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Family caregivers' experiences of caring for COVID-19 infected relatives at home: A qualitative study in Shiselweni, Eswatini

Pengalaman pengasuh keluarga dalam merawat kerabat yang terinfeksi COVID-19 di rumah: Studi kualitatif di Shiselweni, Eswatini

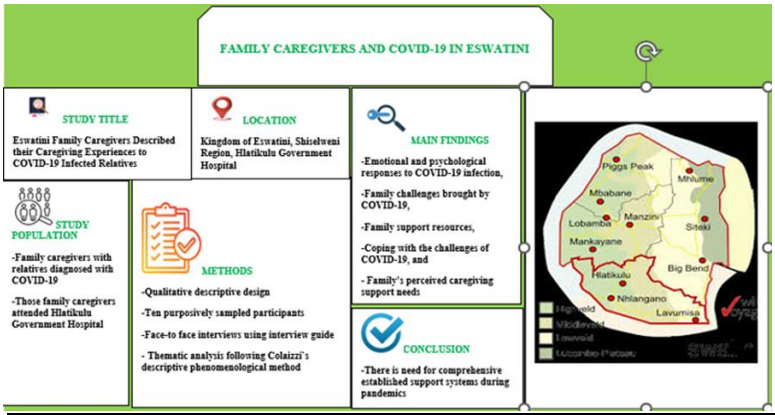
Thamsanqa G. Masilela[1], Thulani R. Nhlabatsi*[2]

[1, 2] Department of Community Health Nursing Science, Faculty of Health Sciences, University of Eswatini, Mbabane, Eswatini

Abstract
The emerging literature on COVID-19 has increasingly recognized families as essential care units, yet limited evidence documents how untrained family caregivers experienced home-based care during acute infection in low-resource settings, and how culturally grounded values may inform caregiver support. This study aimed to describe the lived experiences of family caregivers of COVID-19 patients in the Shiselweni region of Eswatini. A qualitative descriptive phenomenological design was employed among ten purposively selected family caregivers, with the final sample size determined by data saturation. Data were collected through in-depth face-to-face, audio-recorded interviews using a pre-tested SiSwati semi-structured interview guide, then analyzed thematically following Colaizzi's descriptive method. Trustworthiness was strengthened through forward–backward translation and dual coding, and the study adhered to relevant ethical principles. Five themes emerged: (1) emotional and psychological responses to COVID-19 infection, (2) family challenges brought by COVID-19, (3) family support resources, (4) coping with the challenges of COVID-19, and (5) family-perceived caregiving support needs. Findings indicate that caregivers faced substantial emotional and psychological burdens amid fear of infection, limited competence, and inadequate protective equipment. Public health responses should prioritize home-care packages that combine caregiver training, provision of personal protective equipment, and accessible consultation channels; these can be strengthened through islamic ethical principles of rahmah (compassion), amanah (responsibility), and mutual support to protect caregiver wellbeing and family resilience.

Abstrak
Literatur yang berkembang tentang COVID-19 semakin mengakui keluarga sebagai unit perawatan yang esensial, namun bukti yang terbatas mendokumentasikan bagaimana pengasuh keluarga yang tidak terlatih mengalami perawatan di rumah selama infeksi akut di lingkungan dengan sumber daya terbatas, serta bagaimana nilai-nilai yang berakar pada budaya dapat memengaruhi dukungan bagi pengasuh. Studi ini bertujuan untuk menggambarkan pengalaman nyata pengasuh keluarga pasien COVID-19 di wilayah Shiselweni, Eswatini. Desain kualitatif deskriptif fenomenologis diterapkan pada sepuluh pengasuh keluarga yang dipilih secara purposif, dengan ukuran sampel akhir ditentukan berdasarkan saturasi data. Data dikumpulkan melalui wawancara tatap muka mendalam yang direkam audio menggunakan panduan wawancara semi-struktural SiSwati yang telah diuji coba, kemudian dianalisis secara tematis mengikuti metode deskriptif Colaizzi. Keandalan data diperkuat melalui terjemahan bolak-balik dan pengkodean ganda, dan studi ini mematuhi prinsip-prinsip etika yang relevan. Lima tema muncul: (1) respons emosional dan psikologis terhadap infeksi COVID-19, (2) tantangan keluarga yang disebabkan oleh COVID-19, (3) sumber daya dukungan keluarga, (4) mengatasi tantangan COVID-19, dan (5) kebutuhan dukungan perawatan yang dirasakan oleh keluarga. Temuan menunjukkan bahwa pengasuh menghadapi beban emosional dan psikologis yang signifikan di tengah ketakutan akan infeksi, keterbatasan kompetensi, dan perlengkapan pelindung yang tidak memadai. Tanggapan kesehatan masyarakat harus memprioritaskan paket perawatan di rumah yang menggabungkan pelatihan pengasuh, penyediaan perlengkapan pelindung pribadi, dan saluran konsultasi yang mudah diakses; hal ini dapat diperkuat melalui prinsip-prinsip etika Islam tentang kasih sayang, tanggung jawab, dan dukungan mutual untuk melindungi kesejahteraan pengasuh dan ketahanan keluarga.

