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# Conceptual Framework for Resilience and Support: A Job Demands–Resources Model for Healthcare Workers in Pandemics

Jimmy F. M. Maliro[1]

[1]Eswatini Medical Christian University

ORCID: 0009-0008-7094-4046

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**Abstract: Healthcare workers (HCWs) are the backbone of resilient health systems, yet pandemics expose them to extreme job demands that threaten their well-being and performance. Drawing on the Job Demands–Resources (JD–R) theory, this conceptual paper develops a framework for strengthening HCW resilience and systemic support in Eswatini's pandemic response. Using an abductive analytical approach, qualitative insights from 15 HCWs at a COVID-19-designated hospital were integrated with recent literature (2020–2025) to map job demands and resources into a resilience model. Key job demands identified included excessive workload, infection risk, emotional strain, and organizational gaps, while job resources encompassed training, teamwork, supportive leadership, psychosocial services, and fair compensation. The framework outlines two interrelated pathways: a health-impairment process, where excessive demands without adequate resources lead to burnout and disengagement, and a motivational process, where sufficient resources foster engagement, resilience, and retention. Policy and institutional interventions are proposed across individual, organizational, and national levels emphasizing resilience training, inclusive decision-making, mental health services, and protective legislation. The JD–R-based framework provides a holistic, evidence-informed model to balance HCWs' demands and resources, serving as a practical guide for policymakers and health managers. By institutionalizing systemic support, healthcare systems can safeguard worker well-being, sustain motivation, and strengthen pandemic preparedness.**

***Keywords:*** *Healthcare Workers, Resilience, Job Demands–Resources Theory, Eswatini, Pandemic Response, Occupational Health, Systemic Support.*

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## I. INTRODUCTION AND BACKGROUND

The COVID-19 pandemic redefined the global landscape of healthcare, demanding extraordinary resilience from healthcare workers (HCWs) while exposing the fragility of support systems designed to protect them. In many parts of Asia, countries such as China and India witnessed unprecedented pressure on medical staff who operated under conditions of extreme uncertainty. In China, hospitals quickly established psychological first-aid teams to help HCWs manage anxiety and exhaustion; these interventions were credited with restoring emotional balance during the height of the outbreak, as Chen et al. (2020) observed when examining mental-health trends among frontline workers. Similarly, Ho et al. (2021) reported that Chinese hospitals which implemented on-site counselling units experienced measurable improvements in staff engagement. India's experience differed in its slower institutional response; Spoorthy, Pratapa, and Mahant (2020) noted that inconsistent PPE distribution and erratic scheduling drove severe burnout among nurses and resident doctors. The introduction of online peer-support groups by the Indian Ministry of Health later demonstrated that structured digital interaction could reduce feelings of isolation and renew commitment to patient care, as Kumar et al. (2021) documented.

Across the African continent, systemic challenges amplified the pandemic's psychological toll. In Nigeria,

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shortages of protective gear and irregular hazard allowances created widespread anxiety among frontline nurses. Ogbolu et al. (2021) described how these material gaps undermined trust in hospital management and left many workers feeling disposable. Kenyan healthcare facilities faced similar difficulties, but Kariuki et al. (2022) found that informal peer networks and collective coping practices such as rotational support teams helped staff manage stress even in the absence of formal institutional programmes. These findings resonate with the Job Demands–Resources (JD–R) theory, which Bakker and Demerouti (2018) argue captures the delicate equilibrium between the pressures employees face and the resources that sustain them. When the two are balanced, motivation and engagement increase; when demands overwhelm resources, emotional exhaustion and withdrawal follow.

In South Africa, the pandemic exposed persistent inequalities in the health sector that pre-dated COVID-19. Schwartz et al. (2022) documented compassion fatigue and moral distress among nurses working in overstretched public hospitals, while Hoover et al. (2023) observed that government-led initiatives such as the "Caring for the Carers" programme although well-intentioned were unevenly implemented and failed to reach all provinces. The situation illustrated what Demerouti et al. (2001) call the health-impairment process: excessive demands, coupled with insufficient managerial communication and recognition, eroded resilience even in relatively well-resourced environments.

