



Exploring the Resilience of Healthcare Workers Working with Home-Based Palliative Care Clients in Rural Communities: A Case of St Bernard's Hospice, East London, South Africa.

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Abstract

This study explores the resilience of healthcare workers, working with home-based palliative care clients in rural communities: The case of St. Bernard's Hospice, East London, South Africa. A qualitative research design, grounded in an interpretivist paradigm, was employed. Primary and secondary data sources were used. Semi-structured interviews were administered to eleven participants purposively selected. Findings on home-based palliative healthcare workers' experience of resilience revealed that resilience is interwoven and integrated into multiple domains of the palliative healthcare workers' lives, reflecting how assets and resources exist within a person, their life, and their surroundings. Contrary to the family's need to "hold on", complicates end-of-life care for the patient, as the family's suggested treatments may not align with the patient's comfort and dignity. The non-availability of human, physical and financial resources hurts palliative healthcare workers and their patients. The ability of healthcare workers to persevere in rural palliative care settings, such as nurses, community health workers, and home-based caregivers, is a crucial but frequently overlooked element that keeps care going in locations with limited resources. This resilience has important implications for social workers' roles in rural health policy advocacy, support system structure, and multidisciplinary team operations.

Keywords: Clients, Healthcare Workers, Home-Based Palliative Care, Resilience, Rural Communities

Introduction

Palliative care is the active, all-encompassing treatment of people of all ages who are suffering from severe health-related symptoms because of a serious illness, particularly those reaching the end of life (Radbruch et al., 2020). Its major purpose is to improve the quality of life for patients, families, and

caregivers by preventing and alleviating suffering, managing pain, and meeting physical, emotional, and spiritual needs (World Health Organisation (WHO), 2020; Teoli et al., 2023). Globally, the demand for such treatment is particularly evident in developing countries. South Africa, an upper-middle-income economy, has a significant healthcare imbalance, with most of its population underserved (Rensburg, 2021). Approximately 84% to 85% of the population relies on the under-resourced public health sector, while a well-funded private sector serves only the 14% to 16% who can afford premium health insurance (Statistics South Africa, 2026).

This inequality has a significant impact on a population burdened by a complex quadruple illness profile: human immunodeficiency virus (HIV), tuberculosis (TB), noncommunicable diseases (NCDs), and trauma (Samodien et al., 2021). South Africa has the world's largest HIV population, estimated at 8 million persons (about 12.7% to 12.8% of the population) (Spotlight, 2025). South Africa is still one of the World Health Organisation's top 30 high-burden nations for tuberculosis (TB), drug-resistant TB, and HIV-associated TB (Davids & Crowley, 2024), making the disease a primary natural cause of death and a major public health emergency. According to World Health Organisation data, an estimated 249,000 persons in South Africa contracted tuberculosis in 2024, with roughly 54,000 fatalities attributed to the disease (Spotlight, 2024). South Africa's large-scale antiretroviral therapy has successfully decreased overall fatalities and new HIV infections (Reniers et al., 2017). Millions, however, continue to have unsuppressed viral loads due to gaps in connecting patients to care, retaining them in treatment programs, and ensuring daily medication adherence (Reniers et al., 2017).

Peri-urban and informal settlements are often characterised by lower infrastructure densities, systemic poverty, and geographic fragmentation from central metropolitan health facilities (Hall, 2020). These socioeconomic limitations frequently impair a community's capacity to attract and sustain infrastructural investment (Hall, 2020). In these under-resourced settings, formal healthcare infrastructure is constrained, putting the burden of end-of-life care onto home-based palliative programs. Consequently, the well-being and sustainability of community-based healthcare workers directly influence the quality and safety of patient care in vulnerable communities (Strasser et al., 2016). When staff experience burnout or stress, patient outcomes inevitably suffer (Strasser et al., 2016). Daily exposure to chronic, terminal illnesses alongside systemic resource constraints severely threatens the psychological well-being of these professionals (Zanatta et al., 2020; Zhang et al., 2023).

Caregivers face immense physical, mental, and financial hardship while providing home-based care in low resource environments (Moore, 2023). Scant access to medical supplies, severe poverty, and social isolation compound this burden, frequently culminating in caregiver burnout and compromised patient outcomes (Raina et al., 2005). Similarly, professional healthcare personnel bear profound emotional costs when operating without institutional backing. In the absence of a supportive workplace safety net, coping with phenomena like moral distress, compassion fatigue, and vicarious trauma takes a significant psychological toll (Filaj & Sota, 2026). Ultimately, this lack of institutional support often leads to professional depersonalisation and a subsequent decline in the quality of care provided (Hodkinson et al., 2022).

Despite these pervasive risks, empirical literature offers limited insight into how community-minded, home-based healthcare workers navigate these challenges. Resilience, defined as the positive adaptive responses of individuals or communities to adversity, trauma, or severe stressors (Grygorenko & Naydonova, 2023), provides a vital conceptual framework for understanding workforce sustainability. Increasingly, resilience is viewed as both a malleable competency and a proactive professional attitude that enables home-based palliative care workers to maintain high-quality patient relationships despite overwhelming systemic hardships (Jackson et al., 2007; Zwack & Schweitzer, 2013).

This study explores the experiences of home-based palliative care workers at St Bernard's Hospice in East London, South Africa. Specifically, it aims to: (1) explore how home-based palliative healthcare workers experience resilience, (2) identify the structural and emotional hurdles they face in achieving resilience, and (3) isolate the core resilient characteristics common to these individuals. The paper concludes by outlining the relevant research methodology, results, and discussion.

