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# *How can we help you?* A qualitative study of the provision of care to culturally and linguistically diverse clients in community pharmacy

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## Abstract

**Objectives:** Clients from culturally and linguistically diverse (CALD) backgrounds experience challenges in receiving care from community pharmacies, resulting in poorer health outcomes compared with the majority population. The aim of this study was to explore migrants' and pharmacy staff's understanding of the facilitators for the delivery of care to CALD clients.

**Methods:** Focus groups were conducted with predominantly older, female Nepali-speaking migrants. Individual interviews were undertaken with pharmacists and pharmacy assistants. Verbatim and translated transcripts were inductively coded to establish themes.

**Key findings:** Three major themes emerged: getting the message across, building trust, and improving understanding. Key findings included the need to increase the use of professional interpreters, and empathy and patience from pharmacy staff. Modifications to communication using re-phrasing and more detail about the community pharmacy system in post-arrival orientation for migrants are required.

**Conclusions:** Multilingual staff is an effective way to overcome the language barrier, but its use is limited by staff resources. Pharmacy staff should be required to use the services of professional telephone interpreters to surmount language barriers. Modification of communication techniques and having an empathetic attitude improve communication and care provision. Pharmacists should liaise with migrant support services to provide orientation for new arrivals.

*Keywords:* community pharmacist; pharmacy assistant; barriers; facilitators

## Introduction

Community pharmacists are the most frequently accessed health professionals. With longer opening hours, convenient locations, and no appointment required, community pharmacies are uniquely placed to improve medication management [1]. Pharmacy staff have to provide patient care, often being the last health professionals to interact with clients before their taking medicine [2].

Clients who are culturally and linguistically diverse (CALD) experience unique challenges in accessing healthcare services, with language being the greatest challenge facing these clients when they enter a community pharmacy [3–6]. Sometimes CALD clients assume that they will not be understood and avoid seeking care, or leave pharmacies without having their questions answered and feeling undervalued [5, 7–11]. Evidence shows pharmacists, when faced with a language barrier, offer unsatisfactory counseling and inadequate medication review, putting clients at risk of negative health outcomes [7, 10, 12, 13].

Despite the evidence highlighting the risks that language barriers pose to clients' health, there is a paucity of evidence about overcoming this barrier, and where evidence exists there is poor uptake by community pharmacists [6, 9]. The use of professional interpreters in community pharmacy is low, attributed to lack of awareness, time constraints, and frustration with the inability to find an appropriate interpreter [6, 8, 9, 11, 14]. Research from Europe, America, and Australia indicate that the use of translated written materials is also poor due to lack of awareness, mistrust in the appropriateness and accuracy of the translation, and doubt of its effectiveness where poor literacy is assumed [7, 9, 15, 16].

Low health literacy is a further barrier for refugees and migrants receiving care in pharmacies [5, 15, 17]. CALD clients struggle to describe their symptoms, understand medical terminology, and have limited understanding of disease processes and management. Cultural beliefs also affect how CALD clients seek care and how they manage their medicines, with belief in higher powers, karma, or traditional medicine affecting the uptake of recommended treatment [4, 5, 7–12, 18]. Pharmacy staff can lack cultural competency, further impacting on the quality of patient care for CALD clients [4–6]. Despite the overwhelming evidence that CALD clients face challenges to receiving quality care and subsequently have poorer health outcomes [3], very few studies give migrants a voice concerning facilitators that can overcome these challenges [4, 15].

To effectively reach CALD clients in the wider community, facilitators need to be integrated into the community pharmacy

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system. The aim of this study was to explore migrants' and pharmacy staff's understanding of the facilitators for the delivery of care to CALD clients.

## Methods

Data were collected from semi-structured interviews with community pharmacy staff and focus groups with migrants based in two metropolitan cities in Australia, between February and May 2022. A descriptive approach was used to explore the understanding and experiences of pharmacy staff and CALD clients in relation to the delivery of care to CALD clients in pharmacies [19]. Ethical approval was granted by the James Cook University Human Research Ethics Committee (*Human Ethics Approval Number H8631*).

Purposive sampling was used to identify and recruit participants who had specific experience from being a CALD person needing pharmaceutical care or pharmacy staff providing care to a CALD population, ensuring that the data collected were relevant to answering the research question. Pharmacy staff were recruited either by email from a pharmacy banner group or by phone (see Table 1). Migrants were personally invited to participate in the study by Australian Migrant Resource Centre (AMRC) staff and community leaders (see Table 1).

