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Researching local public health priorities in the locked down city using online community focus groups: Reflections and recommendations

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ABSTRACT

In this commentary paper we reflect on our experiences of conducting two qualitative public health projects in Leicester UK around health inequalities and marginalised groups during the Covid 19 pandemic in 2020 and 2021. To contextualise the commentary, we first provide information about Leicester and how and why it was disproportionately affected by the pandemic, as well as describing the origins, aims, and methodologies of the two projects. In the second half, we describe and evaluate some of the adaptations we made to our studies and conclude with suggestions for future qualitative community health research as we adapt to the post-pandemic research landscape.

1. Leicester and COVID-19

With a population numbering roughly 368,600 (Office for National Statistics, 2022), Leicester is one of the most culturally diverse and fastest growing cities in the United Kingdom. The city, centrally situated in the United Kingdom, is home to several ethnic and religious communities, including people of: Black, Asian, Arab, and Eastern European background, many of whom identity as: Christian, Muslim, Hindu, Sikh, Buddhist, or Jewish ('Leicester City Commissioning Group' [LCCG] & 'Leicester City Council' [LCC], 2020). Leicester's British South Asian communities are amongst the largest in the country-representing 43.4% of the city population, with several community languages including: Gujarati, Punjabi, Urdu, and associated dialects widely spoken. Leicester is also a relatively poor city; the most recently published 'Index of Multiple Deprivation' cites Leicester as the 32nd most deprived local authority in the UK (LCCG & LCC, 2020) with several council wards scoring poorly on key indicators like income, living environment, and barriers to housing and services.

Leicester's cultural and community composition, is like most European cities, both unique and dynamic. The city has often championed as an example of 'progressive civic multiculturalism' but naturally patterns of inclusion and exclusion are complex within and between communities and for most individuals from minoritized ethnic backgrounds racism remains a significant part of everyday life (Clayton, 2012; Hassen & Giovanardi, 2018). Whilst recognising many of the strengths of community relations in Leicester, Hussain, Haq and Law (2003) amongst others have argued that the city arguably provides an urban model based more on *multi*culturalism rather than *inter*culturalism. The sociocultural and politico-economic landscape of Leicester has been shaped by multiple migrations including larger scale mass movements of established communities such as the arrival of significant numbers of East African Asians from Uganda and Kenya in the 1970s (Martin & Singh, 2002) and post-millennial, more varied and fragmented patterns of migration from multiple parts of the world that Vertovec (2007) has described as 'superdiversity'. One significant example of this has been a rapidly growing Somalian community in the city which has attracted considerable research attention (Jones et al., 2010; Clayton, 2012). Those who argue that Leicester represents a more successful model of community integration and inter-group acceptance than most other British cities generally point to explanatory factors such as relatively good political representation for those from minoritized communities, and investment in the development and maintenance of community-based projects from key institutions such as the city council (including the public health department), faith organisations and the police (see Clayton, 2012 for a fuller discussion). It is also worth noting that the more established migrant communities often relocated in extended families so kinship

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and faith bonds were typically well-established and have therefore often flourished in the diaspora (Martin & Singh, 2002).

Leicester is also of particular interest to public health researchers and commentators as it was one of the cities most affected by the COVID pandemic in the UK. It was the first authority to be placed under a local lockdown which ran between July and October 2020 with some subsequent relaxing of regulations (Shand et al., 2022). Furthermore, because of disproportionately high levels of COVID-19 death and disease, Leicester experienced the longest socio-legal restrictions of any English city. In keeping with national trends around the disproportionate impact of COVID on deprived and minoritized ethnic communities, high levels of death and hospital admissions were especially associated with people living in a cluster of generally impoverished council wards in the east of the city where people of Asian-British heritage represent three quarters of the population (Nazareth et al., 2020). Fully understanding the reasons for elevated and sustained COVID-19 rates is complex and contested, although certain high-risk factors appear to have contributed, included: failings in the local testing, track and trace systems, high density living conditions, poor adherence to self-isolation regulations from some individuals testing positive, as well as poor provision of personal protective equipment and little effort to increase safety regulations in many of the city's factories, especially those producing fast fashion clothing items (Johnston, 2021; Gill et al., 2020; Martin et al., 2020; Sullivan et al., 2022). Whatever the reasons, it is clear that people in many parts of Leicester were exposed to higher levels of COVID-associated death, distress and disruption than most people in the United Kingdom.