Methods

Participants

This study adopted a qualitative research design situated within the interpretivist paradigm. This approach views reality as socially constructed and subjective, aiming primarily to understand the experiences, meanings, and social contexts that shape human behaviour (Otani, 2020). Rather than gathering objective, quantitative metrics, interpretivist researchers seek profound insights into how individuals make sense of their lived experiences (Ismail et al., 2021). This framework emphasises qualitative methods, such as interviews and observations, to explore how participants understand their reality and how knowledge is co-created through the interaction between the researcher and the participant. Throughout this process, reflexivity was meticulously maintained to acknowledge and manage how the researcher's background might influence this co-creation. A case study design was employed from April to October 2023 to investigate the resilience of healthcare workers providing home-based palliative care at St Bernard's Hospice in East London, South Africa. Rather than pursuing broad statistical generalisations, the goal was to achieve a thorough, contextual grasp of the phenomena under study.

The study population comprised the multidisciplinary palliative healthcare team at St Bernard's Hospice in East London, South Africa, who provide home-based palliative care to patients within the Buffalo City Metropolitan Municipality. According to institutional directorate data (2023), the full hospice team consists of 19 personnel (Table 1). This institutional cohort served as the target population from which the final sample was drawn.

Table 1

Palliative healthcare team

Palliative care team role	Number
Nurses	3
Carers	12
Social worker	1
Social auxiliary worker	1
Spiritual counsellor	1
Medical doctor	1
Total	19

Source: Hospice Directorate Data (2023).

A sample of 11 participants was selected using purposive sampling (Table 2). Purposive sampling is a non-probability sampling method widely utilised in qualitative research to deliberately select participants who possess specialised knowledge or direct experience with the central phenomenon (Adeoye, 2023; Etikan et al., 2016). This technique allows researchers to focus on specific demographic cohorts and professional roles, yielding a deeper, information-rich exploration of the research questions (Palinkas et al., 2015; Patton, 2015).

To be included in the study, participants had to meet the following criteria: (1) a minimum of 12 months of employment or affiliation with St. Bernard's Hospice; (2) fluency in English; (3) active provision of home-based palliative care services within the Buffalo City Metropolitan area; (4) formal registration or appointment in their respective institutional roles; and (5) a voluntary willingness to participate. Based on these criteria, three nurses, one social worker, one medical doctor, and six carers were selected, culminating in a final sample size of 11 participants.

Table 2*Selection of study participants*

Palliative care team role	Total	Purposive sampling
Nurses	3	3
Carers	12	6
Social worker	1	1
Social auxiliary worker	1	0
Spiritual counsellor	1	0
Medical doctor	1	1
Total	19	11

Source: Field Work (2023)

The study utilised both primary and secondary data sources. The primary data consisted of verbatim transcripts from individual, semi-structured interviews, which allowed the researchers to use open-ended questions to elicit detailed narratives regarding the participants' motivations, emotions, and lived experiences. These interview data were supplemented by non-participant observations. The researchers recorded real-time behaviours, environmental dynamics, and interactions in their natural settings within detailed field notes, reducing sole reliance on participant self-reports. Secondary data sources, including government reports, hospice documentation, and peer-reviewed literature from databases such as Google Scholar, ResearchGate, ScienceDirect, and Web of Science, were utilised to provide structural context, theoretical grounding, and comparative insights.

Survey Instrument

The primary qualitative data collection instrument was an in-depth, semi-structured interview guide developed by the researchers. The guide was divided into two distinct sections: Section A captured demographic and professional profiles, while Section B comprised open-ended questions targeting the core research objectives and structural hurdles to resilience. To ensure data fidelity, digital voice recorders were used to capture the audio of each session, supplemented by dedicated field notebooks for contextual observations.

Procedure

Data collection was executed through face-to-face, individual interviews conducted in a quiet, private room at St. Bernard's Hospice to ensure participant comfort and confidentiality. Prior to commencing each session, the researchers explained the study's purpose, scope, and objectives, and walked the participant through the informed consent process. Once voluntary, written consent was secured, the interview proceeded using the semi-structured guide. The open-ended format allowed participants to express their experiences freely, with the researchers using neutral prompts to explore emerging themes. All interviews were digitally audio-recorded with explicit permission.

Statistical analysis

In alignment with the study's interpretivist paradigm, an inductive thematic analysis was conducted to organise, interpret, and derive meaning from the qualitative datasets (Williamson et al., 2018). The analysis followed the six-step iterative framework outlined by Naeem et al. (2023) to systematically move from raw text to conceptual themes:

- Immersion and Familiarisation: Repeated reading of the generated transcripts and field notes to gain an intimate understanding of the narratives.
- Topic Induction: Identifying recurring patterns, concepts, and broad issues across the entire dataset.

- Coding: Generating and assigning meaningful codes to discrete segments of text.
- Elaboration: Restructuring, merging, and exploring fine nuances within the codes to capture complex relationships.
- Interpretation: Moving beyond descriptive reporting to attach conceptual and theoretical meaning to the emerged themes.
- Verification: Validating the finalised themes against the raw transcripts to ensure rigor, trustworthiness, and descriptive accuracy.

Ethical Considerations

Prior to the fieldwork phase, all institutional and formal ethical protocols were strictly addressed. Ethical clearance to conduct this research involving human participants was officially obtained from the University of Fort Hare Research Ethics Committee (UREC). Concurrently, formal administrative permission to conduct the study was secured from the executive management of St. Bernard's Hospice in East London, South Africa.