Pharmacy staff who responded to the invitation to participate were contacted by the researcher who answered any questions, provided information sheets and consent forms, and arranged a time and location for the interview. Focus groups were arranged by AMRC staff and, before starting the first author and a translator from the AMRC, explained the research aim and process, approached participants individually to answer questions, and assisted them in completing the demographic data questionnaire offline.

Interviews and focus groups were conducted by the first author, digitally audio-recorded, and when conducted in English, transcribed verbatim [19]. Where the migrant participants were all Nepali speakers, the focus group was conducted in Nepali. For these groups, data were transcribed directly into English by the first author (a Nepali speaker), with interpretation reviewed by a native Nepali speaker. Identification codes such as P1 (Pharmacist), PA3 (Pharmacy assistant), or FG2 (focus Group) were added to ensure anonymity [20].

In both the interviews and focus groups, the first author used verbal storytelling to share five scenarios with participants (see Table 2 for the summary and Supplementary Material 1 and 2 for the full interview script). Each scenario depicts a client for whom English is not their primary language, presenting to a community pharmacy. During each interaction, an issue arises which takes some negotiation between pharmacy staff and client. The scenarios were based on real-life examples of interactions between CALD clients and pharmacy staff as experienced by the authors and covered major issues identified in a literature review [21]. Using five scenarios allowed coverage of most issues while keeping interviews within an acceptable time length. Scenarios were reviewed by AMRC staff and adjusted according to feedback, principally simplifying the scenarios for improved understanding. The same scenarios were used for migrant and pharmacy staff, enabling data source triangulation to be undertaken and enhancing findings from this study. However, simpler language was used for the focus groups to accommodate participants' lower-level of English comprehension. After each scenario, all participants were asked to reflect on their own experiences of similar situations and give suggestions as to how the fictional client could be assisted. It was found that as data collection progressed, no new responses were being offered. Given the resource restriction on this study, the research team agreed to terminate data collection.

Data were uploaded to NVivo data management software and analyzed using Braun and Clarke's established method of inductive thematic analysis [22]. The first two authors familiarized themselves with the data and double-coded approximately a third of the transcripts to ensure confirmability. After coding the remainder of the transcripts, the first author discussed the outcomes with the research team and together they identified themes from the codes. Development of the thematic framework came about through review of the relationships between the codes and themes and discussion among the research team, adding to the credibility of the data.

**Table 1.** Recruitment and data collection strategies.

Pharmacy Staff
Method A
1. Invitations to participate in the research were disseminated through pharmacy banner group networks.
2. Pharmacists that responded to the email from the banner group were phoned or emailed by the researcher and an interview was arranged.

Method B
1. Pharmacies within the AMRC service area were contacted by telephone. The study was explained over the phone, questions were answered, and staff were invited to participate.
2. Interested people were emailed an information sheet.
3. Follow-up was conducted via phone and an interview time and method arranged.

Migrants
1. A poster inviting participation in the study was displayed in an AMRC.
2. AMRC staff personally invited participants from their service population. They also requested community leaders to invite people they felt would participate.
3. AMRC staff, in conjunction with community leaders, organized participants into focus groups and arranged meeting times.

AMRC, Australian Migrant Resource Centre.

## Results

Three pharmacists responded to a general email invite and direct phoning recruited another pharmacist and

**Table 2.** Summary of scenarios.

- Client wants to access antibiotics without a prescription. Is frustrated by staff only offering symptom relief.
- Female client using teenage son to translate, where there is uncertainty about the mother's familiarity with the medicine prescribed and ambiguity about a product recommended by the prescriber. Potential for son needing to translate about a cream for vaginal use.
- Misunderstanding about the role of concession cards and the Pharmaceutical Benefits Scheme.[a]
- A presented prescription has expired, and the client is without medication. The client is concerned about the staff calling the doctor.
- Client is confused when offered a generic substitution.

[a]The Pharmaceutical Benefits Scheme (PBS) is subsidization of essential medicines by the Australian Government. See www.pbs.gov.au for details.

three assistants (see Table 1). Face-to-face interviews were conducted with one pharmacist and one pharmacy assistant. Three pharmacists and one assistant were interviewed by Zoom, and one assistant was interviewed by telephone. One pharmacist and an assistant were from the same site, while all other staff were from different community pharmacies in two Australian cities.

