Original Research

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Celebes Nursing Journal

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# Caring Against the Tides: A Phenomenological Study of the Lived Realities of Nurses in Coastal Community Settings

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**Article Info:**
https://doi.org/10.70848/cnj.v3i2.128
pISSN 3063-9247
eISSN 3063-9255

**Article History:**
Received: May 4th, 2026
Revised: June 24th, 2026
Accepted: June 30th, 2026

## Abstract

Introduction: Coastal communities in the Philippines represent a critical yet persistently underserved area of public health, where geographic remoteness, environmental risks, and systemic resource limitations collectively hinder the effective delivery of essential healthcare services. While nurses play a central role in healthcare delivery in these communities, their lived experiences and the implications of these experiences for perceived care quality remain insufficiently explored. Objective: This study aimed to explore the lived realities of nurses in coastal community settings and how these realities shaped their perceptions and delivery of care. Methods: The study employed a qualitative phenomenological design and purposive sampling to recruit 10 registered nurses from a Level 1 hospital and selected rural health units in Bulacan, Philippines. Data were gathered through semi-structured face-to-face, telephone, and online interviews and analyzed using Colaizzi's seven-step phenomenological method. Results: Three themes emerged: (1) Steered by Humanistic-Altruistic Values: Foundations of Nursing Practice in Coastal Settings; (2) Sailing through Barriers: Challenges in Coastal Health Delivery; and (3) Keeping Heads Above Water: Adaptive Coastal Nursing Strategies. Conclusion: Participants described sustained commitment despite significant barriers to healthcare delivery and reported extending beyond their formal roles to bridge systemic gaps. Although resilience and adaptive practices helped them maintain essential services, policymakers must establish adequate infrastructure and institutional support to ensure safe and sustainable care delivery without compromising nurses' well-being.

Keywords:
Community Health Nursing, Healthcare Delivery, Coastal Communities, Remote Settings

## INTRODUCTION

Coastal communities are settlements along shorelines whose unique culture and social identity are shaped by their reliance on the sea and its resources (Kiptiah & Wahyu, 2022). Despite this deep environmental connection, these communities remain vulnerable to barriers imposed by their geographic remoteness, limited access to essential services such as healthcare and education, and heightened exposure to climate shifts and geological hazards (Environmental Science for Social Change [ESSC], 2024).

Evidence shows that individuals residing in deprived coastal areas are at increased risk of adverse health outcomes (Murray et al., 2024). This vulnerability is further compounded by the heavy burden of ill health in coastal communities, where poverty, rising rates of non-communicable diseases, and poor health outcomes among children and young people together point to a growing public health concern that requires urgent attention (Asthana & Gibson, 2022). These negative health trends are closely linked to gaps in healthcare infrastructure. In particular, geographic isolation in coastal communities limits access to adequate healthcare facilities, making it difficult to deliver consistent and effective health services to the population (Babawarun et al., 2024). Furthermore, these physical barriers are intensified by service delivery challenges, as access to healthcare is impeded not only by distance but also by the limited quality and availability of services offered by health professionals (Collado, 2019).

The Philippines has 832 (55.47%) of its 1,500 municipalities, 57 (48.72%) of its 117 cities, and 64 (81.01%) of its 79 provinces situated along the coast (Climate Change Commission [CCC] & Department of Environment and Natural Resources [DENR], 2024). Within these provinces, 236 single-coastal communities have been documented (ESSC, 2024). Approximately 55.3 million individuals, representing around 60% of the country's total population, inhabit coastal areas (Philippine Space Agency, 2019, as cited in Azanza et al., 2022).

Public health nursing serves as a cornerstone of community health in these remote coastal settings, with nurses leading prevention, health promotion, and efforts to address health disparities by assessing community needs, implementing evidence-based interventions, and advocating for policies that strengthen health and service access among vulnerable populations (Albert, 2023). However, public health nurses face significant challenges in delivering care due to scarcity of health resources and facilities (Azzeri et al., 2020; Bayhakki et al., 2024), transportation barriers (Bayhakki et al., 2024), and workforce shortages (Parial et al., 2024; Tamata & Mohammadnezhad, 2022).

Existing literature has largely examined health service accessibility (Collado, 2019) and its effects on residents' health outcomes in coastal communities (Halliday et al., 2022). Nurses' experiences in comparable settings have also been documented (Bayhakki et al., 2024), but the influence of these experiences on the quality of care they provide remains unexamined. In the Philippines, an archipelagic nation where a considerable share of the population lives in coastal communities, research on nursing practice in such settings remains limited. The present study sought to address this gap by exploring the lived experiences of nurses working in coastal community settings and how these experiences shaped the care they provided.