Graphical Abstract



Keyword
caregivers; covid-19; eswatini; family health; family support

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Correspondence
University of Eswatini, Faculty of Health Science, Box 369, Mbabane, Eswatini.
tnhlabatsi@uniswa.sz

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INTRODUCTION

The COVID-19 pandemic has generated profound disruptions to family functioning worldwide, particularly where infected relatives were managed in home settings. To prevent health-system overload and reduce community transmission, guidelines recommended that moderately ill patients isolate and receive care at home, thereby shifting substantial caregiving responsibilities to families (World Health Organisation [WHO], 2021b). This shift required family caregivers to provide multidimensional support—physical, emotional, spiritual, and psychological—while simultaneously safeguarding themselves and other household members from infection risk (Rahimi, Dastyar, & Rafati, 2021). Such home-based caregiving during a high-transmissibility outbreak created complex demands that affected family wellbeing and resilience, including heightened fear of infection, uncertainty, and intensified domestic responsibilities.

From a global public health and development perspective, these challenges align with Sustainable Development Goals (SDGs) that emphasize health, wellbeing, and social protection, particularly SDG 3 (good health and well-being) through strengthening health systems and ensuring psychosocial support, and SDG 10 (reduced inequalities) through protecting vulnerable families who experience disproportionate burdens during crises. Clinically, early COVID-19 presentations were characterized by severe acute respiratory syndrome with fever, cough, and severe hypoxia, necessitating hospitalization and advanced therapies in many cases (WHO, 2020a). Yet surges in transmission contributed to overcrowding, making home care for mild-to-moderate illness a pragmatic necessity, often without adequate skills or protective resources. In Eswatini, the Ministry of Health reported 74,323 cases and 1,425 deaths as of March 11, 2023, underscoring the pandemic's sustained burden and its testing of family systems and daily life (Eswatini Ministry of Health, 2023).

Although home-based management reduced hospital congestion, it exposed families to substantial caregiving strain, characterized by economic insecurity, psychological distress, and limited access to protective equipment and caregiving guidance. Many households experienced decreased income due to job loss, retrenchment, and bereavement, compounded by travel restrictions and school closures that increased domestic pressures (Panchal et al., 2023; Saulle et al., 2022). Concurrently, anxiety, depression, guilt, and grief were common, particularly when death occurred within family care (Tantrarungroj et al., 2022; Tang et al., 2021). A general solution is to strengthen family-centered outbreak preparedness through structured home-care support packages—including caregiver training, clear consultation pathways, and provision of personal protective equipment (PPE)—integrated with culturally and spiritually congruent psychosocial support to protect caregiver wellbeing and family resilience (Rahimi et al., 2021; WHO, 2021b).

Evidence indicates that family caregiving during infectious disease crises can adversely affect caregivers' quality of life and mental health. Caregivers may face discrimination, social isolation, and fear of contagion while performing demanding tasks such as assisting with activities of daily living and administering prescribed treatments (Hailu et al., 2025; Rahimi et al., 2021). Several studies describe depression, loneliness, and constrained social functioning among family caregivers, particularly when caregiving demands interfere with employment and social participation (Fogel et al., 2022; Rahimi et al., 2021). Additionally, sustained exposure to others' suffering can precipitate compassion fatigue, which may reduce caregiving capacity and worsen emotional exhaustion (Orbay et al., 2022). Over time, caregiving strain may contribute to long-term outcomes such as post-traumatic stress symptoms and disturbances in sleep and eating patterns (Russell et al., 2022; Beach et al., 2021), reinforcing the need for targeted caregiver protection and mental health support.

Conversely, the literature also highlights adaptive responses and protective factors. Some caregivers report compassion satisfaction, acquisition of new caregiving skills, and strengthened family relationships, suggesting that caregiving can function as an expression of love and responsibility under crisis conditions (Rahimi et al., 2021). Resilience has been observed as families adapt amid lockdowns, resource constraints, and social isolation (Rico-Blázquez et al., 2024). Coping strategies include problem-focused actions (seeking information, planning care routines) and emotion-focused strategies (positive self-talk, acceptance, meaning-making), alongside spiritual practices such as prayer (Del Castillo, 2021; Upenieks & Ellison, 2022; Rahimi et al., 2021). These findings collectively support interventions that not only reduce burden (training, PPE, consultation) but also strengthen coping resources, including spiritually informed support pathways.

