

Notes from the Field: Conducting Research with Resettled Refugee Women

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Understanding the unique health and behavioral health needs of refugees is critical to developing culturally sensitive interventions and services for this vulnerable population. This paper highlights the process of recruiting participants for a study exploring these needs for resettled refugee women from their own perspectives and the perspectives of resettlement service providers. We recruited 14 resettled refugee women and seven service providers to participate in a semi-structured interview, which included open-ended questions and culturally-relevant vignettes designed to stimulate discussion about health and behavioral health issues. Participating women were receptive to the vignettes and were highly engaged in the study. With respect to methods, we found that it is feasible and practical to collect qualitative data using vignettes coupled with semi-structured interview questions. With respect to recruiting strategies, participants were more responsive to personal connections rather than to advertisements for recruitment. This paper reports the methodology; study results are reported separately.

Keywords: resettled refugee women, qualitative study method, feasibility, recruitment

Introduction

Refugees are persons who have fled their countries to escape war and persecution. Currently, at an estimated 26 million the number of refugees worldwide is at its highest ever recorded and almost a quarter of these individuals are from Syria ([United Nations High Commissioner for Refugees 2019a](#)). The large and growing number of refugees worldwide represents the most severe war-related humanitarian crises in the history and surpasses the displacement caused by World War II ([United Nations High Commissioner for Refugees 2019a](#)).

There is significant concern about how to address refugees' unique health and behavioural health needs, many of which arise from exposure to war and the trauma of displacement and are left undiagnosed and untreated because most of these individuals do not pursue or do not have access to health and/or behavioural health services (Efird and Bith-Melander 2018). Thus, conducting culturally sensitive research to explore and inform the development of psychosocial interventions to address the many health and behavioural health needs of resettled refugees warrants timely attention (United Nations High Commissioner for Refugees 2019a).

Conducting culturally sensitive research is particularly vital for the large and growing number of resettled refugee women from Syria, especially given the relatively new but complete dismantling of the infrastructure of Syria which has resulted in a mass exodus of Syrians whose urgent needs for food, housing, and medical attention take precedence over their behavioural health needs (Thiel de Bocanegra *et al.* 2018; Assi *et al.* 2019). Women comprise more than half of the 7 million Syrian refugees and approximately 77% of Syrian refugees are women and children (United Nations High Commissioner for Refugees 2019b).

Western countries host about 20% of the total number of refugees and the US has provided resettlement to more than 3 million refugees since 1975, when it formally began accepting refugees (United States Department of State 2019). Further, approximately 30,000 Syrian refugees are resettled in the US and North Carolina remains among the top 10 resettlement states (United States Committee for Refugees and Immigrants 2019). Given that most research about resettled refugee population is conducted in Western countries, it is important to employ culturally sensitive research methods that keep the refugee perspectives in the forefront and to avoid the inclination to apply Western models of research and interventions to these unique populations (Silove *et al.* 2017).

Often refugees' perspectives are not considered when developing solutions to address their problems (Gabriel *et al.* 2017) and there is a great need for existing knowledge to be combined with input from experts' perspectives and from refugee women themselves in order to gain a clear understanding of their health and behavioural health needs such that interventions can be developed accordingly (Kirmayer *et al.* 2011; Bartolomei *et al.* 2016). Understanding how to collect data for unique populations, such as Syrian refugee women, in order to develop a knowledge base becomes a critical first step. Hence, many investigators present descriptive reports of their experience in recruiting diverse populations for research studies or clinical trials (Orsmond and Cohn 2015).

Furthermore, a qualitative approach is often taken when exploring a new problem and although sample sizes are small, qualitative methods offer a holistic approach which complements the conventional methods of scientific inquiry and provides rich, in-depth perspectives of the respondents (Padgett 2004). For research with refugees, qualitative data provides valuable insights which are especially useful to countries that provide resettlement to refugees. In this context, more information is needed about culturally sensitive research methods and data collection strategies focused on gaining a deeper understanding of the health and

behavioural health needs of the large and growing number of resettled Syrian refugees.