Four focus groups were held at the AMRC—two groups with mixed nationalities, conducted in English ($n$ = 4, $n$ = 4), and two groups with Nepali speakers, conducted in Nepali ($n$ = 16, $n$ = 3). As the first author spoke Nepali and Nepali-speaking Bhutanese refugees are predominant in the AMRC's geographic area, AMRC staff recruited purposively to invite participants that would benefit from the focus groups being conducted in Nepali [23]. This resulted in migrant participants being predominantly older, Nepali-speaking, Bhutanese women (see Table 3). Their experience in managing medications for the household is reflective of the cultural context from which they come where women take this role. Their age meant they were predominantly not working and available to participate in the study. Most of the migrants had been in Australia between 2 and 9 years, which is considered long enough to have experiences of community pharmacy and recent enough to remember the difficulties experienced as new arrivals.

The participants treated the scenarios as a trigger for reflecting on their own practise or experiences, rather than responding directly to the case (see interview protocol). Data analysis identified three major themes—"getting the message across," "building trust," and "improving understanding." Evidence for each theme is given in Table 4.

## Getting the message across

The theme "Getting the message across" captures strategies used by pharmacy staff and migrants to communicate in the pharmacy. Subthemes include family and friends as interpreters, professional interpreters, modification of

**Table 3.** Demographic data ($n$ = 34).

| | | Participants | | Participants |
|---|---|---|---|---|
| Role | Pharmacy staff | 7 | Migrants | 27[a] |
| | Pharmacist | 4 | | |
| | Pharmacy Assistant | 3 | | |
| Age | ≤40 | 2 | ≤40 | 7 |
| | 41–55 | 4 | 41–55 | 7 |
| | 56–75 | 1 | 56–75 | 11 |
| Gender | Male | 5 | Male | 3 |
| | Female | 2 | Female | 22 |
| Country of birth | Australia | 2 | Bhutan | 16 |
| | Egypt | 1 | Nepal | 4 |
| | Iran | 1 | Afghanistan | 2 |
| | Malaysia | 1 | Ethiopia | 1 |
| | Pakistan | 1 | India | 1 |
| | Poland | 1 | Myanmar | 1 |
| Years in Australia | >20 | 5 | >20 | 2 |
| | 10–19 | 1 | 10–19 | 3 |
| | 5–9 | 0 | 5–9 | 10 |
| | 2–4 | 1 | 2–4 | 9 |
| | 6–23 months | 0 | 6–23 months | 1 |
| Spoken languages (other than English) | Arabic | 3 | Nepali | 21 |
| | French | 2 | Dari | 2 |
| | Hindi | 1 | Amharic | 1 |
| | Italian | 1 | Burmese | 1 |
| | Persian | 1 | Farsi | 1 |
| | Polish | 1 | Hindi | 1 |
| | Punjabi | 1 | Mizo Chin | 1 |
| | Russian | 1 | | |
| | Urdu | 1 | | |
| | Vietnamese | 1 | | |
| Main language spoken at home | English | 5 | Nepali | 21 |
| | Arabic | 1 | Dari | 2 |
| | Urdu | 1 | Amharic | 1 |
| | | | Mizo Chin | 1 |

[a]Two participants chose not to share their demographic data.