2. The public health projects and priorities: 'FFUFL' and 'SICCIL'

De Montfort University (DMU) began to prioritise increased engagement of staff and students with the local city and its residents in 2014 through a multi-faceted university-wide scheme called *DMU Local.* Essentially the aims of this enterprise were to enhance bonds between the university and its home city and use university capital (in all forms) to enhance social justice, health and well-being. In 2019, as part of these continuing university initiatives, an agreement was made between senior public health staff at the Leicester City Council (LCC) and an interdisciplinary team of researchers in the Faculty of Health and Life Sciences at DMU, to work together on co-created collaborative projects funded by LCC that focused on public health priorities in the city, especially among marginalised communities. This alliance has resulted in a series of projects, some still ongoing at the time of publication, but for the purposes of this paper, the first two of these projects and their development is described below.

2.1. Public health project one: families feedings under fives in leicester (FUFFL)

Towards the end of 2019 it was agreed that the first study would focus on at exploring the social and structural barriers that Leicester parents face supporting their young children's health, in terms of: breastfeeding, providing healthy meals, and dental care. Despite several well-established initiatives in Leicester in recent years, such as the 'Healthy Teeth, Healthy Smiles' intervention (see https://www.leicester.gov.uk/health-and-social-care/public-health/get-oral-health-advice/healthy-teeth-happy-smiles/), the city continues to report poorer rates on key indicators of child health than many other parts of the country. In the LCC Health and Well-Being Survey (2018), it was reported that only 1-in-5 local residents reliably met the five-a-day target for fruit and vegetable consumption, while 1-in-8 households regularly run out of money which can make shopping for good quality nutritionally-rich foods challenging. Children's oral health is also relatively poor in the city, with significant evidence of problematic practices that include the prolonged use of bottles filled with sugary drinks or sweetened tea and poor teeth-brushing routines.

The project that emerged from this collaboration was called 'Families Feeding Under Fives in Leicester' (FFUFL, Williamson et al., 2021). The study aimed to increase knowledge and awareness among members of the Public Health department with city wards, and to train Public Health staff in carrying out community focus group methods. FFUFL was focused in four of the poorest city wards with two characterised by high levels of white working-class families and two with mostly Asian-British families. A two half-day training programme, named 'excellence in public health community focus groups', was devised by the DMU team with an aim to train twelve public health officers in community centres across the city. Following ethical approval and a data protection risk assessment (which involves identifying and minimising potential data protection breaches as research data are stored and shared), all study data were due to be collected in a range of spaces including community centres, local libraries, and larger GP surgeries. The aim was to conduct six focus groups across the four council wards (each to be facilitated by two members of the council's public health department). The first training session for the trainee focus group facilitators was held in person at Leicester's African Caribbean Centre in late February 2020 but the second session, which was scheduled for late March 2020 was postponed and moved online and as the pandemic evolved, the whole of the rest of the project was switched to an online format through 2020. After a series of delays, partly exacerbated by the local lockdown that persisted in Leicester, focus groups for FFUFL ran in November and December 2020. The adaptions made will be discussed after a brief explanation of the second public health project, SICCIL, and its aims and methodologies.

2.2. Public health project two: social isolation and coping with COVID-19 in leicester (SICCIL)

Whilst planning for the first project pre-dated the pandemic, the second project was planned during and directly as a response to the pandemic and the particular difficulties that Leicester experienced through extended restrictions (Shand et al., 2022). This took a focus primarily on mental health and built on ongoing work from some team members on loneliness and social exclusion, alongside a rising appreciation that the pandemic threatened psychological well-being as much as physical health especially among those reporting loneliness and social isolation (Banerjee & Rai, 2020; Clayton et al., 2022; Pancani et al., 2021). Rather than focusing on different council wards of the city, for this project we focused on two communities of concern during the pandemic: elderly individuals living alone and regular users of community mental health services living alone (Hart et al., 2022). Evidence suggests that in both these social groups, chronic social isolation is associated with poor quality of life, higher disease burden and shortened life expectancy (Buffel et al., 2021; Pentaris et al., 2020). Indeed, Buffel's team argue how the pandemic enforced a 'double lockdown' on elderly individuals, particularly those living in socially and/or materially deprived environments. They argued that as well as managing social distancing restrictions, the pandemic led to a reinforcement of existing social and structural inequalities, especially for marginalised sub-communities such as older LGBT+, disabled or individuals from minoritized ethnic communities. This was accompanied by various ageist discourses that circulated in the pandemic (see Søraa et al., 2020).

