Patient Preference and Adherence

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ORIGINAL RESEARCH

Experiences and Perspectives of Medication Information and Use Among Arabic-Speaking Migrant Women in Sweden: A Multistage Focus Group Study

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Purpose: Medication non-adherence is a global public health issue influenced by various factors, including the quality and comprehensiveness of medication information provided to patients. Migrants, particularly women, face unique healthcare and societal challenges in their new home countries. This study aims to explore Arabic-speaking migrant women's experiences and perspectives on medication information and use.

Methods: This study was part of the Equal Health program, a health promotion initiative established in socially vulnerable areas to address health inequities. Arabic-speaking women aged 40–80 years with chronic illnesses participated in multistage focus group sessions exploring their experiences with medication information from healthcare, medication use, and perspectives on necessary improvements in medication information at hospital discharge. The sessions were conducted in Arabic, audio-recorded, transcribed verbatim, and translated into Swedish for analysis. Data were analyzed using Braun and Clark's six-phase reflexive thematic analysis.

Results: Four multistage focus group sessions with 15 participants were conducted. The analysis generated three themes: *receiving or not receiving professional medication information, medication adherence patterns*, and *needs and suggestions for improved medication information—a call for action*. Participants reported inadequate medication information from physicians, particularly at the time of discharge from the hospital, and described instances of intentional and unintentional non-adherence. Suggestions for improvement included providing written medication information at discharge in their native language, using interpreters, and including a current medication list detailing overall medication information and potential drug interactions.

Conclusion: This study highlights inadequate medication information provision to Arabic-speaking migrant women, which may impact medication use and pose patient safety risks. Although the adherence patterns of the study subjects resembled those of the general population, unique barriers require additional healthcare support. This study can inform healthcare practices and establish a foundation for further research on medication information and use in this group, including comparisons with native-born individuals.

Keywords: medication adherence, migrant health, health equity, vulnerable population, health perception

Introduction

Medication adherence, defined as the process by which patients take their medications as prescribed, including initiation, implementation, and discontinuation, is a global public health concern.[1] Non-adherence is associated with increased morbidity, mortality, and healthcare costs.[2,3] Despite efforts to address this issue, fewer than 50% of patients with chronic illnesses in developed nations adhere to their prescribed medication regimens, with even lower adherence rates observed among migrants.[4,5]

Adherence among migrants is influenced by a complex interplay of factors, such as patient-related beliefs, language proficiency, socioeconomic status, and cultural beliefs.[5] The unprecedented scale of global migration[6] might further

Received: 18 October 2024
Accepted: 29 January 2025
Published: 8 February 2025

complicate medication adherence. Developed countries, including those in Europe, are common destinations for migrants, a considerable proportion of whom are Arabic-speaking.[6] In Sweden, for example, with a population of 10.5 million and around two million migrants, a significant proportion are native Arabic speakers.[7]

Medication adherence is influenced by various dimensions, including socioeconomic factors, healthcare system-related issues, therapy-related factors, medical conditions, and patient-specific factors.[8] Despite this complexity, research addressing adherence among migrants remains limited.[5] Compared with native-born individuals, migrants tend to have lower adherence rates, including disparities in treatment duration and discontinuation rates. For instance, migrants have shown significantly lower adherence to antihypertensive medications, with similar lower adherence to antidepressants and psychotropic medications.[9–11] A qualitative study conducted in Sweden with one-third of the participants being migrants identified quality of care, beliefs about medicines, and knowledge gaps as common barriers to medication adherence in asthma.[12] Another Australian study on medication-taking behavior among migrant individuals with diabetes highlighted factors such as lack of understanding of medication importance, fear of side effects, and concerns about medication dependency, which impeded their medication adherence.[13]

From a healthcare perspective, migrants face numerous challenges that affect their healthcare experiences.[14] Language and cultural barriers are commonly cited as major obstacles, hindering effective communication and leading to misunderstandings that undermine the delivery of adequate care. Healthcare professionals report that migrants often struggle with limited understanding of the host country's healthcare system, leading to underutilization of specific services. Additionally, differences in perception of the patient-provider relationship among migrants may contribute to uncertainty and mistrust.[15]