**Table 4.** Supporting evidence.

| Theme and evidence | Source |
|---|---|
| Getting the message across | |
| Family/friends as interpreters | |
| Some people go together friend. One good speak English ….and children. | FG3 |
| Yes, some people bring their children who knows English. … But that one also sometimes make a mistake. And that medicine may not be the same what they're taking. | FG1 |
| It's a bit awkward. I think it might be a bit awkward for the son as well. He might not even know what [vaginal thrush] is. | P3 |
| It's been difficult for the mother, and now it's difficult for the son. For the mum because she doesn't have other options. Just to tell to the son. | FG2 |
| Professional interpreters | |
| Requesting an interpreter is good. … The interpreter can talk to us. We can say what we need to say. | FG4 |
| Now in larger places an interpreter is available. But … there's not interpreters available… in pharmacies. | FG4 |
| Modification of language | |
| Simplification | |
| If someone … has a issue with the language barrier, try to reduce the complexity of the words as much as possible. | PA2 |
| Use of non-verbal communication | |
| If I'm giving two tablets, I just mention it with my body language [holds up two fingers] to deliver the message. | P4 |
| I would actually … show them the [device for administration of medication] … I would just grab it and just grab a bit of my belly and just show them how you would do it. | P3 |
| Re-phrasing | |
| We don't know how to explain, but if you say, for example, … if you ask me…. Here [holds upper arm], "Is paining or sore or what?" You can use the different [words] … you can ask the exact one, then I can understand. When you say, "Pain?", then I say, "Oh yes! 'Pain.'" | FG1 |
| Slowing speech | |
| They speak so fast…. If they speak slowly then we can understand. | FG2 |
| Multilingual staff | |
| We've got an Asian grocery across the road. We've actually called them in to help us out. | PA1 |
| My dad, he goes to [pharmacy name and location], because there's a lady who speaks the same language. We live in [place A], he doesn't come in [place A], he goes to [place B, 25 mins drive away] to see a same-language person. | FG3 |
| Perceived success of communication | |
| But we seem to always get through to what they need…. hope for the best. | PA3 |
| You're banking on them having already been explained this stuff…they'll take it by how the doctor's told them. | PA2 |
| I'm just staring at them, and… I say, "Yes, yes". And what are they actually saying? | FG4 |
| Building trust | |
| Being available and showing kindness | |
| Take two or three seconds, some questions. She make herself comfortable to you. She trust you to tell the problem… Be friendly with your customers, especially the migrant, refugees, because they are so suffering from their country. | FG3 |
| Patience is definitely a key. | PA3 |
| Being empathetic | |
| We can't just let her walk out of our pharmacy without having any tablets with her because there is a duty of care as a pharmacist. | P1 |
| Our customers are all patients… they're not just coming to do a car service or something like that. They are taking medications and we should show empathy to them first of all. | P4 |
| Improved understanding | |
| Orientation for new arrivals | |
| New people need to be taught and helped. They need to be shown the way. | FG4 |
| But simple explanation by somebody who can speak their language and explain to them… would go a long way to negating a lot of that anxiety… About how the health system runs here. | P2 |
| Improved understanding for pharmacy staff | |
| The immigrant people says, "Oh, I am getting cough and cold and I want some medicine. And the staff took that man or woman and show the medicine. 'This one, this one, this one, this is all for cough and cold'. And People bothered, you know, seeing all the medicines, …how can we know which one is the right medicine? … The staff should say 'This should be better for you, and you take it.'" | FG1 |
| Medicine which is cheaper, that works very little. | FG1 |

language (simplification, use of non-verbal communication, re-phrasing, and slowing speech), and multilingual staff.

Communication difficulties were consistently highlighted as a challenge by both the pharmacy staff and migrants.

> In the pharmacy, what can you ask? What can you say? Will they understand or not? You need to tell them things, but they don't understand. This is the problem. (FG4)

Many participants expressed the benefit of using friends or family as interpreters. However, both migrants and pharmacy staff expressed concerns with using non-professional interpreters; the potential for medication misadventure if a translation mistake is made and the awkwardness caused by a breach of privacy.

Migrant participants emphasized the need for a professional to translate both what the pharmacy staff are saying to them and to clearly express their needs to the pharmacy staff. However, none of the migrants had experienced professional interpreters being used in community pharmacies. Despite working in areas with high numbers of CALD clients, only three pharmacy staff had used the government-funded telephone translating and interpreting service (TIS) [24], and one of these only used it as a last resort.

Instead of using professional interpreters, pharmacy staff altered their communication with migrant clients to improve understanding. This included simplifying language and using non-verbal communication, such as gesturing and demonstrating the use of devices.

Migrants suggested that saying the same thing in different ways would increase the chance of them recognizing a familiar word and indicated that slowing speech was helpful for improving understanding.

All the pharmacy staff referred to the use of multilingual staff in bridging the language barrier, either in-house, or, in one case, staff from nearby shops. Migrants aimed to attend pharmacies that had a staff member who spoke their language, traveling further to reach such a pharmacy. Participants suggested that migrant assistance agencies could facilitate the dissemination of information regarding the location of multilingual pharmacists.

Pharmacy staff were either confident that they were able to adequately communicate with migrant clients or relied on the client having received sufficient communication from the prescriber. However, migrants indicated that understanding was not as high as perceived by the pharmacy staff. Migrants reported pretending to understand what was being said, when they did not understand.

