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Unmet Support Needs in Elderly Multimorbidity Patients' Self-Management: A Phenomenological Study

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Abstract

The rapid expansion of the ageing population is accompanied by an increasing prevalence of multimorbidity linked with a decline in quality of life, functional disturbances and reduction as well as increased frequency of hospital visits. Literature reveals that to have successful outcomes, self-management is encouraged. Self-management in this study is defined as, "taking personal responsibility to carry out those activities that promote and maintain self-health and well-being". This study aims to uncover the unmet support needs for self-management in elderly patients with multimorbidity through this qualitative study that used the interpretive phenomenological design. It was carried out in the largest referral hospital, the University Teaching Hospitals - Adult Hospital, which was purposely sampled to give divergent perspectives from patients across the nation. Thirty (30) elderly patients 60 years of age and older with multimorbidity who were seeking treatment at the hospital during the study were purposefully selected to participate. Data was gathered using the in-depth interview guide in audio-recorded in-person interviews and analysed using interpretative phenomenological analysis (IPA) which saw three superordinate themes encompassing the need for a responsive healthcare delivery system, a well-functioning socioeconomic system, and social support networks. These systems, working together or independently can help multimorbidity patients focus on self-management. This is the first study that has looked at the unmet support needs for self-management in elderly patients with multimorbidity, which can help this special group to reap the benefits of self-management.

Keywords: *Elderly, Multimorbidity, Patients, Self-Management, Support, Unmet Needs .*

Introduction

The ageing population is rapidly expanding worldwide [1]. In 2020, an estimated 1.05 billion people were aged 60 and older in the world constituting 13.6% of the world's total population [2]. This rapid expansion of the ageing population is accompanied by an increasing prevalence of multimorbidity [3, 4]. Multimorbidity, however, occurs in all ages and both sexes, but the prevalence tends to increase with age [5]. According to Kanesarajah *et al* [6] and Aramrat [7], multimorbidity is linked with a decline in quality of life, functional disturbances, and reduction as well as increased frequency of hospital visits [8]. The quality of life for elderly patients becomes compromised and poses a significant challenge in healthcare systems [9]. Literature reveals that to have successful outcomes, self-management is encouraged even in elderly patients [9]. Self-management in this study is defined as "taking personal responsibility to carry out those activities that promote and maintain self-health and well-being as explained by Bodenheimer et al [10]. Self-management is considered to have an important role in improving the quality of life and delaying the occurrence of complications [11, 12]. It is for this reason that self-management support becomes imperative.

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According to Poitras et al, [13] interventions that support self-management at different levels of care may give positive outcomes for patients with chronic diseases, especially the elderly with multimorbidity. The benefits of self-management for older adults include reduced reliance on the health system, enhanced quality of life, empowerment of the individual, and reduction in the burden associated with chronic illness [14].

This study, therefore, seeks to have an in-depth understanding of the perspectives of elderly patients with multimorbidity on unmet support needs for self-management. Self-management support is increasingly being recognized as a key component for improving the overall health of people with multimorbidity [15, 16]. Self-management support for elderly patients is the organization of service areas and programs for elderly patients to provide and facilitate the acquisition and enhancement of skills for them to manage to live with their conditions [15]. This concept relates to the activities each person carries out to improve their quality of life despite multimorbidity [17]. Self-management support uses collaborative goal-setting and self-efficacy strategies to enable patients to carry out normal roles and activities to manage the medical and emotional effects of their illnesses in partnership with healthcare providers in adaptable ways [18].

There are several self-management support activities which include providing effective information, education, and communication, peer group meetings where they can share experiences and information, motivational counselling to keep the efficacy, case management, and follow-ups [19, 20]. These interventions can help elderly patients to begin to accept their conditions and learn how to positively live with them. In all this, the elderly patients' experiences, attitudes, and the gist attributed to self-care should be closely taken into consideration [21]. Recent research suggests that supporting older patients with multimorbidity in communicating their needs and concerns to healthcare providers could reduce risks to patient safety [22]. While in hospital healthcare providers play an important role in all sections of patient care to support elderly patients to manage themselves by putting them in the Centre of their care and making sure to do everything possible during each hospital visit [14]. However, elderly people are encouraged to maintain a healthy lifestyle within their homes through modern healthcare programs [21]. This is believed that this will reduce the hospital visits and the attached costs.

Conversely, despite all these put in place elderly multimorbidity patients still have unmet needs for this kind of support. There are quite many aspects that are associated with the self-management capacity of elderly patients which may include a lack of knowledge on health-related issues, difficulties in mental health capacity as well as resources and support [14]. Gobeil-Lavoie et al [18] also acknowledged technical hitches to self-management for patients who have intricate needs for health care. They asserted that these patients may concentrate and emphasise the care of the condition that is giving them the most problems. Despite having experience in managing and advancing self-management ability, getting inconsistent data from care experts, hopelessness, emotional grief and reduction in zeal sets an increased risk for hitches. Additionally, Kristensen, et al [16] revealed that having multiple conditions is also related to the feeling of desolate and inability to participate fully in economic, social, political, and cultural life and also with a bigger support system which may demonstrate the need for the well-organized backing system while in this trail. Also, it may point out that managing oneself mostly for older adults with multiple conditions, is linked to diverse factors of societal affiliations [9]. Earlier literature presented that many older adults do not show satisfaction with societal affiliations and

involvement [17]. Conducting this study will help to uncover the unmet needs for self-management support that are much needed by this group of patients and subsequently any strategies adopted and support they may need to carry out self-management activities. This will also help to relieve the burden of care which is now solely on the shoulders of family carers in part as well as the health care system.

Ethical Considerations

The study was approved by ERES Converge Ethical Review Board in Zambia on reference number 2023- Mar-005. This study was also cleared by the National Health Research Authority (NHRA) on reference number NHRA00001/5/06/2023. And permission to conduct the study was sought from the clinical care department of the university teaching hospitals. Participants were requested to sign consent forms and assured of confidentiality to enable them to participate in the study freely and without fear. The questionnaire and consent form were then kept under key and lock to avoid unauthorised access to information.

Conceptual Framework

The Loring and Holman self-management model of 2003 helped to summarize and understand self-management activities to give elderly multimorbidity patients the support they need to carry out self-management activities [23]. These activities include managing one's health, one's emotions, and one's role. Activities such as building an interactive relationship with the health care system for consultation, guidance, and relief of emotions, as well as a change of lifestyle to conform to morbidity requirements which includes exercising and healthy eating, all done to manage the role or social function. In social activities, there is a network of different support groups comprising health professionals, peers, family members, and multimorbidity associations from which elderly multimorbidity patients can get all they need to facilitate self-management from their perspective. Well-managed self-management activities will result in reduced mortality, reduced healthcare use, improved quality of life, and increased skill utilization.

