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Abstract

Previous research has often visualised ageing and migration as risk factors for poor health, pointing to a need for targeting health-promoting efforts towards ageing persons born abroad. However, most research has been conducted from an objective and poor health perspective, loosing the broader picture of health in the context of ageing and migration. A key issue left unexplored is meaning of health from a subjective perspective with focus upon persons who constitute the target groups for health promotion and other health-care services. A great amount of persons are now ageing in other countries than their country of birth. Therefore, studying meaning of health in relation to this part of the population is of growing importance. As part of a larger health promotion project, the aim of this study was to explore meaning of health to ageing persons who have migrated from the Western Balkan region to Sweden. Data were collected by individual interviews, conducted in the participants' mother tongue. Inspired by Ricoeur's hermeneutic approach, health was interpreted as a retrospective and prospective process of exercising control over one's own life, daily activities and social commitments. This interpretation is discussed in relation to how a person-centred approach to healthcare services could bridge health inequities in an ageing and globalising society.

Introduction

Health has been visualised as an important influential factor for the perception of old age, affecting the quality of life and attitudes towards ageing (Prevc and Topič 2009). Thus, current demographic changes with an ageing population encourage an exploration of how to support healthy ageing. However, previous research has mainly focused on persons who are native-born, limiting the knowledge on healthy ageing among the growing population of persons who age in a foreign country (Philipson 2007; Warnes *et al.* 2004).

Striving to make health available for all people, the present study is part of a larger Swedish health promotion project, which aims to provide appropriate health promotion tools for ageing persons who have migrated to Sweden. As described by Laverack (2004), the appropriateness of health promotion is dependent upon how the persons of the target group define health. For the aim of the larger health promotion project, the target groups are ageing persons from the Western Balkan region and Finland since they currently constitute the largest groups of persons who are 65 years of age and have migrated to Sweden (Statistics Sweden 2014). How persons from Finland experience their health has been explored in previous research (Kulla, Ekman and Sarvimäki 2010; Kulla *et al.* 2010), and will be explored further by other researchers within the present larger health promotion project. The health of ageing persons who have migrated from the Western Balkan region, however, is to our knowledge left unexplored.

The Western Balkan region has traditionally been a source for labour migration (Kupiszewski *et al.* 2009), and with the war in Bosnia and Herzegovina in the 1990's, the migration rate from the region increased significantly (Mollica *et al.* 1999; Kupiszewski *et al.* 2009). Thus, a great amount of persons from the Western Balkan region are now growing old in countries outside of their country of birth, and it is therefore believed that a deeper knowledge of the meaning of health to them is of public health importance.

Health and health promotion in the context of migration

Several attempts to define health have been made. Perhaps the most well-known is the World Health Organization's (WHO 1948) definition, stating that health is a state of complete physical, social and mental well-being. This definition has been of major importance when it comes to acknowledging that there is more to health than absence of disease. However, health is an elusive concept and there can be no universally adopted notion of it. This means that understandings of health need to be nested in contexts, and in relation to the heterogeneity of persons (Bircher 2005).

Health is a human right, and all persons ought to be entitled to the same possibilities to be healthy (Bloch and Schuster 2002, Evans *et al.* 2001). However, there is a notion that possibilities to age healthily differ between people depending on country of birth (Kulla, Ekman and Sarvimäki 2010; Pudaric, Sundquist and Johansson 2003; Warnes *et al.* 2004). Research has shown that ageing persons who are born abroad are at a high risk of developing poor health, and that they generally have a poorer health status than their native-born counterparts (Wiking, Johansson and Sundquist 2004; Silveira *et al.* 2002;

Westman *et al.* 2008). Additionally, both healthcare access and quality might be compromised by high age and migration status (Fiscella *et al.* 2000; Lanari and Bussini, 2012).