The study strictly adhered to the following core ethical principles throughout the research process:

- Informed Consent: The researchers verified that all participants were legally and psychologically competent to provide autonomous, written consent. Before signing the consent forms, participants were fully briefed on the study's purpose, scope, potential risks, and their right to withdraw from the research at any stage without fear of penalty, institutional prejudice, or loss of benefits.
- Voluntary Participation: Engagement in the study was entirely voluntary. No incentives, coercion, or institutional pressure were used to recruit participants, ensuring that the decision to take part was an exercise of absolute participant autonomy.
- Anonymity and Confidentiality: To safeguard the identities of the participants, all personally identifiable information was stripped from the interview transcripts and field notes. Participants were assigned alphanumeric codes (e.g., Nurse 1, Carer 3) to ensure complete anonymity. Furthermore, the participants were guaranteed that no identifying institutional or personal details would be disclosed in the final research report or any subsequent publications.
- Data Security: All digital data, including audio recordings, verbatim transcripts, and analytical matrices, were encrypted and stored on password-protected cloud storage devices accessible exclusively to the primary research team. Hardcopy field notes were secured in a locked filing cabinet and will be retained for the institutionally mandated period of five years, before being permanently destroyed.
- Minimisation of Harm: Given the sensitive nature of discussing palliative care, moral distress, and burnout, the researchers remained highly sensitive to emotional distress. Participants were monitored throughout the interview process, and provisions were made to pause or reschedule interviews if a participant experienced discomfort.

Results from Analysis

The results focused on the three themes that emerged from the study, with accompanying subthemes that emerged from the interpretive data analysis. These themes and subthemes are presented and discussed (Table 3).

Table 3

Themes and subthemes

Themes	Subthemes
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Integrative resilience	1. Well-being resilience
	2. Therapeutic interventions
	3. Resource resilience
Barriers	1. Organisational challenges
	2. Familial conflict
Desperation for life	1. Familial
	2. Medical

Source: Field work (2023)

Theme One: Integrative Resilience

Resilience is the ability to effectively negotiate, adapt to, or manage major causes of stress or trauma (Windle, 2011). Individuals' assets and resources, as well as their life and surroundings, contribute to their ability to adapt and 'bouncing back' in the face of adversity. According to information from the in-depth interview:

Firstly, by talking, we had 14 deaths in 20 days, and it's hard to process all of that, but we are a team, and we talk, we share, and we cry. We also ensure that we take time off regularly to fill our cups, and generally we love each other, and we love our job, and we love our patients, and we realise that a problem shared is a problem halved, and we do utilise that, I utilise that a lot with the spiritual worker (P. 1).

Another respondent said: *"I love that I give and support to the people and see the people die in peace, and families still have that support from us"* (P. 3).

Resilience processes in palliative healthcare workers occur across multiple domains where they need to consider their own skills and experiences, which builds their resilience levels to the concept of holistic resilience.

Subtheme One: Well-being Resilience

The ability to employ well-being resilience in daily functioning with terminal patients has been supported by the participants' comments noted below:

"Being a palliative care worker is difficult; we are dealing with death and dying, but I have the greatest privilege that could ever be given to any person, and I am the one who is with the patient through their walk, and none of my patients will ever go to hell" (P. 5).

Another participant added that: *"To make sure that the patient is pain free and for them to accept what is happening and so see the love and smile on the patient's face when they die"* (P. 10).

A participant was of the view that: *"There is often conflict because it is a very hectic job. There are a lot of deaths, a lot of admissions and a lot of old patients, and our tensions run high"* (P. 7).

Subtheme Two: Therapeutic Interventions

When exploring the therapeutic intervention processes of participants, the following resilience processes were revealed by the participants.

According to information from the in-depth interview, a participant advanced that:

"I am a Christian; I speak to God a lot, and I ask for his guidance and wisdom".
 "So generally, I try to take care of myself. Sport helps if you can do sport or walking and just also being very aware of yourself and where you are at" (P. 6).

To add to this view, another participant said:

If I am going through a hard time, I pray, and I get someone to talk to. Mostly, I talk to my pastor." "I pray in the evening and in the morning, at three O'clock. I got three times after eight O'clock with the Lord. I put on a DVD and worship, and

then I worship and sit under that music and worship God and talk to God. We have one of our board members who is a psychologist, so if we do have problems that we cannot overcome, we will go to her and speak to her (P. 2).

Subtheme Three: Resource Resilience

Hospice Palliative Care Association (HPCA) adopted an integrated community-based home care model for palliative care in 2004 to address the crisis of insufficient nurses and doctors providing palliative care services in rural communities in South Africa (Drenth *et al.*, 2018). The National Department of Health and the Department of Social Development recognised and approved this model and commissioned Hospice Palliative Care Association to duplicate this model in urban, peri-urban and rural communities where limited care is available (Drenth *et al.*, 2018). According to a participant, in-depth interview revealed that:

I was living in Duncan village, and there was an announcement that the hospice needed people to train as home-based carers, so I was one of the people who were elected by the community to come into the Hospice and train (P. 4).

The palliative care workers shared that providing palliative care in a home-based environment provided support to the patient and the healthcare worker.

The positive is:

Working together with the family at home, they know exactly what is needed. You know, that's what makes life easy for us" (P. 9).

