspectives such as working in a researcher–community partnership and the theoretical underpinnings of the health promotion program (Damschroder et al., 2009). This is considered a strength by posing opportunities to transfer the findings to contexts other than the actual study setting.

The study design was beneficial as it captured the interplay of reasons influencing negotiations about adaptations during implementation. However, neither were quantitative measures traditionally recommended to monitor implementation used, nor were data with regard to cost of the adaptation process, which may be seen as a limitation. Thus, future studies may gain from using a mixed-method approach. Another possible limitation may be that the interviews about adaptations were partly conducted retrospectively, which might have caused a recall bias. As a safeguard, reasons and actions toward suitable solutions were triangulated in the analysis by using various data sources. In addition, the ability to highlight the collective view of adaptations by first conducting focus groups provided information of important events and adaptations, which were then further investigated in the individual interviews.

Several steps were taken to establish credibility of findings. Data were triangulated to identify both divergence and convergence of findings (Stake, 1995; Yin, 2009). Divergence was reached by capturing the diverse views of

health care personnel, the steering committee, and the research team. Findings from different data sources and perspectives were converged into the overall case description, thereby adding credibility to our findings (Yin, 2009). Despite being integral to the adaptation process, the reference groups and older people participating in the senior meetings were not interviewed in this study as we focused the data collection on individuals involved in the decision on adaptations. This methodological choice neglected the opportunity to capture the target groups' perspective, which could have enriched the results. However, that perspective has been explored in another study reporting older migrants' experiences and benefits of the adapted program (Barenfeld, Gustafsson, Wallin, & Dahlin-Ivanoff, 2015).

Conclusion

This study explains how and why a researcher–community partnership with health care personnel, a research team, and a steering committee, contributed to program adaptations to support optimal aging in the context of migration. Our results show that research–community partners advocated the creation of adaptations to build on both the target population's needs and resources, which is key to accessible health-promoting services. The partnership not only helped to shape adaptations to meet the needs and resources of the target group, but also defended core components and advocated evaluability. Thus, the researcher–community partnership helped to balance program adaptations with fidelity and supported the process of integrating knowledge from research, professional experiences, and experiences from the targeted group. In addition, insights were gained into how bilingual person-centered group meetings can be administrated while maintaining the evidence brought by the original program core components. However, our results also raise issues that require further investigation such as how to bridge remaining barriers to meet the needs and resources of the target group in time and over time. Future studies also need to evaluate health-related effects as well as health economic aspects of the adapted program.

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