## METHODS

### 1. Design

A qualitative phenomenological research design was employed to investigate nurses' lived experiences of care delivery in coastal communities. Qualitative research facilitates the acquisition of in-depth insights into issues considered significant for investigation and provides comprehensive perspectives on specific topics (Tenny et al., 2022). The phenomenological approach provides a systematic method for describing participants' lived experiences and examining complex social phenomena through their subjective perspectives (Adeniran & Tayo-Ladega, 2024; Creswell & Poth, 2018). This design was selected because nurses' firsthand accounts were considered essential for understanding the realities of healthcare delivery in geographically isolated and resource-limited coastal settings.

Specifically, the study employed Husserl's (1931) transcendental phenomenology. The researchers practiced bracketing to reduce the influence of their own interpretations, perceptions, and prior assumptions on data collection and analysis (Neubauer et al., 2019). Accordingly, they engaged in epoché by consciously setting aside prior assumptions, clinical knowledge, and personal perspectives concerning nursing practice in coastal communities. This process promoted researcher self-awareness and supported a deeper understanding of participants' lived experiences (Thomas & Sohn, 2023).

### 2. Participants and Sampling Technique

Data collection was conducted from March to April 2025 in a Level 1 hospital and selected rural health units (RHUs) serving the coastal communities of Bulacan, Philippines, specifically in the City of Malolos and the municipalities of Hagonoy and Paombong. Eligible participants were registered nurses who (1) held a valid license, (2) had at least six months of experience in direct patient care or community health, (3) were currently practicing in a coastal community setting, and (4) voluntarily consented to participate. Nurses not actively engaged in patient care or community health during the study period were excluded.

A total of ten registered nurses were recruited through purposive sampling, which prioritizes the deliberate selection of participants who are most likely to provide rich, meaningful, and experience-near accounts of the phenomenon under investigation rather than statistical representation (Stratton, 2024). Participants were selected based on their direct clinical experience in coastal community health settings, ensuring that their situated knowledge was aligned with the central inquiry of the study. Eight participants were initially interviewed. No new codes, meanings, or themes emerged during the ninth interview, and this pattern was confirmed during the tenth interview. Data saturation was assessed through an ongoing review of the interview data by M.D.L.A. and B.K.N.Q., who agreed that no additional interviews were required. All participants agreed to participate, and none withdrew from the study. Their demographic characteristics are presented in Table 1.

**Table 1.** Demographic Characteristics of the Participants (*N* = 10)

| Code | Age | Sex | Length of Experience | Area of Assignment |
|---|---|---|---|---|
| NI1 | 47 | Female | 25 years | Rural Health Unit |
| NI2 | 25 | Male | 6 months | General Ward |
| NI3 | 25 | Female | 6 months | Emergency Room |
| NI4 | 33 | Female | 4 years | Labor/Delivery Room |
| NI5 | 39 | Female | 16 years | General Ward/Nursing Service Administration |
| NI6 | 38 | Male | 4 years | General Ward |
| NI7 | 24 | Male | 7 months | General Ward |
| NI8 | 24 | Female | 7 months | Outpatient/Emergency Room |
| NI9 | 35 | Female | 11 years | Rural Health Unit |
| NI10 | 45 | Male | 5 years | Rural Health Unit |

3. Semi-Structured Interview Guide

The study utilized a semi-structured interview guide comprising open-ended questions that enabled an in-depth exploration of nurses' experiences in coastal community settings. Semi-structured interviews provide researchers with opportunities to obtain detailed responses and explore participants' perspectives more deeply (Ruslin et al., 2022). The interview guide was organized around three thematic domains: (1) nurses' perceptions of the quality of care they were able to provide in coastal community settings; (2) the challenges and constraints they encountered in delivering health services; and (3) the strategies and adaptive practices they employed to maintain effective care under these conditions.

The guide was subsequently submitted for expert validation to a panel of three specialists comprising an expert in qualitative research, a psychometrician, and a municipal health nurse. The validators reviewed each question for clarity, relevance to the study objectives, and suitability for the target population. Questions that required improvement were revised or removed based on the experts' recommendations.