The effects of the pandemic and especially social distancing and lockdowns on those living with chronic mental health concerns have been well documented and include not only the social and psychological impact on individuals, but also the challenges of reorganising and adapting community care and support services, especially for regular users. Though the focus of the emerging research over the last three years has focused primarily on the challenges and negative aspects, more positive developments including innovation in practice and building of new communities of peer support have also been acknowledged within the literature (Antoine et al., 2020; Sheridan Rains et al., 2021). For this study, we aimed to train twelve members of the public health department (with some overlap with FFUFL in regard to council staff) to conduct three online focus groups with mental health service-users and three with older adults living alone. These focus groups ran in July and August 2021.

3. Practical and methodological challenges and adaptations

3.1. Moving online for training and data collection

Our training programme was assembled by members of the team experienced in running focus groups in community settings on potentially sensitive public health topics (Williamson et al., 2019) and preparation for training had included a detailed training needs analysis of the trainees. However, whilst some members of the team had experience of conducting individual interviews online or by telephone, facilitating discussion groups online was a new experience and training had to be adapted very quickly. We incorporated accounts of best practice from the (then) relatively modest range of published articles (Abrams & Gaiser, 2017; Stancanelli et al., 2010) and used recent and ongoing experiences from members of the public health team—many of whom at this time were working regularly online on various health promotion and support schemes with members of the public. This disrupted the expert-novice dynamics of training sessions, but generally in a positive way as we jointly interrogated how well traditional principles and practices of focus group research translated to an online context. A more practical problem around the training schedule was that staff's attendance for full half-day training was problematic (especially in the second FFUFL training session in 2020) as members of the public health team routinely had to prioritise other aspects of their role.

In line with recent findings of other researchers (Dos Santos Marques et al., 2021), during the focus groups it emerged that there were a range of both positive and negative elements to the online mode. Some benefits included the convenience to participants, along with more flexible ways of participating (i.e., with web-cameras on or off). Sustained participant engagement was good and most participants did elect to keep cameras on throughout. However, turn-taking and observing and interpreting others' nonverbal communication proved much more difficult online. This may have been exacerbated by the inexperience of some facilitators and made focus groups more difficult to run in the planned 'role retraction' mode (Stewart & Shamdasani, 2014), where the facilitator only starts the discussion before allowing other group members to take control of the conversation. Thus, especially in the FFUFL groups, a 'process moderation' model seemed to emerge where the facilitator guided the participants through the topic guide while providing active encouragement to speak. This produced adequate data and democratic participation modes (with most participants contributing roughly equally) but tended to adopt a one-person-speaks-after-another mode which did not well represent the 'natural discussion' element of focus groups. In addition, we had promoted the projects as local research for local people and our aim had been to embed focus groups within familiar local contexts, rather than the arguably dislocated and characterless online space. That said, as Howlett (2022) has observed, there is in many ways an increase in intimacy when collecting online data; while we may be spatially removed from the community of interest, we are 'remotely embedded' in participants' homes—seeing aspects of their domestic lives (pets, décor, family members etc.).

Furthermore, promoting use of the chat function as an additional or alternate method of contributing, helped facilitate the interactive elements that are key to focus group methods and data. Some less confident participants preferred using the chat function and this provided an alternate, and in some groups, rich extra form of data. Evaluating the contribution of chat data in online groups is worth fuller consideration. Some have argued that using the chat function, especially in an asynchronous format, can generate good amounts of data including more considered (rather than spontaneous) responses and expand participation rates, particularly around sensitive topics (Estrada-Jaramilo et al., 2022). With hindsight, making an ethics amendment to pilot and run an asynchronous mode may have been beneficial, especially where we had challenges with recruitment which is considered more fully below.