To this end, this article highlights the process of recruiting resettled refugee women from Syria and their resettlement service providers for an exploratory study regarding their health and behavioural health needs and service use. We present challenges and successes from recruiting and collecting qualitative data from resettled refugee women and their service providers, as well as any ethical or methodological challenges encountered in the process.

Current Study

A study to examine the health and behavioural health needs of refugee women resettled in the US was approved by the IRB at the University of North Carolina at Chapel Hill. The study was undertaken as part of the PI's doctoral dissertation and sought perspectives of refugee women from Syria, who were resettled in the Southeastern US.

Informed consent was obtained from study participants and all interviews were voice recorded and lasted approximately 1 hour. The target was 20 women and 10 providers or until data saturation is reached. Based on attaining data saturation, we recruited 14 resettled refugee women and seven resettlement service providers to participate in a semi-structured interview, which included open-ended questions and eight culturally relevant vignettes which were developed specifically for the study. The vignettes related to behavioural health were based on the DSM-5 criteria and knowledge of the Syrian culture and refugee resettlement process. The vignettes were used to engage and help study participants feel more comfortable in having difficult conversations about health and behavioural health. That is, study participants were engaged first in a conversation about the health and behavioural health needs of resettled refugee women presented in a series of vignettes, rather than being asked direct questions about themselves. The rationale for this was that the participants may find it easier to talk about the circumstances in the vignettes rather than about their own situation. Moreover, using vignettes to conduct semi-structured interviews with ethnically diverse families has been used as an effective method to elicit insight on participant experience (Lapatin *et al.* 2012; Rizvi 2019; Aujla 2020). All eight vignettes were read by the PI to each participating refugee woman. The PI conducted member checking during the interviews to ensure accuracy of data. Once data analysis was complete, external assessment by experts with a breadth of knowledge in behavioural health and refugee populations further increased the credibility of the findings and data interpretation.

Data for the study were collected in the Summer of 2019 and analysed in Fall 2019. Data were analysed to address the study aims of understanding the health and behavioural health needs and service utilization of refugee women from Syria who are resettled in the US. The target sample size was 20 resettled refugee women and 10 resettlement service providers or until saturation is attained. At saturation, no new information is obtained, therefore, further data collection would be redundant and is no longer necessary (Mason 2018). Thus, for this study data

saturation was reached at 14 resettled refugee women and seven resettlement service providers.

Research Team

At the time of conducting this research, the PI was a PhD candidate at a university in the Southeastern US and also a clinical social worker with more than 8 years of formal experience working with resettled refugees. All interviews were conducted by the PI. Separate questionnaires for the providers and refugee women were developed under the direction of the research advisor and dissertation chair who has expertise about the mental health needs and service utilization for individuals living with severe mental illnesses. The questionnaires are provided in the Appendix. Other doctoral committee members included a faculty member who is also a physician for displaced populations in conflict zones; another faculty member with qualitative experience; and two other faculty members with experience in working with international populations including conducting research in developing countries. At the time of publication of this manuscript, the PI has been awarded a Ph.D.

Recruitment Capability

The PI determined that the projected sample size was reasonable, and the likelihood of successful recruitment was high. This decision was based on a review of existing studies on refugee health and behavioural health, the PI's long-standing work with local resettled refugees, and the PI's prior research study and professional relationships with resettlement agencies and their community partners. In addition, the PI consulted with qualitative researchers, experts on refugee health and behavioural health, and conducted extensive and systematic literature reviews, prior to developing the study protocol, which further confirmed the feasibility of the research plan.

Consent Process

To ensure true voluntary informed consent the PI ensured that each participant understood the implications of providing consent. The PI explained the purpose, methods, risks and benefits of study participation and addressed any questions presented by the participants. For all married women, the PI had to take an additional step of discussing the research with their husbands in accordance with Syrian culture. In doing so, the PI first screened the women for eligibility and consent, then discussed the research with their husbands, and upon approval from their husbands, again sought consent from the women. All men were supportive of their wives' participation. However, this additional step of once again seeking consent after their husbands' approval ensured the women were empowered to make the final decision.