Eswatini's health system experienced these global and continental dynamics on a smaller but equally intense scale. HCWs in the country's main COVID-19 hospitals faced exhausting workloads, emotional strain, and inconsistent supplies of PPE. Maliro (2025) recorded testimonies of frontline staff who described alternating between moments of collective courage and deep despair. Many relied on faith, humour, and teamwork to stay afloat, yet the absence of structured psychosocial programmes meant that personal resilience often substituted for institutional care. Community solidarity also became a significant buffer; spontaneous donations of food and hygiene items, organised by local groups, provided tangible and emotional relief to fatigued workers. This social support underscores that resilience in low-resource settings often emerges from interpersonal and communal bonds rather than formal infrastructure.

Taken together, evidence from Asia, Africa, South Africa, and Eswatini reveals a consistent pattern: the endurance of healthcare systems depends on protecting the people who sustain them. The JD–R framework offers a conceptual foundation for analysing these experiences. Bakker and Demerouti (2018) describe two parallel processes within this model: a health-impairment pathway, where overwhelming job demands deplete energy and foster burnout, and a motivational pathway, where adequate resources such as supportive leadership, teamwork, and recognition generate engagement and well-being. By applying this lens, Eswatini and comparable nations can transform individual coping into systemic resilience through multi-level interventions. These may include training programmes that enhance psychological preparedness, organisational policies that institutionalise mental-health support, and national strategies that ensure financial protection for HCWs during crises. Lessons from global and regional contexts affirm that the health of a nation ultimately rests on how effectively it balances the burdens placed on its caregivers with the resources extended to sustain them.

## II. THEORETICAL FRAMEWORK

This study is anchored in the Job Demands–Resources (JD–R) Theory originally proposed by Demerouti, Bakker, Nachreiner, and Schaufeli (2001) and later refined by Bakker and Demerouti (2018). The JD–R model posits that every occupation has its unique set of job demands such as workload, emotional strain, or role conflict and job resources such as supervisory support, autonomy, and professional development that together shape employee well-being and performance. When demands chronically exceed available resources, workers enter a health-impairment process that leads to fatigue, burnout, and reduced commitment. Conversely, when sufficient resources are available, a motivational process occurs, resulting in engagement, satisfaction, and resilience.

The theory is particularly useful for examining healthcare systems under stress, as pandemics create surges in job demands while simultaneously undermining key resources. Bakker and Demerouti (2018) emphasize that resources not only have a direct motivational role but also buffer the negative effects of high demands a dynamic often observed among frontline health workers during crises. In Eswatini, where healthcare infrastructure and psychosocial support systems are limited, this framework helps explain why some healthcare workers maintained resilience despite adversity. The JD–R model thus serves as both an explanatory lens and a diagnostic tool, guiding the identification of leverage points for improving institutional and policy-level support. Through the JD–R theory, the study conceptualizes resilience not merely as an individual trait but as a systemic outcome emerging from the interaction between job conditions and resource availability a perspective supported by recent empirical work in South Africa (Schwartz et al., 2022) and China (Ho et al., 2021). The framework therefore informs both the analysis and the development of interventions to strengthen healthcare worker well-being in Eswatini.

## III. LITERATURE REVIEW

The global outbreak of COVID-19 brought renewed attention to the mental health and working conditions of healthcare workers. Across Asia, countries such as China and

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India responded with varying levels of preparedness. Chen et al. (2020) observed that frontline medical staff in Wuhan experienced high anxiety levels, prompting hospitals to create psychological support units that significantly improved emotional stability. Similarly, Ho et al. (2021) found that hospitals offering counselling and debriefing services reduced rates of burnout among physicians. In contrast, Indian healthcare institutions initially lacked such support systems. Spoorthy, Pratapa, and Mahant (2020) documented that nurses and junior doctors endured extreme fatigue and stress due to inconsistent PPE supply and prolonged work hours. The later introduction of digital wellness programs and stress-management training (Kumar et al., 2021) demonstrated that structured institutional support can reverse the downward spiral predicted by the health-impairment pathway of JD–R theory.