Before full implementation, a pilot interview was conducted with one nurse who met the eligibility criteria but was not included in the main study sample. The pilot interview was used to assess the flow and comprehensibility of the questions and the appropriateness of the estimated interview duration. Based on feedback from the pilot participant and the researchers' debriefing discussion, minor revisions were made to the sequence and wording of selected questions to improve conversational flow and reduce ambiguity. The finalized interview guide was used consistently across all ten participant interviews.

4. Data Collection Process

Semi-structured interviews were conducted face-to-face, by telephone, or online, with the mode selected in consultation with each participant to accommodate individual schedules and communication preferences. All interviews were conducted in private settings, with only the participant and interviewer present, to protect confidentiality. Interview durations ranged from 20 to 90 minutes, allowing sufficient time for in-depth probing and clarification.

The interviews were conducted by M.D.L.A., R.P.D.J., B.K.N.Q., A.R.M.G., and F.V.M., who served as the primary instruments for data collection. There were no pre-existing relationships between the researchers and participants before the study. Written informed consent was obtained from each participant before the interview. Participants were informed about the purpose of the study, their role, the confidentiality procedures, the voluntary nature of participation, and their right to withdraw at any time. Each participant was assigned a unique alphanumeric code based on the order of recruitment, which was used in the transcripts and research outputs.

With participants' consent, all interviews were audio-recorded and transcribed verbatim. The interviewers prepared the transcripts, and each transcript was reviewed against the corresponding audio recording to verify accuracy. Field notes were prepared immediately after each interview to document relevant observational and reflective information. Audio recordings and transcripts were stored in a password-protected Google Drive folder accessible only to the research team.

5. Data Analysis

The interview data were analyzed using Colaizzi's seven-step phenomenological method. The process involved: (1) reading each transcript to understand the overall context; (2) identifying significant statements relevant to the phenomenon; (3) formulating meanings from the significant statements; (4) organizing the formulated meanings into theme clusters and emergent themes; (5) developing an exhaustive description of the participants' experiences; (6) identifying the fundamental structure of the phenomenon; and (7) returning the fundamental structure to participants for validation (Colaizzi, 1978; Praveena & Sasikumar, 2021). All ten participants reviewed a summary of the findings and confirmed that it adequately represented their experiences. No substantive changes to the thematic structure were requested.

6. Rigor and Trustworthiness

The study adhered to Lincoln and Guba's (1985) criteria of credibility, transferability, dependability, and confirmability. Dependability was supported through reflexive journaling, in which the researchers documented analytic decisions and the reasoning underlying each stage of the analysis. Reflexive practices increase the transparency of analytic pathways and strengthen dependability (Braun & Clarke, 2021). Confirmability was supported by grounding interpretations in participant data and maintaining an audit trail of the analytic process.

Credibility was strengthened through member checking, whereby participants reviewed preliminary interpretations to assess whether the findings adequately reflected their lived experiences. Member checking supports constructive engagement between researchers and participants and contributes to the authenticity of qualitative findings (Lincoln & Guba, 1985; McKim, 2023).

Transferability was supported by providing detailed descriptions of the participants, study context, and findings, enabling readers to assess the potential relevance of the results to comparable settings. Comprehensive contextual description is important for evaluating the transferability of qualitative findings (Ahmed, 2024).

7. Research Ethics

Ethical approval was obtained from the Dr. Yanga's Colleges, Inc. Research Ethics Committee on February 25, 2025 (Approval No. DYCI-REC-2025-CHS04), before participant recruitment and data collection commenced. In accordance with Republic Act No. 10173, or the Data Privacy Act of 2012, written informed consent was obtained from all participants, and confidentiality was maintained throughout the study. Participants were informed that they could decline to answer any question or withdraw from the study at any time without penalty or negative consequences.

## RESULTS

Analysis of the participants' narratives generated three major themes: (1) Steered by Humanistic-Altruistic Values: Foundations of Nursing Practice in Coastal Settings; (2) Sailing through Barriers: Challenges in Coastal Health Delivery; and (3) Keeping Heads Above Water: Adaptive Coastal Nursing Strategies. These themes describe the lived realities of nurses working in coastal community settings. A summary of the themes and their corresponding subthemes is presented in Table 2.