Aiming to overcome health and healthcare inequities, health promotion involves structured processes to promote health, prevent disease and prolong life by enabling all persons to take control over, and improve their health (WHO 1986). However, the causal pathways leading to health inequities are multidimensional and complex (Braveman and Gruskin 2003), and health promotion needs to be understood in relation to the dynamic relationship between different contexts, personal behaviour, and health determinants (Glass and McAtee 2006; WHO 2012). According to previous research, ageing and migration seems to be important determinants of poor health, but when it comes to the underlying mechanisms of healthy ageing in the context of migration there are still some important research gaps that needs to be filled.

Migration experience is one aspect that might influence the experience of health and well-being during the ageing process (Torres 2006; Kulla, Ekman and Sarvimäki 2010). However, there are a variety of complexly interrelated aspects that need to be considered when aiming to promote healthy ageing in the context of migration (Lood *et al.* 2014). Ageing persons who are born abroad are a heterogeneous group, with different capabilities, migration experiences and health-related beliefs, within as well as between different ethnic, cultural and other forms of identity-based groups. Thus, health promoters need to be aware of how each person narrates his or her experiences and resources. Therefore, the present study is based on narratives of ageing persons who

have experienced migration, and the scope was to provide a standpoint for health promotion development and implementation. With focus on healthy ageing within a living context, the aim was to deepen the understanding of the meaning of health to ageing persons who have emigrated from the Western Balkan region to Sweden.

Methods

Fifteen individual interviews with focus upon participant narratives were employed in order to answer to the aim of the study. Inclusion criteria were: having migrated from the Western Balkan region to Sweden, being 65 years or older, living in ordinary housing, and being independent in performing activities of daily living (i.e. bathing, using the toilet, grocery shopping, meal preparations and laundry). Allowing the authors to develop an intersubjective knowledge on meaning of health, the interpretation took on a hermeneutic approach inspired by Ricoeur (Ricoeur 1976; Ricoeur 1981). The narrated meanings of health were interpreted through a dialectal movement between explanation and understanding, with consideration to the intricate interrelationship between the interpretation of the text and the authors' pre-existing understandings.

Data collection

The participants were gathered employing snowball technique (Ulin, Robinson and Tolley 2005). This meant that a research assistant (MC) contacted an initial person through her existing social networks, and following the first interview, the participant mediated contact details to another person who met the inclusion criteria. The choice of method for data collection was carefully and critically discussed with the research assistant who was a social anthropologist from the Western Balkan region, able to

communicate with the participants in their mother tongue. According to her experiences, ageing persons from the Western Balkan region might have difficulties in trusting professional interpreters, consequently it was not considered to be appropriate for the authors to conduct any of the interviews. After conducting ten interviews, the research assistant transcribed and translated all collected data into Swedish before sending it to the first author.

After reading all translated data thoroughly, the authors detected a serious limitation to participant heterogeneity. All of the narratives came from persons who had fled from the war in the 1990's, whereas there are also large amounts of persons who have migrated from the Western Balkan region for other reasons. In order to capture a wider array of narratives on the meaning of health, there was consequently a need for further interviews. Another research assistant (AS) from the Western Balkan region was contacted. She had a different social network and profession (occupational therapist) than MC and was therefore considered to be an appropriate complement to the first interviewer. Applying the same sampling, transcription and translation procedures as with the first ten interviews, five more interviews were conducted with ageing persons who had other reasons for migration than war.

Demographic data on gender, age, years lived in Sweden, age at migration, reason for migration, marital status, living arrangements, work experience in Sweden, education level and self-rated health were collected before the interviews commenced. Data on objective health, such as chronic illness, was omitted based on the belief that this would have influenced both data collection and interpretation, putting an inappropriate focus

on disease rather than meaning of health.

All interviews followed the same topic guide with open questions developed in collaboration between the authors and the first interviewer (MC) who had experience from conducting qualitative research with the target group. The topics were: health, ageing, everyday life and meaningfulness in life. In order to achieve a richness of data (Patton 2002), follow-up questions were asked when needed to elaborate on the thoughts of the participants more deeply. The interviews were conducted in the participants' homes and in their mother tongue, and they were more like conversations than formal interviews. They ranged from four to 13 pages of transcribed and translated text (from 16 minutes to one hour).

