

(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 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 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.

Results Analysis produced three factor solutions for both the 'Causes' and 'Solutions'. These rich, shared accounts can be broadly summarised as: 'Causes' i) 'Unfair Society', ii) 'Individual Responsibility', iii) 'Hard Lives' and for 'Solutions' i) 'More than Money', ii) 'Guiding Choice', iii) 'Make Society Fair'.

No professionals were among respondents who exemplified (had a significant association with) 'Causes – Individual Responsibility' or 'Solutions – Guiding Choice' and no community participants exemplified 'Solutions – Make Society Fair'. There was an expected correlation between the 'Causes' and 'Solutions' factor solutions given the accounts identified.

Conclusion While there was some disagreement among professional participants, there was more of a focus on material, social and environmental factors. Community participants recognised a range of causes of worse health but even among those identifying structural causes as the main problem, structural solutions were not recognised. Despite the plurality of views there was broad agreement across the accounts about issues relating to money. While no easy solutions exist, addressing basic needs and the unpredictability of finances are seen as important for good health.

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 were 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.

RF25 THE ROLE OF SOCIAL NETWORKS IN WEIGHT MANAGEMENT INTERVENTIONS DURING PREGNANCY AND POSTPARTUM FOR WOMEN WHO ARE OVERWEIGHT AND OBESE: A SYSTEMATIC REVIEW

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Background Maternal obesity is a growing public health issue. It is associated with pregnancy and birth complications and increased risk for childhood and long-term obesity. Interventions focusing on individual behaviour change have had a modest impact on clinical outcomes. There is increasing evidence that social networks are an important driver of obesity-related behaviours. The aim of this systematic review is to explore the effectiveness of lifestyle interventions that use social networks for weight management and to explore participants' experiences, and the process outcomes of these interventions.

Methods MEDLINE, PsychINFO, EMBASE, Cochrane, CENTRAL and CINAHL databases were searched as well as reference lists of included studies. Eligibility criteria included: intervention studies with a comparator group and qualitative studies/process evaluations of the included intervention studies; pregnant or postnatal women (<2 years) with BMI >25 kg/m²; a lifestyle intervention with a social network component; and a gestational or postpartum weight outcome. Protocol papers were included to aid extraction of intervention components and behaviour change techniques (BCTs). Articles were screened by two independent reviewers. Data extraction is ongoing and studies will be assessed for quality and risk of bias. BCTs and social network functions are also being coded by two reviewers and will be summarised in tables. We will assess heterogeneity and, if possible, a random-effects meta-analysis and a priori specified subgroup analyses will be conducted. We will carry out a narrative synthesis.

Results A total of 10 211 records were identified from databases with 73 full-text articles and another 25 identified from references screened. 30 articles (15 studies) were included. 8 potentially relevant studies are ongoing or results have not yet been published. Searches will be rerun before the final analyses. Preliminary findings are that the interventions are heterogeneous but most were group-based and delivered face-to-face. Interventions often advised on obtaining social support from existing social network (e.g. family), arranged support through created social networks