Materials and Methods

Research Design

This qualitative study used an interpretive phenomenological design which aimed at gaining insights into the unmet support needs for self-management among elderly patients with multimorbidity. This research approach facilitated the identification of the perceived unmet and desired support needs among elderly multimorbidity patients, providing a valuable understanding of improvements needed to enhance their quality of life.

Study Setting and Sampling Procedure

This study was carried out in the largest referral hospital in Lusaka, Zambia, the University Teaching Hospitals - Adult Hospital (UTHs - AH), which treats highly specialised cases, including multimorbidity cases. This site was purposefully selected specifically to present a range of perspectives from patients across the nation. Therefore, even though the study focused on all elderly patients 60 years of age and older with multimorbidity, who were seeking treatment at UTHs - AH during the time of the study, all elderly patients who were seeking treatment at these facilities were included in this population. Purposive sampling was used to sample participants. As a result, thirty (30) participants took part in the study.

Data Collection Procedure and Tools

Data was gathered using the in-depth interview guide with open-ended questions. Audio-recorded in-person interviews were conducted. Additionally, with the participants' permission, the researcher recorded field notes while they were observed to avoid missing the non-verbal cues that could provide meaning to the gathered data. To ensure comfort, safety, and freedom of speech, the interview was

conducted in the participant's preferred setting—at home or in the hospital [25]. The researcher kept the interview length between forty and sixty minutes to minimise fatigue in participants. The researcher eased participants into the interview process by having an open discussion and mingling with them for ten to fifteen minutes before the interview started. All ethical concerns were addressed to allow free participation. English or Nyanja, depending on preference, was used for the individual interviews.

Data Management

All transcribed interview voice files were protected on the computer hard disk with a password and stored in a lockable cabinet alongside a physical copy of the transcribed data and the signed consent forms to ensure safety [26]. Validity was demonstrated throughout the study by employing a research design suitable for the methods used, which effectively addressed the research questions [27]. Credibility was attained and maintained by conducting a pilot study and consulting with the research supervisors on transcribed data and translating it to themes to ensure accuracy [28]. A peer review for data analysis was utilized to eliminate mistakes and validate the interview data [29]. Dependability was maintained through a well-defined framework of the Interpretative Phenomenological Analysis (IPA) interview procedure, utilizing open-ended questions with probes to gain a comprehensive understanding of the views of elderly patients on unmet needs for self-management support. The researcher also observed a variety of non-verbal cues during the interview to aid in the transcription of interviews, which enhanced the depth and complexity of the information gathered. The study's findings, however, will not be applied to all elderly patients. They will be used to illustrate a significant cohort of elderly patients with multimorbidity. Extensive details and comprehensive explanations of every phase of the research process, including data collecting and analytic techniques, may offer some guidance that researchers in other contexts could use to replicate a comparable structured interpretative phenomenological study. Periodically, the data and emerging themes were examined to ensure external validity [30]. Despite the importance of the researcher's role in the interpretive phenomenological study, it is also crucial to recognize that the participant's perspectives are not superseded by the researcher's [26, 31]. For this reason, the data was read several times to establish associations with the responses, thematic trends, and the full transcript. Therefore, the discovery of interpretations of data was stated in great detail to improve and promote confirmability.

Data Analysis

The data were analyzed using interpretative phenomenological analysis (IPA). This IPA process used a six-step, iterative, and inductive data processing procedure [32]. The six processes were reading and rereading, making quick notes, creating themes that emerged, finding connections between themes, going on to the next case, and searching for patterns among instances. Every transcript was given a unique code and included in the NVIVO 12 data matrix [33]. To find important themes, similar codes were categorized. The final product that best captured the viewpoints of the multimorbidity elderly patients about the subject matter became superordinate themes.

Results

Thirty (30) multimorbidity elderly patients in all participated in the study. The group's specific demographic features are displayed in Table 1.

Table 1. Summary of Demographic Characteristics of Participants

Name	**Characteristic**									
	Sex	**Age**	**Education level**	**Occupation**	**Income**	**Residence**	**Living with**	**Conditions**	**Diagnose same time**	**Duration**
P1	Male	60	Form 5	Lecturer	20,000	Urban	Spouse	Diabetes mellitus and Hypertension	Not sure	10 years
P2	Male	70	Form 2	Pastor	5000	Urban	Spouse	Diabetes mellitus and Hypertension	Not sure	5 years
P3	Male	64	Form 2	Peasant farmer	2000	Rural	Spouse	Arthritis and Hypertension	Not sure	2 years
P4	Female	73	Form 2	Business	5000	Urban	Caretaker	Diabetes mellitus and Arthritis	Yes	3 years
P5	Female	81	Nil	Nil	Nil	Urban	Children	Heart failure, Renal dysfunction, Diabetes mellitus, Arthritis and Hypertension	Not sure	3 years
P6	Female	62	Form 2	Peasant farmer	3000	Rural	Children	Diabetes mellitus, and Arthritis	Not sure	2 years
P7	Female	72	Form 5	Business	5000	Urban	Spouse	Heart failure, Renal dysfunction, Diabetes mellitus, Arthritis	Not sure	10 years

								and Hypertension		
P8	Female	75	Form 2	Peasant farmer	200	Rural	Relatives	Diabetes mellitus, Renal dysfunction, Hypertension	Not sure	4 years
P9	Male	73	Nil	Nil	Nil	Rural	Grandchild	Renal dysfunction, Diabetes mellitus, Hypertension	Not sure	2 years
P10	Female	65	Form 5	Teacher	5000	Urban	Spouse	Diabetes mellitus and Hypertension	Yes	4 years
P11	Female	65	Form 2	Peasant farmer	3000	Rural	Relatives	Diabetes mellitus and Hypertension, Asthma	No	
P12	Female	70	Nil	Nil	Nil	Rural	Grandchild	Arthritis and Hypertension	Not sure	1 year
P13	Male	61	Form 5	Business	2000	Urban	Spouse	Diabetes mellitus and Hypertension	Yes	10 years
P14	Female	63	Form 5	Lecturer	25000	Urban	Spouse	Diabetes mellitus and Hypertension	No	4 years
P15	Female	65	Form 5	Teacher	7000	Urban	Children	Diabetes mellitus and Hypertension, Asthma	Yes	2 years