Participants logged on to focus groups using a variety of equipment, including mobile phones, tablets, and desktop computers. Most participants seemed quite comfortable with moving to an online format. For FFUFL, a vignette component that had been designed to stimulate discussions was piloted in the first two groups but did not work well and was subsequently dropped from the protocol for later groups. Mainly for data protection risk reasons, the host University insisted that Microsoft Teams was to be used for all focus groups. From a technological point of view, this software naturally worked well but as a primarily business software, it was unfamiliar to many participants. This proved challenging and frustrating for many – some struggled with functionality whilst others had more fundamental issues such as opening or downloading the software to their home equipment. Several participants said they would have much preferred to use software with which they were already familiar, such as 'Zoom' or 'Skype'.

Some, especially the older participants had already been trained in navigating on-line video chat software, typically by younger relatives. Others arranged for a neighbour or relative to help with these aspects in order to take part in the research, but we are aware that other potential participants may not have had access to this support. Even where there was familiarity with other software, it was essential to extend the anticipated length of the focus groups for participants as frequently it took up to 20 min to set up and train participants in using Teams, despite sending information on accessing and using Teams by email ahead of the session. We employed post-graduate students to provide technical support as needed throughout the sessions with those struggling and this worked well, though as we invariably had two facilitators in each group it could mean that in smaller groups there were as many individuals affiliated to the research as actual participants. Financially, the team saved money by not being required to cover travel expenses.

3.2. Sampling, recruitment and data quality

Both studies fell someway short of recruitment targets. The target for both studies was six groups with around 30–36 participants in total. We believed that this was viable within the time-frame and budgets for both studies and provided a reasonable likelihood of achieving data saturation (Saunders et al., 2018). For FFUFL, we convened four focus groups (duration 55–70 min) with a total of 14 participants. Recruitment was especially poor in the two primarily white working-class wards where only one group was convened and ultimately ran with just one participant. In the other wards we were much closer to target with 13 Asian-British participants (all female) taking part across three focus groups.

For SICCIL, the groups were significantly longer in length (85–120 min). Three groups were convened for the mental health service user group and two for the older adults. In this project we allowed participants to attend multiple groups if they so wished. This was for various reasons. Firstly, it allowed us time to explore complex and potentially existential ideas around loneliness and isolation (which some participants perceived as self-stigmatising) more deeply. It helped insure that participants, some of whom lacked confidence initially in expressing themselves, had more than one opportunity to have sufficient 'air time' to do justice to their experiences. This was especially important in the service-users' groups where participants were recruited from several different agencies across the city and arguably needed time to develop the trust to build research relationships with peers and researchers for deep disclosure. Finally, it also provided the research team with an opportunity to listen back to the recordings of earlier groups and use the subsequent data collection sessions to probe interesting ideas which had been left under-developed.

In total 12 participants took part in the study. Four Asian-British women attended the older adults' group with two attending both groups. One other was available and wished to participate in the second group but was unable to because of technical difficulties. Eight people (six female and two male) attended the service-users' groups with all but one participant attending on multiple occasions. Five of these participants identified as British-White and three as Asian-British.

For both studies the research projects were widely advertised across social media and council services, and via third sector agencies. Sessions ran on various days and times to increase possible participation. We kept a detailed recruitment log for both studies so as well as being able to identify trends in under-recruitment (most obviously Black-British and male participants). We could also log how participants came into the study. Only a relatively small number of participants indicated an interest and failed to follow through to participation. More fundamentally, we struggled to get participants interested in the studies in sufficient numbers in the recruitment windows that we had available. Most of our participants came from a small number of well-established community initiatives. For example, all 13 of the mothers in FFUFL had belonged to a single inner-city breastfeeding support group or joined the study via snowballing and word-of-mouth from friends or family members who had used that service. Likewise, all the older adults in SICCIL were of Gujarati heritage and had been members of a community gardening scheme which had switched to an online social group during the pandemic. Interestingly Jordan and Lahiri (2022) have recently documented how digital spaces were often 'sites of diasporic solidarity' for leisure and sociability amongst individuals from various minoritized communities during the pandemic. Our core group of older-adult participants shared deep cultural and community bonds dating back to their and their families' migration from East Africa in the 1970s and they also met regularly as a small knitting and conversation on-line group.