Overall, international evidence establishes that family caregivers experienced substantial emotional and psychological distress during COVID-19, driven by

fear of infection, social stigma, economic disruption, and the complexity of home-based clinical tasks (Rahimi et al., 2021; Panchal et al., 2023; Saulle et al., 2022). The broader caregiving literature further indicates that inadequate support and prolonged stress can compromise caregiver wellbeing and family functioning through depression, compassion fatigue, and trauma-related symptoms (May et al., 2023; Russell et al., 2022; Beach et al., 2021). At the same time, studies also document positive adaptations—compassion satisfaction, strengthened relationships, and resilience supported by spiritual coping and meaning-making—suggesting that caregiving experiences are heterogeneous and shaped by contextual resources and cultural values (Del Castillo, 2021; Fogel et al., 2022; Rico-Blázquez et al., 2024).

Despite these insights, there remains a dearth of empirical evidence from Eswatini regarding the lived experiences of family caregivers who provided home-based care to relatives with COVID-19, particularly within the Shiselweni region. This gap limits the ability of health services to design context-appropriate caregiver support for future outbreaks. The novelty of the present study lies in generating setting-specific qualitative evidence to illuminate how family caregivers in Eswatini navigated caregiving demands, psychological burdens, available support resources, and coping strategies while caring for infected relatives. Accordingly, the objective of this study was to describe the experiences of family caregivers of patients with COVID-19 attended one of the hospitals in the Shiselweni region of Eswatini, to inform family-centered preparedness and culturally congruent caregiver support interventions.

METHODS

Study type and design

A contextual, qualitative descriptive phenomenological design was employed to explore and describe family caregivers' lived experiences of providing home-based care to relatives infected with COVID-19 (Aspers & Corte, 2019). This design was selected to capture participants' socially constructed meanings and interpretations of caregiving rather than treating experiences as neutral and fixed realities. The approach enabled an in-depth understanding of caregivers' perceptions, feelings, and sense-making processes, thereby illuminating contextual insights relevant to family caregiving during infectious disease emergencies.

Study period and setting

The study was conducted from May to August 2025 at Hlathikhulu Government Hospital in the Shiselweni region of Eswatini. The hospital has a 250-bed capacity and provides services to an estimated 300 outpatients daily. It offers medical, surgical, maternal, paediatric, laboratory, radiology, non-communicable disease (NCD), and antiretroviral therapy (ART) services. The Outpatient Department (OPD) and ART Department were used as recruitment points because family members commonly attend these services and could be reached efficiently for screening and enrolment.

Population, eligibility criteria, and sampling

The target population comprised individuals who provided home-based care to relatives diagnosed with COVID-19. Inclusion criteria were: (i) being an immediate relative of a COVID-19 infected patient; (ii) aged 18–60 years; (iii) having had close contact with or provided caregiving for at least two consecutive weeks; and (iv) willingness to participate. These criteria supported participant homogeneity to enhance the identification of central and shared themes related to caregiving experiences. Individuals who had provided care for less than two consecutive weeks were excluded.

Purposive sampling was used to recruit information-rich participants capable of providing detailed accounts of caregiving experiences. Ten relatively homogenous participants (seven females and three males) were included to support an in-depth qualitative exploration; this sample size is consistent with qualitative research conventions, which often use small samples to achieve depth rather than representativeness. The final sample size was determined through data saturation, whereby no new information emerged after consecutive interviews.

Recruitment procedures

After obtaining permission from the hospital administration, the first researcher requested data clerks in the OPD and ART departments to screen and register family members who had cared for a relative infected with COVID-19. Registered individuals were referred to the first researcher for eligibility screening using the inclusion criteria. The study purpose, procedures, and ethical considerations were explained verbally, and each eligible participant received an information sheet. Those who agreed to participate were scheduled for a face-to-face interview at a mutually convenient time.

Data collection procedures

Prior to data collection, introductions were exchanged with participants, and COVID-19 infection prevention and control protocols were observed. Data were collected through in-depth, face-to-face interviews using a pre-tested semi-structured interview guide in SiSwati, conducted in a private designated room within the hospital to promote confidentiality and participant comfort. Interviews lasted approximately 25–45 minutes and were audio-recorded with participants' consent. Field notes were taken to document contextual observations and non-verbal behaviours (e.g., prolonged silence, crying). Each interview began with a broad opening question, followed by probing to elicit rich descriptions and ensure that participants addressed key domains relevant to caregiving experiences. To enhance credibility during data collection, the interviewer periodically summarized participants' responses and invited clarification or correction (participant validation). Audio recordings were transcribed verbatim and translated into English using forward and backward translation procedures.

