

Recruiting UK-born ethnic minority women for qualitative health research – lessons learned from a study of maternity care

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Abstract

Recruitment of participants for health research is a vital part of the research process. If not done well it can lead to research bias and/or limit the generalisability of the findings of a study. Many investigators report difficulties in recruiting ethnic minority participants, in particular women. Previous articles have tended to explore strategies used to recruit people from migrant populations to quantitative studies, especially clinical trials. Drawing on a qualitative study about maternity care experiences of UK-born ethnic minority women in England, this paper describes and compares the efficacy of six recruitment strategies used for women from Black African, Black Caribbean, Irish, Pakistani, and Indian backgrounds. We explore women's motivations and experiences in taking part in the study through retrospective interviews with participants and with health professionals who recruited participants through maternity clinics. The findings indicate that women's motivations to participate in research are similar to those found in previous studies with minority and non-minority groups. Traditional routes of recruitment for ethnic minorities, such as through community groups, were less effective indicating that UK-born migrants require more diverse methods. Recruitment through health professionals requires an effort to 'recruit the recruiter' and a more collaborative relationship is recommended.

Keywords: Participant recruitment, ethnic minority research, research methods, second generation ethnic minority

Introduction

Under-representation of ethnic minorities in empirical studies is well documented (Foster, 1998; Sheldon *et al.*, 2007). There is a critical need to understand why this occurs and how it can be remedied. Empirical studies provide an important mechanism for understanding social inequalities in health. Inadequate recruitment can result in a biased or unrepresentative sample, leading to a study with little generalisability or robustness (Brown *et al.*, 2000). Furthermore, difficulties in the recruitment of 'hard to

reach' participants leads to greater expenditure of finite research resources (McCormick *et al.*, 1999). A fuller explanation of recruitment strategies will contribute to our understanding of how they affect sample composition and the interpretation of the study, along with more practical issues of efficiency (Arcury & Quandt, 1999; Barbour, 2001).

The majority of previous studies on recruitment of ethnic minorities have focused on problems experienced in randomised trials (e.g. Roberson, 1994; Mohanna & Tunna, 1999; Ross *et al.*, 1999;

Madsen *et al.*, 2002; Oakley *et al.*, 2003). Many of these studies come from the US and describe specific issues related to clinical trials, such as fear of medical intervention, mistrust of randomisation, statistical power and heterogeneity (Hussain-Gambles *et al.*, 2004). Few studies have addressed methods of non-probability sampling used in qualitative research, such as purposive or theoretical sampling designed for the deliberate selection of persons of interest to the research question (Patrick *et al.*, 1998; Barbour, 2001).

Common issues in recruitment to quantitative and qualitative studies include the underestimation of the time and resources that are needed (Connett *et al.*, 1993), overestimating the pool of potential participants (Hunninghake *et al.*, 1987), and respondents' reasons for participating (Cassileth *et al.*, 1982 Paskett *et al.*, 1996). In the literature relating to the motivation of ethnic minority respondents to participate in research, some themes re-occur including: altruism, wanting to contribute to scientific research (Cassileth *et al.*, 1982 Paskett *et al.*, 1996; Elam *et al.*, 2001; Graham, *et al.*, 2006) and 'liking the recruiter' (Ross *et al.*, 1999).

Research on the recruitment of ethnic minorities has tended to concentrate on migrants, as has published research on maternity care. The numbers of people from ethnic minorities who were born in the UK are growing, leading to an increasing focus on the transmission of health risk across generations (Harding & Balarjan, 2001; Harding *et al.*, 2004; Bhui *et al.*, 2005). Women from some ethnic minority groups are likely to have poorer maternity outcomes and face barriers in accessing health and social care (Ibison *et al.*, 1996; Collingwood Bakes, 2006; Lewis, 2007). Very little is known, however, about the maternity care experiences and perspectives of UK-born women from ethnic minorities.