P16	Male	75	Form 2	Nil	Nil	Rural	Relative	Renal dysfunction and Hypertension	Not sure	1 year
P17	female	81	Nil	Nil	Nil	Urban	Children	Heart failure, Diabetes mellitus and Hypertension	Not sure	5 years
P18	Male	72	Form 2	Peasant farmer	3000	Urban	Caretaker	Heart failure and Hypertension	No	6 years
P19	Female	74	Nil	Peasant farmer	5000	Urban	Relatives	Diabetes mellitus and Hypertension	Not sure	1 year
P20	Male	68	Form 5	Teacher	7000	Rural	Spouse	Renal dysfunction and Hypertension	Yes	1 year
P21	Male	60	Form 5	Business	8000	Urban	Spouse	Diabetes mellitus and Hypertension, Asthma	No	11/2 years
P22	Female	70	Nil	Peasant farmer	500	Urban	Grandchild	Heart failure, Diabetes mellitus and Hypertension	Not sure	5 years
P23	Female	72	Nil	Peasant farmer	600	Rural	Caretaker	Heart failure and Hypertension	No	2years
P24	Male	63	Form 5	Lecturer	15000	Urban	Spouse	Diabetes mellitus and	No	1 year

								Hypertension, HIV		
P25	Female	65	Form 2	Pastor	6000	Urban	Spouse	Renal dysfunction and Hypertension	Yes	3 yeas
P26	Female	61	Form 5	Nurse	7000	Urban	Children	Diabetes mellitus and Hypertension, Asthma	No	2 years
P27	Female	75	Nil	Nil	Nil	Rural	Relatives	Diabetes mellitus, Arthritis and Hypertension	Yes	2years
P28	Female	80	Nil	Nil	Nil	Rural	Grandchild	Diabetes mellitus, Arthritis and Hypertension	Not sure	1 year
P29	Male	66	Form 5	Teacher	5000	Rural	Spouse	Hypertension, Diabetes mellitus, HIV	No	3 yeas
P30	Female	79	Form 2	Nil	Nil	Urban	Children	Hypertension, Diabetes mellitus ,Asthma	Not	2 years

Table 1 shows that Thirty (30) multimorbidity elderly patients participated in the study. Of the thirty (30) participants, eleven (11) were males and nineteen (19) were females. Their ages ranged between sixty (60) and eighty-one (81) years. Ten (10) of these respondents went only up to form two of their education and in their younger days some of them were able to secure jobs while nine (9) of them did not go further in education and eleven (11) of them managed to go up to form five an equivalent of grade 12 of nowadays. Twenty-three (23) of these participants were involved in some activities (lecturing, pastoring, peasant farming, teaching, Nursing and business) which helped them have a bit of income though not enough for some of them to manage themselves. In contrast, the minority (7) depended on others for a living. Almost all (24) participants have lived with their conditions for

a period ranging from 2 years to 15 years except for six (6) who have had their conditions for a period less than two years. Only eleven (11) out of thirty participants live with their spouses, while the majority (19) live with either a caretaker, children, relatives, or grandchild. These may be determinants of some unmet support needs for self-management which may arise due to lack of knowledge, resources, and poor functionality arising from illness or ageing among others.

Recurrent Themes Identified

Table 2. Summary of Superordinate Themes

		Responsive healthcare service delivery system	**Well-functioning Social economic systems**	**Support networks**
Participant	P1	Yes	No	Yes
	P2	Yes	Yes	No
	P3	Yes	Yes	Yes
	P4	Yes	No	Yes
	P5	Yes	Yes	Yes
	P6	Yes	Yes	Yes
	P7	Yes	Yes	Yes
	P8	Yes	Yes	Yes
	P9	Yes	Yes	Yes
	P10	Yes	Yes	Yes
	P11	Yes	No	No
	P12	Yes	Yes	Yes
	P13	Yes	No	Yes
	P14	Yes	No	Yes
	P15	Yes	Yes	Yes
	P16	Yes	Yes	Yes
	P17	Yes	Yes	Yes
	P18	Yes	Yes	Yes
	P19	Yes	Yes	No
	P20	Yes	Yes	Yes
	P21	Yes	Yes	Yes
	P22	Yes	Yes	Yes
	P23	Yes	Yes	Yes
	P24	Yes	Yes	Yes
	P25	Yes	No	Yes
	P26	Yes	Yes	Yes
	P27	Yes	Yes	Yes
	P28	Yes	Yes	No
	P29	Yes	Yes	Yes
	P30	Yes	No	No
Present in 80 to 100% of participants		30 (100)	24(80)	25(83)

Table 2 presents superordinate themes from the data that was collected from participants where about 80 to 100 percent of these three themes were present.

Superordinate and Subordinate Themes

The results from our data have been grouped into three superordinate themes and some subordinate themes based on the main goal of this study. They included the need for a responsive healthcare delivery system, a well-functioning socioeconomic system, and social support networks. The need for a responsive healthcare delivery system comprised of healthcare navigation support and patient-centered care. The need for a well-functioning socioeconomic system included economic stability, and healthcare policy and funding. The need for social support networks included community engagement, resources and services, Family support and involvement, and peer support networks.

Participants felt that these systems need to be well established for self-management in multimorbidity elderly patients to work well. These systems, working together or independently can help multimorbidity patients focus on self-management which will in turn will improve their quality of life.

Superordinate Theme 1: Need for a Responsive Care Delivery System

The healthcare delivery system plays an important role in ensuring that care facilities and their management meet the needs of the various categories of patients they are intended to serve. These systems should be able to facilitate the acquisition of knowledge and monitor the implementation of self-management. Multimorbidity elderly patients are among these categories and asserted the concerns below.