Data analysis and presentation

Socio-demographic characteristics were summarized descriptively using Microsoft Excel. Qualitative data analysis followed Colaizzi's descriptive thematic approach. Analysis began after the completion of two interviews, with audio recordings transcribed verbatim. Researchers read transcripts repeatedly, line-by-line, to gain an overall understanding of the content. Two researchers independently coded statements directly relevant to the research questions. Differences in coding were discussed until consensus was reached, enhancing analytical rigor. Codes were then examined to identify formulated meanings that reflected caregivers' experiences of providing home-based care to relatives with COVID-19. Related meanings were clustered into theme categories by identifying common threads and patterns consistent with the study aims. Findings were presented as themes supported by verbatim participant excerpts to preserve participants' meanings and strengthen interpretive transparency.

Ethical considerations and informed consent

Ethical approval was obtained from the Eswatini National Health Research Review Board (FWA00026661/IRB00011253/SHR002/2025) and subsequently from Hlathikhulu Government Hospital Management. Participants were informed of the study's purpose, procedures, risks, and benefits, and were assured of confidentiality and their right to withdraw at any time without consequences. Written informed consent was obtained prior to participation, including consent for audio recording. Given the sensitive nature of discussing caregiving during COVID-19, onsite counselling support was arranged with a psychiatric nurse for participants who experienced distress during or after interviews.

Trustworthiness

Trustworthiness was enhanced through several strategies. Interviews were conducted in participants' vernacular language (SiSwati) to support authenticity of expression. Two researchers independently coded the data and reached consensus through discussion, strengthening dependability. Credibility was supported by participant validation during interviews, careful cross-checking of transcripts against audio recordings, and maintaining detailed field notes. Transferability was supported through rich, contextual descriptions of the setting and caregiving experiences, accompanied by verbatim excerpts. Confirmability was strengthened through reflexivity processes, including regular author debriefings, documentation of evolving ideas and potential biases, and conducting interviews in a neutral private environment with non-hierarchical interaction to promote openness and confidentiality. Data collection continued until saturation was achieved, indicated by repetition of ideas and absence of new insights from additional interviews.

RESULTS

Participants` socio-demographic characteristics

A significant majority of the participant were females (70%; n=7), and the largest fraction (50%; n=5) had ages ranging from 41-50 years. The proportion of those who achieved tertiary education was 10% (n=1). See Table 1 and Table 2 for participants` socio-demographic characteristics.

Main study findings

From the data set, the overarching theme was that, caring for a relative with COVID-19 was not an easy task for family members. Therefore, five major themes surfaced: emotional and psychological responses to COVID-19, family challenges brought by COVID-19, family support resources, coping with the

Tabel 1
Participants socio-demographics

Characteristics	Frequency	Percentage
Age		
31-40 years	3	30
41-50 years	5	50
51-60 years	2	20
Gender		
Male	3	30
Female	7	70
Relationship with the patient		
Mother	5	50
Wife	2	20
Sister	1	10
Son	1	10
Uncle	1	10
Employment status and level of education		
Employed	4	40
Unemployed	6	60
Primary school	5	50
High school	4	40
Tertiary	1	10

challenges of COVID-19, and family's perceived care-giving support needs. For the themes and subthemes (see Table 3).

Emotional and psychological responses to COVID-19 infection

This theme means that family caregivers experienced psychological and emotional responses following a relative diagnosis with COVID-19. Like the general public, many participants experienced intense fear and anxiety of contracting the fatal virus. However, the fear and anxiety were exacerbated by a family member diagnosed with COVID-19, and having relatives dying of the virus. The participant shared his experience as:

> *"The situation with COVID was so scary, at the back of my mind I had it that I had lost my wife, but I also had hope."* (Participant 1)

Another participant had this to share:

> *"I was always anxious and I was helping her because she was my sibling."* (Participant 2)

The fear and anxiety were particularly severe at night when sick relative`s symptoms, including breathing difficulties and sinusitis, worsened. Due to the constant fear of contracting the infection, participants reported to frequently engage in steaming with eucalyptus barks and leaves, onion leaves and lemon to an extent of experiencing mild burns. A participant expressed her fears as:

> *"Caring for my uncle with COVID-19 was a nightmare; I had to nurse him while fearing the virus. I ended steaming daily with eucalyptus leaves as we were told it prevent COVID-19".* (Participant 3)

The diagnosis itself was a significant shock for family caregivers. Participants fear for a potential loss for their relatives as the virus was perceived as very deadly. The shock was intense as their relatives contracted COVID-19 despite rarely leaving home; so families wondered about the source of infection. The participant recounted:

> *"Having my mother diagnosed with COVID-19 was a shock; it was really difficult and was a dilemma. Once diagnosed with COVID-19, you were labelled as dead,"* (Participant 7)

The emotional and psychological effects of COVID-19 pandemic on caregivers was profound, encompassing fear, anxiety, shock, caregiving demands and constant wondering about the prognosis.