Although time-consuming, this extra step approached the consent process with an effort to promote autonomy, establish trust and mutual respect, and was inclusive of the Syrian women's families and culture; an effort, which was valued by them. Furthermore, this collaborative process provided a culturally safe environment and thoughtfully addressed the clinical practice ethics, which involve responding to context-specific issues in the process of conducting research (Pittaway *et al.* 2010; Block *et al.* 2013; Hassan *et al.* 2016). At the end of the interview, some women also sought their husbands' opinion on selecting the gift card (e.g. Walmart vs. Target) offered by the PI as a token of appreciation for participation.

Methodological Challenges

Recruiting resettlement service providers was a relatively simple process, due to the PI's knowledge of local refugee resettlement agencies, professional networking, and excellent relations with community partners. Logistics (i.e. finding a convenient place to meet) and scheduling (i.e. finding the best time to meet) were the only problems encountered. However, recruitment of resettled refugee women from Syria turned out to be much more difficult than expected. First, the requirement for speaking (fair to moderate) English significantly reduced the number of resettled Syrian refugee women eligible to participate in the study. In the first round of screening, more than twenty of the women who were screened were found ineligible to participate due to low comprehension of the English language. One woman who spoke English relatively well, who agreed to participate could not be reached as she could not explain her address accurately due to her non-familiarity with the area in which she lived. Second, when screened in front of their families, specifically their husbands, most of the women were shy or reluctant to express interest in the study or acknowledge that they could speak and understand English. The screening process was adjusted accordingly and in a second attempt to reach resettled refugee women from Syria, female-only settings such as women's groups or women's appointments at the resettlement agencies were used. This approach proved to be effective and the PI was able to successfully recruit a convenience sample of participants for the study.

Additional challenges were encountered related to the recruitment of refugee women. For example, there was some difference in the view of the PI versus respondents regarding English proficiency and at least one woman's level of English was much lower than what she had reported during initial contact. There was also some confusion related to one of the demographic questions. Specifically, when asked about the place of birth in Syria (i.e. town vs village) and location (i.e. urban vs rural) some women reported their hometowns or birth locations to be urban but upon checking, the PI learned that some of the areas were classified as rural.

With two exceptions, the women who participated in the study were also unable to pick the correct age range for their age and instead reported their actual age. Yet, another issue was related to education system in Syria where grades 10–12 are

classified as upper secondary education, whereas in the US high school generally education means completion of 12th grade. For example, women who completed 11th grade did not want to report their highest education level as middle school, but rather preferred to report their highest level as high school stating that, 'its almost 12 grades'.

All resettlement agency providers chose to be interviewed at either at their place of employment or at a neutral location, but all resettled refugee women chose to be interviewed in their homes. Syrians are very family-oriented people and the interview was considered a family event by the participating women. The PI was greeted by the entire family and the transition after initial greeting to a more formal interview setting with the women required cultural understanding, competence and careful explanation of the research process such as why it was important to hear only the participant's perspectives and why the responses of the entire family could not be recorded. This was done tactfully while remaining respectful to the family's desire to be included which helped the PI maximize trust and collaboration with the participants and their families.

There were also some challenges in limiting noise from children and other household activities during the interviews. To address this issue, after the first two interviews, the PI switched to using a more sensitive voice recorder that cancelled external noise to better capture the respondents voice. Another challenge was role confusion wherein the resettled refugee women requested information pertaining to resettlement issues, such as information regarding childcare, section 8 housing (government subsidized housing) and extending Medicaid services, which were beyond the role of the PI. To address these issues, the PI referred the participating women to appropriate agencies.

Resulting Sample Characteristics

There was a variation in the professional roles of the service providers who participated in the study (e.g. case managers, care coordinators, employment specialists, policy makers, social workers, community support, and immigration service providers). All resettlement service providers were female, and the average number of years of experience among the providers was 9 years ($SD = 7.83$) with a range of 3–26 years.