**Table 2.** Themes and Sub-themes

| Themes | Sub-themes |
|---|---|
| Theme 1: Steered by Humanistic-Altruistic Values: Foundations of Nursing Practice in Coastal Settings | 1.1 Compassion-Focused Care<br>1.2 Patient-Centered Approach<br>1.3 Passion-Driven Care<br>1.4 Perceived Effectiveness of Care |
| Theme 2: Sailing through Barriers: Challenges in Coastal Health Delivery | 2.1 Geographic Isolation<br>2.2 Transportation-Related Barriers<br>2.3 Staff Shortages and Excessive Workloads<br>2.4 Inadequate Health Resources<br>2.5 Beliefs and Practices |
| Theme 3: Keeping Heads Above Water: Adaptive Coastal Nursing Strategies | 3.1 Resilience and Resourcefulness<br>3.2 Utilization of Transport Resources<br>3.3 Partnership and Collaboration |

1. Theme 1: Steered by Humanistic-Altruistic Values: Foundations of Nursing Practice in Coastal Settings

Four subthemes emerged under this theme: (1) Compassion-Focused Care; (2) Patient-Centered Approach; (3) Passion-Driven Care; and (4) Perceived Effectiveness of Care.

1.1 Sub-theme 1: Compassion-Focused Care

Findings reveal that nurses view quality care as rooted in their willingness to respond with kindness and understanding to patients' needs during moments of uncertainty. Participants recognized the financial constraints experienced by patients in coastal communities. To ensure patients receive adequate care, nurses described extending care by providing out-of-pocket support and contributing their own resources to address basic needs that would otherwise go unmet. As NI6 shared:

> *"Almost all of us in the hospital sometimes help each other out like, 'Hey, give this person some clothes,' or 'Let's buy milk for the child,' because the mother has this—some of their*

*other needs are sometimes overlooked. We're willing to provide whatever we can."*

Similarly, NI9 described:

*"Out-of-pocket expenses have become more frequent because of the existing shortages, so at times we ourselves provide for the patients' needs—that's how it is."*

1.2 Sub-theme 2: Patient-Centered Approach

Participants reported prioritizing patient-centered care by addressing all dimensions of patient needs, responding to concerns, and delivering hands-on care that encompasses both physical conditions and other critical aspects of well-being, thereby ensuring comprehensive support. As NI10 remarked:

*"Of course, give your best so that it's not just about health—everything—it's all about psychological, spiritual—everything is involved."*

1.3 Sub-theme 3: Passion-Driven Care

While their initial motivation for entering the nursing profession was to secure employment overseas, participants shared that their actual experiences in the field shifted this perspective toward the intrinsic value of service. They noted that, despite the lack of significant financial compensation, the ability to provide meaningful help and witness the impact of their care on patients' lives offered a profound sense of personal and professional reward. As NI9 recalled:

*"I studied nursing to go abroad, that was really the goal, but what I found was that it's truly very rewarding to be able to serve people even if we are not well compensated. Just the feeling that you helped them, that you touched their lives, that you made a change in them—that is a very huge thing."*

1.4 Sub-theme 4: Perceived Effectiveness of Care

Drawing on their established relationships with the community, participants described assessing the perceived effectiveness of their care through patients' reported adherence during informal community encounters. Nurses interpreted these reports as indications that patients had followed recommended practices outside formal healthcare settings. As NI4 shared:

*"Sometimes when we run into them on the street, they share things like, 'Oh, I already did what you told me,' or 'I followed what you said.' I guess that could be considered a sign of effective nursing management."*

Participants also described expressions of gratitude, including locally sourced food, as signs of appreciation for the care provided. These gestures reflected patients' acknowledgment of the nurses' support rather than objective evidence of clinical effectiveness. As NI3 shared:

*"Their way of saying thank you here is by giving seafood, like oysters and shrimp. We feel happy about it because, in that way, they are able to show their gratitude to us—for taking care of their loved ones, like their mother, father, or children."*

Overall, this theme highlights how humanistic and altruistic values shaped participants' nursing practice in coastal communities. Their accounts suggest that they understood quality care as involving not only clinical competence but also authentic human connection and sustained commitment to the welfare of the communities they served.

2. Theme 2: Sailing through Barriers: Challenges in Coastal Health Delivery

This theme describes the operational, environmental, and sociocultural barriers encountered by nurses delivering healthcare in coastal settings. Five subthemes were identified: (1) Geographic Isolation; (2) Transportation-Related Barriers; (3) Staff Shortages and Excessive Workloads; (4) Inadequate Health Resources; and (5) Beliefs and Practices.