Family challenges brought by COVID-19

The theme means that family caregivers had set of challenges while providing care to their loved ones. Many participants dealt with the practical difficulties of caregiving, which often involved additional responsibilities. Family caregivers had to ensure that their relatives adhere to medication, three times steaming sessions per day and maintain relative hygiene, feed them, especially those with poor appetite, and caring for other family members like children. The steaming remedy called for relatives to go around looking for eucalyptus leaves on daily basis. The caregiving demands were worsen by financial difficulties as family members were stop from work, and there was limited support from extended family members. The participant admitted:

> *"My wife had an infant during that time and I was supposed to take care of her and the child, which was difficult for me as a man. It felt like I was abused."* (Participant 1)

Isolation measures were a critical aspect of caregiving during the COVID-19 pandemic, with participants implementing various strategies to prevent

Table 2
Characteristics of each respondent

Respondent	Age (years)	Gender	Relationship	Employment status	Level of education
Participant 1	35	Male	Wife	Employed	High school
Participant 2	43	Female	Sister	Unemployed	Primary school
Participant 3	61	Female	Uncle	Unemployed	Primary school
Participant 4	45	Female	Son	Employed	High school
Participant 5	43	Female	Mother	Employed	Tertiary
Participant 6	47	Female	Mother	Employed	Primary school
Participant 7	58	Female	Mother	Unemployed	Primary school
Participant 8	42	Female	Mother	Unemployed	Primary school
Participant 9	40	Male	Mother	Unemployed	High school
Participant 10	38	Male	Wife	Unemployed	High school

the spread of the virus within their homes. Participants had to prepare a separate room within limited rooms in the family compound, provide meals to isolation room, and protective clothing for the infected relative. The isolation measures meant re-arrangement in family bedrooms; children had to share room with their fathers in some instances. The participant who had his wife sick shared:

> *"I had to move out of the bedroom and stay with the children in the sitting room. If she (sick wife) needed something, we would send it to her."* (Participant 1)

Due to scarcity of isolation room, other family members passed items to infected relative through windows, while taking necessary precautions such as frequent hand washing and wearing masks. A participant recounted:

> *"We used the windows to pass things through to her, also washed hands frequently and used masks always."* (Participant 8)

Many participants experienced deep sorrow due to the loss of loved ones under restrictive conditions accompanied by restrictions on funerals. The fear and stigma associated with COVID-19 were reminiscent of the early days of the HIV epidemic. The dynamics within families and between caregivers and patients were significantly impacted during the COVID-19 pandemic, revealing a spectrum of effects on emotional bonds and relationships. For some, the pandemic heightened emotional stress within relationships. A participant described the deeply emotional experience of caring for his wife, explaining:

> *"Hey my brother, the situation with COVID was so scary, at the back of my mind I had it that I had lost my wife, but I also had hope as we live in hope."* (Participant 10)

In contrast, the pandemic experience strengthened relationships for others. A participant found that the crisis actually deepened the bond between her and her son. She shared:

> *"There was a strong bonding as he did feel being home and well taken care of."* (Participant 4)

The family's efforts to stay close and supportive were particularly valued by her son during this traumatic time, illustrating how the crisis brought them closer together. The family caregivers' dedication and the emotional responses they navigated played a crucial role in shaping these dynamics, reflecting both the challenges and the resilience within families during this global health crisis.

Family support resources

Amidst the emotional and psychological challenges, families acquired support from within and/or outside families. Such support enabled families to navigate the challenges. Family support comprised food parcels from extended family members, words of encouragement, praying together, dividing of extra caregiving roles, and visits from extended family members. The participant shared:

> *"At my uncle's place, there was no food, we solicited food from other family relatives."* (Participant 3)

> *"All we did as a family we put hope on God as he had a plan, we prayed together and encouraged each other."* (Participant 9)

However, participants lamented that family relatives` physical visitations were very limited due to fear and movement restrictions. One participant recounted:

> *"People had the mentality that we were no longer visiting each other."* (Participant 7)

Apart from intra-family support, family caregivers obtained support from churches, rural motivators, healthcare emergency personnel, and community members (neighbors). The support comprised prayers and words of exhortation from church members via mobile telephones, regular visits and calls to monitor progress of relative from rural motivators and healthcare emergency personnel, and