"Sometimes I think an independent hospital, like there are hospitals for children can help in self-management business. These hospitals would strictly look into issues of the elderly, where properly trained and experienced providers of elderly care are readily available and there for elderly patients especially those with multimorbidity... These would then come up with deliberate strategies to sensitize the elderly multimorbidity patients, their carers, and communities on the importance of self-management" (P1). In this discussion, P1 expressed his need for a specialized hospital for elderly patients. He believed that if such a hospital were to be available, then it would be equipped with specialized staff that would give the guidance the multimorbidity elderly patients needed for them to be able to carry out self-management activities as articulated in the discourse, *"Where properly trained and experienced providers of elderly care are readily available"*. What he meant was that available hospitals may not have specific programs targeted for elderly multimorbidity patients and self-management as a whole. He is of the view that these hospitals would take the lead in self-management sensitization as well as community engagement to help in understanding the self-management concept which is an old concept but seemingly relatively new *as conveyed in the discourse, "These would then come up with deliberate strategies to sensitize the elderly multimorbidity patients, their carers and communities on the importance of self-management".*

The concerns were similar to those of P3 who said, *"There is a serious and urgent need for a one-stop hospital, where a single hospital appointment can cater for all conditions. Right now all l do is chasing hospital appointments. If only services could be integrated so that I remain with time to concentrate on following instructions and reorganizing my life".* P3 reported inadequate time to concentrate on self-management activities because hospitals did not prioritize his needs as a multimorbidity elderly patient. Hospital appointments were split apart making self-reflection, direction, and management unattainable as seen in his

discussion sentiments, *"There is a serious and urgent need for a one-stop hospital, where a single hospital appointment can cater for all conditions'.* "One-stop hospital" means a hospital that has specialized personnel and equipment that would be used in the management of elderly patients with multimorbidity to reduce movement from one hospital to another. He blames the hospital management for his failure to attain self-management with some degree of frustration in the sentiments*," Right now all l do is chasing hospital appointments".*

"It's the constant navigation of our healthcare system for me. It is quite taxing to have multiple chronic illnesses, a combination of problems that need the attention of numerous specialists or care providers, but often you have no idea where they are……..... and that's not even talking about the drugs and other necessities". (P8). This participant expresses the difficulties encountered to locate the care providers in hospitals which she thinks needs some kind of improvement to make it easier to access the services. This discourse correlates with P16, *"I don't know how to locate the places they send me to……..I always have to go round and round, so tiring and time wasting……we need care experts in the village as well may be it would reduce these movements"*. P16 is lamenting the difficulties associated with navigating the health care system, such that he wishes the healthcare system can take the care experts even to remote areas for easy access. *"We need care experts in the village may be it would reduce these movements".* He observed that he follows particular experts who are not there in the nearest accessible hospitals and it requires him to trek these difficult-to-access care facilities to go and be seen by them.

"Every time you come to the hospital there is confusion. Nobody is collaborating with a clear understanding of how the system or service is meant to operate, and everyone is doing things uniquely. Even among Physicians, they will desire to pursue their interests, today you see this one tomorrow it is that one……well…… it is okey but being organised is the best". (P7). For P7 she wishes to have a hospital whose staff are coordinated and can give proper direction to patients as seen in this statement *"Nobody is collaborating with a clear understanding of how the system or service is meant to operate". "Today you see this one tomorrow it is that one".* P7 here stresses that it is important to at least see the same doctor each time she visits the hospital probably to have a known starting point unlike explaining himself repeatedly.

P2 shares the same line of thought with P7. *"What I want is the care expert to know me, that's all I want… It bothers me to say my problems repeatedly to doctors, and then they say, "Oh! This case! okey…". One care expert who would know something is not usual about me makes a huge difference".* (P2). P2 here wishes to have a patient-provider relationship that is interactive and therapeutic. *"Oh! This case! okey…"* to P2. indicates "the simplicity without touch" lack of interest to detail about him but just simply known as a "case".

P6, *"It's shameful, in my opinion……. I don't know……. I'm not sure of the solution, I don't believe I should wait for 3 months if I feel the need to see the doctor, I can't see the doctor of my choice if I require medical attention".* In this discourse, P6 wishes to see the doctor at the point of need rather than waiting for a longer period. P6 showed some kind of frustration and disbelief that continuity of care is almost not there as doctors keep changing. This is seen from the statement, "*I can't see the doctor of my choice if I require medical attention".*

P4 goes on to say*, "It is extremely distressing considering my age and health status because sometimes even when the day to see the doctor comes I still have to wait for several hours, one wonders what the whole system thinks of us elderly patients".* P4 feels healthcare providers delay seeing patients for

unknown reasons that make them wait in queues.

It is difficult to follow or remember the management of all three conditions I have. …it is too much but I wish I had written information that I could read and follow to remind me strictly of what I need to do about my health…am willing to do anything possible but it's just difficult… us now it's just to die unless God Himself intervenes……. (P10). P10's view was that of the health care system that would take into consideration the quandary of the multimorbidity elderly patients and support their self-management by coming up with simple non-complicated individual daily self-care checklists according to conditions one has. The personalized checklists done by experts should be able to help the patients follow what is required of them in the implementation of self-management as picked in her thinking *"I wish I had written information which I can read and follow to remind me strictly of what I need to do about my health".* Her words "*us now it's just to die unless God Himself intervenes……"* Showed that she gave up on the better health care system but somehow believed God could serve her deriving some hope and a reason to keep trying to look after herself.

P11 *it is very difficult to say what your problems are in these hospitals……. People already think your old age is your problem……..... nothing good comes after suffering to see the doctor. All they say is to continue on the same treatment and come for a review after three months. This is arrived at without examining you properly to understand the problem"*. P11 here indicated a waste of time to tell the doctors about her problems, they attach her problems to her age. The old people lack proper attention as illness is always expected and viewed as normal. This was seen in, "*people already think your old age is your problem*" This is the notion society has of elderly people. Unfortunately, this makes the care experts fail to make evidence-based decisions as seen in, "*continue with same treatment without examining you properly*. "*Nothing comes out well after suffering to see the doctor"* indicating some level of frustration and giving up.

P26 believes *elderly care is not among the priorities in our healthcare systems …. I don't know may be they know that they will waste both time and resources to engage in this type of care as it is already written that it is normal for the elderly to be sick ..... yes, I agree but the quality of life can be improved.* P26 sees a healthcare system that is not responsive enough to the way geriatric conditions are managed. He assumes that ageism is the cause as seen in, "*it is already written that it is normal for the elderly to be sick*". However, he agrees that despite the situation of the elderly their life is worth living with improved quality, indicating some level of care is vital.