Resettled refugee women were from both urban and rural areas of Syria and varied with respect to their education and employment. One woman was an information technology professional employed full time and two of the women were former teachers who were now employed in different lower paying jobs. All except three women were married (one divorced, one not married, one widow) and all but two had children. The average number of children in the household was 2.39 ($SD = 3.80$) and the number of children ranged from 0 to 9. The participating women also had a range of formal education from no formal education to a bachelor's degree. The most common level of education reported was 6th grade (five women). Not much variation was found in the length of stay in the US after resettlement and two of the women reported 2 years of stay in the US, whereas 12

women reported 3 years of stay. The average length of stay in the US was 2.85 years ($SD = 0.36$) and the length of stay ranged from 2 to 3 years.

Materials and Methods

All interviews were conducted in English using a semi-structured interview guide. Interviews were voice recorded with the option to opt out of voice recording. However, all participants consented for voice recording. Verbal consent rather than written consent was obtained, to preserve the anonymity of study participants and all study documents were numbered for each participant. No identifying information was retained that connected the data to the participant. This decision was made to make the confidentiality of participants a top priority, which is a prerequisite in ethical qualitative research (Surmiak 2018).

A few demographic questions were asked at the beginning of the interview to further confirm that the participants met study eligibility requirements. At the end of each interview, study participants were assessed to determine if they had any thoughts of harm to self or others. The PI who is also a clinician used clinical knowledge to inform that judgement in addition to three screening questions presented in a separate form to assess any risk or ideation for harm to self or others. This was an important clinical strategy because many Syrian refugee women may have experienced various forms of trauma (Georgiadou *et al.* 2018), and although none of the questions in the interview asked about personal trauma, any thoughts or distressing memories can act as a potential trigger (Schweitzer *et al.* 2018). Participating women were offered a \$20 gift certificate to a national retailer; but no compensation was offered to the service providers.

Fidelity in the interview process was ensured by using a fidelity checklist maintained by the PI. The checklist included going over: introduction, study facts, study flyer, obtaining verbal consent, voice recording, and upon completion, assessing for any thoughts of harm to self or others.

The PI transcribed all interviews with both the providers and resettled refugee women. This decision was based on the PI's ability to better understand the communication style of the refugee women and ability to efficiently add data from memo's and field notes as addendum to the transcripts. All interviews were transcribed verbatim and NVivo software (QSR NVivo 12) was used to analyse data. During transcription, if a service provider had used the name of another service provider or agency, a blank was used to maintain deidentification. Deidentified demographic information was used for reporting sample characteristics.

All transcripts were coded by three researchers to identify themes, with several rounds of coding, using a codebook developed by the PI after consultations with experts. Results from the analysis are reported in a separate research paper.

Resources and Ability to Manage

The PI conducted all the interviews. There were several reasons for this decision: (1) this study is part of a doctoral dissertation, (2) the PI is a clinical social worker

and has experience in conducting interviews with refugees and other diverse populations, (3) the PI was most suitable for conducting interviews with the participants based on her knowledge of the population, and (4) no funding was available to hire additional personnel.

As with most qualitative studies, the sample size was small ($n = 7$ for providers and $n = 14$ for resettled refugee women). However, the study design took several months of preparation to ensure a rigorous design and process. The PI and the research advisor submitted the Institutional Review Board (IRB) application in Spring 2019. The application took one month to develop and another two months for review. Approval was granted in Summer 2019, and the PI started the recruitment process immediately. The PI discussed the study with three local resettlement agencies who agreed to help with the recruitment. This process was expedited due to the PI's established professional relationship with these resettlement agencies. The process of data collection took one month to complete. An additional month was spent transcribing and coding the data, and finally, it took 2 months to analyse the data. Hence, the entire process of data collection, transcription, coding and analysis took 4 months. Several additional rounds of coding were conducted after the initial data analysis to capture the rich details provided in the transcripts.

Preliminary Evaluation of Participant Responses

Qualitative data included voice recorded interviews, memos, and field notes. Some demographic questions were also asked to further enrich the data. The PI evaluated all participant responses to develop a codebook, which was refined with expert consultations, a subsequent round of coding and triangulation with two other researchers. The three coders communicated regularly to develop codes and identify themes. All responses were included in the sample and the final themes along with notes and demographics were united to fully capture the participants' perceptions. Selected quotes were used in the manuscript to give a voice to the participants while contributing to the credibility of the research (Anderson 2010).