Table 3
Themes and subthemes

Themes	Subthemes
Emotional and psychological responses to COVID-19 infection	Fear and anxiety to contract the virus
	Shock about relative COVID-19 diagnosis
Family challenges brought by COVID-19	Caregiving demands
	Isolation difficulties
	Family relationship dynamics
Family support resources	Intra-family support
	Extra-family support
Coping with the challenges of COVID-19	Health-related information empowerment
	Spiritual coping
Family's perceived caregiving support needs.	Health education and the involvement of rural health motivators
	Mobile clinics
	Provision of food and protective clothing to families

greetings from neighbors enquiring about condition of sick family member. One participant recounted church support like:

> *"He received calls most especially from the youth who called in the morning and also sending WhatsApp messages,"* (Participant 7)

Another participant appreciated help as:

> *"The emergency personnel also made phone calls on a daily basis wanting to hear about her progress."* (Participant 8)

Coping with the challenges of COVID-19

This theme refers to the strategies used by family caregivers in dealing with the caregiving demands, loss of relatives and the entirety of difficulties brought by the pandemic. Family caregivers leveraged the information broadcasted in media platform about dealing with COVID-19, and prior general medical knowledge. The reliance on media information provided a practical framework for caregiving. A participant shared:

> *"We did not consult nurses, we used only the advice they gave us through the media such as hand washing, social distancing use of protective clothes in caring for him."* (Participant 3)

Despite the hardships, family caregivers banked their hopes and faith in God. Families received prayers from church members and also started engaging in prayers; conducting their own services at home, maintaining their spiritual routines. One participant recalled while sobbing*:*

> *"All I did I put my hope on God as he had a plan to heal my mother. My church prayed with me."* (Participant 3)

Another shared:

> *"As a family, we would have our own prayer service."* (Participant 5)

Family's perceived caregiving support needs

This themes refers to suggestions that participants alluded to which were observed to ease the caregiving hardship during COVID-19. The suggestions, to a certain extent, are lessons for handling similar future pandemics in home settings. Participants recommended that government should provide accurate and timely preventive information on pandemics like COVID-19 in both English and Siswati languages (local language of Eswatini). Such information was perceived to be vital in preventing deaths observed during COVID-19. In information dispensation, rural motivators should be involved as they are in proximal contact with communities and families. Reflecting on the experience, participant 1 suggested:

> *"Firstly, I would like to say that knowledge is power, the government should put forward preventive education because we lose our lives because of lack of knowledge. Should also involve the rural health motivators to help in providing education and needed help."* (Participant 5)

Looking to the future, participants recommended that the government must provide mobile clinics closer to communities to offer early assistance. The mobile clinics must be sufficiently equipped with health personnel, medicines and medical equipment. One participant emphasized:

> *"The government should provide well equipped mobile clinics closer to the chiefdoms so that we can get help as early as possible,"* (Participant 4)

Families recounted that COVID-19 left them with food scarcity as families had insufficient financial incomes (some family members were retrenched, lost jobs, and/or lost a breadwinner) yet food was essential in the recovery of their relatives. Therefore, participants suggested supply of food by government. A participant suggested:

"The government should assist with food as it is very important for the sick individuals to have a meal." (Participant 10)

Families also pleaded for supply of protective clothing to utilize while caring for their relatives in similar future pandemics.

DISCUSSION

The findings show that family caregivers experience emotional and psychological challenges while caring for their relatives during COVID-19 pandemic. The challenges were attributable to mortality risks associated with the disease such as fear of contracting the virus while providing care. Consequently, the caregiving experience was anxiety-laden, and such was worsened by caregivers` lack of caregiving information and skills, preventive materials, financial constraints and/or sudden changes in family functioning. Similar studies (Daari et al., 2024; Irani et al., 2021; Russell et al., 2022) reported that, during COVID-19, family caregivers experienced high levels of fear and anxiety, highlighting the emotional strain of caregiving under intense duress. Russell et al. (2022) further observed an increase in mental health issues, including depression and anxiety, among family caregivers. The caregiving experience was worsened by pandemic related disruptions like disrupted way of life routines and increased caregiving duties (Chiu et al., 2022), preventive strategies employed by various government structures, and fear of disease transmission (Najafi et al., 2023). These findings demonstrate that caregiving during the COVID-19 pandemic was a complex and anxiety-laded experience for family caregivers. While many family caregivers faced increased emotional and psychological challenges, the extent and nature of these challenges varied based on factors such as the family caregiver's circumstances like financial constraints.