Across Africa, limited resources exacerbated the psychological burden of the pandemic. In Nigeria, PPE shortages and irregular hazard pay eroded workers' trust and heightened anxiety, as Ogbolu et al. (2021) highlighted in their qualitative accounts of nurses' experiences. Kenyan healthcare workers reported similar strain; however, Kariuki et al. (2022) observed that informal peer networks served as emotional lifelines, exemplifying how social resources can compensate for material deficits. These findings echo Bakker and Demerouti's (2018) argument that interpersonal support acts as a key moderating resource within the JD–R model.

In South Africa, the pandemic exposed deep-seated inequities in healthcare delivery. Schwartz et al. (2022) described how chronic understaffing and moral distress among nurses triggered compassion fatigue, even as the Department of Health attempted to implement the "Caring for the Carers" initiative. Hoover et al. (2023) later noted that while this initiative improved awareness, it lacked consistency and scalability. The South African experience reinforces that institutional resources particularly managerial communication and recognition are essential for sustaining engagement, aligning closely with JD–R's motivational process (Demerouti et al., 2001).

In Eswatini, the pandemic magnified existing workforce shortages and infrastructural limitations. Maliro (2025) documented that frontline HCWs often operated with minimal PPE, unclear communication from superiors, and no dedicated psychosocial services. Despite these barriers, staff demonstrated remarkable collective resilience, relying on teamwork, faith, and community support to cope. These adaptive behaviours align with what Bakker and Demerouti (2018) term personal and social resources, which enhance intrinsic motivation and buffer stress. However, such resilience was largely unsystematic driven by individual effort rather than institutional design. This gap underlines the need for a conceptual framework that translates JD–R principles into actionable policies for Eswatini's healthcare sector. By articulating the relationship between demands, resources, and outcomes, the framework proposed in this study aims to guide evidence-based strategies that promote sustainable well-being among healthcare workers and strengthen the overall resilience of the health system.

- *Problem Statement*

Healthcare workers in Eswatini bore the brunt of the COVID-19 pandemic, facing extreme workloads, emotional distress, and inadequate systemic support. Although similar challenges were documented globally, the Eswatini context reveals distinct vulnerabilities rooted in resource scarcity, weak psychosocial infrastructure, and limited policy protection for frontline staff. Existing studies in the region (Hoover et al., 2023; Kariuki et al., 2022) suggest that when institutional communication, recognition, and safety measures are inconsistent, worker morale and resilience decline sharply. In Eswatini, these deficiencies manifested in staff exhaustion, reduced motivation, and attrition from key clinical departments (Maliro, 2025). The absence of a structured national framework for healthcare worker support meant that coping strategies were largely individual often grounded in faith, teamwork, or community goodwill—rather than institutionalized mechanisms of care. Consequently, while the pandemic illuminated the heroism of Eswatini's HCWs, it also revealed systemic fragility: resilience was expected but rarely supported. The problem, therefore, lies in the lack of a coherent conceptual and policy framework that addresses how job demands interact with institutional resources to influence healthcare worker well-being. Without such a framework, interventions remain reactive and fragmented, leaving HCWs vulnerable to burnout and compromising health system stability during future crises.

- *Purpose of the Study*

The purpose of this study is to develop a conceptual framework, grounded in the Job Demands–Resources (JD–R) Theory that explains how workplace experiences and systemic support mechanisms influence the resilience and well-being of healthcare workers in during pandemic conditions.