Arabic-speaking migrants in Western countries encounter unique challenges in accessing comprehensive medication information, resulting in lower adherence rates than the general population.[16,17] Factors such as beliefs about medicines, mistrust of Western medicine, and inadequate access to medication information contribute to this disparity.[16,18] For example, a study among older Arabic-Australians found that they relied heavily on Arabic-speaking general practitioners and pharmacists for medication information, with dissatisfaction stemming from limited access to comprehensive information.[19] Migrant women, in particular, are vulnerable to social exclusion and marginalization in their new home countries,[20,21] which can negatively impact their health.[22,23] Medication adherence behaviour is also profoundly influenced by the quality and comprehensiveness of medication information provided to patients, including the intended purpose, rationale for selection, administration guidelines, potential adverse effects, and overall treatment plan.[8,24] Insufficient medication information can significantly affect patients' perceptions and beliefs about their prescribed medications, leading to low adherence.[25]

Despite the critical role of medication information in shaping adherence behaviour, research focusing on Arabic-speaking migrants' experiences with medication information and use remains limited, necessitating qualitative studies exploring their experiences and perspectives on medication information and use.

Aim

To explore Arabic-speaking migrant women's experiences and perspectives on medication information and use.

Ethics Approval

Ethical approval was obtained from the Swedish Ethical Review Authority (2018–591). The study was conducted in accordance with the Declaration of Helsinki. All participants received verbal and written information about the study and provided written informed consent, which included permission for the publication of anonymized quotes. They were assured that participation was voluntary and that they could discontinue participation without explanation. The data were handled confidentially.

Methods

Context

This study was conducted in an area in southern Sweden inhabited by a migrant population with low socioeconomic status and identified by the Swedish Police Authority as particularly socially vulnerable.[26] The study was part of the

Equal Health program, a health promotion program established in 2016 in socially vulnerable areas to address health inequities and promote health.[27–29] The program was led by researchers from Malmö University in collaboration with local community and stakeholders.[30,31] During workshops, participants from this community proposed suggestions on important health-related topics, which led to the creation of six health promotion labs (HPLs) focused on oral health and diet, physical activity, mental health, women's health, social health, and neighbourhood safety.[29,32,33] These labs were facilitated by lay health promoters (LHPs) employed by the program. Participants in the HPLs actively planned, implemented, and evaluated activities with researchers through participatory and multistage focus groups. This study was conducted in the Women's HPLs, based on the participants' previously expressed interest in discussing medications and enhancing their health literacy.

Study Design

This qualitative study employed a multistage focus group approach involving several focus group sessions over time.[34] In our adaptation of this approach, participants engaged in reflective dialogues facilitated by a researcher using a guide comprising open-ended questions to foster discussions and elicit detailed responses. These questions focused primarily on participants' experiences with medication information provided by healthcare professionals, their understanding of the information, and their suggestions for improvement, Table 1. Additionally, participants' medication use and the relevance of the medication information to their medication-taking habits were explored. The multistage approach allowed participants to reflect individually and collectively on previous sessions and incorporate new experiences and perspectives into subsequent sessions. This study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.[35]

Table 1 Examples of Questions Used in the Multistage Focus Group Sessions

Medication information	Can you describe how you experienced medication information? - Understanding of the information - Format of the information – verbal/written - Medication information at discharge - What would you like to see included in discharge medication information?
Medication use/ adherence	How do you manage taking medications? What was your experience with taking medications after discharge? Can you share experiences with medication adherence? What support do you think is needed to help you use prescribed medications?
Probing questions	Tell us more about… What do you think led to that… Can you give an example?

Participants and Recruitment

Women from the Middle East who spoke Arabic as their native language, with continuous contact with healthcare due to chronic illnesses, medications, and personal healthcare experiences were invited to participate. Most experienced difficulties speaking Swedish. As participants in the Equal Health program, the majority were from Iraq, Syria, and Palestine, had resided in Sweden for over ten years, and were educated at the primary school level. Participants in this study were aged between 40 and 80 years.