Disclosure of Respondent Experiences

The focus of this article is the feasibility of conducting research with resettled refugee women, hence, disclosure of respondent's responses, for both resettled refugee women and their resettlement service providers, is not included in this article. Responses from both groups of participants provided rich data which begin to expand our understanding of the health and behavioural health needs of resettled refugee women and inform the strategies to address these problems. The findings from the study are reported in a separate research paper.

Results

Participants were highly engaged in the study and all participants completed the entire interview. Participants answered all questions, and none asked to skip

questions. Participating women were receptive to the vignettes and were eager to talk. Even when describing difficult experiences none of the participants requested to stop or take a break from the interview. Participating service providers shared their insights with enthusiasm and provided valuable recommendations.

Limitations

There are several limitations to this study. First, only English-speaking women were recruited, and their perceptions may not apply to non-English speaking women from Syria. Second, the sample only comprised of refugee women resettled in three towns in the Southeast US, and views of women resettled in other parts of the country may differ. Finally, all providers were female, and perceptions of male providers may differ from those expressed by the female providers.

Discussion

A small body of literature is available on the feasibility of conducting research with resettled refugees of which only three studies directly address the challenges in conducting research with resettled refugee women (Mackenzie *et al.* 2007; Baird *et al.* 2017; Gabriel *et al.* 2017). These studies have acknowledged the difficulty in conducting research with ethnic minorities who speak different languages. Mackenzie *et al.* (2007) emphasize the importance of obtaining true informed consent, whereas Baird *et al.* (2017) recommend the need for continual adjustments to research procedures to accommodate cultural preferences of the ethnic populations, such as punctuality, shyness, or health literacy. Using a different approach, Gabriel *et al.* (2017) inquired directly from the refugees about their willingness and challenges regarding engaging in research studies and report that refugees are willing to participate in research but building trust and rapport is important such that participants feel safe and comfortable. A few other studies that describe challenges of conducting research with refugees in conflict settings are also useful (Jaff and Margolis, 2017; Silove *et al.* 2017; Charlson *et al.* 2019), but recommendations may not be fully applicable in the context of resettlement (Habib 2019).

Based on the dialogue with those interviewed, both the resettled refugee women and their resettlement service providers found the interview questions to be engaging. In addition, the type of questions used (vignettes) were acceptable to the refugee women, as evidenced by their engagement, comments, and willingness to share their own stories. Women reported that the vignettes helped them talk about sensitive issues without making the questions seem too threatening or personal. Research on the use of vignettes with refugees as a qualitative study method is limited; nevertheless, our experience in conducting our study suggests this approach offers promise as a culturally appropriate way to explore and understand their health and behavioural health needs.

Challenges around recruitment of resettled refugee women from Syria led to important lessons learned about the limitations imposed when only English-

speaking participants are sought from a pool of newly arrived refugees who speak a different language. Although attainable, the success of such recruitment depends to a great degree on ties with local refugee resettlement agencies, and the knowledge and cultural competence of the persons responsible for the study sample recruitment.

In addition, it is feasible and practical to collect qualitative data using semi-structured interviews with resettled refugee women from Syria and their resettlement service providers. However, resettled refugee women from Syria were found to be more responsive to personal connections rather than to research study advertisements for recruitment. In addition, offering study information to Syrian women in a women's-only setting allowed more women to be able to ask questions and agree to participate. The women also preferred to be interviewed at their homes after discussing their participation with their husbands. Logistics of scheduling was the biggest challenge encountered in the recruitment of providers.

In order to give a voice and representation to refugees, it is important to conduct research with these vulnerable populations, and success in recruiting study participants is critical. This article adds to the knowledge base by outlining a research protocol of a recently completed study in detail, identifying challenges and making recommendations for future research with resettled refugee women. This recommended process of data collection and the outlined approach is likely to help researchers conducting similar studies with resettled refugee women.