Enthusiastic engagement of individual service leads was often key to bringing people into the study. Other recruitment routes (through larger charities in the city or council media) were almost entirely fallow. Recruitment success and failure was very localised. Like most towns and cities, despite a reputation for good inter-community relations, Leicester is 'economically, spatially and relationally polarised' (Koch et al., 2021). Whilst acknowledging that it is a problematic term, the wards where we failed to recruit parents for the FFUFL study could be considered as 'left behind' parts of the city characterised by alienation and poor community mobilisation, alongside more objective sustained poverty markers, like: lone parenthood, benefit entitlement and long-term illness and disability (Hirsch et al., 2014). Essentially, we either lacked the links and local intelligence to identify and/or mobilise vibrant and active community groups in these areas as we were able to do in other parts of the city, or those groups are less active or outward-looking.

Digital poverty is a significant challenge to research participation (Faith et al., 2022). Whilst we have discussed issues with lack of literacy and experience with the software used, more profoundly, a lack of actual access to the necessary technology was another barrier to participation (Dos Santos Marques et al., 2021). Some potential participants used pay-*as*-you-go mobile phone top-ups and felt they could not afford to participate whilst others had no equipment altogether. For SICCIL, we were able to have participants come onto campus to undertake the study in a research room if they wished, and one participant took part in two of the groups in this manner.

As noted above, while the methods used in the two studies were almost identical, the length of focus groups was typically fifty per cent longer for SICCIL than FFUFL and the team's perceptions were that data were typically not just fuller but better quality. There are multiple likely explanations for this. It may have been related to increased confidence and skills in the SICCIL facilitators who had significantly more time to adjust to online research than in the FFUFL study. However, it seems equally likely that the nature of the participants and timely salience of the topics were also contributing factors. In 2020, breastfeeding maintenance and teeth-brushing regimes were likely perceived to be of less acute importance than the many challenges to family life and well-being that the ongoing pandemic and extended restrictions in Leicester represented. Parents of young children are also typically time-poor and were managing childcare with reduced support and therefore participation in the research was relatively functional. In contrast, the SICCIL participants all lived alone and enjoyed the social and well-being benefits of the discussion groups and generally had more time and investment in the research process itself.

Arguably, one additional benefit of the repeat engagement of most participants in the SICCIL study, especially in the service users arm of the study where three groups were convened in a matter of a few weeks by the same facilitators was that it allowed for the second and third groups to both extend the previous discussions and also act as a 'light-touch' form of 'member checking' where facilitators were able to reflect the research team's initial summarising and sense-making of the previous discussions, and present this material at the beginning of the next discussion group for verification (Thomas, 2017). This generally worked well, in a fairly organic manner with participants generally affirming the initial conclusions and interpretations being drawn by the team from the prior data, although it needs to be noted that views and experiences are arguably more likely to change when the focus of study is a dynamic event like a pandemic and its consequences evolved both locally and nationally. Ideally the team would have liked to have incorporated more systematic member checking procedures into the studies' protocols and are incorporating these more fully in our subsequent evaluation and research work whilst also considering some of the tensions and challenges that these processes can involve. For example member checking has been argued to simplify the nature of complex data rendering it overly descriptive and static and can be more challenging in a focus group context than in an individual interview. Please see Motulsky (2021), Birt et al. (2016) for thoughtful discussions on this issue.

4. Ethical challenges and adaptations

There were a range of changes we needed to make moving to a virtual context including being flexible on mechanisms around how we gained and evidenced consent, and how we aimed to support and protect participant well-being. As we learned more about working online, so our procedures became more robust and evolved. Although no-one during the FFUFL studies had logged off from the groups without warning or appeared distressed, we became more alert to this prospect as we ran the groups. Consequently, during SICCIL we established a parallel 'break-out room' where participants who were feeling upset, either about the research itself or struggling with their mental health more generally, could speak with a trained mental health advisor and be offered either immediate low-intensity support and/or be signposted to other services available. This worked very well and was used by two participants.