Participants

All persons enquired agreed to participate, in total nine women and six men, aged between 67 and 82 years (median age 72 years). They had all been living in Sweden for more than ten years (range 14-52 years), and most of them had fled from their country of birth, nine due to the war in the 1990's and one due to political threats before the war. The remaining five participants had come to Sweden for family, work or health reasons. Eight of the participants were married and lived with a spouse, and seven were living alone. All of the participants had finished upper secondary school or higher, and more than half had been working in Sweden. Predominantly those were participants who had come to Sweden due to other reasons than war. Nine participants rated their health as good, two as very good, two as fair, one as poor, and one participant rated his health as pending between good and poor.

Ethical considerations

When conducting a study based on narratives, it is impossible to predict how each person will react. Some might be confronted with painful memories, and some might feel that they revealed too much of themselves. When persons who are born abroad are asked to participate in a study, ethics might become even more important. Since the participants and the authors did not speak the same language it was important to ensure that information was clearly mediated. Therefore, the first interviewer (MC) assisted with formulating the information letter and developing the topic guide. Additionally, the choice of interviewers who could communicate with the participants in their mother tongue was important in order to be able to conduct the interviews in a respectful and open manner.

During the initial phone call from the interviewer, the participants received information on the aim of the study and that it was completely voluntary to participate. All information was provided to in their mother tongue and they got the opportunity to ask questions to the interviewer prior to the interview. They also received a letter with information about the study, that a report will be written, and that they are assured confidentiality. Furthermore, the voluntariness and possibility to terminate participation at any time without explanation was stressed. After receiving all information mentioned above and before the interview took place, all included persons signed a consent form to participate in the study.

Interpretation

Starting with a naïve approach to text interpretation, the authors grasped an instant and unreflected interpretation of the text as a whole, explaining its' content. Potential meanings were constructed and written down as notes representing significant parts of the text (clues). The interpretation then moved forward by a distanciation of the text, meaning that the authors acknowledged the many different meanings of the text and put them in relation to their different pre-understandings as an occupational therapist (QL), an occupational scientist (GHK) and a social anthropologist (LD). By multiple readings and discussions between the authors, parts of the text were explained and put in relation to the whole, and vice versa. Interpretive themes were constructed from the clues, and in order to further explain the meaning of the text the authors confronted the themes with explanations from previous literature. Through this confrontation, the authors could finally decide whether the themes should be confirmed, rejected or expanded in order to reach appropriation of the text, revealing a deeper meaning. If the interpretive themes fitted well within the confrontations, within the clues and the text as a whole, they were confirmed. If they felt too narrow or exaggerated, the authors rejected or expanded them until four final themes were reached. To ensure critical reading, contact with the interviewers was maintained throughout the interpretation process, seeing the interpretations through their eyes. This also allowed the authors to achieve cultural translations of proverbs and expressions.

Results

The interpretation of the participants' narratives describes four different meanings of health: 'Finding a place for the "real me"', 'Being capable of executing what is expected and desired', 'Creating a feeling of home', and 'Feelings of affinity'.

Finding a place for the "real me"

Health was narrated as a place where the participants felt secure enough to articulate the "real me", representing who they really are and what they are capable of doing. In the context of migration, the country of birth represented a place of importance for their "real me", as a place to which they could return to and be themselves together with other people.

"Socialising - you can't find anyone... we're a strange lot, new friendships can't… okay, it works, but going to a café like we do there [in the home country], and then in the afternoon we'll go and have a drink, we talk … Here [in Sweden] it's not easy to make a friend…who you can open up your heart to and be honest, everything here is lies and artificial." (Participant two, female).