### Building trust

Migrants and pharmacy staff spoke of the vulnerability of new arrivals and pharmaceutical needs being unmet because fear prevented migrants seeking care. The theme "Building trust" captured strategies used by pharmacy staff to overcome this fear and open up dialogue, with subthemes including being available, showing kindness and being empathetic.

All participants agreed that the way pharmacy staff spoke to migrants affected the migrants' sense of ease and their candidness in response. Instances of impatience and rudeness from pharmacy staff impacted the migrants' ability to access care.

> Some innocent people tolerate there [in the pharmacy] so many things and go out. (FG1)

Being available, approachable, and patient were commonly cited as important steps to building trust and therefore improving care. Pharmacy staff voiced the need to show empathy when interacting with migrant customers.

### Improving understanding

The theme "Improving understanding" illustrates strategies used to build knowledge and mitigate disparity caused by cultural misunderstanding. One of the scenarios depicted a migrant with an expectation of an Australian pharmacy that was based on his experience in his country of origin, and another was about the subsidized medicines scheme in Australia. Migrant participants stressed the differences between their host and origin countries and detailed their frustration with navigating the unfamiliar pharmacy system. Consistently participants suggested that orientation for new arrivals would improve access to care.

A sub-theme was improvement of understanding for pharmacy staff. For example, understanding that migrants are overwhelmed by excessive choice and the unfamiliarity of the products. They suggested that pharmacy staff should offer clear and direct advice.

Pharmacy staff need to understand migrants' preferences and ways of thinking. Migrants across the focus groups perceived cheaper brands of medicines as being inferior in terms of efficacy and became less trusting of pharmacy staff that were encouraging them to take a generic version. One pharmacist who understood this thinking described it as so ingrained, that trying to convince clients otherwise might result in discomfort, confusion, and have a negative impact on the relationship between the client and pharmacy staff. This pharmacist described having educated staff to improve their understanding of CALD clients.

## Discussion

This study identified facilitators for enhancing patient care including improving communication, building trust, and improving understanding. Data indicated inconsistencies in outcomes between pharmacy staff's desire to provide effective care and the experiences of CALD clients. The multiple voices were a strength of this study, and the variance is discussed below. Another strength was the participation of the CALD community; the boldness with which they shared their concerns and the ideas for facilitators they proffered. While evidence for facilitators to the provision of quality care to CALD clients in pharmacies is lacking, this study adds testimony from the voices of the recipients. Although literature focuses on tertiary settings (e.g. hospitals, refugee camps), this study explores ideas to improve care in community settings [21].

The small number of pharmacy staff included is a limitation of the study. However, pharmacists and pharmacy assistants with daily experience with CALD communities were purposively invited to participate to provide rich data. Most of the pharmacy staff who responded to the request for interview were migrants themselves, all had traveled outside their country of birth at least once, and all but one spoke at least two languages. Despite the small number of participants, the study was able to capture differing perspectives. The scope of the study is limited to Nepali speakers living in a southern Australian metropolitan city. However, some findings may be useful for pharmacists working with other CALD clients. This study is not powered to speak to the difference between the migrant and refugee experience, nor generational differences. Some loss of data may have occurred through the translation process. To mitigate this, transcripts were checked by a native speaker. As the first author was a novice researcher the rigor of the data could have been compromised. However, close supervision by two experienced researchers and team decision-making throughout the study mitigated this threat.

The barriers to CALD clients receiving quality patient care as described by these participants were consistent with the literature. The language barrier between pharmacy staff and migrants is the greatest challenge [7, 9, 12, 17, 25]. Pharmacy staff were positive about their efforts to communicate with migrants with low-level English, describing situations where, despite communication being difficult, understanding was achieved. Methods employed to improve communication included the use of demonstrations, body language, and simplification of language, which aligned with other literature findings [14, 17]. However, the confidence of pharmacy staff in communicating was misplaced. Migrants across the focus groups described pretending to understand community pharmacy staff when they did not. Consistent with our results, Terui [26] found that this behavior is common in CALD people as an attempt to protect self-esteem, respond to social pressure, and cope with anxiety. Low levels of English comprehension, education, and health literacy result in inferior healthcare [9]. As Clark et al. [9] also found, CALD participants had experiences of leaving community pharmacies without having their needs met. The RESPECT model outlined by Mutha et al. [27] encourages health professionals to "check often for understanding," and "use verbal clarification techniques," including asking open questions. As suggested by Murray et al. [15], asking the client to express what they have learnt in their own words ("teach-back") could have identified poor understanding.