For gaining consent we used a variety of mechanisms. Consent forms were sent electronically where it was possible for participants to complete and sign electronically and in other instances we sent consent forms by post with a stamped addressed envelope. As a fail-safe we also asked all participants to read a short sentence which we posted in the chat function confirming that they had read the participant information sheet and actively gave consent. This was included in the recording of the session. Building this flexibility into our initial ethics applications was key in saving time with not having to make amendments subsequently.

The maintenance of confidentiality became more threatened in the online space, as it became harder to monitor the privacy of the physical locations in which people took part in the study. Although we asked participants in the groups to keep the identities of group-members and content of discussions private from their significant others, the fluidity of people moving around whilst participating, and the proximity of others, such as people helping with technology, increased the risk of data being shared beyond researchers and participants or of others who had not consented to be in the study becoming inadvertently captured in the session recordings. The increasing use of mobile 'phones and tablets for participation in on-line qualitative research makes this aspect quite challenging to manage.

Our approach to managing the ethical aspects of this study was to adopt an 'ethics of care' approach as outlined by writers such as Groot et al. (2022) and Reich (2021) as much as possible. This involves thinking about power, positionality and promoting the dignity and holistic well-being of participants, who are viewed as equal status partners in the research venture. Prioritising the moral responsibility to as Groot et al. label it 'tend and befriend' valued relationships was key to our methodology, especially in the SICCIL study where being socially isolated was an inclusion criteria. This did however raise challenges. As noted previously, many (indeed most) participants in both the older adult and mental health service user's streams attended multiple focus groups forming a warm but by necessity temporary peer-community network of support. In some cases, as noted above, this was a continuation of well-established relationships, but in others, new friendships began to develop. This therapeutic and peer-support element is indeed of potential benefit to participants, and it meant some participants in the SICCIL study took part enthusiastically in almost 4 h of focus group time– yielding deep, conversational data that broke away from the rather linear (one after another) approach to discussions that characterised many of the FFUFL groups. However, disengaging from these regular discussion groups proved challenging with some participants from both the older adult and mental health service user arms, expressing considerable dismay that the discussion groups were closing. However, most acknowledged that taking part in the study had increased their digital literacy and connection which was a valued by-product of the study. In addition, by summer 2021 some participants were beginning to suffer from what one participant called 'Zoom fatigue' and were looking forward to using online communication less.

We tried to extend our ethics of care approach in relation to our public health colleagues so we could monitor their well-being at a time where they were trying to develop and refine research skills whilst also being stretched in their standard day jobs responding to the pandemic challenges which as noted previously were more acute and longer-lasting in Leicester than other British cities. In addition to providing detailed preparatory training workshops for the studies, one of the main ways that we did this was by linking specific members of the university research team to sub-groups of the public health workers, setting up project sub-teams for council wards (FFUFL) and research arms (SICCIL) and providing peer support and buddying opportunities. Our training needs analyses conducted early in the process of both projects allowed all the council employees to disclose their confidence and expertise in the various aspects of the work allowing us to pair more and less experienced colleagues and facilitating informal mentoring and support. We also routinely evaluated both sets of training sessions so that feedback from earlier sessions was always incorporated into the later ones and as we moved through the projects from FFUFL to SICCIL so colleagues from the public health-team developed the skills and expertise to co-facilitate training to their colleagues, as mentioned above.

5. Final reflections and recommendations

The central aim of the partnership between DMU and LCC was to collect contextualised data on local city health priorities and inequalities, to feed into future policy and practice in the city, and to get staff, students, and especially council public health officers better acquainted and engaged with different parts of the city in multiple ways (culturally, socio-politically, spatially, and geographically). The plans were for all aspects of the project (training, data collection and dissemination) to be embedded in city communities and potentially inform council policy and practice. The pandemic and related restrictions therefore initially felt like an almost total negation of the entire enterprise – especially for a team of experienced qualitative researchers who had generally eschewed non-face-to-face methods of collecting data. However, we learned that with sufficient flexibility and motivation, good quality and relevant qualitative data can be collected online. This does require ensuring ample technical support and modifying and, in some cases, strengthening ethical procedures and materials around consent reporting and confidentiality maintenance. Managing the multiple threats to confidentiality in particular requires additional guidance to both participants and facilitators.