The participants were familiar with each other from their involvement in other activities within the HPLs. Recruitment was facilitated by a LHP who acted as a gatekeeper between the research team and participants.[32] Initially, the research team provided the LHP with verbal and written information about the study in Arabic. The LHP then informed potential participants verbally during their attendance at other program activities. Interested participants were subsequently gathered and provided additional verbal and written information by the first author (AAM) in Arabic. They had the opportunity to ask questions before providing written informed consent. Participants were included after giving written informed consent. The date and time for the focus group session were arranged in consultation with the participants, LHP, and research team.

Data Collection

Data collection took place between October 2021 and February 2022 at a social meeting place commonly used for activities within the health promotion program. To create a welcoming atmosphere conducive to open communication, we assured participants that there were no right or wrong answers and that their diverse perspectives were highly valued. AAM was the facilitator, clearly explaining the study's aim and providing participants detailed instructions regarding conversation rules. The last author attended two sessions to support AAM in facilitating the discussions.

Four multistage focus group sessions were conducted, each lasting 70–90 minutes and comprising 7–11 participants.[36] The first, second, and fourth sessions included 11, 8, and 7 participants, respectively, and involved the same women. The third session, with 7 participants, comprised both returning (3) and new participants (4). In total, 15 participants were included in the study. Figure 1 illustrates the distribution of participants across sessions as well as the content of each session.

In the initial session, participants shared their experiences with medication information from physicians in primary and secondary care settings, focusing on information provided at discharge. Discussions also explored participants' understanding of the information and their satisfaction with its delivery. The conversation then shifted to participants' experiences with medication information from their home countries and their current medication usage practices. At the conclusion of the second session, participants were assigned homework to reflect on desired improvements in medication information provision at discharge. This assignment was developed in agreement with the participants and based on discussions held during the sessions. Participants were instructed to prepare for a discussion of the homework in the following session.

In the third session, participants discussed their experiences and perspectives on medication information and use, as well as their reflections on the assigned homework. This session included new participants whose involvement was prompted by increased interest in the study among other women participating in the Equal Health program activities. This inclusion aimed to enrich discussions with additional data and perspectives. Both returning and new participants had the opportunity to present and discuss their needs and suggestions, revisiting prior discussions while incorporating new perspectives on medication information at discharge. The fourth session focused on the participants' needs and suggestions regarding medication information at discharge, as outlined in their homework reflections.

Because the participants were native Arabic speakers with limited proficiency in Swedish, all sessions were conducted in Arabic. A health promoter attended sessions to assist with logistics, provide refreshments, and welcome participants. All sessions were audio-recorded with participants' consent. Transcripts were initially created in Arabic and then translated into Swedish for discussion within the research team. Quotations used to complement each theme in the results section underwent a three-step translation process: from Arabic to Swedish, Swedish to English, and Arabic to English. This approach aimed to ensure accuracy and identify potential discrepancies between translations.

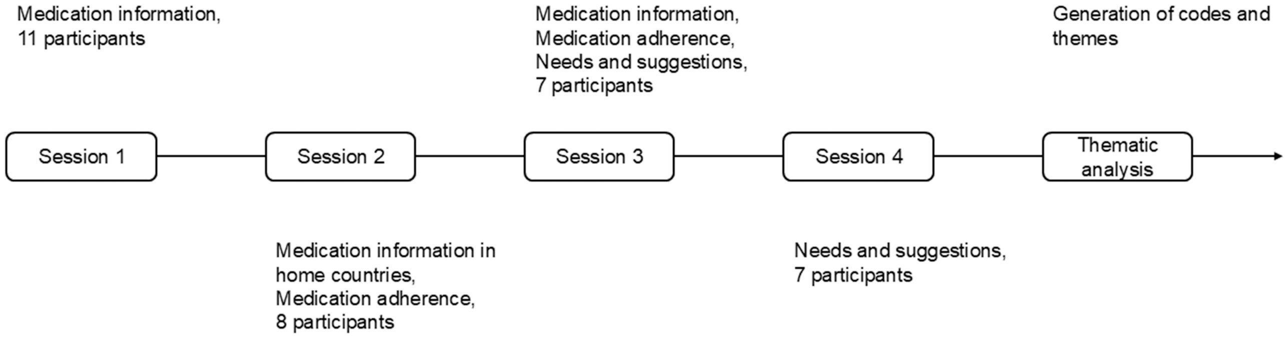

Figure 1 Flowchart of the multistage focus group sessions. The data were fully analyzed thematically after all sessions concluded.