Migrants in this study suggested that re-phrasing increases the chances that they will understand. Currently, pharmacy staff are taught to ask a series of assessment questions, requiring clients to have advanced levels of vocabulary to respond [28]. For CALD clients, it would be more helpful for pharmacy staff to suggest possible symptoms, as migrants indicated that it is easier for them to understand what they hear than think of the right word to say.

The use of multilingual staff is seen as a useful tool by pharmacy staff in overcoming the language barrier, but its use is limited by the availability of skilled staff so is not feasible in all community pharmacies [14]. Migrants also valued staff who spoke their language and would travel further for this service but lacked the knowledge of how to find such a pharmacy. Migrant support agencies could play a role in disseminating information regarding the location of multilingual pharmacists.

The use of family and friends as interpreters is common practise but has pitfalls as well as benefits. Informal interpreters are easily accessible, aid understanding, and are familiar with the clients' history [9, 15]. Previous research has emphasized the concern of health professionals regarding breaches in confidentiality with the use of non-professional interpreters [7, 12, 13]. This study highlighted the migrants' voices, as they described uncomfortable experiences where they felt their decisions regarding their health would conflict with the views of the interpreter or be shared with others in the community. Pharmacy staff in this study were less concerned with the use of informal interpreters compared with research [7, 12, 13, 25], even employing staff from nearby shops who are not bound by patient confidentiality.

Studies detail pharmacy staff's concerns about the accuracy of translation when non-professional interpreters are used [6, 7, 12, 25]. This study adds to the data by elucidating the clients' concerns about translation errors. The risk of error reinforces the need for professional interpretation, as asserted elsewhere [15, 17]. The use of professional interpreters results in better quality care and better health outcomes [29]. Migrants prefer the use of professional interpreters but doubt their availability in community pharmacy settings [9]. In Australia, the telephone TIS is free and accessible to community pharmacies, with more than 2700 interpreters in 150 languages available 24 hours a day, 7 days a week [24]. However, pharmacy staff are often unaware of the availability of the phone interpreting service and those that were aware of it cited a lack of need, reflective of the overestimation of migrant clients' understanding [8, 9, 11]. Therefore, there is a need for governing bodies to mandate the use of translation services, as recommended by Clark et al. [9].

Even without interpretation, communication should be culturally sensitive and pharmacy staff need training to respond appropriately to CALD clients [9, 30]. Participants discussed the need to alleviate fear and confusion with reassurance, kindness, and friendliness, consistent with the RESPECT model [27]. Other research suggests pharmacy staff should be open-minded, compassionate, and understanding when serving CALD clients [8, 31, 32]. Migrants expressed that good customer service would lead to a relationship where clients feel comfortable seeking care and detailed experiences where rudeness from staff had resulted in having their needs unmet. Building trust leads to the provision of better care, and this can be achieved even without speaking the same language [11, 15, 31, 32].

Consistent with other studies, migrants benefitted from orientation to the health system provided by support agencies on arrival [10, 18]. However, this training could be improved by including more details about the pharmacy system.

The outcomes from this descriptive study indicate the need for a broader quantitative study of pharmacy staff framed around the theme generated herein. Further research is needed to validate facilitators that are effective in improving access to quality patient care and that are practical for implementation by community pharmacies. Research into overcoming language barriers should investigate communication techniques that improve understanding when there is limited comprehension of a common language and removing barriers to the use of professional translation services.

## Conclusions

Facilitators were identified for overcoming barriers to the provision of patient care to CALD clients in community pharmacies. The voice of migrants was showcased as they described how care could be improved in community pharmacies. Communication remains the greatest challenge for CALD clients in community pharmacies, a greater challenge than pharmacy staff perhaps realize. Empathy is needed; understanding of the hardships they experience in their daily life in an unfamiliar country. Approaching clients with kindness and patience will build the trust that will ultimately result in better health outcomes, through improved delivery of patient care. The need for pharmacy orientation for new arrivals is an opportunity for pharmacists to work alongside migrant support agencies and meaningfully support CALD clients while investing in the health of their community.

## Data Availability

The data underlying this article will be shared on reasonable request to the corresponding author.

## Supplementary data

Supplementary data is available at *International Journal of Pharmacy Practice* online.

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