P12 *"I don't know who to run to when I have concerns……. I would go from one consultation room to another for someone to see me …. "wait" ……Just wait" …. imagine!... so exhausting".* P12 wishes to have access to someone who would clear her concerns as needed without spending long hours and the puzzle of locating this expert. This was seen in her discourse "*I would go from one consultation room to another for someone to see me". This process* seemed to drain her further *as seen in "Imagine!... so exhausting".*

P13 "*My medications are all over, I don't know what is taken for what reason, nobody is explaining these medicines properly, people seem to be busy and not caring at all"*. P13 wants to have information about his medicine. "*I don't know what is taken for what reason*," says it all. He wishes somebody could come on board to explain the whats and the whys of his medication but nobody is available, "*people seem to be busy and not caring at all"*. He is overwhelmed by the number of medications he takes. For P17 the issue is about the non-availability of medicines in the hospital. "*I was told to buy medicine; the hospital has no medicine I don't know why they tell me to come*

when there is nothing. The hospital needs to stalk enough medicine otherwise us the old we will finish dying……what kind of care will one do without medicine? During each hospital visit P17 goes with a prescription of medicine and now she wonders why and this makes self-management difficult because she believes no matter what she does if the medicine is not available the outcome may not be good.

P14 "*I think my conditions are not being managed properly…. I have to go back to the hospital several times without improvement at all….. worse still I have no tangible feedback*". P14 feels the health care system does not adequately treat his conditions as seen in, "*I have to go back to the hospital several times without improvement at all*", meaning the help she gets from the health care facility does not make her feel any better. She receives no explanation about it. This is seen in, "*Worse still I have no tangible feedback"*.

"Some investigation results take so long, two to three months…. What will remain of the patient all this long? If lives are to be served, this system needs to do better". (P15). P15 in her sentiments, *"some investigation results take so long"*, shows concern for the delayed response for diagnostic investigations that would lead to specific treatment which indicated the potential for deterioration of the patient. "This system needs to do better" meaning the system needs to put in place certain measures that will help promote self-management.

P18 "*As an old patient now I understand a lot of things, otherwise, as a beginner I had a lot of challenges. I take it upon myself to ensure that I see the experts and get what I need to enable me to manage myself".* P18 here says the care system is difficult to navigate for a beginner which means that there are some issues that need to be put in place to make navigation easy as seen, "it *needs more and a lot*".

I think the hospital and its systems has no problems, for me to manage myself better I have to take it upon myself and get the services I need. I have to remind the care experts from time to time of my status to help them make the best decisions about my illness. It is not easy though….. but what can I do? (P30). Participant number 30 believes that to be able to manage herself she does not look up to someone, she takes responsibility and makes sure she has what it takes for self-management. However, her sentiments, *"It is not easy though….. but what can I do"* indicate some difficulties encountered which means the health care system has to relook at elderly patient management to encourage and support self-management.

'This healthcare system has no proper leadership in elderly patient management as a whole because us as elderly patients worse with multimorbidity surfer more than any other group of patients, they don't take us seriously, looks like no one is available to specifically improve our services. It shows a lack of a system that allows acceptable flow of elderly care". (P22). According to P22 there is no system in place to support elderly patient care, that in turn will enhance self-management. If this system was available, this group of patients would also have specific services like other groups of patients. He ruminates that if this leadership was available it would pursue the development of a care delivery system that would take you for your word and user friendly to reduce the agony this group of patients go through, *"us as elderly patients worse with multimorbidity suffer more than any other group of patients, they don't take us seriously"*.

P21 *"I wish I could have flexible scheduling and telehealth options like what other countries do to reduce movements and expenses.* P21 feels telehealth options and spaced scheduling would help to reduce time wasting and movement to care facilities which in turn would leave space for self-management as time and energy would be spent on other things that need his presence in his self-management journey.

P24 shares similar thoughts with P21, *"I wish services could be integrated in such a way that when I come to the hospital am seen as a whole through a well-coordinated multidisciplinary system. This is better because it will reduce the cost of care and time wasted while waiting for appointment dates in different units, sometimes tests may be done some paid for but will take forever or will go missing due to prolonged appointments*". P24 want services to be integrated so that a multidisciplinary approach can be used in the management of these elderly multimorbidity patients. He believes that if a patient can be seen by different experts at the same time, the patient's time and money can be saved, and in turn, there will be enough time for self-management.

"I need the services when I need them, there are too many delays…… today the physician is not there, tomorrow medicine is not available and the other day it is the examination machine which is down…….. Oops! How can one survive like this? (P20). *P20's sentiments show that service delivery is not adequately given to people as most of the time there is a range of shortages either human resources, medicine or non-availability of equipment. This makes it difficult to access the services as needed as picked from, "there are too many delays…… today the physician is not there, tomorrow medicine is not available and the other day is the examination machine which is down". "……..Oops!"* indicates a sigh of disbelief, frustration and tiredness. How can one survive…... meaning this perpetual happening is out of hand and fears for his wellbeing?

P29 "There is no information about self-management of core morbidities in elderly patients in these hospitals. This is vital and would make it easy to follow certain interventions and procedures according to different hospital policies without wasting so much time and resources". P29 here wants to see charts, the posters that bear different directional and instructional messages about service access, multimorbidity self-management for elderly patients among others to easy acquisition of information and location of service areas.

Superordinate Theme 2: A Well-Functioning Socioeconomic System

This superordinate theme discussed how the socioeconomic system was perceived to be a driver of self-management by elderly patients with multimorbidity though they had some concerns as reported below. Understanding these concerns will help policymakers and healthcare providers to design targeted interventions that will improve the economic stability to support self-management in elderly multimorbidity patients.

P3 "How can I afford medications?..... I struggle to afford medications and treatments because my resources for money is barely enough for food. P3 Here was thinking about the cost of medication. *"How can I afford medications?*". He could not have been affording decent meals, now to add the cost of medication was distressing for him.

"I don't have enough money, am forced to choose between food and healthcare. How I wish healthcare services and medications were that affordable". P8. P8 seemed to be in line with P3, however for P8 it was either he had food or medication as seen in his words, "*am forced to choose between food and healthcare".*

*"I usually worry about putting a financial strain on my family due to medical expenses. I depend on my children, but I'm concerned about their financial security. I think financial support for caretakers like them would lessen their stress"(*P5). P5 was able to meet his needs without bothering anyone. Now he has to wait upon his children who he thinks may not progress financially because of his healthcare expenses. *"I depend on my children, but I'm concerned about their financial security"*. His face was visibly withdrawn. *"I think financial support for caretakers like them would lessen their stress",* This could mean he is not just okey for his children to use all their savings on

him but wishes for some help from somewhere maybe the government could supplement the children's effort.