Data Analysis

Data extracted from the audio recordings of the focus group sessions were analyzed using Braun and Clark's six-phase reflexive thematic analysis.[37] The data were fully analyzed after all sessions concluded, with ongoing research team discussions to review progress, overview the focus group discussions, and plan subsequent sessions. The results, in the form of themes, were generated after all sessions, during this analysis. The thematic analysis commenced with the *familiarization phase*, where the data were read repeatedly to develop a profound understanding of its content. In the *coding phase*, initial codes were systematically generated to capture fundamental features relevant to the study's aim. These initial codes were then aggregated to formulate *initial themes*. The *reviewing phase* involved refining these initial themes to ensure they closely aligned with the study's aim. In the *defining and naming phase*, the themes were further refined and given appropriate and informative names. Finally, *the writing-up phase* involved finalizing the results. Table 2 illustrates the analysis process, from excerpts of raw data to the development of final themes. The analysis followed an inductive approach, allowing the generation of codes and themes directly from the raw material without predetermined labels. Our preunderstanding was acknowledged and discussed within the research group. Relevant quotations from the data material were selected to exemplify the identified themes. The analysis process was iterative, requiring ongoing navigation between codes and themes to identify commonalities and their relevance to the study's aim. AAM proposed the initial codes and themes and further developed them through multiple meetings with the research group. Constructive discussions led to a consensus on the codes, themes, and final draft.

Rigor

We applied four criteria—credibility, transferability, dependability, and confirmability—to ensure the rigor of the study.[38] The research team was actively involved in the analysis process to enhance credibility, and findings were presented to participants. Supporting quotations were also included throughout the result section. Transferability was addressed by describing the participants and the study's context. For dependability, the research process was transparently documented and clearly traceable. To ensure confirmability, the findings were grounded in the data, and the research team remained aware of how our background, assumptions, and pre-understanding might influence analysis. These considerations were discussed openly and reflectively throughout the analysis process.

Results

The results are derived from a thematic analysis conducted at the conclusion of four multistage focus group sessions involving 15 participants. The analysis generated three themes (Table 2); *receiving or not receiving professional medication information, medication adherence patterns, and needs and suggestions for improved medication information: a call for action*. Each theme is described and illustrated below with anonymized quotations from the focus group sessions, which reflect dialogues in different focus group sessions.

Table 2 The Thematic Analysis Process. Data Extracts are Excerpts From the Raw Data, Leading to the Development of Codes (Examples of Many), Initial Themes, and Final Themes, Which Represent the Results of the Analysis

Data Extract	Codes	Initial Themes	Final Themes
The physician did not explain clearly how I should use the medications.	Receives unclear (ambiguous) information about the medicines from the physician	Unclear medication information from the physician	Receiving or not receiving professional medication information
Sometimes I think; what is the purpose/why should I have to do with them (medications)? So I stop taking them/let them be. I do it by myself.	The participant consciously stops taking medicines.	Stop taking medications	Medication adherence patterns
The report (discharge information) must be written in the native language that the patient understands.	Discharge information to be written in the patient's native language	Suggesting medication information in the native language	Needs and suggestions for improved medication information—a call for action

Receiving or Not Receiving Professional Medication Information

Participants shared varying experiences of receiving medication information from healthcare professionals and pharmacies in Sweden and their home countries. Some participants described instances where physicians in Sweden did not provide medication information. Even when information was offered, it was often perceived as insufficient. This was particularly problematic when participants were prescribed new medications, leaving gaps in knowledge about the purpose, possible interactions, and side effects, as reflected on in session one.

> He (the physician) did not tell me the times to take the medication, be aware of the time you take your medication, this medication with this and that; he would tell explain that to me.
>
> The physician did not explain clearly how I should use the medications.
>
> It is the same issue for me. I have Levothyroxine for the thyroid; I swear to God I did not know anything. I just took it, and then it turned out that it does not work on my body; why? Because no one told me any information.

In session two, some participants reflected on this issue further, stating that their physicians did provide medication information.