In this article, we describe the advantages and disadvantages of recruitment strategies used in a study of the maternity care needs of second generation ethnic minority women. In particular, we examine the process of recruiting participants through health care professionals and use retrospective interviews to explore the views of these health care professionals who helped with recruitment. The UK's National Health Service has made recruitment to health-related research increasingly reliant on health care professionals who approach their clients in the course of their clinical work (McAllister, 2005; Peel *et al.*, 2006). Little previous research has examined this recruitment process undertaken by third parties whose primary reason for contact with potential participants is for the completely different purpose of delivering clinical care. We also report the reasons given by respondents for consenting to take part and their experiences of participating. Second generation women were defined as those born in the UK, with both parents born abroad in the same country or region.

Methods

The UK Born Project was an explorative qualitative study using in-depth, face-to-face interviews with 34 second generation ethnic minority women who had given birth in the previous twelve months and 30 health care providers (see Puthussery *et al.*, 2008 for more on research with the health care providers). Approval for the study was gained from the South East Thames Multicentre Research Ethics Committee and local Trust Research and Development offices.

The original design included focus groups and individual interviews. The aim was to recruit 120 UK-born, ethnic minority, first-time parents (60 men and 60 women) and 25 health care professionals over a period of twelve months. Numerically large ethnic groups with a longstanding history of migration into the UK were targeted, that is:

Irish, Black African, Black Caribbean, Indian, Pakistani and Bangladeshi. Initially, recruitment was carried out only through antenatal clinics in NHS maternity units by health care personnel. Approaches were made to community/religious groups, media, toddler groups and via personal contacts (including 'snowballing') in order to boost recruitment rates, and the sample criteria were extended to include multiparous women (i.e. those who had given birth more than once). Attempts were made to recruit male partners through the women participants but little interest (from partners) meant that they were ultimately dropped from the study design. The methods were amended to replace the focus groups with larger numbers of individual interviews when difficulties with recruitment became apparent.

Researchers kept a log of recruitment progress, including method and date of recruitment for each participant and time and activities undertaken within each recruitment strategy. Time spent on recruitment from each method is reported as a percentage of total time spent on recruitment (Table 3). Seven months after the main interviews took place, ten participants - three Indian, two Irish, two Black Caribbean, one Black African, one Pakistani and one Bangladeshi - were contacted for a further interview by telephone. Eight of these had been recruited through maternity services since we were particularly interested in their experiences with the third party recruiters. One was recruited through a toddler group and one through snowballing. Respondents were chosen to reflect the spread of respondents and the dominant characteristics of the 34 women, thus the majority were multiparous, had a degree or professional qualification and were between 30 and 39 years of age. Interviews lasted between 15 and 20 minutes and explored how respondents heard about the study, motivations for taking part, experience of the interview and their views on why partners did not want to

participate. Five midwives who were involved as recruiters were also re-contacted for a telephone interview on their experiences of taking part in the study. Interviews were recorded and transcribed.

The interviews were analysed using methods from the grounded theory approach (Glaser & Strauss, 1967). The first stage of analysis involved immersion in the data through reading and re-reading of the interview transcripts. After this, codes were attached to sections of the interviews, reflecting their meaning or key message. Constant comparison of data emerging (Glaser & Strauss, 1967) was conducted throughout the process to compare codes and categories with one another and further data were elicited in the ongoing interviews.

The research was undertaken through a subcontract from Maternity Alliance (MA), a national voluntary organisation which initiated the study. When MA went into insolvency, overall responsibility for the project was transferred to Women's Health and Family Services (WHFS), a voluntary organisation based in Tower Hamlets in East London, but with a London wide remit.