"*Accessing quality healthcare services is difficult without money as in my case. A steady income would allow one to manage one's health conditions without financial stress. I have managed to pay for healthcare all this long because I sold my house. Right now, I have nothing".(P2).* This discourse reveals that P2 sounds frustrated as she is concerned about tomorrow, *"Accessing quality healthcare services is difficult without money as in my case*". She feels vulnerable, uncertain and some kind of loss of control at the loss of her house for medical expenses as seen in, *"right now, I have nothing".*

For p6 what matters is the financial assistance and health services that are tailored to the needs of the elderly patients. She said, *"Elderly-friendly healthcare services and economic support would give me peace of mind. I now worry about going into poverty as a result of medical bills. Having access to reasonably priced health insurance would protect my future".* She is also aware of the health insurance which she thought self-management would be much easier if it can be used.

"*Am tired .....it is not easy…. sometimes it is difficult looking up to others… even family gets tired. I wish the government could look into this, just a small stipend would do. Medicine, food, and transport all need money. The roof of my house was blown off with wind…. This illness!!!" P7*. P7 fears that his family is now thinking that it is too much of her as seen in, *"Am tired .....it is not easy…. sometimes it is difficult looking up to others… even family gets tired",* such that she wishes that government can render her some help. The statement, *"This illness!!!"* indicates that she was doing well before it but now she feels useless and helpless.

"*I have no problem taking care of myself but I have no resources, am old and retired from work …….. but I need money to come to the hospital, buy the required medicines and also to manage the required dietary needs of my conditions* (P10). P10 lamented the lack of resources for self-care. Without financial stability which was coupled with advanced age, it was difficult for her to meet self-management tasks as stated in his sentiments, *"I have no resources".*

"*I wish the government through community services could help some of us the elderly with financial support to facilitate meeting some required self-management needs, otherwise self-management in itself as a whole is good and manageable. However, it makes me sick realising I can't fully manage myself because of lack of resources". (*P9). P9 argues that he cannot take care of himself fully as expected because the self-care resources are inadequate. This made him wish the government could assist him through other channels, like the community. "Otherwise, self-management in itself as a whole is good and manageable," he said, praising the idea of self-management.

P12 "Thanks to the insurance scheme, some of my care costs are being met halfway some complete depending on the procedure. However, many people are still unaware of how to go about these schemes." P12 here shows some gratitude for the insurance which aims to provide equitable healthcare services for all. "Thanks to the insurance scheme, some of my care costs are being met halfway some complete" He urges that others be enrolled so that they benefit as well.

P 22 *"The cost of living is too high…… I don't know how I'll pay for my treatments…. I'm struggling to survive; this life is not easy … anyway God is there".* P22 is lamenting on the cost care like others. She has hope that somehow God will find a way for and this gives her some hope.

" *I fear what the future holds for me in my old old age when I will not be able to find money for tests and treatment ….. I can't leave without medicine they told me to take this medicine for me to survive I feel like the system has left alone…. "* (P16). P16 sees a system

failure, self-management as observed requires money which is so hard to come by as one ages. This entails a failure of self-management in these individuals without resources.

*Transportation and medication are becoming so difficult for me…. I wish the system was more understanding ..... Yes, we are elderly but patients without resources for care, we need food we need shelter amidst so many self-care challenges….so tough". (*P29). P29 wishes to have a system that would set aside the challenges of the multimorbidity elderly patients and find ways of meeting their financial needs in their self-management process. This is picked from his words, "*I just wish the system was more understanding ..... yes, we are elderly but patients without resources for care*". "*so tough*" indicates helplessness.

P 27 *I'm worried about how I'll keep a roof over my head when all the little resources I find support my health, it is hard to manage these long-standing conditions ..... I'm just a burden to my family…... That's how I feel".* Managing chronic conditions can be expensive, and many elderly patients struggle to make ends meet. This shows in P27's discourse, "*All the little resources I find support my health, it is hard to manage these long-standing conditions". "*I'm just a burden to my family" shows that P27 is dependent on his family for resource mobilisation and feels bad to be dependent.

Superordinate Theme 3: Need for Social Support Networks

One clear thing from these conversations was the yearning for social support networks which included community engagement, resources and services, Family support and involvement, and peer support networks that would help them to deal with self-management issues. Participants reported social isolation which was believed to not only be as a result of multimorbidity but also of getting older.

"Yes the community is important to me personally because out there I would meet my friends preferably old, with many conditions like me and we would be able to compare and share notes….

But such places or groupings in the community are not there, or some wouldn't want to be known that they have multimorbidity". (P4). In this discussion P4 indicated that self-management would be enhanced if there were amenities within his community where he could mingle with other elderly patients with multimorbidity because they would learn from each other's experiences as shown in "*out there I would meet my friends…… We would be able to compare and share notes*". "Friends" denotes the elderly with multimorbidity preferably those who had the same conditions as hers for the sake of sharing information and experiences about self-management activities. *"Some wouldn't want to be known that they have multimorbidity"* exhibited the awareness that not everyone would see such an activity as an opportunity for learning and understanding self-management in different situations.

"*I look forward to seeing a community that dedicates itself to elderly care, where those that are enlightened about them such as nurses or social organizations can bring the community together to help the elderly multimorbidity patients to have workable self-management plans". (*P7). For P7, the community houses these patients and they must be engaged by stakeholders through sensitization to ensure that programs for multimorbidity patients are put in place where self-management can be promoted.

"Communities such as churches need to come up with some activities such as peer groups that will help the elderly to manage themselves as they learn and encourage one another, sowing a seed of doing one's part and leaving the rest to God". (P3). P3 seemed to be inclined in togetherness for better outcomes such as in community peer groups where people can share different views that might work in their best interest.

My wife…. is gone to be with the Lord…. It was much easier then, with her constant push and reminders……. I did not worry much about what to do with myself…. she helped me to manage myself better, I took medicines on time, I never missed hospital appointments, ate meals according to what is permitted in conditions such as mine…. life is hard now". (P9). For P9 Family was important to help him handle self-management activities. His wife made it easier because she understood the importance of self-management as such she constantly pushed him to do the right thing at the right time. *"She helped me to manage myself better"*, suggesting that she did not take over his autonomy but worked with him to achieve better clinical outcomes.

"The challenge is the many medicines because of many conditions…… quite difficult to master and follow their instructions, this makes it inevitable to have a second person from within the community who has the knowledge to guide and take me through until a time am comfortable because doing it all by myself becomes a challenge". (P5). She lamented the burden of coping with several instructions for several conditions as seen in her discussion "*quite difficult to master and follow their instructions*". "*This makes it inevitable to have a second person from within the community who has the knowledge to guide".* The second person probably could have been a buddy or treatment supporter who would be with him for some time to guide him in the initial phase of implementing self-management.