The current study showed that COVID-19 brought challenges to family members that comprised increased caregiving demands, isolation difficulties and changes in family relationships. On top of the usual family activities, the caregivers had to care for their sick relatives providing feeding, bathing, and many more, while fearing their lives in the process. Russell et al. (2022) argued that caregiving during COVID-19 pandemic heightened mental health burdens among caregivers as the jungle routine home responsibilities and caregiving, particularly those caring for children. Family caregivers were further in a dilemmatic situation of fear to contract the disease and heightened sense of responsibility of caring for their loved ones. However, the increase sense of caregiving responsibility characterized by disrupted routines rendered most family caregivers to depression and anxieties (Chiu et al., 2022). Findings of the current study further highlights the difficulties that were associated with isolating a family member diagnosed with COVID-19. Family caregivers had to re-arrange bedrooms and share with children, and use windows to pass items to infected family member. This highlight housing challenges that caregivers experienced that could be related to financial constraints, as most of the participants were unemployed. However, such arrangements required families to sacrifice certain privileges for the betterment of their sick relatives. These findings corroborate with prior studies (Allen et al. 2022; Buecker & Horstmann, 2022; Williams et al., 2021) that reported that isolation came with disruptions in family routines and social interactions that significantly impacted individuals' lives, leading to increased loneliness and decreased social interactions. The current findings highlight mixed effects of the pandemic on family relationships as some participants felt intense grief as they were restricted to bury their loved ones while others treasure the bonds created while caring for their relatives. Majority of Eswatini family members bid farewell to their dead relatives through funeral rituals that assist with the grieving process and closure. However, such was not observed during COVID-19 era leaving some family members not coping with the death. However, the feeling that they had at least given care to their dead loved ones consoled some caregivers. Consistent with Mohammadi et al. (2021) and Younesi et al. (2021) family members authority was disregarded during burials, and the burial was regarded by most family members a bitter farewell. However, Kentish-Barnes et al. (2021) and Petry et al. (2021) argued that the strain in family relationship started when family members were not allowed to visit their admitted relatives which broke the bond and further lowered patient`s perceived chances of surviving. Despite the challenges on family relationship, Partington et al. (2022) highlighted that family connection appeared to have been boosted due to increase time spend together caring for each other during the pandemic. Rahimi, et al. (2021) emphasized that family caregivers had compassionate satisfaction as they care for their loved ones. Although the family challenges were diverse, the current findings underscore the need for tailored support strategies to address the diverse

needs of family caregivers in different situations during any pandemic.

Family caregivers of the current study exploited support from within and outside their families. The social support from relatives, church members and other members of the community assured the family caregivers that they were not alone in the caregiving journey. Family caregivers gained courage to continue caring for their sick relatives lessening distress in the process. The findings corroborate with prior studies (Hen et al. 2022; Irani et al., 2021; Mancone et al., 2025; Martín-Rodríguez et al., 2024) who posited that different forms of support like psychological, spiritual, instrumental and physical support obtained within and/or outside family predict emotional well-being, psychological resilience and enhances the healing process as it protects one from pervasive grief and depression. However, Fogel et al. (2022) underscored the importance of maintaining quality of life during the pandemic, with close and frequent family interactions as it positively impacts the well-being of family members. These findings highlight the complex nature of intra and extra-family support during the pandemic, influenced by individual circumstances and pre-existing family relationship quality.

Family caregivers employed coping strategies while caring for their sick relatives (Javed & Parveen, 2021). Family caregivers engaged in health-related information empowerment through media platforms and spiritual coping through prayers. Health-related information improved the care offered to the sick relatives, while allaying certain anxieties of the caregivers. Additionally, to some participants, prayer brought hope that the relatives will recover as they care for them; intrinsically motivated them to continue caring for their relatives. Similarly, Goodyear et al. (2021) and WHO (2020b) found that media was instrumental in dispensing COVID-19 preventive messages that facilitated health behaviours, self-management during the pandemic and increases confidence among family caregivers as they care for their relatives. However, Marciano et al. (2022) reported that social media heightened the anxieties associated with the pandemic, suggesting varied experiences among family caregivers. The findings on spiritual coping are supported by Upenieks and Ellison (2022) who found that relying more heavily on God and discussing religious and spiritual matters with close confidants could mitigate the negative effects of spiritual struggles on mental health during any pandemic. Del Castillo (2021) emphasized the importance of spiritual care in promoting well-being during times of crises or major life stressors; because there is intimate link between health and spirituality. However, Marciano et al. (2022) argued that spirituality's positive impact on mental health varies depending on individual`s lifestyle, social support, and belief systems. This, therefore, suggests that spiritual practices may not benefit all individuals equally during a crisis like COVID-19.