Ideologically all of the team are committed to research *with* communities rather than *on* communities. However, we arguably failed in our initial aim of the projects genuinely being enterprises of co-creation and co-production. Priorities were picked by councillors (albeit sometimes lobbied by, and/or in consultation with key community leaders) and we were not able to co-create the focus, methods and design of the studies with community members or experts by experience as we had wished. Going forward we intend that wherever possible two individuals from the communities of relevance will be incorporated into projects from conception through implementation to dissemination and evaluation (Vargas et al., 2022).

Adding time into every step of the research process (a challenge given the timeframe of most funded projects) is also important. In our experience, recruitment takes longer when people are socially more isolated and certainly it takes longer to set up online focus groups when they occur. Training and encouragement in using the technology is important and ideally flexibility in which platforms are used would be helpful – mirroring the platforms used by people for social interaction is likely to facilitate participation but may raise challenges with data security. Building rapport at the start of online groups (which can feel like they begin rather more abruptly than when meeting people at a venue), may need further consideration, although for many of us regular and increased interaction online has been one of the sequelae of the pandemic and arguably people are generally more familiar with building relationships via this medium.

Online focus groups allow a greater flexibility in how people participate in focus group discussion and may assist participation from those reluctant or unable to attend a community venue. That being said, digital poverty is one of the most significant threats to social inclusion and meaningful participation in modern life, and research projects need to include funds and support for individuals with poor digital literacy skills and/or poor, or inconsistent, access to technology to ensure exclusion is not reinforced and to bring the digitally poor into participatory public health research and evaluation projects. Research is showing how significant both digital literacy and accessibility were for building and maintain social capital, providing a sense of belonging and for sharing and making sense of news and information for members of groups and communities from diverse backgrounds during the pandemic (Milenkova & Lendzhova, 2021).

Regarding future proposals, there is need to consider both resources and strategies for outreach work-ideally taking technology and training into the community. Without this, significant numbers of voices will remain disenfranchised from the research process, exacerbating inequalities further. Utilising an ethics of care model more comprehensively and working with all stakeholders on the co-creation and evaluation of projects can go some way to addressing such concerns and in making sure that especially when investigating health and well-being in a time of crisis and uncertainty, qualitative research participation is a meaningful and beneficial activity for all parties.

Some Recommendations for Researchers Considering On-line Focus Groups

- Digital poverty and/or poor digital literacy may be barriers to participation so researchers should consider both training and accessibility needs to access representative samples.
- Participants with significant on-line skills and knowledge may be unfamiliar with platforms being used for research and require guidance. Providing materials ahead of the session and allowing

adequate time at or ahead of the official start of the session should minimise disruption and facilitate collection of quality data.

- Mechanisms for managing apparent participant distress during focus groups need thought. One idea is to host a parallel break out room for any participant wishing to take time away from the discussion and/or to be offered psychological support.
- Breaches of confidentiality can pose a particular challenge for on-line focus groups and participant information materials need to provide clear guidance and explanation on why avoiding these is important. If participants require the presence of others for appropriate reasons (e.g. support with disability) simple confidentiality agreements can be used.
- Allowing participants the opportunity to attend multiple groups can potentially increase data depth and facilitate equitable contributions as some participants may initially lack confidence and need time to trust the group setting as a safe environment for significant disclosure.

CRediT authorship contribution statement

Iain R. Williamson: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Resources, Supervision, Writing – original draft, Writing – review & editing. **Benjamin Lond:** Data curation, Investigation, Methodology, Writing – original draft, Writing – review & editing. **Andrew Clifton:** Conceptualization, Investigation, Methodology, Project administration, Writing – original draft. **Tania Hart:** Conceptualization, Data curation, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft. **Bertha Ochieng:** Conceptualization, Formal analysis, Funding acquisition, Project administration, Resources, Supervision, Writing – original draft.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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