> The physician explains to me how to use it (the medication)
>
> Yes, it is possible; as the other one said, the physician explains sometimes…

In terms of experiences with pharmacies, in session one, some participants reported receiving adequate instructions on medication use during their visits. Others, however, identified a lack of information from pharmacies as a significant issue.

> The physician did never explain (how to use the medication), but the pharmacist, sometimes I find her understanding, and I do what she says/recommends …Yes she (the pharmacist) explains, plus-minus the knowledge of our friends who take medications…
>
> It was the pharmacy that explained to me how to use it/take it (the medication)
>
> But the pharmacy also does not explain; they just give you the medication
>
> No, I swear to God, she explained, she told me that it is like this. No indeed she explained

Experiences receiving medication information from pharmacies were also described in session three.

> They (the pharmacies/the pharmacists) give us the medication, but they do not tell us how to use it… maybe some medications should be taken before or after a meal, but some medications are forbidden to take with food, but they do not say it, this is a big problem

In session one, participants reflected on their need to seek medication information outside healthcare settings because of perceived gaps. They relied on alternative sources such as family members, acquaintances, the internet, and other users.

> I have diabetes and did not know when to take the medication; the pharmacist said that it is not mentioned (in the prescription), so my friend told me that I have to use the medication with food, not after.
>
> …I realized that the medication does not give me effect so I asked people who take the same medication. They said I must take the medication at dawn because it awakens. (making one more alert)
>
> I learned from others, not from the physician.

In session two, social media was mentioned as a source of medication information.

> We relied on ourselves…I got into the research of specialist doctors (on YouTube)

> …yes they (YouTube) have become the doctors

In session three, similar aspects were reflected on.

> Go to Google and check it out

> Well, you know how to use Google, but others might not

> Not everyone knows how to use Google, and not everyone can read

Participants noted significant differences when comparing their experiences between Sweden and their home countries. In their home countries, they often received clear and accessible medication information from physicians during appointments and pharmacists when collecting prescriptions. Participants found it easier to communicate with physicians and pharmacists in their home countries, where they could ask questions about medication interactions and the next steps if the current treatment was ineffective.

> Yes, of course, it is understandable (medication information), what I want from him, for example, and ask him (the physician) about it, I ask him, and he would answer…

> …so they (the pharmacy) will also inform you on many things. They will tell you, if you need injections, try the medication, if it does not work, come back and I can give you injections

> In Iraq, the first thing is that we do not have a barrier between us, so we have the same language. So when we ask directly question and answer, so a conversation takes place. The physician has taken money from me, which means he has to give me time

> Here (the new home country), there is the thing of testing; they give you the medication and tell you to try, and then they decide (after the test period). We (in the home country) will give you the medication, and you have to take it, so it is a good thing to try it first and then use it. (continue to use it)

In session two, participants described several barriers to receiving adequate medication information in Sweden. These included physicians' limited time during appointments, language barriers, and the use of complex medical terminology. Such challenges often resulted in important medication information being overlooked, making it difficult for participants to understand their treatments comprehensively.

> First, they do not have time, and second, it is the language as well; when I speak with them, they speak quickly quickly, I do not understand them, and medical terms, I do not understand them, but when I use (something/web page) I can translate quickly with the language I want, it is easier for me (it will be easy for me)

This issue was also echoed in session three.

> There are physicians who help and those who do not; they do not have time. Some patients do not know the language, so if the physician, for instance, has half an hour, he would waste his time and speak if the patient does not have the language to understand.

Medication Adherence Patterns

This theme explores participants' experiences with at-home medication use. Some participants reported issues with forgetfulness, leading to discussions about its potential health risks. During these discussions, participants proposed solutions such as using a pill organizer to aid memory recall, as in session two.

> My problem with the medication is that I forget. Sometimes, I take the medication twice. Yes, I swear. How can I solve this? I do not know.

> Pill organizer, which is already divided into days.