Another participant said that:

The positive aspect of the patient being at home is that you are in your own environment. You are in your own room, which you know. You have your family members that you see often, your loved ones, and it makes the pain so much easier (P. 8).

Theme Two: Barriers

Several participants commented on the challenges they experienced in providing palliative care in a resource-limited country. According to a participant:

We have huge areas to cover, so the nurses can't stay in the house the whole day, they must stay maybe for two hours only (P. 7).

Another participant said that:

This patient is HIV-positive, and she has TB in her spine, so she cannot move; she needs assistance. She is staying alone in the shack, she can't do anything, she is bedridden. We must involve the community members to take care as well, to make sure the patient is looked after, because our carers start at eight and end at four (P. 10).

In the same vein, a participant reiterated that:

The homes that we go into are poor and people don't have facilities, and you know, you are lying on a mattress on the floor of a shack" (P. 1)

From the above participation quotations, it can be surmised that the findings support the literature in that the increase in demand for palliative care services in rural communities in South Africa has led to various barriers in palliative care and, as a result, has placed a significant amount of pressure on hospice services and palliative healthcare workers in South Africa.

Subtheme One: Organisational Challenges

The study revealed many organizational challenges faced by St Bernard hospice in East London, South Africa. A participant posits that:

I find my biggest challenge is probably the administration side of things because there isn't enough time and there are too few staff and are called at any time" (P. 4).

Another participant stated that:

There are challenges as in equipment as a hospital bed is often ideal to nurse a terminal patient, to lift, to change and most of the patients don't have (P. 3).

Another participant said,

I have other patients that I often feel I must neglect due to the priority, we always prioritise on the dying people, the people who are really needing our care at the time" (P. 1).

Another participant advances the view that:

Often, it's the distance we must travel, it's the lack of equipment, like it's not a proper hospital bed or there's not enough space or you don't have all the equipment available can be a problem (P. 6).

Subtheme Two: Familial Conflict

The quotations below highlight the frustrations that the palliative healthcare workers experienced when being faced with familial conflict. According to a participant:

So, there is often a lot of conflict near the end, often a lot of unresolved feelings between the kids. The patient lingers and lingers and should be dead; however, the patient holds on because they would like to see unity amongst the kids. This is a huge challenge for me (P. 11).

To support this view, another participant said:

I think you need to be compassionate, and you need to have empathy, empathy to put your shoes in theirs. But what you know, that breaks that at times, is the families. Most of the time, the families are the ones that are the patients (P. 4).

Theme Three: Desperation for Life

The following comments from participants highlight the challenges that palliative healthcare workers experience when a patient's death is prolonged:

According to a participant:

The longer a patient lingers, the more complications develop, like the wet chest, bed sores and things like that, which pushes totally against what we as palliative care sisters want for the patient (P. 1).

Similarly, another participant said:

So, we have a specific protocol that we follow; we usually just give Buscopan injections to dry up the secretions and check to ensure that the patient is calm and dies a beautiful death as deserved (P. 11).

Subtheme one: Familial

The participants shared the following comments, which highlight the desperate need for the family to keep their loved ones alive.

According to the information from the in-depth interview:

The hardship I encounter is when the family are adamant that this patient must go to the hospital. As we are not a curative department, we are palliative. So usually, we can see if there's no need to like, go rush the patient to the hospital, to have an IV, to have all that, which is going to get worse if you see the condition of the patient. It is not going to help; it is going to elongate the sickness (P. 3).

Another participant said:

Most of the time, the husband still wants to sleep with the wife or vice versa and wants to sleep in a double bed, but it is very difficult to do palliative care in a double bed (P. 2)

In the same light, a participant expresses the view that:

Often, the families panic, and the patient ends up in the ICU, and you know, people don't get to that place of acceptance. So, if there has been inter-family stress, there's more inter-family stress; that is what I find hard (P. 1).

Subtheme two: Medical

The findings support the above statement by Pfeil *et al.* (2015), as a participant shared the following:

So, I think the biggest challenges come from working with oncologists in that the oncologists don't know when to stop. They don't have those difficult discussions with the patients and then don't afford the patient and their families time to come to a sense of acceptance and peace, and refer the patients to us way too late, by which time they are already very terminal (P. 8).

Discussion

The study explores the experiences of home-based palliative care workers at St Bernard's Hospice in East London, South Africa. Specifically, the study aims to: (1) explore how home-based palliative healthcare workers experience resilience, (2) identify the structural and emotional hurdles they face in achieving resilience, and (3) isolate the core resilient characteristics common to these individuals. The discussion of findings focused on the three themes which emerged from the study, with accompanying subthemes that emerged from the interpretive data analysis.

Examining a person's internal capabilities as well as the external resources they have access to in their daily lives and environment is necessary to integrate resilience. Instead of seeing the palliative care worker as an isolated person in need of repair, this systemic approach sees them as a component of a greater ecosystem. The palliative healthcare worker's capacity to recover and adjust during hardship and difficulties in their workplace is facilitated by these combined assets and resources (Pangallo *et al.*, 2016). This ability to overcome hardship is reinforced for the home-based palliative care workers at St. Bernard's Hospice in East London, South Africa, via active resilience processes that allow for favourable results despite systemic constraints (Van Breda, 2018).