In addition, researchers and practitioners who serve resettled refugee women in service or clinical settings, may benefit from the use of culturally sensitive and relevant approaches as they build trust and rapport with their clients. Likewise, future research using culturally relevant approaches such as vignettes may generate evidence that can help inform policy level decisions in countries of resettlement.

Conclusion

Gaining an understanding of the perception of health and behavioural health needs of resettled refugee women provides an important starting point for addressing these needs. Accordingly, persons conducting research with refugee groups should be culturally aware, competent and sensitive to successfully manage participants' expectations regarding the research. For researchers without such knowledge, adequate training must be provided prior to engaging in data collection with these groups.

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Conflicts of Interest

The author certifies responsibility for the manuscript and reports no known conflict of interest for this study.

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Appendix 1: Culturally Relevant Vignettes used for the Research Study

Definitions: (for the Reader)

Behavioural health: mental health, emotional health, alcohol use, drug use, tobacco use, unhealthy lifestyle, etc. such as those that pertain to the overall well-being.

Vignettes

Depression

Fatima is a 30-year-old, married women with four young children. She and her family recently arrived from Damascus. Fatima feels sad most of the time and cries a lot. She feels like she is useless as she cannot work outside the house to earn money due to household duties and taking care of small children. Sometimes she starts to feel better but starts feeling bad again soon. Recently, she has started being quiet even when her husband tries to talk to her. When her children are loud or fighting, she just ignores them. She doesn't feel like eating much and feels tired most of the time.

Questions:

1. What do you think is going on with Fatima?
2. What do you think Fatima should do?
3. Do you ever feel this way?

Anxiety

Zaitoon is a 33-year-old, married and has three children who are 2, 4, and 5 years old. Her family arrived from Baghdad 2 years ago. She is a shy person, but recently, she has started feeling nervous all the time. When her husband leaves for work, she gets worried that he will not come back. She is afraid to enroll her 5-year-old son in school. If she has to go somewhere in a bus, she feels like she will take the wrong bus and get lost but is afraid to ask the bus driver if she is on the right bus. When she goes to a store, she thinks that people are looking at her and laughing at her. She is also afraid to make friends with other women in her neighbourhood because she is not sure if they will like her.

Questions:

1. What do you think is going on with Zaitoon?
2. What do you think Zaitoon should do?
3. Do you ever feel this way?

PTSD

Sana is unmarried, 20 years old and just arrived in the US from Baghdad where she lived with her parents and six siblings. Her family escaped from their house moments before it was bombed. No one in the house next door survived. She can still hear the loud sound of the blast and sometime wakes up from her sleep thinking it will happen again. The sound of fire trucks and police car sirens make her jump. Certain types of smells make her think she is back in her house when it was bombed.

1. What do you think is going on with Sana?
2. What do you think Sana should do?
3. Do you ever feel this way?

Prescription Drug Misuse or Overuse

Zainab is 25 years old, and lives with her mother, Karima. They used to live in Aleppo but had to leave and live in a camp in Turkey. Now they are resettled in the US. Zainab's mom has a lot of sad feelings and bad thoughts in her mind, for which the doctor gave her some medicine. When Karima takes the medicine, she feels better. When she does not feel better, sometimes she takes more medicine. Sometimes Zainab feels sad and has bad thoughts in her mind. Sometimes she takes Karima's medicine and feels better and can also sleep better.

1. What do you think is going on with Karima?
2. What do you think Karima should do?
3. What do you think is going on with Zainab?
4. What do you think Zainab should do?
5. Do you ever feel this way?

Tobacco Use (Addiction)

Hania is a 40-year-old widow, with one daughter who is 16. She is a newly arrived refugee and has some government assistance. Her case worker told her that she has to find a job in 3 months, or she will lose her apartment. She speaks little English but goes to English class 2 days a week. Her daughter goes to school and works at Bojangles on the weekends, but the money is not enough to support both of them. Hania used to smoke hookah in gatherings and sometimes smoked cigarettes before coming to the US but now she is smoking every day. Even though she has little money for food, she buys one pack at a time and finishes it in 2 days. She also bought a cheap hookah from a store and is using it daily.