Meaning of health was further associated with being able to articulate the "real me" in encounters with Swedish healthcare professionals. The participants shared the belief that physicians or other healthcare professionals could assist them in managing different health-related problems but felt insecure on how to express their needs in Swedish. As a means to find the place for the "real me" within the Swedish healthcare system, the participants preferred to interact with professionals with whom they could communicate directly, in their mother tongue without the use of an interpreter.

"At the hospitals there should be physicians, nurses, who can speak our language, so that we can communicate and understand each other. So that we can say what bothers us and what hurts, then you would feel some safety, you would feel better and more secure and you would trust the physicians." (Participant three, female).

Being capable of executing what is expected and desired

The participants described meaning of health as having the capability to fulfil what they expect of themselves, as well as what they desire to do. This was expressed as being independent in daily activities, such as household chores, self-care and physical exercise, but also to attend social gatherings with friends and family. With the intent to contribute to their own as well as other people's well being, the participants articulated health as both a prerequisite and a result of being capable.

"I'm glad that I can look after myself, that I can do things for myself, that are to my liking. To do this I need my health and that I feel alive and that I can actually do it, that's the major objective – to look after myself and others around me." (Participant three, male).

Sparked by uncertainty of not knowing what will happen with their physical and cognitive capacities, the participants described a fear of growing old and becoming physically alone. They were curious to maintain physical control over their bodies, and described how they fight not to let age create gaps between what they expected and desired to do, and what they actually could do. The majority of the female participants regularly visited thermal baths in their country of birth in order to improve their physical health. Other participants prepared for change by maintaining a physically and

socially active lifestyle, securing the ability to manage with future challenges to health.

"I don't give up, walks, I love reading, I do crocheting, I do that, I watch TV, I don't know what else. Whatever I need I go shopping. I walk into the city if I want to by some clothes. I walk all over the city, I am able." (Participant eight, female).

Migration related gaps, as a result of Sweden's cold climate and hardships with finding friends in Sweden were minimised by nurturing nostalgic memories of their lives as younger persons in the country of birth. Such memories provided the participants with tools for a readiness to act upon challenges to their capability. They recalled what they once were capable of doing, and found solutions to problems by applying previous successful strategies. This accumulated experience stimulated them to find motivation for putting an extra effort into preserving their strength and stamina, persistently continuing executing what is expected and desired. They also compared themselves with others in order to feel capable, and they adapted their activity repertoire according to their present capability.

"I try to live a normal life. I behave in a normal manner, as if I was in good health. As if I could live to be 100 and as if I could die tomorrow. Younger, healthier people than I have passed away, so I try to maintain the little I have. But what I mean is than when I look around I see there are those worse off and less mobile than me." (Participant ten, male).

Creating a feeling of home

In relation to meaning of health, the participants described how they felt comfortable

with growing old outside of their country of birth by creating a feeling of home. This was expressed as a process in which they struggle for familiarity, within the physical as well as the social environments surrounding them. For many of the participants, the country of birth represented such a familiarity, representing both the geographical and social place to which they felt a sense of belonging. Those participants made annual travels to the country of birth to charge their batteries for the rest of the year in Sweden, representing a means to promote their health by spending time in a familiar context.

"I feel really satisfied there [in the home country]. I get to meet my sisters, I see our environment… I feel different, I feel different yes… The most important thing is to meet those I haven't met for many years, or those who I have waited a year to see and so-on. You're completely different when you get back to Sweden, you're completely different." (Participant twelve, female).

Reflecting hybrid feelings of home, some participants described how they felt a connection to both the country of birth and Sweden. Creating a feeling of home through social networks, those participants could not say that one geographical place was better for their health than the other. They interchangeably described the country of birth and Sweden as their homes, but the country of birth was also described as a place to which they could never return. By accepting that they had left it, they could handle their hybrid feelings and create a feeling of home in Sweden.