Results

Evaluation of mode of recruitment

i. Maternity Services

Recruiting women through hospital-based antenatal and, later, postnatal clinics with the help of midwives was the primary recruitment strategy. Nine hospital maternity units within areas of high ethnic minority population density were selected using data from the England and Wales 1991 Census (National Institute for Ethnic Studies in Health and Social Policy, 1997). Maternity units had different Research Governance requirements resulting in significant delays in starting the process of recruitment in some units. All midwives in the maternity units were briefed about the study and the sample required. They were

asked to give potential participants an information leaflet and a questionnaire to assess eligibility. Responses were returned in a prepaid envelope addressed to the research team. On receipt of the questionnaire, researchers contacted the eligible women to arrange an interview. Interviews were undertaken at a minimum of twelve weeks after delivery to avoid the 'halo effect' which is thought to produce a positive bias in respondents' accounts of their birth experience (Lumley, 1985).

This method of recruitment was used for the entire twelve month recruitment period and, for the first seven months, it was the only method used. It yielded the largest number of women (Table 1), the most diverse in terms of educational and occupational backgrounds (Table 2) and relative to other methods took about a third of researchers' time (Table 3). Time was primarily spent on 'chasing up' midwives to monitor and encourage recruitment. Recruitment via maternity units was less successful for Pakistani and Irish women. Poor recruitment of Irish women appeared to be linked to difficulties in identification of 'white' women as part of an ethnic minority group (Hickman *et al.*, 2001; Puthussery *et al.*, 2008). Some Irish women also self-identified as White English.

Some women were recruited by the midwives but did not ultimately take part in an interview (Table 1). Five Pakistani women left incomplete forms or did not respond to contacts made by the researchers. One Black African woman also left incomplete details. The Black Caribbean and Indian women were not interviewed as 'saturation' point had been reached in the data collection from these particular groups. That is, no new data were emerging (Strauss & Corbin, 1990). When it became apparent that we were not recruiting enough women via maternity units, the project steering group decided to try other approaches.

Recruiters' feedback

Midwives involved in recruiting identified time as a major barrier. To offset this, they reported choosing particular studies for which they would recruit based on the perceived importance of the study. The following statement captures these views of the midwives:

They [midwives] must really be convinced of the importance of the study, unless the study is sexy, I mean, appealing, then they're just not going to think it's important. (White British, over 15 years experience)

Not being convinced of the importance of a study also contributed to discomfort in asking a woman to take part. Efforts were made to ensure a good understanding of the importance of the study amongst the recruiters, mainly through presentations at group meetings and some one to one discussions, the latter being more difficult to arrange. The researchers felt that close rapport between the recruiting midwives and the researchers, through increased individual contact, was most effective in ensuring a clear understanding of the study and motivation to recruit. This kind of relationship was established in only a few of the recruiting hospitals, as contacts were hampered by time constraints on the part of researchers and midwives and by some changes in the research staff.

Some midwives felt that a financial incentive for the health care providers after each respondent was recruited would also encourage recruitment:

I think sometimes studies offer rewards to the health professionals when they're recruiting, usually, I mean, I'm sure that would help... (White Irish, 5-10 years experience)

The evidence for using financial incentives is not strong (Ross *et al.*, 1999; Bryant & Powell, 2005) and some suggest it may act

as a *disincentive* to recruit by going against health professionals' personal ethical values (Lavender, 2000; Rubin *et al.*, 2002).

ii. Community/religious groups

In the early phase of the study, members of community organisations acted as advisors in the study protocol. We revisited these organisations when recruitment difficulties became apparent. We also contacted more groups which were linked with the Irish, African, Pakistani and Bangladeshi communities, with whom we were having the most difficulty in recruiting. Groups were identified through a wide sweep of internet searching and referrals from organisations through a snowballing technique. The community organisations involved included: advocacy and advice organisations; community and cultural groups or centres; and religious groups, mosques, churches and temples. Groups were, on the whole, enthusiastic to help but only one participant was successfully recruited (Table 1). This was primarily because the majority of their members were first rather than second generation or targeted men and women of non-reproductive age. Some women sent in response forms but did not participate in the study (Table 1). This was due to incorrect or incomplete contact details being given by Pakistani and Bangladeshi respondents. Community members and health care professionals suggested that these women tended to move house after the birth of their child, usually to stay with their extended family.