"*Neighbourhood volunteers who are trained by health care systems to assist with self-management activities would be a blessing for me. Just coming once in a while to check how am doing and give me some encouragement."(P6).* P6 wouldn't mind having a volunteer trained by the healthcare system to help him with self-management activities as seen in the statement "*Neighbourhood volunteers who are trained by healthcare systems to assist with self-management activities would be a blessing for me". "Just coming once in a while to check how am doing and give me some encouragement."* Shows some level of lack of confidence in self-management which may be due to not having adequate knowledge of the dos and don'ts of self-management, on the other hand showing the readiness to work towards achieving self-management goals with the community.

"Community education programs on managing multimorbidity would help. I need to see some instances where patients and families would be taught separately according to need or together for general highlights of self-management to reduce conflicts between the patient and family (P8). P8 wishes to seed the community being active through education or sensitisation. She wants to see family members being taught about the elderly and self-management*. As stated in, "patients and families would be taught separately according to need or together for general highlights of self-management." "To reduce conflicts between the patient and family".* means she acknowledges that there are some areas that these social networks need to work on to ensure that self-management is well supported by all stakeholders.

P14, "I need to be linked to support groups, especially those that deal with similar conditions as mine. The healthcare providers will facilitate some educational programmes to help me and my colleagues learn more about our conditions and how to self-manage them in the initial days. I think this would be good enough". P14 wants a healthcare system to encourage social interaction among patients with similar conditions. He sees it as an opportunity where first-hand information about self-management and its various aspects can be taught as picked from his discourse, "*the healthcare providers will facilitate some educational programmes to help me and my colleagues learn more about our conditions".*

P 20 shares some similar thoughts with P14 *"It is not easy to identify these community groups, but the health care system through community engagement would link us to those community resources such as faith-based groups and volunteer programs, I think this will lighten the burden".* P20 discusses the visibility of the community groups if there are any in the communities, they need to be made known so that these patients can access them easily. This is illustrated in his discourse "It is not easy to identify these community groups". "This will lighten the burden", entails that P20 believes that he has something to benefit from such groupings.

"Personally I have very little knowledge about my conditions and self-management. I need someone to lean on. I feel so alone in all this after the loss of my wife" (P18) For P18 this is an indication of loneliness and longing for social support. May do better in social groups for he will not only learn self-management but may benefit from the sense of belonging and network expansion.

P25 "*I need help with both food medication and transport, but I feel shy to say it at my church ……. I don't know how they will take it. But I need someone to talk to……My life is taking a different turn".* P25 knows where to go for help, but she doesn't have the courage as seen in "*I feel shy to say it at my church or anyone…….. I don't know how they will take it". "My life is taking a different turn"* denotes hardships, hence the need to support her in taking the initiative to connect with others, join groups, or participate in self-management activities that will improve her quality of life.

Discussion

In this study, support networks were thought to be crucial for self-management. Findings suggested that support from the healthcare system, socioeconomic system, the community as well as the family can affect how well the elderly multimorbidity patients manage their situations. These findings were incongruent with the studies which concluded that support systems needed to be put in place to achieve self-management and improve the quality of life of these elderly patients [34]. This support is essential in addressing the complex and interrelated medical, social, and economic challenges that these individuals face.

Furthermore, the study suggested that the implementation of an effective healthcare system can enhance the achievement of self-management. The elderly multimorbidity patients yearn for a health care system that would support their self-management by placing knowledgeable professionals who would holistically coordinate the health services. These findings were in tandem with those of Eyowas et al [35] who stated that the healthcare system is not adequately equipped to provide multimorbidity patients with holistic individualised care. This might even be worse for elderly multimorbidity patients whose services seem to be already fragmented. Chen et al, Hernandez et al and Yang et al [36-38] further elaborated that the healthcare systems tend to focus on a single disease-oriented model that does not necessarily meet the needs of those living with multi-morbidity and can lead to fragmentation of care. It is for this reason that an all-inclusive system should be promoted because it will not only be disease-specific but also work to improve the quality of life for these aged multimorbidity patients.

Conversely, the elderly multimorbidity patients lamented the numerous difficulties they encountered traversing the health care delivery system. They were required to transition between various care facilities and appointments for different conditions would fall on different days making them spend most of their time chasing these appointments leaving them with inadequate time for self-management. Providers also occasionally gave contradictory directions which sometimes would be too much to comprehend. These findings mirrored those of Lee et al, Federman and Gobei-Lavoie et al [39, 40, 18] who

concluded by confirming difficulties in traversing the health care system and that multiple care providers may further result in the provision of conflicting information or information overload. This may be worsened in elderly multimorbidity patients because the patient may already have cognitive impairment or be fatigued with the diagnoses and other aspects related to their conditions resulting in frustration, further compromising self-management. Healthcare professionals who took time to educate patients and discover their priorities facilitated patients' navigation of the healthcare system by making relevant information accessible in a way they could grasp it [39]. This implies that health professionals need to personalise the support they give to these patients as this strategy is likely to meet their needs at personal level. The universal level of support could undervalue the intricacy of each person's situation and potentially mentally overwhelm the patient [40, 41]. It would be interesting to understand the organization of health services and guidelines for the management of elderly multimorbidity patients in Zambia as this can give insights into detailed self-management support required from a delivery system perspective. It is this system support which is necessary to facilitate the acquisition of necessary self-management skills among care professionals, that will enable them to organize and teach other systems the necessary skills that would support and reinforce self-management implementation among the elderly multimorbidity patients throughout the gamut of care [42].

Furthermore, the current study revealed that elderly patients with multimorbidity, frequently require significant socioeconomic support to adequately manage their health and preserve their general well-being. These findings support those of Nwadiugwu and Lee et al [43, 39] who indicated that access to affordable healthcare services is one of the most important types of socioeconomic support for self-management that elderly patients with multimorbidity require. This covers continual monitoring and management of their health as well as access to medications, specialised care, and medical treatment for their different chronic diseases. They also need assistance with transportation to honour their hospital appointments and navigate the convoluted healthcare system to make sure they get the service they need.

