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CHALLENGES AND OPPORTUNITIES OF ONLINE FOCUS GROUP DISCUSSIONS IN REFUGEE STUDIES WITH SYRIAN MOTHERS: HOW CAN WE OVERCOME THE BARRIERS?

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Abstract

Objectives: Refugee studies require extra attention due to ethical concerns and language-cultural differences. We aimed to compare the challenges and opportunities of online focus group discussions (FGDs) conducted with Syrian refugee mothers.

Materials and Methods: We used data from face-to-face and online FGDs of a study investigating the breastfeeding characteristics of Syrian mothers. FGDs were carried out with Syrian mothers and grandmothers (Group I-II), and Syrian healthcare workers (Group III) in Turkey. A total of 7 focus group discussions (FGDs) were performed face to face. 47 Syrian mothers and grandmothers and 16 Syrian HCWs attended these meetings. In two different provinces, a total of 7 FGDs were conducted online with 30 Syrian refugees, and 15 Syrian HCWs. All face-to-face FGDs were performed in Refugee Health Centres (RHCs). Online FGDs with Group I-II were performed using the technical equipment-facilities of RHCs. Group III attended the FGDs with their own devices from wherever they wanted. Thematic analysis of the transcripts in a deductive-inductive fashion was carried out with MAXQDA 11.

Results: Online FGDs were more favorable than face-to-face FGDs in terms of planning, selection of participants, cost, moderation, providing a heterogeneous group, equal participation, ease of recording and transcribing, privacy and anonymity, and comfort of participating. On the other hand, internet interruption and not focusing on the meeting were disadvantages of online FGDs with Group III.

Conclusion: Providing technological and technical support and utilizing facilitators and interpreters of the same nationality as the refugees at every stage of the study eliminated many disadvantages of online FGDs.

Keywords: Qualitative studies, online focus groups, face-to-face focus groups, refugees.

Introduction

Due to the COVID-19 pandemic, options other than face-to-face interviews have become more preferred as a data collection method in many qualitative studies.[1-5] Online FGD is not a new method, and some advantages of this method have been reported in advance.[6-8] The advantages are online meetings provide a comfortable environment, participants can join from their homes, and they do not have to travel anywhere.[6,7] The participants can turn off the video and use pseudonyms so they can feel more comfortable talking about sensitive topics.[8,9] Online meetings provide access to participants from different geographical regions.[7] However, this method requires technology and literacy for technology.[3,7,10-12] So, online methods cannot represent the whole population of socioeconomically disadvantaged groups such as refugees.[13] One predicted advantage of face-to-face FGDs is that they provide interpersonal interaction and a better discussion environment.[6,12] Refugee studies have additional challenges as they require interpreters and specific ethical considerations.[14-16] Salam et al. recently published a study about the methodological and ethical challenges of refugee studies in the Covid-19 era. However, those who could not access the technology and did not speak English were not included in that study.[17] Language barriers and limited access to technology are common problems for all refugees, leading to selection bias for the most disadvantaged group and a reduced validity of qualitative research.

We used L´evesque et al.'s conceptualization of access to health care as a theoretical input to support the research design.[18] This conceptualization framework takes into account the characteristics of both participants and researchers. The dimensions of investigators are approachability, acceptability, availability, affordability, and relevance. The dimensions of the participants, such as refugees, are the ability to perceive, the ability to search, the ability to reach, the ability to pay, and the ability to connect.

We aimed to determine the challenges and opportunities of online FGDs by using face-to-face and online pilot FGD applications of a study conducted with Syrian refugees (mothers, grandmothers, and healthcare workers). The online FGD model, which we carried out through an interpreter by providing technology, could be adapted for further studies, including vulnerable populations and other refugee populations.