## IV. METHODOLOGY

This study adopted a conceptual qualitative design embedded in the Job Demands–Resources (JD–R) Theory to develop a framework illustrating how workplace experiences and systemic support shape the resilience of healthcare workers (HCWs). Guided by an interpretivist paradigm, the research applied an abductive reasoning approach that moved iteratively between theory and empirical observation to generate new conceptual insights. This triangulation ensured a comprehensive understanding of the balance between job demands (such as workload, emotional strain, and infection risk) and job resources (including teamwork, psychosocial support, and recognition) during pandemic conditions. Data analysis followed Coliazzi's phenomenological data analysis method focusing on identifying, coding, and interpreting patterns related to job demands and resources. Themes

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emerging from participant experiences were systematically mapped onto the JD–R to depict two interrelated processes: the health-impairment pathway, where excessive demands cause burnout and disengagement, and the motivational pathway, where adequate resources foster engagement and resilience. The framework was refined through comparative analysis with global studies (Hoover et al., 2023; Schwartz et al., 2022), ensuring both contextual sensitivity and theoretical coherence. Peer debriefing with a health workers helped validate conceptual accuracy, while reflexive journaling enhanced interpretive transparency.

Ethical clearance for the primary data was obtained through relevant authorities, and confidentiality was maintained by anonymising participant accounts. The final Workplace Resilience and Support Framework was generated through an iterative synthesis of evidence, illustrating how demands and resources interact to influence HCW well-being at individual, organizational, and policy levels. Although limited by its reliance on a single country case, the study's integration of empirical data with theory provides a credible foundation for future empirical testing. The methodological approach ensured that the framework was both evidence-based and theoretically grounded, offering actionable insights for improving systemic support and resilience among healthcare workers in Eswatini and comparable low-resource contexts.

## V. RESULTS: THE RESILIENCE AND SUPPORT FRAMEWORK

The resulting conceptual framework, informed by the Job Demands–Resources (JD–R) Theory, illustrates how job demands and job resources interact to shape the well-being and resilience of healthcare workers (HCWs) during pandemics. Consistent with the JD–R model proposed by Demerouti et al. (2001), the framework demonstrates two interconnected processes: a health-impairment pathway, where excessive demands deplete energy and lead to burnout, and a motivational pathway, where adequate resources enhance engagement and resilience. In Eswatini, the study found that workplace experiences during COVID-19 reflected both processes, aligning with global evidence from China, South Africa, and Kenya (Chen et al., 2020; Schwartz et al., 2022; Kariuki et al., 2022).

### *A. Job Demands*

Healthcare workers described overwhelming workloads and time pressure, as many worked extended shifts without rest. Participant 8 explained, "*We worked double shifts for weeks. There was no one to relieve us, so even our off-days became workdays."* This experience mirrors observations from China, where prolonged working hours were strongly associated with burnout and emotional exhaustion (Ho et al., 2021). Similarly, South African studies reported that nurses' fatigue and moral distress increased under extreme patient loads (Schwartz et al., 2022).

Emotional and psychological demands were equally pervasive. Participants spoke of trauma from witnessing multiple patient deaths, one stating, "*Watching patients die alone every day broke me; you carry those faces home,*" as explained by Participant 5. These findings corroborate Petzold, Plag, and Ströhle's (2020) observation that repeated exposure to patient suffering during COVID-19 heightened moral distress among HCWs. Fear of infection was another major stressor. Another participant, Participant 3 explained, "*We handled samples without enough PPE, and every cough made us panic.*" This aligns with Spoorthy, Pratapa, and Mahant (2020), who found that the fear of contracting and transmitting COVID-19 significantly contributed to anxiety among Indian health professionals.

Organizational and communication challenges further aggravated strain. Participants described confusion from abrupt policy shifts as Participant 2 said, "*Decisions were made above us, and we were just told to comply*" reflecting what Ogbolu et al. (2021) also noted in Nigeria, where poor managerial communication undermined trust during the pandemic. Social stigma added another layer of demand. Some workers recounted being shunned by neighbours: "*People crossed the road when they saw us in uniform."* Lamented Participant 7. Similar patterns were observed in Kenya, where HCWs reported isolation and discrimination due to public fear (Kariuki et al., 2022). These cumulative pressures embody the health-impairment process of JD–R, where persistent demands without compensatory resources result in emotional depletion and disengagement (Bakker & Demerouti, 2018).