The results presented in this study demonstrate the participants' natural capacity to deploy resilience holistically by utilising both internal coping strategies and external support networks. This is consistent with research on self-care among palliative care workers by Bovero *et al.* (2025), which found that highly successful carers often use a combination of lifestyle and emotional coping strategies. Participants recognised certain therapeutic interventions; mindfulness, debriefing, and spirituality, as essential systemic and individual resources in the resource-constrained Buffalo City Metropolitan area.

In these rural communities, prayer and upholding a relationship with God emerged as a potent internal component for overcoming adversity, enabling workers to turn to their faith for consolation and hope (Manning *et al.*, 2019). On the outside, mindfulness training was a useful tactic for fostering resilience, allowing employees to stay in the present and successfully handle demanding emotional situations (Nuere & De Miguel, 2021). Additionally, organisational resources like self-care routines and structured debriefing provide vital team-level assistance, allowing employees to consider important events and work together to enhance performance in the future (Floridis, 2023). In the end, creating a localised home-based palliative care paradigm will improve these multilayered resilience processes and foster professional flourishing by viewing resilience through this integrated, socio-ecological lens.

The second major theme emphasises the significant obstacles that palliative healthcare professionals face in their efforts to provide high-quality treatment. Results show that these obstacles are caused by a lack of institutional resources, patients' low socioeconomic level, and

complicated family dynamics, all of which have a negative impact on patients' and healthcare worker's wellbeing.

One of South Africa's least economically feasible areas is East London. Palliative care services are very limited in this town, which significantly affects patient longevity because basic nursing care is lacking. Palliative services in rural South African communities are also severely strained by the growing prevalence of both infectious and non-communicable diseases, such as cancer, HIV, and tuberculosis. Healthcare workers are subjected to more demanding and emotionally taxing workloads due to the rising disease burden (Koontalay et al., 2021), which puts their optimistic outlook, which inspires them to persevere in the face of difficulty to the test.

Both nationally and organisationally, these systemic issues are reflected. According to Drenth et al. (2018), 40% of South Africans will eventually need palliative care. St. Bernard's Hospice, a non-profit organization that offers free palliative care, is a prime example of this pressure because it no longer receives funding from the Department of Social Development and must instead rely solely on individual donors and independent fundraising. Due to significant funding constraints, South Africa confronts widespread challenges in providing palliative care because of critical shortages in both people and physical resources (Smith et al., 2020). As a result, even though the World Health Organization clearly acknowledges palliative care as a basic human right that ought to be provided through integrated public services (Pangallo et al., 2016), empirical research demonstrates that socioeconomic disparities and a lack of resources prevent universal access throughout the Buffalo City Metropolitan area (Smith et al., 2020).

Similar challenges with relation to operational continuity and resource allocation have been reported worldwide. According to Midtbust et al. (2018), one of the main obstacles to providing good palliative care is a lack of staff consistency. Frail, bedridden patients are disproportionately disadvantaged by strict time limitations and increased efficiency demands, leaving medical professionals professionally divided between the need to help the larger resident population and the need to maximise individual patient contact. The high deployment of temporary nurses and doctors, along with frequent patient migration between sheltered and long-term wards, seriously compromises the continuity of care planning and delivery, even though advanced care planning is an essential facilitator for high-quality care (Midtbust et al., 2018).

Another significant barrier to providing care is interpersonal conflict. Even though death is a natural part of life, dealing with it is nevertheless quite difficult since family networks must make difficult end-of-life decisions (De Stefano et al., 2021). When stakeholders are under a great deal of emotional stress, family conflict becomes extremely difficult to handle, even if it can occasionally encourage open discussion if it is thought to be resolvable. These conflicts have disastrous effects on the patient, the healthcare worker, and the larger family network if they are not resolved near the end of life (Benson et al., 2019).

In palliative settings, staff-to-family conflict and inter-family friction are common (Lichtenthal & Kissane, 2008). The study's empirical results support those of Benson et al. (2019), showing that severe end-of-life family conflict significantly impairs care. In the end, family conflict poses a significant operational and psychological challenge for palliative care providers; participant reports indicate that dying patients often go through extended periods of active dying ("lingering") as a psychological expression of their wish to see family reconciliation prior to death.

The urgent necessity for the patient's family and the medical community to keep the dying patient alive despite the cruel medical problems that may arise was the third major issue that surfaced from the data analysis. In addition to feeling despair when they are unable to alleviate their loved one's suffering, family members frequently experience significant levels of stress that manifest as anger, sadness, interpersonal conflict, and psychosomatic issues (Akdeniz et al., 2021). Families often find it difficult to accept the fact that death is imminent, even after a protracted illness and admittance to palliative care. The family frequently feels a strong urge to

"hold on" when they realise that recovery is not feasible, even though a palliative healthcare worker may be able to perceive that death is imminent (Kehl et al., 2009). This way of thinking makes end-of-life care extremely difficult because it frequently results in harsh therapies that jeopardise the patient's comfort and dignity.

Extending a patient's life goes against the core principles of palliative care, posing serious moral conundrums that have a detrimental effect on the patient's and the healthcare worker's wellbeing (Gauge et al., 2023). Legal frameworks and professional guidelines require that the patient's interests take precedence over the family's when these ethical dilemmas occur during treatment decision-making (Akdeniz et al., 2021). Legally, doctors are not required to save lives at any costs, and patients cannot seek care that is not in their best interests (Akdeniz et al., 2021). True end-of-life care entails a change in treatment objectives to prevent or alleviate suffering while scrupulously honouring the patient's wishes rather than stopping therapy altogether (Masel & Kreye, 2018).