In addition, participants described instances of deliberate non-adherence to prescribed medication regimens. This behaviour was influenced by their perceptions of the medication's value. Some participants discontinued their medication after experiencing health improvements, deeming it unnecessary. Conversely, others stopped taking their medication when they perceived no improvement in their health. Some informed their physicians about their decision to stop medication, while others did not. The use of alternative products as replacements was also mentioned. Notably, some participants emphasized the importance of consistent medication use, viewing interruptions initiated by patients as inappropriate. Despite experiencing side effects, some participants continued their medication regimen as discussed in session three.

> No, it is fine/no, it is ok for me; if the medication does not work with me, I stop taking it and inform the physician.

> No, I do not stop (do not stop taking the medications)

Participants in session four also reflected on this issue.

> I have not told him (the physician) yet, but I continue to take the morning dose

> …and then I quit taking all the medications, including the medication for high blood pressure.

> It is wrong

> I bought manuka honey instead of the cholesterol medicine

The role of family support in managing medication adherence at home was also highlighted. Family members often assisted with medication management, which was particularly beneficial for participants who frequently forgot to take their medications or faced difficulties adhering to their medication regimen.

Needs and Suggestions for Improved Medication Information: A Call for Action

This theme captures participants' reflections on the improvements needed to enhance the provision of medication information. Participants expressed a need for clear, comprehensive, and easily understandable medication information from physicians at the time of discharge. They suggested several ways to meet this need, including providing written discharge information—referred to as a report below—in the participant's native language. This was seen as especially beneficial for those facing language barriers. However, not all participants agreed, with some raising concerns about the potential financial burden on the healthcare system, as reflected on in session three.

> The report must be written in the native language that the patient understands

> This is expensive for the state

> Why expensive? They just print it

> Yes, but they have to translate it

The need for interpreters when interacting with healthcare professionals was emphasized in session three.

> You tell them you need an interpreter, and they will provide you with one.

> There are terms that we do not know in Swedish, so we need an interpreter.

In session four, participants reflected on the need for interpreters where written medication information in the native language was unavailable. They suggested that healthcare providers should have readily available interpreters, and that family members could assist with translation when interpreters are unavailable. However, they acknowledged that this solution had limitations.

> ..if there is an emergency, he (the interpreter) will not make it; if there is an emergency, one can bring someone from the family (to follow with the patient)

> But it is not the family's responsibility to come, because you know everyone has their job, their home, one might not have a family
>
> But the interpreter might not be available at 7 a.m. or midnight, right
>
> Yes, but the law guarantees it
>
> I saw (noticed) this thing in a health center (primary care center); there are interpreters in Arabic and Somali.
>
> Yes, this is a good thing, and the interpreter already works eight hours, so having he (the interpreter) available at the hospital makes sense

In the same session, participants further highlighted the importance of receiving medication information in both written and verbal formats. Written information was considered necessary for reviewing at home to help patients retain accurate information. This written discharge information, referred to as a written report below, should include a current medication list and brief description of each medication, its purpose, and any potential interactions.

> If they give me a written report, it will be better so that I can see it and keep it in my memory because there is a possibility that I will forget some words and so on
>
> If there is a new medication, in my opinion, they can write a sentence that if you are using the other medication, if it contains this and that substance, then you should not take it at the same time (to avoid interactions), so the patient can be careful and can see his medications

In the same session, participants emphasized the importance of physicians dedicating more time to discussing medications thoroughly during consultations.

> So the physician can sit (with the patient) for, for example, 15 minutes and explain to the patient, especially that this is a developed country so that they can bring an interpreter, they can everything, and in the case that there is no interpreter, the interpreter can be present via telephone…

Discussion

This study aimed to explore the experiences and perspectives of Arabic-speaking migrant women in Sweden on medication information and use. Our findings, organized into three themes, revealed that participants often received insufficient medication information, particularly at the time of discharge from the hospital. They also described instances of medication non-adherence, such as skipping doses or discontinuing treatment without consulting physicians. To address the issue of inadequate medication information, participants proposed several improvements, including providing written discharge information in their native language and a current medication list detailing each drug and its potential interactions.