### *B. Job Resources*

Despite these challenges, participants identified several resources that buffered the effects of stress. Foremost among them was teamwork and peer solidarity. Participant 8 explained, "*We kept each other going. When one of us broke down, others filled in.*" This collective coping strategy parallels findings from Kenya and South Africa, where collegial support was shown to mitigate burnout and strengthen motivation (Kariuki et al., 2022; Schwartz et al., 2022). Supportive leadership also enhanced resilience. Participants valued managers who maintained transparent communication and empathy: observed by Participant 1 who said, "*Just a thank-you or checking on us made a big difference."* Chen et al. (2020) similarly observed that empathetic leadership improved HCWs' sense of safety and belonging in Chinese hospitals.

Material and structural resources such as PPE, staff rotations, and professional training played a crucial role in promoting psychological security. Participant 4 remarked, "*Once training came, we felt safer and more confident handling patients.*" This reflects findings by Hoover et al. (2023), who reported that access to training and clear operational guidelines significantly reduced psychological distress in low- and middle-income countries. Personal and

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spiritual resources further contributed to resilience. Several HCWs relied on faith to maintain meaning: *"Faith helped me see purpose in my suffering,"* an utterance by participant 12. This mirrors observations in African literature that spirituality serves as a powerful coping mechanism for frontline workers (Kariuki et al., 2022; Ogbolu et al., 2021).

Recognition and reward also emerged as vital motivational resources which were not available for health workers. One participant revealed that intrinsic recognition could have enhanced engagement an effect supported by Bakker and Demerouti (2018), who found that acknowledgment and reward stimulate the motivational process within JD–R systems. As the participant 15 explained, *"Sometimes just a simple thank you or acknowledgment of our effort would have made a huge difference*." Together, these resources formed the buffering mechanisms that protected HCWs from the worst outcomes of high demand.

*C. Outcomes and Contextual Interactions*

The interaction between demands and resources determined whether HCWs experienced burnout or resilience. Those overwhelmed by workload, uncertainty, and lack of recognition often reported exhaustion and thoughts of leaving: *"I wanted to quit every week; I was just too tired,"* remarked Participant 10. This aligns with global evidence linking resource scarcity to turnover intention (Hoover et al., 2023). Conversely, teams with strong peer support and empathetic leadership maintained higher morale and engagement as Participant 14 commented that; *"We told ourselves, if we don't stand up, who will? That kept us going."* These findings echo Schwartz et al. (2022), who found that South African HCWs in supportive environments sustained commitment even, under pressure.

Contextual factors such as Eswatini's limited funding, small workforce, and strong community networks shaped the framework's dynamics. Community solidarity, through food donations and moral support, emerged as an external resource that balanced institutional deficiencies. This supports WHO (2022) recommendations emphasizing multi-level interventions individual, organizational, and societal to enhance workforce well-being. The Resilience and Support Framework therefore portrays a dynamic equilibrium: when job demands outweigh resources, HCWs experience strain and burnout; when resources are strengthened, they achieve engagement, motivation, and psychological resilience. The findings reaffirm that resilience is not merely an individual trait but a systemic outcome produced through deliberate investment in supportive structures a conclusion consistent with both JD–R theory and global literature on healthcare workforce sustainability (Bakker & Demerouti, 2018; Hoover et al., 2023).

Overall, the Eswatini findings extend existing JD–R research by showing how contextual constraints in low-resource settings intensify the health-impairment process while emphasizing the power of social, spiritual, and organizational resources in sustaining motivation. The framework aligns with studies across China (Chen et al., 2020), India (Spoorthy et al., 2020), Kenya (Kariuki et al., 2022), South Africa (Schwartz et al., 2022), and Nigeria (Ogbolu et al., 2021), confirming the JD–R theory's universality while demonstrating its adaptability to African healthcare contexts. It highlights that balancing demands and resources is not a static task but a continuous process requiring institutional, policy, and societal commitment to HCW well-being.