This method was time consuming as it required constant contact to ensure ongoing recruitment by the organisations (Table 3).

iii. Media

Press releases were sent by the Maternity Alliance (MA) to over 100 local, national, and community newspapers. A posting was also made on the 'Black History Month' website with an online form for participation. Although local radio

advertising was considered, it was found to be too expensive for the limited output. The effectiveness of using the media was compromised by the fact that MA unexpectedly ceased trading just after the press releases were sent out with its contact details, and its phone lines were then cut off. A corrected press release with revised contact details for the research office was sent out later but this was printed in only two newspapers.

Although six women contacted us through our media efforts, only one woman completed an interview (Table 1). Three were ineligible and two later decided they were too busy. While numbers recruited were low, the demise of MA compromised our ability to assess response rates accurately. Because MA had an extensive pre-existing email list of media contacts, the time spent on sending out press releases was minimal (Table 3).

iv. 'Snowballing' and personal contacts

Snowballing involves participants recommending other eligible women for the study and is generally referred to as a 'convenience style' sampling method. This method yielded five interviews and no refusals. Homogeneity is a recognised bias associated with this method and Table 2 shows that these women were broadly similar in age, parity and education. Exclusive use is also likely to exclude the recruitment of socially isolated individuals (Kalton & Anderson, 1989; Arcury & Quandt, 1999). Our overall diversity of recruitment strategies avoided these potential biases. This method is very time efficient and resulted in the highest yield of participants relative to the proportion of researchers' time expended (Table 3). It was an effective method of recruiting Irish women.

v. Toddler groups

Eleven toddler play groups run by local volunteers or parents located near to the 'target' NHS hospitals were contacted by

telephone. These toddler groups were independent of the community groups mentioned, though one toddler group was specifically for Muslim women. Three groups reported ineligible members and one refused access but offered to advertise the study to the playgroup. Researchers gave presentations about the study to the remaining seven toddler groups and invited eligible women to participate. Despite assessing group eligibility beforehand with the group leaders, most group members were White English or did not have a baby born within the previous year so only three women were recruited through this method (Table 1). Because women attended at different times and days, two to three presentations were made on average to each group. This increased the time spent on this method (Table 3).

Women's feedback

From the interview data with the women we identified three main motivations for taking part in this study: interest in research, altruism and boredom. These did not differ between ethnic groups though 'interest in research' was associated with higher education or previous experience in research through work:

Well, I've been to university myself so you know, I'm interested in research, research methods was one of my topics and I thought well why not? (Indian, 30-39, degree, primiparous – having given birth once)

I do research as part of my work, for a government agency and so... I know it's important to do research, to take part... yeah, it's necessary. (Indian, 20-29, degree, primiparous)

Other women with less interest or experience in research mentioned a desire to help other women through their participation in the study. For example, a Black African woman said "I wanted to help

other women ... help the services I suppose, make sure they got my feedback" (30-39, degree, primiparous). Motivation to help others was regardless of a good or bad experience with a general belief in the benefit of research emerging from the data:

I was quite happy [to participate] I had a good experience and I wanted to share that, I mean if it's going to help others and encourage other people then it's a good idea. (Black Caribbean, 30-39, degree, primiparous)

I just did it because ... the whole experience was so dreadful I wanted to make it known that actually the NHS ... between my first and second child there was such deterioration in the level of service. (Pakistani, 20-29, degree, multiparous)

Two women appeared to be ambivalent about research *per se* but described enjoying the opportunity to talk about their experiences. These women had both been recruited postnatally. One woman said: "I wanted to talk about my experiences ... I had the time, I was happy to talk about it" (Black Caribbean, 30-39, A-level, multiparous). In fact all the women interviewed felt it was a good experience to talk about their recent birthing experiences. For example, one woman said:

It was good to have someone to talk to about all these things, especially about problems with my mother in law, I thought it was good to have someone come to the house to discuss these things. (Pakistani, 20-29, degree, multiparous)

Previous research has shown that respondents can view the interview as a 'therapeutic' opportunity to discuss recent changes in their life (Brannen, 1993; Birch & Miller, 2000). This may have encouraged some of the women to participate. A factor that may have favourably biased the responses on participation was that these

follow-up interviews were conducted by one of the original researchers.

Women felt that the poor response from partners was a result of men not seeing themselves as part of the maternity experience. For example, one woman said “he has other interests, more gentleman type interests ... he wasn’t even in the labour room” (Indian, 30-39, degree, primiparous). Another woman felt that men were less willing than women to share their experiences, she said:

I think they probably think it’s a personal thing for them, ’cause men think quite differently from women, don’t they? So men would see it differently, men are quite private when it comes to things like that. (Black Caribbean, 30-39, A-level, multiparous)

Women also felt that men were busy at work and would find it difficult to find the time, unlike the women, the majority of whom were on maternity leave or working part-time.

Discussion

This article is based on an analysis of recruitment procedures utilised in a qualitative study on maternity care experiences. The study was not designed to compare recruitment strategies but, nonetheless, we feel that some valuable insight can be gained from our experiences. Maternity services yielded the highest number of participants but there were significant challenges to recruitment. In particular, lack of time to recruit was a major barrier cited by the health professionals who are often juggling multiple recruitment tasks along with their clinical work (see also Ross *et al.*, 1999). Placing this further burden on health professionals may have ethical implications and researchers need to ensure that the burden of recruitment is as light as possible with recruitment procedures and paperwork

kept to a minimum. With this in mind, success with recruitment often depended on health professionals’ appreciation of the study and their relationship with the researchers.

Another caveat of working with health professionals was that it was not possible to shape the interaction between the recruiter and the client/patient. We know that potential participants can be motivated to participate by their confidence and affection for the recruiting clinician (Ross *et al.*, 1999) and the ethnic background of the recruiter (Elam *et al.*, 1999; Elam & Fenton, 2003; McLean & Campbell, 2003). Neither of these is possible to control through an intermediary. Furthermore, there is a possibility that health care professionals introduce bias into the sample selection by selectively inviting clients. Because of concerns from the ethics committee, it was not possible for the researchers to attempt to recruit women directly on site. Nonetheless, health care professionals can contribute through their expertise and knowledge of clients or patients and shared ownership of the study could create a ready route for dissemination. A more collaborative model of research with health professionals is worth exploring. Funding the time a midwife spends on recruitment may also help and the research team is currently experimenting with this on a different project at one of the sites used in this study.

A study of recruitment of older ethnic minority adults into research concluded that success in recruitment with ethnic minorities depends on establishing a “close and collaborative liaison with the target community” as well as taking into consideration the cultural and social issues which may deter research participation (Araan & Gallagher-Thompson, 1996). This raises the questions of how to establish these links and exactly with whom? Who can we say ‘represents’ the community? Despite our extensive effort in establishing links with community organisations, there

was little gained in terms of recruitment, as organisation members tended to be foreign-born rather than UK-born. Approaching groups not specifically associated with ethnic minorities such as an advice bureau, training and information centres or local shops might be more effective for reaching UK-born ethnic minority groups as they may be less likely to be affiliated with 'ethnic minority' community groups (see also Elam *et al.*, 2001).