The systemic conflict between palliative teams and oncologists is a major obstacle to providing the best possible end-of-life care. According to Pfeil et al. (2015), oncologists often show resistance to discussing therapeutic limitations or making early referrals to palliative care. As a result, patients are referred to palliative care too late, which reduces the efficacy of these services and leaves families struggling to find peace and acceptance. Oncologists frequently utilise their professional authority to deliver harsh, ineffective treatments because they are reluctant to conduct timely end-of-life conversations. Palliative healthcare workers can comprehend the structural factors affecting their personal and professional well-being as well as the dignity of the dying patient by analysing these transactional power relations.

Social work and palliative frameworks need to think beyond simple vulnerability to traverse these complicated processes. A thorough assessment must recognise that a client is more than just their problems; it must actively uncover their coping mechanisms and strengths, even though social work typically poses pathogenic concerns about how adversity affects vulnerable people (Van Breda, 2018). To reduce family suffering and fend off the systemic pressures of over-medicalization at the end of life, it is crucial to foster these cooperative partnerships.

Conclusion

Three major themes and seven subthemes resulted from the data analysis, which the researchers presented. Relevant quotes from participants were used to support these conclusions, which were then critically examined and contextualised through a review of the literature.

Resilience is intertwined and integrated into many aspects of the lives of home-based palliative healthcare workers, according to the research. This resilience reflects the resources and assets that are present in an individual, their life, and their environment, enabling them to overcome hardship and adjust to obstacles in the workplace. Developing a closer relationship with dying patients reduced levels of death dread and provided a sense of fulfilment, which acted as a buffer against stress-like symptoms. Additionally, debriefing, spirituality, and mindfulness were found to be effective therapeutic therapies. Prayer and a relationship with God were acknowledged as potent elements for overcoming hardship and building resilience, allowing employees to rely on their faith for consolation and hope. Additionally, by enabling a more humane approach to palliative care and offering additional support to the patient, family, and healthcare worker, the home-based strategy improved resilience.

The second subject emphasised the significant obstacles faced by palliative care workers because of the rise in both communicable and non-communicable diseases in rural South African communities. Healthcare professionals are under a great deal of pressure to "keep going" in the face of difficulty because of the increased demand for services. This is made worse by Hospice East London's lack of financial, human, and material resources, which has a detrimental impact

on both staff and patients. Palliative care is not being effectively implemented in these rural regions despite the World Health Organization's recognition of it as a human right to health because Hospice East London does not receive government financing. Family strife also posed a serious problem; patients would frequently "linger" because they wanted to see the family come together before passing away.

The third topic focused on the medical community's and the patient's family's frantic need to keep the patient alive despite potentially cruel medical issues. Palliative care workers faced a significant obstacle because of this "desperation for life" mentality, which puts patients through unnecessary pain. Because recommended therapies might not be in line with the patient's comfort and dignity, the family's need to "hold on" makes end-of-life care more difficult. The patient, the family, and the healthcare worker are ultimately harmed by what seems to be a lack of understanding between the two professions. The study recommends that, based on the findings, it will be important to support public-private financial partnerships to maintain rural healthcare models and incorporate structured psychological support and spiritual care into palliative worker training.

Limitations

This study's limited, qualitative sample size and localised, single-site case study design are its main drawbacks. The results cannot be extensively applied to all home-based palliative care contexts in South Africa or other developing countries due to the exclusive focus on St. Bernard's Hospice in East London, which reflects the socioeconomic realities of the Buffalo City Metropolitan area. Additionally, the study used a selective sample of just 11 participants from a multidisciplinary team of 19, thus eliminating the opinions of spiritual counsellors and social auxiliary workers who would have provided different perspectives. Lastly, the study lacks the objective generalisability and standardised metrics found in quantitative research because it is based on an interpretivist paradigm that uses self-reported semi-structured interviews and qualitative thematic analysis. As a result, the data is intrinsically subjective and co-created through researcher-participant interaction.

Recommendations

Given that organisations like Hospice East London do not get government funding, the study suggests creating and promoting public-private financial partnerships to sustainably fund and maintain rural healthcare models. To assist healthcare professionals in managing stress, burnout, and moral anguish, it is advised that formal, structured psychological support networks be incorporated into palliative care training programs. To better prepare palliative professionals to manage their own spiritual needs as well as those of patients and families facing end-of-life difficulties, the study suggests integrating spiritual care frameworks into their training.

References

- Adeoye, M. A. (2023). Review of sampling techniques for education. *ASEAN Journal for Science Education*, 2(2), 87-94. <https://ejournal.bumipublikasinusantara.id/index.php/ajsed>
- Akdeniz, M., Yardımcı, B., & Kavukcu, E. (2021). Ethical considerations at the end-of-life care. *SAGE Open Medicine*, 9, 205031212110009. <https://doi.org/10.1177/20503121211000918>
- Benson, J. J., Parker Oliver, D., Demir, G., & Washington, K. (2019). Accounts of family conflict in Home Hospice Care: The central role of autonomy for informal caregiver resilience. *Journal of Family Nursing*, 25(2), 190–218. <https://doi.org/10.1177/1074840719828091>
- Bovero, A., Spada, M. F., Cito, A. L., Pidinchedda, A. V., Tosi, C., & Carletto, S. (2025). Self-care in palliative healthcare professionals: A qualitative study. *Nursing Reports*, 15(5), 139. <https://doi.org/10.3390/nursrep15050139>