The Job Demands–Resources (JD–R) Resilience and Support Framework developed through this study serves as both an analytical model and a practical guide for strengthening healthcare systems during pandemics. The framework affirms that resilience is not an inherent personal attribute but a systemic process shaped by the dynamic balance between job demands and job resources (Bakker & Demerouti, 2018). Findings revealed that healthcare workers in Eswatini, like those in other global contexts, encountered overwhelming workloads, exposure to infection risks, and emotional distress during the COVID-19 pandemic. Their capacity to endure such pressures was largely determined by the extent of resources available teamwork, psychosocial support, leadership empathy, spiritual coping, and institutional recognition.

The results correspond closely with international studies demonstrating that when adequate resources counterbalance job demands, healthcare workers maintain motivation and well-being (Chen et al., 2020; Schwartz et al., 2022). Conversely, when support structures are weak or inconsistent, burnout, disengagement, and attrition rise sharply (Hoover et al., 2023). Within Eswatini's context, resilience was sustained more through informal social and spiritual mechanisms than through formal institutional support, reflecting a critical gap in health system preparedness. The framework therefore offers a context-sensitive model that operationalizes JD–R principles for low-resource environments, illustrating that the protection of healthcare worker well-being is fundamental to system resilience.

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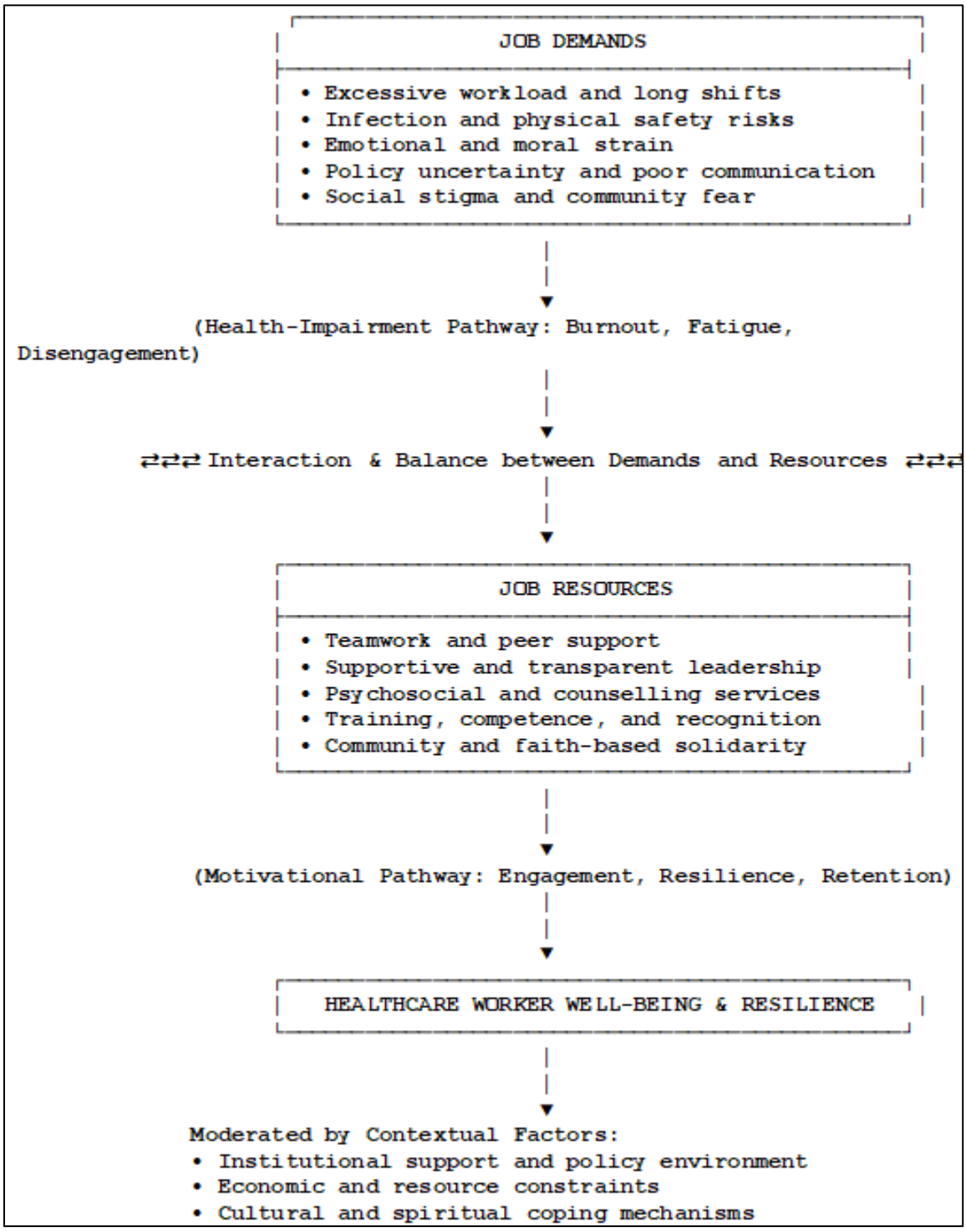