Participants also reported experiencing inadequate information from physicians. This is consistent with an Australian study among chronically ill Arabic-speaking patients where patients perceived the quality of medication information as low, despite interactions with Arabic-speaking physicians.[19] However, our participants referred to physicians in general, not exclusively Arabic-speaking ones. A study in Sweden focusing on individuals with asthma, one-third of whom were migrants, also reported inadequate medication information.[12] This suggests that the issue of receiving inadequate medication information may be systemic and not limited to migrant populations. Our findings partly align with a recent Swedish study, where participants described a lack of knowledge about prescribed medications due to language difficulties and, therefore, not understanding medication information and feeling distrusted by healthcare staff.[39] While participants in our study mentioned language difficulties and their impact on communicating and understanding medication information, they did not explicitly report a sense of distrust, suggesting variability in migrants' experiences. These findings indicate that medication information may involve an interplay of factors.

According to the Swedish Patient Act, patients are entitled to individualized medication information, including details about their treatment and written discharge information. However, participants in our study reported not receiving this information adequately, which could influence the sources of information patients choose to rely on. When information from healthcare professionals is insufficient, patients may turn to alternative sources, as our participants reported. They mentioned using sources such as the internet and social networks, consistent with trends observed in studies on migrants' health-seeking behaviour.[18,40] This reliance on non-traditional sources is common, even among non-migrant populations.[41,42] A systematic review found that patients generally perceived online health information as positively influencing their decision-making regarding medication adherence.[41] Additionally, patients who sought health information online were more likely to seek healthcare and were better prepared for consultations. However, another study indicated that patients who used the Internet for health information before consultations with physicians tended to have increased concerns about their medications and lower adherence than those who did not.[43] While using the Internet can supplement healthcare-provided information and enhance patient knowledge, relying on these sources as primary means of medication information can pose risks to patient safety because of potentially poor quality and credibility of the information. Furthermore, an incomplete understanding by the specific patient may negatively impact medication adherence, which, as noted earlier, is linked to a higher risk of adverse health outcomes.[2,25]

To address the challenges of inadequate medication information and its potential consequences, healthcare providers must recognize the specific needs of migrant populations, ensuring that the information provided is understood effectively. Systematic reviews indicate that culturally competent healthcare improves patient satisfaction, healthcare outcomes, access to care, and patient-related outcomes.[44,45] Based on these previous reports and our present findings, we recommend improving cultural awareness among healthcare professionals, employing culturally diverse staff, and establishing well-defined routines to address these issues. Additionally, integrating cultural competence training into healthcare education at the university level is strongly recommended to better prepare future practitioners for working with diverse patient populations.

Migrants are, in turn, responsible for learning about the healthcare system in their new home countries. Previous research indicates that migrants often struggle with limited understanding of the healthcare system.[14] Participating in initiatives such as the Equal Health program, which involves healthcare representatives, can help bridge the gap between migrants and healthcare providers. Such engagement can foster better understanding of the healthcare system and enhance the patient-provider relationship. Research shows that a strong patient-physician relationship is crucial for effective communication and patient satisfaction and significantly affects healthcare outcomes.[46,47]

Participants in our study had varying experiences with medication information at pharmacies, with only some receiving adequate information. A previous study found that language support, including speaking with a pharmacist who speaks the same native language, was a key factor in participants feeling satisfied with pharmacy services, including receiving medication information.[39] However, participants in our study did not explicitly mention this factor or attribute the lack of adequate medication information to the absence of a pharmacist who spoke their native language. This suggests that language support may not be the only factor affecting the receipt of medication information. It also indicates that some pharmacies may fail to provide adequate medication information. To avoid misunderstandings that could negatively impact medication adherence, pharmacies must ensure that all patients leave with a clear understanding of their medications.

Participants reported various behaviors regarding medication use. Forgetfulness, a common cause of unintentional non-adherence observed in various populations,[48] was mentioned. Intentional non-adherence, such as adjusting doses or discontinuing medication after perceiving health improvement or lack thereof, was also noted. Although research on adherence in this population is limited, intentional non-adherence has been documented among Arabic-speaking migrants and is known to occur in non-migrant populations.[18,49] This behavior may stem from a complex interplay of factors, including limited health and medication literacy. Research indicates that improving health literacy enhances understanding and adherence.[50] Additionally, beliefs about medicines influence adherence behaviors[51] and may have contributed to participants' medication-taking practices. The use of non-traditional sources for medication information, as mentioned by participants, may further affect adherence. Conversely, some participants reported adhering to their prescribed medication and consulting their physician before making any changes, indicating an awareness of their medications' importance. While these findings reflect participants' experiences, adherence was not measured. Moreover, in addition to these patient-related factors, healthcare-related factors may also contribute to non-adherence, particularly given this population faces additional barriers and may require extra support from healthcare providers.