The integration of Islamic values in the findings on spiritual coping can be understood through the framework of maqāṣid al-sharīʿah, which emphasizes the protection of religion (*ḥifẓ al-dīn*), life (*ḥifẓ al-nafs*), intellect (*ḥifẓ al-ʿaql*), and lineage/family (*ḥifẓ al-nasl*). In the context of COVID-19 caregiving, spiritual practices such as supplication (*duʿā'*), remembrance of God (*dhikr*), Qur'anic recitation, and tawakkul (reliance on God after exerting effort) may function as sources of meaning and calmness that help caregivers manage fear, uncertainty, and emotional burden. Consistent with Upenieks and Ellison (2022) and Del Castillo (2021), the values of tawakkul, ṣabr (steadfastness), and riḍā (acceptance) may strengthen emotional regulation and psychological resilience, enabling caregivers to sustain balanced family roles during crisis conditions.

Moreover, Islam conceptualizes caregiving as an *amānah* (a entrusted responsibility) and a form of social worship (*ʿibādah ijtimāʿiyyah*) that carries spiritual merit when performed with sincere intention and proper ethical conduct. Values such as *raḥmah* (compassion), *iḥsān* (excellence), and *taʿāwun* (mutual assistance) can provide a foundation for strengthening family social support—for example, by involving other family members in sharing tasks, fostering empathetic communication, and organizing community-based assistance. However, as argued by Marciano et al. (2022), the mental health benefits of spirituality are not uniform. From an Islamic perspective, spiritual benefit also depends on balanced religious understanding and integration with knowledge-based efforts. Therefore, Islamic integration within family health interventions should be inclusive and non-coercive, offering diverse options for spiritual support (e.g., spiritual counseling, guided prayer support, or referral to trusted religious leaders) while maintaining strong emphasis on evidence-based protective measures. This approach positions spiritual coping as a resilience-enhancing resource, while ensuring caregivers receive adequate clinical, social, and educational support so that psychological burden is not intensified by guilt, stigma, or maladaptive religious interpretations.

The study findings emphasize the importance of health education and rural health motivators, and mobile clinics in managing health crises. The participants' suggestions could be informed by their contexts like rural motivators being the extension of the health system primarily focusing on dispensing health related information to communities across the country. Dudley et al. (2023) revealed that rural health systems were less prepared for the COVID-19 pandemic, and national responses often failed to address rural areas' specific health needs. It highlighted the crucial role of local leaders and community health workers in addressing these gaps through government-led education initiatives and mobile clinics with furnished resources. UNICEF Eswatini (2020) report emphasized the impact of rural health motivators in providing essential health services and education in remote areas. However, WHO (2020a) highlighted challenges in retaining health workers in rural and remote areas, noting that the pandemic exacerbated existing health inequalities. This suggests that while health education and rural health motivators are crucial during pandemics, systemic issues like workforce shortages and inadequate infrastructure and medical equipment also require attention

CONCLUSIONS

This study demonstrates that the COVID-19 pandemic amplified the central role of families as frontline care providers for infected relatives in home settings. Family caregivers experienced substantial emotional and psychological burdens, reflecting the cumulative strain of fear of infection, caregiving demands, and disrupted family routines. At the same time, caregivers exhibited resilience and strong dedication to their relatives, sustained by social support networks and coping strategies that enabled them to persist despite uncertainty and resource constraints. These findings contribute to family health knowledge by clarifying how home-based caregiving during a highly transmissible outbreak simultaneously generates vulnerability and adaptive capacity within family systems, underscoring the importance of caregiver-focused preparedness in future health emergencies.

The study has important implications for strengthening family-centered public health responses. Home-care packages should be institutionalized to support caregivers and protect household wellbeing, comprising caregiver training, reliable access to PPE, food parcels to mitigate caregiving-related economic strain, mobile clinics to extend access to services, and clear consultation and referral channels. These services should be coordinated by the Ministry of Health and operationalized through rural motivators, emergency service providers, and the nearest clinics and health centers to ensure rapid, equitable reach, particularly for rural households. Future research should extend these findings by examining the bereavement experiences of family caregivers during COVID-19 to inform trauma-informed psychosocial support, strengthen family resilience, and improve continuity of care during subsequent outbreak.

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Thamsanqa G. Masilela contributed to the conceptualization and study design, led the fieldwork and data collection/acquisition, and performed the data analysis and interpretation. Thulani R. Nhlabatsi contributed to manuscript drafting and critical revision and provided overall supervision of the first author from protocol development through study implementation. All authors reviewed the manuscript and read and approved the final version.

AUTHORS' INFORMATION

Thamsanqa G. Masilela is a graduated affiliated with the Department of Community Health Nursing Science, Faculty of Health Sciences, University of Eswatini, Eswatini. Thulani R. Nhlabatsi is a Lecturer/Researcher affiliated with the Department of Community Health Nursing Science, Faculty of Health Sciences, University of Eswatini, Eswatini.

COMPETING INTERESTS

The author(s) declare no potential conflict of interest with respect to the research, authorship, and/or publication of this article.

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