2.1 Sub-theme 1: Geographic Isolation

Participants identified the open sea as a significant geographical barrier that impedes the prompt transfer of critically ill patients to mainland healthcare facilities. Because advanced emergency services were unavailable in the local facilities, transferring critically ill patients to higher-level healthcare facilities required travel across open water. This situation poses significant risks and logistical challenges, especially if a patient's condition worsens during transit. As NI2 emphasized:

*"Common here are those with heart failure, those who had a myocardial infarction, but they can't be brought immediately to the big hospital because this is the barrier we see there at the sea."*

NI4 also shared:

*"There really isn't a nearby hospital you can go to; you have to first get to the city proper to transfer the patients. So if something happens during the transfer, it's really difficult."*

2.2 Sub-theme 2: Transportation-Related Barriers

Because communities are separated by open water, the physical distance translates directly into daily transportation difficulties. Participants highlighted that geographic isolation in coastal settings creates significant logistical challenges, particularly regarding sea transport. They noted that, as boat travel is the primary means of reaching their areas of duty, the delivery of care remains highly vulnerable to environmental disruptions. Factors such as heavy waves and sudden rainfall frequently compromise the safety and reliability of their travel, presenting a persistent barrier to effective healthcare delivery. As NI8 shared:

*"One of the challenges is the strong waves, and then the sudden rain when you're heading to duty. It's challenging because the only main transportation to get there is by boat."*

Similarly, NI4 added:

*"Because when there's a storm, it's really hard to ride a boat because the waves are big and the water is high. If it's already dangerous on a regular day when you're traveling, it's probably ten times more dangerous during a storm."*

2.3 Sub-theme 3: Staff Shortages and Excessive Workloads

Participants reported that severe workforce shortages sometimes left only two nurses responsible for managing the entire institution. This resulted in excessive workloads, with nurses covering several critical service areas simultaneously. As NI6 noted:

*"The lack of manpower—that's the issue because we reach a point where there's only one nurse on duty for the ER and OPD, and one for the ward. Just two of us running the entire hospital."*

Severe workforce constraints placed a significant emotional burden on nurses. Participants expressed frustration and noted that the inability to provide comprehensive care due to several barriers leads to feelings of distress. As NI2 expressed:

*"Sometimes you find yourself thinking that, emotionally, it can feel depressing on your part because instead of delivering the kind of management you intend, you're only able to provide minimal care due to the many barriers."*

2.4 Sub-theme 4: Inadequate Health Resources

The conditions in these settings were further constrained by limited medical equipment and essential supplies. Participants working on Pamarawan Island reported that the absence of on-site diagnostic facilities required specimens to be transported to mainland facilities, resulting in processing delays. These prolonged turnaround times impeded timely assessment and the initiation of necessary interventions, thereby increasing the burden on both patients and nurses. As NI4 remarked:

*"Here in Pamarawan, one of our struggles is that we don't have laboratories, so it's a bit difficult for us and also for the patients. Sometimes, we even have to wait several days before the lab tests get processed."*

2.5 Sub-theme 5: Beliefs and Practices

Participants reported that some residents initially sought traditional healing practices before obtaining professional healthcare, which sometimes delayed presentation at a healthcare facility. According to the participants, residents commonly consulted traditional healers at the onset of symptoms and sought professional care only when their condition worsened. As NI8 shared:

*"For example, before they go to the hospital, they'll first see a traditional healer for a massage, and then if they suddenly get a fever or something changes with the patient's condition, that's when they'll bring them to the hospital. They prioritize their beliefs first before actually going to the hospital for a check-up."*

In summary, this theme emphasizes the core operational and environmental difficulties that complicate healthcare delivery in coastal community settings. It illustrates how geographic barriers and systemic shortages continuously challenge nurses, necessitating ongoing adaptation to sustain care.

3. Theme 3: Keeping Heads Above Water: Adaptive Coastal Nursing Strategies

This theme describes the resourceful and collaborative strategies used by nurses to maintain healthcare delivery in coastal communities. Three subthemes were identified: (1) Resilience and Resourcefulness; (2) Utilization of Transport Resources; and (3) Partnership and Collaboration.