Materials and Methods

Before the COVID-19 pandemic, face-to-face synchronous structured FGDs were planned with Syrian mothers, grandmothers, and healthcare workers (HCWs) to estimate the breastfeeding practices of Syrian immigrants. Pilot implementations were initiated to make face-to-face meetings. However, due to the Covid-19 pandemic, it was not possible to maintain face-to-face meetings. The procedure was changed, and pilot FGDs were included; all meetings were implemented online. Even though we didn't plan this way at the beginning, we have

performed both face-to-face and online pilot implementations of the same study. In this study, we compared face-to-face pilot implementations and online meetings of the qualitative study.[19]

Participants were Syrian mothers (Group I), Syrian grandmothers (Group II), and Syrian HCWs working in refugee health centers (RHCs) (Group III). In both methods, participants were selected by purposive sampling. Selection of participants and meetings were held through RHCs. The method is detailed in Table 1.

The study was approved by the Ethical Board of Hacettepe University, the MoH Turkish Public Health Institution. All participants gave written informed consent for FGDs.

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Table 1. The methods of face-to-face and online focus group discussions.

	Face-to-face FGDs		Online FGDs	
	Group I and II	**Group III**	**Group I and II**	**Group III**
Organization of meetings	A volunteer Syrian HCW from each RHC was assigned. The HCW formed participant groups of 8-14 people using purposive sampling and informed these participants about the meeting content and schedule. One moderator one notetaker, and one interpreter working in Provincial Health Directors of the selected provinces went to the RHCs for FGD meetings. Also, one interpreter from each RHC took part in the organization of the meetings and the FGDs. The personal information and informed consent were obtained by the interpreters before the interview.	A volunteer Syrian HCW from each RHC was assigned. This HCW selected all the participants and organized the meetings at the RHC where she/he was working. One moderator one notetaker, and one interpreter working in Provincial Health Directors of the selected provinces went to the RHCs for FGD meetings. Also, one interpreter from each RHC took part in the organization of the meetings and the FGDs. The personal information and informed consent were obtained by the interpreters before the interview.	A volunteer Syrian HCW from each RHC was assigned. This HCW selected one participant and one substitute participant for each FGD and informed the participants about the meeting content and schedule. Before the meeting, the responsible HCW obtained informed consent and then started the meeting by clicking the Zoom link that was sent. After that, the HCW showed the participant how to turn the audio and video on and off. After the meeting started, the HCW went to another room and told the participant to call if there was any technical problem. There was only one participant in each room.	The participants were selected voluntarily by the Provincial Health Directors of the selected provinces. Informed consent was obtained online.
Selection of participants	Purposive sampling method	Purposive sampling method	Purposive sampling method	Purposive sampling method
Privacy and anonymity	Each participant was given a pseudonym	Each participant was given a pseudonym	Each participant was given a pseudonym	Each participant was given a pseudonym
Where meetings were held	Meeting rooms in RHCs	Meeting rooms in RHCs	Each participant participated in online meetings using a room with a computer and wireless internet from different RHCs.	Participants were connected to the meetings from anywhere (home, work, etc.) with their own devices and their internet.
Moderation	By principal researcher	By principal researcher	By principal researcher	By principal researcher
Interpretation	RHC's interpreter	RHC's interpreter	By the same interpreter who attended online.	By the same interpreter who attended online.
Training of interpreters	All interpreters were trained individually	All interpreters were trained individually	An interpreter was trained	An interpreter was trained
Number of FGDs	4 mother FGDs, 1 grandmother FGD	2 FGDs	4 mother FGDs, 1 grandmother FGD	2 FGDs
Number of participants	41 mothers (14+11+8+8), 6 grandmothers	16 HCws (9+7)	24 mothers (6+6+6+6), 6 grandmothers	15 HCWs (8+7)
Providence where FGDs held	Ankara	İstanbul	Gaziantep and İstanbul	Gaziantep
Number of RHCs	3 RHCs	2 RHCs	6 RHCs from İstanbul and 6 RHCs from Gaziantep	5 RHCs
Way of obtaining data	Audio recording	Audio recording	Audio recording	Audio recording
Analysis of data	Thematic analysis	Thematic analysis	Thematic analysis	Thematic analysis

Results

In both methods, the same people were responsible for moderating the FGDs and collecting and analyzing the data. Based on our experience and concrete examples, the differences between the two methods can be listed as follows (Table 2).