Fig 1: Job Demands–Resources (JD–R) Resilience and Support Framework

This conceptual model illustrates how job demands and job resources interact to shape healthcare worker resilience and well-being during pandemics. It shows two key processes: the health-impairment pathway (where excessive demands lead to burnout and disengagement) and the motivational pathway (where sufficient resources enhance engagement, motivation, and resilience). Contextual factors influence both pathways.

The model positions healthcare workers not as invulnerable heroes but as human professionals who require deliberate protection, recognition, and care. Through investing in the "resources" side of the JD–R equation such as

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empathetic leadership, organizational support, and community solidarity health systems can ensure that when demands escalate, healthcare workers remain supported, motivated, and capable of delivering quality care. The framework thus provides a foundation for policy and institutional reforms aimed at cultivating organizational resilience through human-centered leadership.

## VI. RECOMMENDATIONS

➢ *Institutional-Level Recommendations*

Healthcare institutions should institutionalize structured employee wellness programs that include counselling services, peer support networks, and post-crisis debriefing sessions. Hospital management should undergo leadership development in crisis communication and empathy, ensuring that staff members feel valued and heard. Workload management strategies, such as rotational shifts and mandatory rest breaks, should be standardized to prevent burnout. Additionally, recognition schemes—both financial (e.g., hazard pay) and non-financial (e.g., appreciation awards)—should be implemented to sustain motivation. Continuous professional development on stress management, mindfulness, and adaptive coping should form part of every institution's human resource policy.

➢ *Policy-Level Recommendations*

At the national level, the Ministry of Health should adopt a Healthcare Worker Resilience and Support Policy grounded in the JD–R framework to guide pandemic preparedness and workforce welfare. Dedicated funding streams should be established for psychosocial support, hazard compensation, and emergency response. Clear standard operating procedures (SOPs) should outline protocols for staff protection, mental health interventions, and communication during crises. The government should also formalize multi-sectoral partnerships with non-governmental and faith-based organizations to mobilize external resources such as transport, meals, and temporary accommodation for healthcare workers. Continuous monitoring of workforce well-being through resilience indicators should be integrated into the national health information system.

➢ *Research and Capacity-Building Recommendations*

Further research is needed to pilot and evaluate the JD–R-based framework in various healthcare facilities to determine its impact on staff engagement and retention. Comparative studies across Southern African countries could provide insights into contextual variations in resilience mechanisms. The development of a validated measurement tool a Healthcare Worker Resilience Index based on JD–R constructs would enhance quantitative assessment of well-being outcomes. Additionally, universities and health training institutions should include JD–R-informed modules on occupational wellness and resilience within their curricula to strengthen future health leadership.

## VII. CONCLUSION

The study concludes that healthcare worker resilience is not a spontaneous outcome but a designed organizational achievement that depends on intentional leadership, institutional compassion, and adequate resource allocation. In Eswatini and similar contexts, embedding the JD–R Resilience and Support Framework into health policy and hospital management practices will ensure that future crises are met not with exhaustion, but with endurance and unity. Sustained investment in human well-being is therefore both a moral duty and a strategic imperative because the health of any system is only as strong as the well-being of those who serve within it.

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