- Davids, L. A. C., & Crowley, T. (2024). Policy analysis: Key milestones in MDR-TB management over the past decade in South Africa. *Journal of Public Health in Africa*, 15(1), 703. <https://doi.org/10.4102/jphia.v15i1.703>
- De Stefano, R., Muscatello, M. R. A., Bruno, A., Cedro, C., Mento, C., Zoccali, R. A., & Pandolfo, G. (2021). Complicated grief: A systematic review of the last 20 years. *International Journal of Social Psychiatry*, 67(5), 492–499. <https://doi.org/10.1177/0020764020960202>
- Drenth, C., Sithole, Z., Pudule, E., Wüst, S., GunnClark, N., & Gwyther, L. (2018). Palliative care in South Africa. *Journal of pain and symptom management*, 55(2), S170-S177. <https://doi.org/10.1016/j.jpainsymman.2017.04.024>
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive Sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1-4. <https://doi.org/10.11648/j.ajtas.20160501.11>
- Filaj, E., & Sota, M. (2026). Burnout among healthcare professionals in high-emotional work environments: A qualitative study from the Burn Unit in Albania. *Burns*, 107916. <https://doi.org/10.1016/j.burns.2026.107916>
- Floridis, J. (2023). Debriefing after critical incidents in rural and remote healthcare settings-a remote clinical perspective. *Rural and Remote Health*, 23(1), 1-4. <https://doi.org/10.22605/rrh7450>
- Grygorenko, Z., & Naydonova, G. (2023). The concept of “resilience”: history of formation and approaches to definition. *Public administration and law review*, (2), 76-88. <https://doi.org/10.36690/2674-5216-2023-2-76-88>
- Hall, E. (2020). Accessibility, Editor (s): Audrey Kobayashi, International Encyclopedia of Human Geography. <https://doi.org/10.1016/B978-0-08-102295-5.10133-7>
- Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., ... & Panagioti, M. (2022). Associations of physicians burn out with career engagement and quality of patient care: systematic review and meta-analysis. *bmj*, 378. <https://doi.org/10.1136/bmj-2022-070442>
- Ibrahim, A. M., Abdel-Aziz, H. R., Zaghamir, D. E. F., Elneblawi, N. H., Elhoty, M. A. E. R. E., kamal Sweelam, R., & Mohamed, H. A. O. (2025). Ethics and moral empathy in end-of-life palliative care. *Palliative & Supportive Care*, 23, e108. doi:10.1017/S1478951525000458
- Ismail, I. A., Abuhamda Enas, A. A., & Bsharat, T. R. (2021). Understanding Quantitative and Qualitative Research Methods: A Theoretical Perspective for Young Researchers Understanding Quantitative and Qualitative Research Methods: A Theoretical Perspective for Young Researchers. no. February, 70-87. DOI: 10.2501/ijmr-201-5-070
- Jackson, D., Firtko, A., & Edenborough, M. (2007). Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *Journal of Advanced Nursing*, 60(1), 1-9. doi: 10.1111/j.1365-2648.2007.04412.x
- Kehl, K. A., Kirchhoff, K. T., Kramer, B. J., & Hovland-Scafe, C. (2009). Challenges facing families at the end of life in three settings. *Journal of Social Work in End-Of-Life & Palliative Care*, 5(3–4), 144–168. <https://doi.org/10.1080/15524250903555080>
- Koontalay, A., Suksatan, W., Prabsangob, K., & Sadang, J. M. (2021). Healthcare workers’ burdens during the COVID-19 pandemic: a qualitative systematic review. *Journal of multidisciplinary healthcare*, 3015-3025. <https://doi.org/10.2147/JMDH.S330041>
- Lichtenthal, W. G., & Kissane, D. W. (2008). The management of family conflict in palliative care. *Progress in palliative care*, 16(1), 39-45. doi: 10.1179/096992608x296914.
- Manning, L., Ferris, M., Narvaez Rosario, C., Prues, M., & Bouchard, L. (2019). Spiritual resilience: Understanding the protection and promotion of well-being in later life. *Journal*