Table 2. Comparison of face-to-face and online FGDs

	Face-to-face FGDs	Online FGDs
Planning	• A limited number of FGDs can be held in one	• A great number of FGDs can be held in one day
Cost and logistics	• Travel and accommodation expenses of the work team • A meeting room for FGD and a waiting room for their companions in the RHC.	• No need for travel and accommodation. • A room with a computer was available in each RHC for Group I-II. • Group III: HCW-FGDs attended the meetings with their own devices and where they wanted.
Selection of Participants:	• Difficult to find many participants for Group I-II via the same RHC • Almost all HCWs from the RHC participated	• One participant for group I-II was taken from each RHC. • Group III: 1-2 HCW from one RHC participated to FGDs
Moderation and interpretation	• Difficult to moderate. • Sometimes interpreters interacted with participants	• Easier to moderate. • Interpreters had little interaction with participants
Participant characteristics	• A homogeneous group from the same RHC for group I-II.	• A heterogeneous group from different RHCs for groups I-II; Since one participant was selected from one RHC, people with different characteristics living in that region could be reached.
Equal participation and interaction	• Dominance of some participants • Useless interaction	• Equal participation • Less interaction
Taking recordings and transcribing audio recordings	• Ambient noise and interruptions of talking participants by others	• No ambient noise interruptions due to connection problems*
Duration of FGDs	• Similar durations • Waste of time before and after	• Similar durations • No extra time wasted
Privacy and anonymity	• Pseudonyms used • Audio recordings were taken, and the security of recordings was ensured • All personal information was collected in a meeting room where all the participants were; anonymity could not be fully ensured	• Pseudonyms used • Audio recordings were taken, and the security of recordings was ensured • The personal information was collected one by one; anonymity was ensured
Comfort of participating	• Went out to breastfeed • Only interested in meeting	• They were able to turn off the screen and breastfeed • Some were interested in other things and could not focus on the meeting*

FGD: Focus group discussion; RHC: Refugee Health Centre; HCW: Health Care Worker; Group I-II: Mother and grandmother as a participant; Group III: HCWs as a participant; * This situation is valid only for online FGDs of Group III.

Planning: One HCW was responsible for face-to-face meetings. We just had to communicate with him/her. However, this person was insufficient to organize two meetings on the same day. Also, a crowded group with their companions had to be in the RHC at the same time, and the health service of the RHC was disrupted. In online FGDs, we had to reach numerous "contact persons," but we made it easier by creating WhatsApp groups. In addition, since the responsible HCWs assisted the participants one-on-one and there was a participant and a companion at the RHC at the same time, there was no chaos or disruption of service in the RHC.

Cost and logistics: Interviews were conducted in various provinces using both methods. In the face-to-face FGDs, the transportation and accommodation expenses of the team were incurred. In RHCs, a meeting room and a waiting room for companions were required.

In online FGDs with Group I-II, the participants participated in the meeting in a room in RHC and used the computer and internet of the RHC.

In the HCW-online-FGDs (Group III), participants used their own devices and internet and attended meetings alone where they wanted. The study team attended the meetings from their home or workplace. There was no need for them to travel and stay elsewhere, nor to allocate funds for them.

Selection of Participants: In both methods, the RHCs were selected by the coordination of the provincial health directorates and the Ministry of Health (MoH). A volunteer Syrian HCW from each RHC was assigned to select the participants and organize the meetings.

In the face-to-face FGDs of Group I-II, it was necessary to find approximately 16-24 participants for two meetings on the same day. It has been difficult to find this number of participants through RHC. Many participants gave up attending the FGDs even though they had been accepted before. In online FGDs, it was easy to find participants since only one refugee from each RHC attended. In case of a problem, we could reach a reservist immediately, or we could find a new one among those who came to RHC for healthcare service.

Moderation and interpretation: Most of the participants and responsible HCWs could not speak Turkish or English. Therefore, bilingual (Arabic and Turkish) Syrian interpreters were used. An interpreter from an enrolled RHC participated in face-to-face FGDs. One interpreter working in the MoH was utilized in the online FGDs. All interpreters were trained before the FGDs not to direct the participants during the meeting, not to add their own opinions to the translations, and not to judge the participants. In face-to-face FGDs, it was necessary to train each interpreter before each FGD. Since one interpreter was utilized in online FGDs, it was enough to give training once. In addition, the interpreter who attended many meetings gained experience, and standardization was achieved in the online FGDs. Unfortunately, this standardization could not be achieved in

face-to-face FGDs due to the attendance of a different interpreter at each meeting. In the face-to-face FGDs, some interpreters guided the participants while others presented their opinions.