The achieved sample was relatively diverse in terms of education, occupation, parity and age groups (Table 2) but numbers of women recruited from Bangladeshi, Pakistani, Irish and Black African backgrounds were low (Table 1). As discussed above, Bangladeshi and Pakistani women appeared to change contact details and the Irish women may not have been identified by the recruiters as members of an ethnic minority group. There are fewer women of Bangladeshi and Black African origin living in the UK. At the time of the 2001 Census, there was a smaller proportion of Black African women born in the UK compared to other ethnic groups (Office for National Statistics, 2004) but this does not explain the disparity experienced by the research team. Previous research suggests that a lack of faith in the value of research and a perception by Black Africans that they had been over-researched may be factors inhibiting participation from this group (Elam *et al.*, 2001).

The team also had difficulties in recruiting partners to the study. A study on the amniocentesis decisions of Latino couples in the US had similar difficulties in recruiting partners when using the woman as a 'broker' to their participation (Preloran *et al.*, 2001). Where the researchers attempted to recruit partners independently or with the women, they were most successful. Reasons for this were unclear, though it appeared that men and women's motivations for taking part were not the same and needed a different approach from the recruiters (Preloran *et al.*, 2001). In this

situation, 'direct' recruitment by the researchers might have been more successful and would have allowed for more innovation in recruitment strategies. On the whole, though, our respondents' reasons for participation are similar to those found in other studies with minority and non-minority groups (Cassileth *et al.*, 1982; Paskett *et al.*, 1996; Elam *et al.*, 2001).

The main difficulty in recruiting resulted from difficulty in accessing second generation minority women. Other researchers have found some association between indicators of social isolation/involvement and survey participation (Groves & Couper, 1998; Loosveldt & Carton, 2002; Loosveldt & Storms, 2004). While there is little evidence that second generation ethnic minorities are more socially isolated, it does point to a need to increase access to and knowledge of health research more broadly. Strong interest in the research outcomes strengthens the case for increased follow-up with research participants to encourage future participation.

Conclusion

As the overall numbers of women recruited were small, particularly when subdivided into individual ethnic groups and/or recruitment method, we are cautious about extrapolating conclusions from this study. There were several important lessons to be learned, however, in particular from our experiences of working with health professionals. We suggest that a more collaborative approach with health professionals should encourage an understanding of the benefits of the study and the importance of recruiting their patients. If funding allows, it may be preferable to employ health professionals to recruit on site. Careful planning and detailed monitoring of recruitment is also required, with constant comparison of the sample emerging through different techniques. Recruiting through maternity services

yielded the largest number. Other strategies such as snowballing, approaches to toddler groups, and advertising were helpful in accessing respondents of Irish descent but are associated with bias and, sometimes, disproportionate effort. Questions remain about the best methods to recruit partners into maternity studies and future research in this area could benefit studies into reproductive and sexual health and family life. In an era of declining response rates in national surveys, there is an urgent need to understand what prevents or facilitates participation in both quantitative and qualitative studies to ensure that reliable inferences are drawn. This study highlights the potential extra effort that is needed to recruit UK-born ethnic minority mothers and the resource implications associated with this.

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Notes on Contributors

Katherine Twamley has been working as a research associate at City University London since 2006. Her work there has concentrated on the reproductive health of second generation ethnic minorities and socially disadvantaged people. She is now pursuing a PhD in Health Research in City University and her doctoral thesis is on the marriage and sexuality of young Indians in the UK and India. Before starting at City, she completed a Masters in Reproductive and Sexual Health Research at the London School of Hygiene and Tropical Medicine and an undergraduate degree in Sociology and Drama from Trinity College Dublin, Ireland.

Dr. Shuby Puthussery is a Senior Research Fellow at the Family and Parenting Institute and a Visiting Research Fellow in the Families and Social Capital Research Group at London South Bank University. Previously she worked as a Research Officer at City University London. Her training background is in Social Work and Public Health, and her research interests focus on the spectrum of maternal and reproductive health, family relations, qualitative methods, and ethnic/racial variations in health and wellbeing.