"Everything in my home country has changed, a different people when you talk to them, everything's different. So I travel there, home, and what do I do? Sit at home all the time until I travel back home here [to Sweden]. (Participant fifteen, male).

Other participants created a feeling of home in Sweden by focusing on the possibilities provided by the Swedish society. Primarily, those participants represented people who had fled from the war, and even if they too struggled with strong emotional bonds to the country of birth, they commonly described their memories as nostalgic dreams rather than a realistic picture. The creation of a feeling of home was then associated with the acknowledgement of how they never could have lived the life they live today, had they stayed in the country of birth.

"I've adapted to life as if I was born here as I don't have anywhere else to go and Sweden is everything to me. Sweden has given us so much more than our home country couldn't." (Participant four, female).

Feelings of affinity

Meaning of health was associated with the participants' feelings of affinity, narrated as the degree, to which they felt accepted, respected, included and supported as equal peers. Emphasising the significance of reciprocity, the participants described how their relationships to family and friends fulfilled their needs of being both supportive and supported.

"They care about me, which means that I'm not forgotten, by both friends and relations, they care about me in the way I'd care about them if something happened to them." (Participant six, male).

Religious beliefs further provided participants who had Muslim or Christian faith in God with cognizance that they will have arms to hold them when health falters. In their

relationship with God, maintained by religious activities and prayers, the participants felt both supported and included, leaving them with a feeling of affinity and sense of control to manage with whatever difficulties life will bring.

"God, just give me health and nothing else. Because if I'm healthy, then I can plan and do everything myself, I do everything myself [independently]." (Participant eight, female).

Acceptance and inclusion were described in words of mutual understanding, i.e. having the possibilities to communicate and share memories and everyday life with other people. Feeling respected by both Swedes and the Swedish society, the participants strived to nourish interactions with people who speak Swedish. However, the sharing of both language and experiences were narrated as crucial for feelings of inclusion and the participants predominantly described feelings of affinity in relation to people from the same country of birth or region.

"In old age you want to talk about how it once was and so on for example. But it is not possible to explain all that for the Swedes, it is easier to communicate with our people, that's the way it is. That's the way it is and then it gets easier. I think that for a person who is very old and sick, it is much better to hear one's own language around you that is my opinion. (Participant thirteen, female).

Discussion

On a deeper level of interpretation, the narratives describe how meaning of health in the context of ageing and migration could be understood as a retrospective and prospective process of exercising control over one's own life, doings and social commitments.

Underscoring the participants' capability to act, control was interpreted as being able to influence health through the articulation of the "real me", the independent execution of daily activities and social commitments, the creation of a feeling of home and through feelings of affinity. Integrating physical and psychosocial origins of health, this involved both the creation, and recreation of places and spaces were the participants could be acknowledged, and respected for both who they are and for what they are capable of doing. Previous qualitative research on ageing in the context of migration has had a focus on the migration process and its' influence on the experience of ageing, visualising health to ageing persons who are born abroad as a struggle (Shemirani and O'Connor 2006; Kulla, Ekman and Sarvimäki 2010). In contrast to this finding, the present interpretation describes the meaning of health to ageing persons who have migrated to Sweden as an ambition more than a struggle, and as a process highly prevalent in the ageing persons' lives. Particular events and activities were recognised to influence health, calling upon the past in order to build a readiness to act. By nurturing their memories from the country of birth, the participants learned to appreciate what they have experienced and feel embraced by the past. In their knowing that previous challenges to their health have been overcome, they felt in control and hopeful for the future, prepared for whatever changes ageing will bring.

Reflections on the interpretation

Visualising a need to redirect health promotion from focusing on personal risk factors, towards acknowledgement of the dynamic nature of health, the present study supplements previous research with an exploration of the meaning of health in the context of migration from a subjective perspective. As described by Hung *et al.* (2010),

conceptualisations of healthy ageing may vary between researchers and ageing persons why subjective understanding of health is important for both health promotion theory and practice. The deeper understanding of meaning of health described in the present study could be used to alert researchers, as well as health professionals of the situated meanings of health.