"Ladies, you are no longer in Syria; this is Turkey, and you will live accordingly (Ankara, mothers' FGD, interpreter)."

"… they (mothers) are sitting on the stairs and breastfeeding in front of the eyes (with judging and shaming) (Istanbul HCW FGD, interpreter. He made his comment on the question about breastfeeding asked to the HCWs)."

Participant characteristics and impact on getting information: In the face-to-face FGDs, participants formed a homogeneous group of refugees using the same RHC (Group I-II). Some participants were neighbors, friends, or relatives. Because of this acquaintance, they may have hesitated to answer some issues or have similar experiences. They had conversations among themselves, and these conversations were not related to the topic; it did not help to have more information on the subject by providing interaction. In the online FGDs, a heterogeneous group was formed, and one refugee from each RHC participated (Group I-II). Participants were not acquainted. More information was obtained, especially on different regional practices. In online FGDs of HCWs (Group III), participants were working in different RHCs. But this time, the most knowledgeable HCWs in the RHC volunteered to attend the meeting as participants. In face-to-face HCW-FGDs, most of the health workers of the same RHC attended the meetings and formed a very heterogeneous group in terms of knowledge.

"I don't have a child yet; I don't have much experience; it would be better if you ask those who have children (Istanbul, female nurse, face-to-face FGD, in response to the question of "How children under the age of 2 should be fed?")."

"Our most important duty here is to follow up pregnant women and children. Frankly, we do not interfere much whether they breastfeed or not (Istanbul, male doctor, face-to-face FGD, in response to the question of "How is the breastfeeding status of the community you currently serve?")."

"Until the age of 1.5 (Istanbul, male doctor, face-to-face FGD, in response to the question of "How much do you recommend breastfeeding?")."

Equal participation and interaction: Although all participants were supposed to speak in the order in face-to-face meetings, some people were very dominant, and they got more voice by intervening. Although it seems to be an interaction between participants, it did not contribute to obtaining further information. The presence of such dominant characters caused some participants to be less involved. In the online FGDs of Group I-II, there

was more equal participation since everyone talked in order and then turned off the device's voice. In online HCW-FGDs (group III), some participants were less involved because of connection problems.

Taking records and transcribing audio records: In both methods, an audio recording was taken. In face-to-face FGDs of all groups, due to ambient noise and interruptions of talking participants, we had difficulties with the transcription of the audio records. In online FGDs for groups I and II, there was no ambient noise or interruptions because only the speaking participant turned on the computer's voice. However, in online FGDs of HCWs, the statements of some participants could not be understood when transcribing due to connection problems. Some even had to leave the FGDs earlier. In both methods, Syrian translators were consulted while transcribing audio recordings.

Duration of FGDs: In both methods, FGD durations were similar. However, in face-to-face FGDs, it took a long time to get into the room, settle down at the tables, ensure order, and end the interpersonal conversations. In the online FGDs, there was no need to maintain order and this process took less time as there was an attendant to assist each participant.

Privacy and anonymity: Pseudonyms were used to identify individuals in all FGDs. In both methods, audio recordings were taken instead of video recordings, and it was explained to the participants when obtaining informed consent, also the security of these recordings was ensured. Some people who participated in face-to-face FGDs had been acquainted before the meetings. For this reason, anonymity and privacy could not be fully ensured.

The comfort of participating: In online FGDs (Group I-II), participants attended the meetings in private rooms, so they were more comfortable. There were breastfeeding mothers among the participants. They were able to turn off the video and breastfeed comfortably during online FGDs. In face-to-face FGDs, they had to go out to breastfeed. In the online HCW-FGDs, the participants were connected from wherever they wanted. This was a great comfort for the participants. However, this comfort reduced the participants' attention to the meetings. Some of them attended the meetings from the workplace, some from the home, and some in a cafe. When it was not their turn, some participants turned off their screens and paid attention to their things. This reduced the quality of the FGDs.