Regarding their needs and suggestions, participants proposed ways to improve medication information provision, particularly at discharge. Receiving both verbal and written, comprehensive, and understandable medication information at discharge was considered essential. Additionally, some participants suggested receiving a medication list in their native language. This aligns with previous findings where participants emphasized the necessity of this service to facilitate medication adherence.[39] However, the suggestions in that study emerged from individual interviews rather than a reflective dialogue session specifically focused on suggestions. Despite contextual differences, both studies highlight the need for tailored medication information for patients with language difficulties.

Participants also emphasized that the discharge medication list include general information, the purpose of the medication, and potential interactions. This reflects a willingness to learn more about their medications to support adherence and demonstrates a positive attitude toward the healthcare system, given participants expressed a desire for information directly from healthcare professionals. Providing both verbal and written medication information can enhance understanding, increase patient involvement in their treatment, and help bridge the gap between healthcare providers and patients. This is especially important because knowledge and understanding of medications are associated with better adherence.[25,52]

Participants also discussed using interpreters, consistent with a previous study in which participants identified interpreters as the most important factor for facilitation.[39] However, our participants did not emphasize the role of interpreters in the same way. This discrepancy may be attributed to differences in participants' language proficiency levels and the fact that other factors were also important to the participants in our study. The use of interpreters is common in healthcare settings and is regulated by the Swedish Patient Act. Given that care transitions are known to put patients at high risk of medication errors,[53] utilizing interpreters at discharge could help mitigate the risk of misunderstandings, particularly for those with language difficulties and prescribed multiple medications.

Our study provided a platform for participants to discuss issues important to them, facilitating participant interaction and reflection and allowing them to identify barriers and propose solutions. Including a homework assignment encouraged individual reflection and group discussion, providing diverse insights into participants' needs and suggestions. Further, introducing new participants brought additional perspectives, while extended sessions over several months helped build trust between participants and the research team. Trust—crucial for co-creating knowledge and addressing community issues, as noted previously[28,54,55]—was essential for conducting this research. The already established Equal Health program was also vital in enabling the current study. The familiarity with co-author MAR and the shared language and culture with the first author, AAM, were critical for establishing trust, enhancing data interpretation, and creating an inclusive environment for sharing experiences, as suggested previously.[56–58]

One limitation of our study is the potential for inaccuracies or loss of nuance because of translation. However, care was taken to ensure high-quality and accurate translations. Another limitation is the study's focus solely on women, which may affect the transferability of the findings. Nevertheless, this focus aligned with the Equal Health program's objectives and addressed women's specific interests in discussing medication-related topics, providing valuable insights for healthcare providers. Additionally, it was possible that the dialogues in the sessions may have been influenced by more dominant participants. However, the facilitator worked to create an inclusive environment and ensured that all participants had the opportunity to express their perspectives.

This study is unique in addressing the gap in knowledge regarding Arabic-speaking migrant women's experiences and perspectives in the context of medication information and use, providing valuable insights for healthcare providers. It highlights challenges related to receiving medication information and using medications within this population, underscoring the need for further research. Additionally, it offers insights that can inform future research on medication adherence. A feasibility study preparing for such research has been published elsewhere.[59]

Conclusions

This study highlights the inadequate provision of medication information to Arabic-speaking migrant women, which may impact medication adherence and pose patient safety risks. While the adherence patterns of the study participants resembled those of the general population, unique barriers necessitate additional healthcare support. This study can inform healthcare practices and provide a foundation for further research on medication information and adherence in this group, including comparisons with native-born individuals.

Acknowledgments

The authors would like to thank all the participants for their involvement in the study.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Funding

Open access funding provided by Malmö University. Further, this study was funded by the Swedish Knowledge Foundation (Grant number 20190063) and the Faculty of Health and Society at Malmö University.

Disclosure

The authors report no conflicts of interest in this work.

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