(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 39–63 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 antiretroviral 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 control 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 decentralisation 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.
Abstracts

RF24 ENGAGING UNDERREPRESENTED WOMEN AS PARTICIPANTS IN STUDIES ABOUT HEALTH RISKS: LIFE STAGE DIFFERENCES IN MOTIVATIONS TO PARTICIPATE

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Background Universal interventions to reduce health risks can widen health inequalities. Targeted approaches, where an intervention is tailored to specific groups, may overcome this limitation. Women aged 16 to 34 years with lower socioeconomic status are hard to engage in research which limits our ability to understand how to address their health and lifestyle behaviours.

According to marketing research on spending, young adults aged 16 to 34 years pass through three main life stages: (1) dependency on older adults and individual interests, (2) leaving home and spending time with peers, (3) setting up home and having a family. The aim of this study was to evaluate how useful these life stage categories are for understanding women’s motivations to participate in health research and for planning recruitment strategies.

Methods Nine focus groups with a total of 49 women (aged 16 to 34 years, without university education) were conducted. Women were recruited from different settings to mirror each of the three life stages above. Women in Further Education colleges represented category (1), women at work for category (2) and mothers were for category (3). The focus groups explored participants’ lifestyles, reasons for participating in the current study and beliefs about how research could be of value to them. Framework analysis was used to integrate theories from existing literature with themes emerging from the focus groups.

Results All women sought personal benefits from participation but these varied by life stage. Mothers wanted social opportunities away from caring responsibilities, while women at work and women in education valued monetary incentives more highly. A common theme across the groups was the desire to escape boring activities. Women’s motivations to participate in health research were not purely altruistic but to improve their own social capital. There were differences in how women would choose to spend free time.

Conclusion The life stages were useful for understanding women’s motivations to participate in health research. Advertising strategies to engage women aged 16 to 34 years in health research should be tailored to fit their life stages, their goals for free time and the value they place on participation.

These findings suggest that different strategies are required to optimise recruitment across this age range. One recruitment strategy does not fit all.