(HICs), multimorbidity has a complex impact on health outcomes, including functional status, disability and quality of life, complexity of healthcare and burden of treatment.

Methods This study aimed to explore the perceptions and experiences of women living with multimorbidity in the Greater Accra region, Ghana: to understand the complexity of their health needs due to multimorbidity, and to document how the health system responded. Guided by the cumulative complexity model, and using stratified purposive sampling, 20 in-depth interviews were conducted across three polyclinics in the Greater Accra region. The data was analysed using the six phases of Thematic Analysis.

Results Overall four themes emerged: 1) the influences on their health experience; 2) seeking care and the responsiveness of the healthcare system; 3) how patients manage healthcare demands; and 4) outcomes due to health. Spirituality and the stigmatisation caused by specific conditions, such as HIV, impacted their overall health experience. Women depended on the care and treatment provided through the healthcare system despite inconsistent coverage and a lack of choice thereof; although their experiences varied by chronic condition. Women depended on their family and community to offset the financial burden of treatment costs, which was exacerbated by having many conditions.

Conclusion The implications are that integrated health and social support, such as streamlining procedures and professional training on managing complexity, will benefit and reduce the burden of multimorbidity experienced by patients with multimorbidity in Ghana.

RF22 HIV AND TYPE 2 DIABETES (T2DM): A QUALITATIVE EXPLORATION OF THE BURDEN OF CARE EXPERIENCED AND PERCEIVED BY PERSONS LIVING WITH THE COMORBIDITIES

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Background Research exploring the intersection of communicable and non-communicable diseases, as well as, the lived experiences of persons with multiple chronic morbidities, is limited. This study sought to explore how persons living with HIV (PLHIV) and Type 2 diabetes (T2DM) experience and manage the burden of treatment related to these comorbidities in the context health systems and culture in small island developing states.

Methods Participants with a diagnosis of both HIV and T2DM for more than 2 years were purposively selected with the assistance of HIV treatment centres on the islands of Barbados and Trinidad & Tobago. Twenty individual, face-to-face semi-structured interviews (10 in each country) explored self-care, health care delivery, socioeconomic support and internal resilience. A total of 13 females and 7 males aged 39–65 years were interviewed. All interviews were audio-taped and transcribed verbatim. Data was analyzed using thematic analysis with constant comparison. ATLAS.ti(7) data management software used to manage the data analysis process.

Results Aspects of T2DM self- care such as daily blood glucose monitoring and controlling diet were more onerous than

perceived minimal HIV care actions of adhering to oral anti-retroviral therapy ('you just take your medication and go') and clinic visits. While HIV was experienced and perceived as having lower physical workload than T2DM, there was a higher psychological workload throughout the disease trajectory, particularly related to stigma and discrimination in health care settings and in general. T2DM's lower psychological workload was perceived as due to the absence of stigma and discrimination attached to the disease, but adhering to multiple modalities to controll blood glucose increased the physical workload. The impact of having HIV on social determinants such as housing and employment, increased the psychological burden, and impacted on participants' internal resilience. A preference for centralised integrated care (instead of de-centralisation to clinics throughout the health care delivery system), with a more holistic approach within health care settings on both islands was also identified by participants (i.e. having comorbidities such as diabetes also checked and treated at routine HIV clinic visits).

Conclusion Integrated communicable and non-communicable care models which assess both physical and psychological workload should be considered in healthcare, especially since HIV treatment now follows a more chronic treatment pathway. In addition, addressing stigma and discrimination in the general population as well as in health care delivery settings, and their impact on health outcomes for PLHIV, is still an area for public health concern within the Caribbean.

RF23 WHO KNOWS BEST? PERSPECTIVES OF PROFESSIONAL STAKEHOLDERS AND COMMUNITY PARTICIPANTS ON HEALTH IN LOW-INCOME COMMUNITIES

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Background Health inequalities in the UK have proved to be stubborn, and health gaps between best and worst-off are widening. While we have an understanding of how the main causes of poor health are perceived among different stakeholders, similar insight is lacking regarding what solutions should be prioritised. Furthermore, we do not know the relationship between perceived causes and solutions to health inequalities, whether there is agreement between professional stakeholders and people living in low-income communities or agreement within these different societal groups.

Methods Q methodology was used to identify and describe the shared perspectives ('subjectivities') that exist on i) why health is worse in low-income communities ('Causes') and ii) the ways that health could be improved in these same communities ('Solutions').

53 purposively selected individuals from low-income communities (n=25) and professional stakeholder groups (n=28), for example, academics, policymakers, public health professionals, financial service practitioners, ranked ordered sets of 34 'Causes' statements and 39 'Solutions' statements onto quasi-normal shaped grids according to their point of view. These 'Q' sorts were followed by brief interviews. Factor analysis was used to identify shared points of view (patterns of similarity between individuals' Q sorts). 'Causes' and 'Solutions' were analysed independently.