Financial inability, which comes with old age because of reduced functional ability and multimorbidity makes it difficult to get high-quality care, it results in increased psychological distress and poor quality of life decreasing the chances of survival [8, 35]. The cost of prescription drugs accounts for a significant amount of patients' out-of-pocket expenditures. The resulting poverty and inability to sustain themselves had an impact on their relationship with their family and the quality of support they got from them. Lack of social and familial support further impeded patients' ability to manage their treatment, placing an additional burden on their already meagre resources. These results are consistent with those of previous studies by Lee et al [39] where elderly patients with multimorbidity may not receive enough socioeconomic support because they are reluctant to discuss financial problems with family and others which makes self-management difficulties worse. Such self-restrictions leave them to battle with both physical and financial dependency. Conversely, elderly people with multimorbidity frequently need help with basic needs including housing and food security. These findings are akin to those of Kantilafti et al [44] who found that food insecurity and lack of good housing exacerbate multimorbidity in elderly patients. This could be because most of these individuals might be on fixed incomes or struggling to make ends meet [39] which are also associated with self-management ability as they fail to pay for the services. Ultimately, comprehensive socioeconomic support is crucial for elderly patients with multimorbidity in executing self-

management activities to preserve their quality of life. Through tackling the intricate social and economic obstacles that these people encounter, there is a compelling need to ensure that they obtain the assistance and resources needed to lead fulfilling lives despite their persistent medical illnesses. This entails that socioeconomic support services, such as aid with applying for government benefits or programmes such as the National Health Insurance Scheme (NHIS) such as NHIMA can help to ease some of these financial difficulties. Therefore, communities need to be sensitized extensively to help these elderly people to utilize this service.

Furthermore, the study found that social support services obtained from social networks, including the community, family and peers are essential in helping the elderly multimorbidity patients with their self-management tasks that would promote their optimal quality of life. These findings were congruent with those of Fleilich and Brekner [16, 9] who showed that support services were crucial for self-management in elderly multimorbidity patients through primary healthcare systems, where these categories of social support networks fall. Nonetheless, the results of this study showed that social support networks can function effectively if they are adopted early enough in self-management to cover the perceived gap between the healthcare system and the social networks. This early engagement may therefore be necessary to influence and unlock the abilities needed for self-management. According to Piolatto et al [45] consistent social engagement and interaction can lower the risk of cognitive decline and other detrimental health effects, while also promoting mental health and general well-being. This support may include access to social activities, support groups, or other resources from social networks that can help elderly patients with multimorbidity stay connected and engaged in activities that will support their self-management.

In this study loneliness, helplessness and frustration were cited to be daunting self-management in elderly multimorbidity patients. These findings reinforced the findings of Roskoschinski et al [46] who reported some positive correlation between loneliness and depressive symptoms which all impede the quality of life in these elderly patients. Therefore, there is a need to ensure that social networks get involved in different activities at different levels of self-management. In the community, local community centres such as churches in collaboration with health care systems can provide educational programs on self-management in relation to medication management, healthy lifestyle choices, navigating the healthcare systems, financial aid and coping mechanisms for dealing with various health issues. Educating these groups about the importance of self-management and their specific needs according to their conditions can foster a supportive environment that empowers elderly multimorbidity patients to take control of their health [47]. This is because the social connections one has can provide emotional support that helps reduce psychological distress experienced as a result of failing health and insufficient income. However, there is a need to ascertain community acceptability and support of self-management in elderly multimorbidity patients, to preserve the plight of this special population.

It was also found in this study that self-management in multimorbidity elderly patients took place in the presence of family members. It was believed that a well-functional family unit can offer constructive emotional support that elderly multimorbidity patients may need. This support may potentially enhance self-management and improve the overall quality of life for these patients. These findings are in agreement with those of Lee et al [39] who found that, the children of these multimorbidity elderly patients (who are part of the family) have a key role as caregivers, interpreters and bridges the existing gap between the patient and

the care professionals that may result from the elderly patients' literacy, language difference, technological literacy and reduction in cognitive capacity related to advancing age. In this case, the family can be encouraged to accompany their loved ones to doctor's appointments, help them in managing medications as well as to develop appropriate coping mechanisms. Family members can also assist in creating a conducive environment for self-management practices and also serve as advocates for elderly patients, ensuring that they receive appropriate care and treatment from professional health carers [48]. However, according to this study, family members need to preserve the autonomy of these patients. They need to leave room for consultation and involvement of these patients in key decision processes, as this will reduce frustration and enhance self-management.

Furthermore, the study revealed that elderly multimorbidity patients might also benefit greatly from peer support since it can be comforting and enlightening to connect with others who are experiencing comparable medical difficulties. These groups offer a means of addressing feelings of loneliness, pessimism, and depression associated with disease and ageing when generational companions have passed away. The results align with the study that was conducted by Joo et al [49], which emphasised the significance of peer support and its myriad advantages for receivers. These advantages include a decrease in social isolation, enhanced self-care skill acquisition, ease of navigating the healthcare system, and access to community-based resources.

Therefore, professional experts can refer and encourage these patients to join peer support groups designed especially for elderly multimorbidity patients. According to Hevey et al [34], these support groups can offer forums for the exchange of knowledge, experiences, and emotional support. It may be possible to create peer-led programmes that assist participants in improving their understanding, self-assurance, and symptom management abilities. Elderly multimorbidity patients who establish a robust support network can get the tools and guidance they require to carry out their self-management responsibilities in a way that will enhance their health and preserve their quality of life. For older multimorbidity patients, peer, family, and community support are crucial facets of self-management. Engaging these groups can help create a more cohesive and empowered system that improves these people's general health and well-being by lowering feelings of isolation, offering essential knowledge for overcoming a variety of health difficulties, and boost self-management motivation. All of these benefits add up to a comprehensive and empowering system that improves these people's general health and well-being. In order to track the progress of self-management and provide the necessary assistance for them to maintain their health, it is necessary to build community-based services like home healthcare services or community outreach programmes through primary healthcare [9, 16]. Nevertheless, information about the adverse effects of support networks is very scanty, more research is needed in this area to create an equilibrium.

Conclusion

This study showed that there are unmet support needs for self-management among elderly patients with multimorbidity. These were discussed under the three pillars of self-management support which included the need for a responsive healthcare delivery system, a well-functioning socioeconomic system, and social support networks. The study revealed the urgent need for a multifaceted approach to address the complex challenges faced by elderly multimorbidity patients that include the development and implementation of policies promoting integrated care that will foster collaboration among healthcare providers, policymakers, and community organisations in

investing in healthcare infrastructure that promotes comprehensive management of elderly patients, strengthening socioeconomic systems to address poverty and inequality as well as establishing and strengthening comprehensive social support networks. However, there is a need to develop evidence-based guidelines for care coordination and evaluate effective support systems which will work to improve the self-management of elderly multimorbidity patients.

Conflict of Interest

The author declares no conflicts of interest related to this research.

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