Discussion

In this study, we can summarize the advantages of online meetings held for Syrian mothers and grandmothers via RHCs as follows: planning and performing were easier, no fee was required for the transfer and accommodation of the study team, equal participation was achieved, there was no ambient noise, there were

participants from various regions, more privacy was provided, and also a more comfortable and baby-friendly environment provided. These results were similar to previous studies.[6-12]

Our second sample for online FGDs was Syrian HCWs. HCWs had sufficient knowledge and technology for internet communication. It is a great convenience for online meetings not to require transport and to ensure participation in the comfort of a home environment. In HCW FGDs, there were both internet interruptions and situations that reduced the quality of the FGDs (such as doing other things or chatting with friends) due to the HCWs' participation in meetings from anywhere with their own devices and internet.

In the study, refugees had to go to RHCs, but it was not difficult because the RHCs were close to their place of residence. Although they were not in a home environment, it was comfortable to be alone in the room. In addition, there were no obstacles, such as the bell ringing, dealing with housework, or being interrupted by other family members, which reduced the quality of online FGDs.[20] Internet interruption is a common disadvantage in online FGDs. Wired internet is recommended for preventing interruptions and for a higher-quality connection.[21]

It is recommended that the participants of Group I-II be informed about Zoom before the meeting and trained on how to use it.[21] Since our target population has a low level of education, only turning on and off the audio and video were shown. All other procedures were done by a volunteer Syrian HCW, but participants attended meetings alone. They asked for help when needed, and after solving the technical problem, the responsible HWC left the room. Although geographical diversity is an advantage in online meetings, this may not provide data saturation in that region.[22] This saturation can be achieved by performing a large number of FGDs.[19,22]

Refugees are one of the most vulnerable groups who have experienced numerous traumas and have language barriers. Therefore, studies with these groups require much more ethical sensitivity.[23] It is necessary to provide adequate information while obtaining informed consent from the participants. Because of power imbalance, they may feel compelled to volunteer, or they may not be able to leave the study whenever they want.[13,14,23,24] To overcome these ethical challenges, it is important to utilize professionals from their language and culture. Syrian HCWs/interpreters were assigned or consulted at all stages of the study, from the planning to the data analysis. In cross-cultural studies, it is recommended to involve individuals from the community of interest in each step of the study. Thus, better communication is achieved, the power imbalance is reduced, and prejudiced or false findings about their culture are prevented.[24] Of course, it is also important to utilize trained interpreters.[25]

The number of refugees is increasing all over the world, and there is a need for qualitative studies to determine and improve their health status. A limited number of qualitative health studies have been conducted with Syrian refugees in Turkey, and they used a face-to-face approach.[26-29] In this study, we presented an online FGD

model that was conducted with refugees by using the technical capabilities of RHCs. We also compared this model with face-to-face FGDs and online FGDs that were conducted without using the technical possibilities of RHCs, and we demonstrated its advantages in many ways. This study can contribute to many future refugee health studies and guide them. On the other hand, the most important limitation is that the health system of each country may not be suitable for this model. However, researchers can modify it according to their country's health systems.

In conclusion, in our experience, online FGD with refugees is more favorable than the face-to-face method in many ways. Our recommendations for performing a quality FGD with refugees are the following: a) Primary health care centers serving refugees can be used for the selection of participants and meetings, b) participants should be provided with a room and a computer with a wired internet connection, c) An HCW or interpreter from the same nationality as the refugees should take part in all steps of the study, d) Interpreters must be well trained in the principles of FGDs and ethical issues. If possible, experienced interpreters should be appointed, e) Participants should be given basic information about the technology to be used, such as turning the audio or video on and off. An HCW as a contact person and interpreter should be available to initiate the meeting and provide technical support if necessary. A greater number of FGDs could be performed to ensure data saturation as well as geographical diversity with this method.

Ethical Considerations: Approved by the Ethical Board of Hacettepe University, the MoH Turkish Public Health Institution. All methods were carried out following relevant guidelines and regulations.

Conflict of Interest: The authors declare no conflict of interest.

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