Within the interpretation lies a description of the intricate interplay of how ageing persons who are born abroad can take control over their health by finding means to manage with changes related to age, migration experience, linguistic skills and social networks. None of those aspects can, however, be understood in isolation to the other, and the narratives drew attention towards the importance of acknowledging diversity within, as well as between, persons from different groups of identification. Meaning of health as described in the present interpretation can, and should not be extrapolated to all ageing persons who are born abroad. Rather, the interpretation contributes with a deeper understanding of the importance to acknowledge who each person is and what he or she is capable of doing. This finding is strengthened by Johansson *et al.* (2013), who describe the relevance of daily activities, current resources and capabilities for ageing in place in the context of migration. What the present study adds to the scientific knowledge is a description of how ageing in place is related to meaning of health. In relation to ageing in place, the participants described how meaning of health involved a transformation of the a physical space that Sweden represented into a meaningful and socially relevant place where they could stay true to themselves and execute what is expected and desired.

Understood as a retrospective and prospective process of exercising control, meaning of health to the participants is clearly related to the Ottawa charter for health promotion (WHO 1986), which has put emphasis on the exercise of control since its' spawning in 1986. The health promotion goal of creating supporting environments, as presented in the Ottawa charter (1986) is also consistent with the interpretation of how ageing persons who are born abroad strive to find a place for the "real me" and a place where they can feel affinity. Taking a step away from single risk factor analysis, and from regarding healthcare equity as equal availability, this means that the whole population ought to have equal possibilities to make actual use of their resources within their specific physical and sociocultural context. This is clearly intertwined with meaning of health as 'Being able to execute what is expected and desired', relating to the health-promoting approach of developing personal skills. As described by Hocking (2009), such development requires, as well as endorses, engagement in meaningful activities. Thus, by adding meaningful activities to health-promoting initiatives, the capability to participate in daily activities can be both employed and enhanced. In the context of migration however, loss of contextual factors such as home, family and community were interpreted as restricting participation in daily activities. Knowledge on how the participants strive to create a feeling of home could then be used as a means to know how to empower communities of ageing persons who are born abroad to take control over their doings. Additionally, 'Creating a feeling of home' puts focus upon the participants taking personal responsibility for health, developing strategies for adapting and maintaining a healthy lifestyle in the context of migration. However, even if the notion of personal control and self-sufficiency was dominant, the narratives could be interpreted to involve both personal skills and the strengthening of community.

Reflecting further upon the interpretations, the authors of the present study take a philosophical standpoint in Paul Ricoeur's (1992) understanding of what it means to be a person in relation to the capability to live a good life. According to Ricoeur (1992), all human beings have the capabilities to speak, act, narrate, take responsibility, remember and make promises. This is clearly visualised in 'Being capable of executing what is expected and desired', describing meaning of health as maintaining the capability to act and take responsibility for one's doings and social commitments. Johansson *et al.* (2013) have previously described how the human capability to act might be influenced negatively in the context of migration. The present interpretation visualises how this influence could be minimised by applying past experiences to future situations. In their search for solutions to health impediments, the participants recalled memories from previous difficulties they have faced. Thus, by embracing their past experiences the participants could stay true to themselves, take responsibility and feel in control over their current as well as future health. Ricoeur's (1992) understanding of human capability is also prevalent in the other interpretations of meaning of health. Without the capability to speak, narrate and make promises to other persons, the participants would neither be able to find a place for the "real me", nor to create feelings of affinity. Without being capable to use their remembrance of the past as a means to act in the present, they would not be able to create a feeling of home in the context of migration.