Alison Macfarlane worked as a statistician in agricultural research, transportation studies, the health effects of air pollution and child health until she joined the newly established National Perinatal Epidemiology Unit in 1978. She remained there until 2001 when she was appointed professor of perinatal health in City University Department of Midwifery. Her research has focussed particularly on settings for birth, health inequalities and multiple births. She specialises in analyses of routine data and is co-author with Miranda Mugford of 'Birth counts: statistics of pregnancy and childbirth' and with Rona Campbell of 'Where to be born: the debate and the evidence'.

Seeromanie Harding obtained her BSc (First Class, Hons) in Applied Social Sciences in 1989 and completed her MSc in Medical Demography in 1991 at the London School of Hygiene and Tropical Medicine. She worked at the Office for National Statistics as a Senior

Researcher managing the inequalities in health research programme in the Longitudinal Study Unit then moved to the London School of Hygiene and Tropical Medicine as a Senior Epidemiologist at the Centre for Public Health Monitoring, before moving to the MRC Social and Public Health Sciences Unit at the University of Glasgow. She is interested in inequalities in health, particularly on the impact of socio-environmental and biological factors on the emergence and accumulation of disparities in health among ethnic groups.

Shamoly Ahmed worked as a researcher for City University for seven years, working on a number of midwifery research projects, using qualitative and quantitative research methodologies to explore issues around access and service delivery of midwifery care. She now works for the NHS Tower Hamlets in implementing two immunisation programmes within the borough, and more recently works as a Public Health Strategist in the area of cancer.

Judith Mirsky started out her career as a journalist and later completed an MSc in Reproductive & Sexual Health Research in the London School of Hygiene and Tropical Medicine (LSHTM). She continued to teach in LSHTM before moving to City University as a Research Officer. She is now studying Medicine at St George's, University of London.

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Table 1 Number of eligible women successfully recruited by ethnic background, recruitment method and whether interviewed

Recruitment method	Black Caribbean	Indian	Pakistani	Irish	Black African	Bangladeshi	Total
Number of women successfully recruited and interviewed							
Maternity services	9	8	2	1	2	2	24
Community groups	0	0	0	1	0	0	1
'Snowballing' and personal contacts	1	2	1	1	0	0	5
Toddler groups	0	1	1	1	0	0	3
Advertising	0	0	0	1	0	0	1
Total interviewed	10	11	4	5	2	2	34
Number of women recruited but not interviewed							
Maternity services	4	3	5	0	1	0	13
Community groups	0	0	0	0	0	5	5
'Snowballing' and personal contacts	0	0	0	0	0	0	0
Toddler groups	0	0	0	0	0	0	0
Advertising	1	0	0	1	0	0	2
Total not interviewed	5	3	5	1	1	5	20
Total recruited	15	14	9	6	3	7	54

Table 2 Characteristics of women recruited and interviewed through each recruitment method

Recruitment Method	Age			
	Under 20	20-29	30-39	40 or over
Maternity services	2	10	10	2
Community groups	0	0	1	0
'Snowballing' and personal contacts	0	1	4	0
Toddler groups	0	1	2	0
Media	0	0	1	0
Total	2	12	18	2
	Parity			
	Primiparous	Multiparous		
Maternity services	14	10		
Community groups	0	1		
'Snowballing' and personal contacts	4	1		
Toddler groups	1	2		
Media	1	0		
Total	20	14		
	Education			
	GCSE or less	A-level	Degree or higher	
Maternity services	9	4	11	
Community groups	1	0	0	
'Snowballing' and personal contacts	1	0	4	
Toddler groups	1	0	2	
Media	0	1	0	
Total	12	5	17	

Table 3 Number of women recruited and interviewed and time spent on each method in the last four months of recruitment

Recruitment method	Women recruited		Time spent
	Number	Percentage	Percentage
Maternity services	4	29	30
Community groups	1	7	35
'Snowballing' and personal contacts	5	36	5
Toddler groups	3	21	20
Media	1	7	10
Total	14	100	100