When she is smoking, she can forget about her worries for a little bit. She wants to find even stronger cigarettes.

1. What do you think is going on with Hania?
2. What do you think Hania should do?
3. Do you ever feel this way?

Overall Health

Shams is 50 years old. She had a large family in Syria. In the war, her family was separated from her and now she is in the US by herself. She has always had good health, but after she lost her family, she started feeling weak and tired all the time. The doctor in the camp checked her and said everything was okay but Shams was still not feeling good. After she came to the US, doctors found out that she had some heart problems. Shams was right, something was not right with her body.

1. What do you think is going on with Shams?
2. What do you think Shams should do?
3. Do you ever feel this way?

Dental Health

Khawla and her family arrived from Syria. The case manager told them they had to see the dentist to check their teeth. Khawla and her family have never been to the dentist. They think they have good teeth and don't need to go. During the appointment, the dentist checked their teeth and cleaned them with a machine. Now Khawla feels like her teeth are hurting and they may fall out.

1. What do you think is going on with Khawla?
2. What do you think Khawla should do?
3. Do you ever feel this way?

Domestic Violence

Halima lives in a small two-bedroom apartment with her husband Bashir and their three children. Bashir works in a restaurant. Halima takes care of their children. Two of her children are in school but the youngest is only 3 years old so she stays with her. Halima works hard at home. Bashir works long days, and sometimes works a double shift. When he comes home, he is usually very tired. Sometimes when the kids are making too much noise, he gets angry and yells at Halima. One day, he threw the

dishes because the food was not warm. Another day her pushed Halima and she fell on the floor.

1. What do you think is going on with Halima?
2. What do you think Halima should do?
3. Do you ever feel this way?

Additional Questions

1. How easy is it to talk about your health and behavioural health?
(Prompts: What makes it easy? What makes it difficult?)
2. What are some of the barriers to accessing care for your health and behavioural health needs?
(Prompts: Religious, cultural, structural, educational, language, transport, childcare etc.?)
3. Have you ever sought treatment for any behavioural health needs?
(Prompts: When was that? What kind of help did you seek?)
4. What do you think of this interview process?
5. Do you want to add anything else to your answers?

Appendix 2: Resettlement Service Provider Questionnaire

Open-Ended Questions

With reference to resettled Syrian refugee women:

1. How well do the refugee women understand their current health needs?
(Prompts: Do they have prior knowledge, health literacy, etc.)
2. How well are the refugee women able to describe their health needs?
(Prompts: Are there any barriers such as language and cultural barriers etc.)
3. How open are the refugee women to medication to address their health needs?
(Prompts: Do they remember, do they understand it's important, is cost a factor, do they feel any shame taking the medicine)
4. How well do the refugee women understand their current behavioural health needs?
(Prompts: Is there a concept of behavioural health, behavioural health literacy etc.)
5. How well are the refugee women able to describe their behavioural health needs?
(Prompts: Are there any barriers such as language and cultural barriers etc.)
6. How open are the refugee women to medication to address their mental health needs?
(Prompts: Do they remember, do they understand it's important, is cost a factor, do they feel any shame taking the medicine)
7. How open are the refugee women to therapy such as counselling and support groups?
(Prompts: Timings, location, importance)

8. In your experience what are some of the psychological barriers that deter refugees from expressing their health and behavioural health needs? (Prompts: moods, personality, mental health, exposure to past trauma—specifics)
9. In your experience, what are some of the cultural barriers that deter refugees from expressing their health and behavioural health needs? (Prompts: Interpreter's gender, provider's gender, religion factors, cultural norms, parenting duties, duties to family)
10. In your experience, what are some of the structural barriers that deter refugees from expressing their health and behavioural health needs? (Prompts: Health and mental health literacy, lack of familiarity with navigating various systems, transportation, childcare, distance, timing, location)
11. In your experience, what services would be most beneficial to address these refugee health issues?
12. In your experience, what services would be most beneficial to address these refugee behavioural health issues?
13. Would you like to add anything else to add to this information?