Reflections on the clinical relevance of the interpretations

With the aim to describe and understand meaning of health to ageing persons who are born abroad, the present study applied a hermeneutic approach (Ricoeur 1976, 1981) to

text interpretation. The interpretation revealed four meanings of health to ageing persons who are born abroad, providing an empirical standpoint for health promotion development around the world. However, bearing in mind the heterogeneity of persons, together with the impossibility of revealing one true meaning of a text, the findings should be interpreted with caution. To assume that the interpretation relates to the meaning of health to all ageing persons who are born abroad is highly inappropriate. Highlighting the need for researchers to recognise and challenge stereotypic views of ageing persons who are born abroad, the authors were cautious to reflect upon, and question, their pre-existing understandings and experiences as a means to improve the validity and trustworthiness (Patton 2002), of the interpretation.

Qualitative research does not aim to reach generalisations, but reflections upon the transferability of the findings are important in order to widen current perspectives and understandings of the world. Previous research on health and health promotion has been conducted from a somewhat depersonalised perspective, relying on statistics and objective measures of health. Ultimately, health promotion deals with the gradual change over time through enabling and facilitating healthy choices (WHO 1986). It is therefore bothersome that the majority of research on the health of ageing persons who are born abroad has been conducted from a poor health perspective. All persons ought to have equal opportunities for making healthy choices, but ageing persons who are born abroad have often been reduced to being risk carriers for poor health instead of being regarded as persons capable to take control and responsibility for health.

Consistent with the theory on salutogenesis (Antonovsky 1987), the present study

describes conditions for health, instead of putting focus on risk factors for poor health or causes for disease. The interpretation of the participants' narratives relates to how Antonovsky (1987) has described health in relation to a person's sense of coherence. Consisting of comprehensibility, meaningfulness and manageability, sense of coherence has been reported to have positive influences on perceived health (Eriksson and Lindström 2006). Additionally, the contribution a salutogenic approach can give to health promotion research and practice has been previously described (Eriksson and Lindström 2008). In relation to the present study, those results validate the interpretation of meaning of health as striving to understand and manage with previous and current experiences in order to find meaning in present situations and yield hope for the future.

Availing appropriate tools for health professionals to promote the health of ageing persons who are born abroad, the present study puts focus on the capabilities of being a person. Even if all persons have different experiences and ways to perceive the world, there are similarities that exist between all human beings, in them being persons. Supported by research on person-centred, multidimensional and integrated approaches to health promotion (Jackson *et al.* 2013; Lood *et al.* 2014; WHO 2012), the authors encourage health professionals to empower ageing persons who are born abroad to make use of their innate capabilities to adapt and compensate for negative changes to health. Descriptions of human beings as persons, capable of speaking, acting, narrating, taking responsibility, remembering and making promises, minimises the risk of reducing ageing persons who are born abroad to risk carriers in need for protection, or as being deviant from the native-born part of the population. Future research should focus on

how human capabilities could be further applied to healthy ageing in the context of migration, and how a person-centred approach could be successfully implemented into health promotion practice around the world.

Conclusion

The present study describes how meaning of health to ageing persons who have experienced migration could be interpreted as a retrospective and prospective process of exercising control. The interpretation describes an intricate interplay of different aspects that influences the meaning of health, providing an understanding of how healthy ageing could be achieved in the context of migration. Meaning of health was not just prevalent in the participants' history, but formed their present and future realities. Yielding hope for the future, the participants strived to be acknowledged for who they are and what they are capable of doing within a meaningful and socially relevant place. Drawing attention towards the complexity of human beings being both similar and different, the authors reflect upon how different health promotion strategies could be appropriately applied to discourage stereotypic assumptions of ageing persons who are born abroad. By shifting focus from what is important to whom it is important for, a person-centred approach to health promotion is described as one brick, out of plenty, in the wall of health equity in an ageing and globalising society.

Ethical approval

The regional ethical review board in Gothenburg granted formal ethical approval of the information letter, the form for consent and the study protocol (reference number 821-11).

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Contribution of authors

The interpretations were carried out by the first author and validated through discussions between all of the authors throughout the interpretation process.

Conflict of interest

None declared

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