- of Religion, Spirituality & Ageing, 31(2), 168–186. <https://doi.org/10.1080/15528030.2018.1532859>
- Masel, E. K., & Kreye, G. (2018). Demystification of palliative care: what palliative care teams don't want you to think about them. *memo-Magazine of European Medical Oncology*, 11(3), 193-195. <https://doi.org/10.1007/s12254-018-0420-2>
- Midtbust, M. H., Alnes, R. E., Gjengedal, E., & Lykkeslet, E. (2018). Perceived barriers and facilitators in providing palliative care for people with severe dementia: the healthcare professionals' experiences. *BMC health services research*, 18(1), 709. <https://doi.org/10.1186/s12913-018-3515-x>
- Moore, E. (2023) Family care for older persons in South Africa: heterogeneity of the carer's experience, *International Journal of Care and Caring*, 7(2): 265–286, DOI: 10.1332/239788221X16740630896657
- Naeem, M., Ozuem, W., Howell, K., & Ranfagni, S. (2023). A step-by-step process of thematic analysis to develop a conceptual model in qualitative research. *International journal of qualitative methods*, 22, 16094069231205789. <https://doi.org/10.1177/16094069231205789>
- Nuere, S., & De Miguel, L. (2021). The digital/technological connection with COVID-19: An unprecedented challenge in university teaching. *Technology, Knowledge and learning*, 26(4), 931-943. <https://doi.org/10.1007/s10758-020-09454-6>
- Otani, T. (2020). Functions of qualitative research and significance of the interpretivist paradigm in medical and medical education research. *Fujita Medical Journal*, 6(4), 91-92. doi: 10.20407/fmj.2020-018
- Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed-method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 42(5), 533-544. <https://doi.org/10.1007/s10488-013-0528-y>
- Pangallo, A., Zibarras, L., & Patterson, F. (2016). Measuring resilience in palliative care workers using the situational judgement test methodology. *Medical education*, 50(11), 1131-1142. <https://doi.org/10.1111/medu.13072>
- Patton, M. Q. (2015). Qualitative research and evaluation methods: Integrating theory and practice. Sage Publications.
- Pfeil, T. A., Laryionava, K., Reiter-Theil, S., Hiddemann, W., & Winkler, E. C. (2015). What keeps oncologists from addressing palliative care early on with incurable cancer patients? An active stance seems key. *The Oncologist*, 20(1), 56–61. <https://doi.org/10.1634/theoncologist.2014-0031>
- Radbruch, L., De Lima, L., Knaut, F., Wenk, R., Ali, Z., Bhatnagar, S., ... & Pastrana, T. (2020). Redefining palliative care, a new consensus-based definition. *Journal of pain and symptom management*, 60(4), 754-764. doi: 10.1016/j.jpainsymman.2020.04.027.
- Raina, P., O'Donnell, M., Rosenbaum, P., Brehaut, J., Walter, S. D., Russell, D., ... & Wood, E. (2005). The health and well-being of caregivers of children with cerebral palsy. *Pediatrics*, 115(6), e626-e636. <https://doi.org/10.1542/peds.2004-1689>
- Reniers, G., Blom, S., Calvert, C., Martin-Onraet, A., Herbst, A. J., Eaton, J. W., ... & Hosegood, V. (2017). Trends in the burden of HIV mortality after roll-out of antiretroviral therapy in KwaZulu-Natal, South Africa: an observational community cohort study. *The Lancet HIV*, 4(3), e113-e121. [https://doi.org/10.1016/S2352-3018\(16\)30225-9](https://doi.org/10.1016/S2352-3018(16)30225-9)
- Rensburg, R. (2021). *Healthcare in South Africa: How Inequity Is Contributing to Inefficiency-Wits*

- Samodien, E., Abrahams, Y., Muller, C., Louw, J., & Chellan, N. (2021). Non-communicable diseases-a catastrophe for South Africa. *South African Journal of Science*, 117(5-6), 1-6. <https://doi.org/10.17159/sajs.2021/8638>
- Smith, P., Vasileiou, K., & Kagee, A. (2020). Experiences of work-related stress and coping among palliative care staff in South Africa: A qualitative study. *South African Journal of Psychology*, 50(3), 425–437. <https://doi.org/10.1177/0081246320902300>
- Spotlight (2024). 54 000 TB deaths in SA in 2024, according to WHO. Available at: <https://www.spotlightnsp.co.za/2025/11/12/54-000-tb-deaths-in-sa-in-2024-according-to-who/>. Accessed August 2026
- Spotlight (2025). In the Spotlight | Graphs that paint the picture of HIV in SA. Available at: <https://www.spotlightnsp.co.za/2025/06/09/inthespotlight-graphs-that-paint-the-picture-of-hiv-in-sa/>. Accessed August 2026
- Statistics South Africa. (2026). *30 Years of Counting South Africa: Advancing Development, Equity, and an Inclusive Future through Data* [Media statement]. Statistics South Africa Official Portal.
- Strasser, R., Kam, S. M., & Regalado, S. M. (2016). Rural health care access and policy in developing countries. *Annual review of public health*, 37(1), 395-412. <https://doi.org/10.1146/annurev-publhealth-032315-021507>
- Teoli, D., Schoo, C., & Kalish, V. B. (2023). Palliative care. In *StatPearls [Internet]*. StatPearls Publishing.
- Van Breda, A. (2018). A critical review of resilience theory and its relevance for social work. *Social Work*, 54(1). <https://doi.org/10.15270/54-1-611>
- WHO (2020). Palliative Care. Available at: <https://www.who.int/news-room/fact-sheets/detail/palliative-care>. Accessed August 2026.
- Williamson, K., Given, L. M., & Scifleet, P. (2018). Qualitative data analysis. *Research Methods: Information, Systems, and Contexts*, 2(2), 453-476. <https://doi.org/10.1016/B978-0-08-102220-7.00019-4>
- Windle, G. (2011). What is resilience? A review and concept analysis. *Reviews in clinical gerontology*, 21(2), 152-169. <https://doi.org/10.1017/S0959259810000420>
- Zanatta, F., Maffoni, M., & Giardini, A. (2020). Resilience in palliative healthcare professionals: a systematic review. *Supportive Care in Cancer*, 28(3), 971-978. <https://doi.org/10.1007/s00520-019-05194-1>
- Zhang, Y., Guan, C., Jiang, J., Zhu, C., & Hu, X. (2023). Mediating effect of resilience on the relationship between perceived social support and burnout among Chinese palliative nurses. *Journal of Clinical Nursing*, 32(13-14), 3887-3897. <https://doi.org/10.1111/JOCN.16532>
- Zwack, J., & Schweitzer, J. (2013). If every fifth physician is affected by burnout, what about the other four? Resilience strategies of experienced physicians. *Academic Medicine*, 88(3), 382-389. <https://doi.org/10.1097/acm.0b013e318281696b>