3.1 Sub-theme 1: Resilience and Resourcefulness

Participants reported that severe staffing shortages require a collaborative approach in which administrative personnel assist with basic clinical tasks, such as monitoring vital signs during periods of increased patient volume. Participants described this informal task-sharing practice as a response to periods when the available nursing workforce was insufficient to meet patient demand. As NI6 stated:

*"Even our admin staff there know how to take vital signs. When there are too many patients, and they come one after another in the OPD, and you're the only one on duty, they help out."*

Maximizing available resources and delivering immediate interventions reflect another resilient and adaptive approach to care management in coastal communities, where distance, limited transport options, and environmental conditions can delay access to higher-level facilities. Participants shared that patient stabilization is prioritized before any transfer, emphasizing that individuals, particularly those experiencing cardiac emergencies, should not be transported unless their condition is stable. As NI5 described:

*"Stabilize first… really stabilize first, because you cannot transfer a patient who is not stable, especially if they are having a heart attack. So as much as possible, whatever can be managed here should be managed here."*

3.2 Sub-theme 2: Utilization of Transport Resources

Participants identified the sea ambulance as an important transport resource for addressing geographic barriers and facilitating access to mainland healthcare services. They explained that one participating institution operated a dedicated boat to transport patients to mainland facilities for diagnostic procedures and referral. The service was provided free of charge, reducing some of the logistical and financial barriers associated with accessing laboratory and other healthcare services. As NI8 mentioned:

*"The hospital has its own boat to bring patients to the town for laboratory work, and the patients don't have to pay anything."*

### 3.3 Sub-theme 3: Partnership and Collaboration

Participants emphasized that inter-facility coordination with tertiary referral centers serves as a crucial mechanism for ensuring continuity of care. They described a formal referral system involving Bulacan Medical Center (BMC), in which approval was obtained before the patient was placed in the transport queue. This process reflected formal coordination between coastal and mainland facilities to facilitate access to higher-level healthcare services. As NI2 shared:

> *"We have a referral system here. You just call BMC, and once they approve it, the patient is placed in the queue to be transported by boat."*

Another example of partnership was highlighted by NI5, wherein they cooperated on initiatives with government agencies to improve patient access to health services and financial coverage. These efforts help ensure that national health programs remain accessible, even in geographically remote areas:

> *"Last year, with the support of our chief of hospital, collaboration was made with the the City Social Welfare Office of Malolos and the Philippine Health Insurance Corporation (PhilHealth) to implement pre-registration here."*

Overall, this theme encompasses nurses' sustained efforts to maintain care delivery in coastal communities despite persistent barriers. It further emphasizes the development of practical solutions by nurses to address healthcare challenges specific to these settings. Such adaptive practices illustrate the resilience and resourcefulness required for effective care delivery in challenging health environments.

## DISCUSSION

The present study reveals how the realities of nursing practice in coastal communities shaped participants' delivery of care. The first theme, "Steered by Humanistic-Altruistic Values: Foundations of Nursing Practice in Coastal Settings," may be interpreted in relation to Watson's (1979) carative factors through both relational and material expressions of caring. Nurses described extending care beyond clinical tasks by providing food, clothing, and other personal contributions to patients experiencing financial difficulties, while also attending to their psychological and spiritual needs. Previous literature has largely characterized compassionate nursing through relational and communicative expressions, including attentiveness and emotional responsiveness (Babaei et al., 2022; Khaleghi & Mohammadi, 2024). In the present study, material assistance was described as another expression of compassion in resource-constrained settings. However, such assistance should be understood as a response to unmet needs rather than as an expected or sustainable professional obligation.

In the absence of formal outcome measures, participants assessed the perceived effectiveness of their care through informal community encounters, patients' reported adherence, and expressions of gratitude. These observations are broadly consistent with literature identifying patient satisfaction and adherence as indicators used in assessments of care quality (Ferreira et al., 2023; Krot & Rudawska, 2019). Expressions of gratitude may also reinforce nurses' sense of purpose and work meaningfulness (Liu et al., 2022). Although formal recognition programs can support nurses' professional confidence within institutional settings (Al Ahmari et al., 2023; Swartwout, 2024), participants in this study described informal gratitude as a meaningful acknowledgment of their caring contributions. Nevertheless, gratitude and patients' self-reported adherence should be interpreted as perceived indications of care effectiveness rather than objective evidence of clinical outcomes.

Participants' sustained engagement in emotionally and materially demanding work appeared to be supported by a personal sense of purpose rather than financial reward alone. This observation aligns with evidence that personal calling and the perceived significance of work sustain commitment to community-based service in geographically disadvantaged settings (Park & June, 2022). Dorie (2025) similarly found that nurses in such areas derive fulfillment from shared cultural identity and a felt sense of responsibility to their communities, even under challenging conditions. These findings suggest that humanistic and altruistic values in coastal nursing were not merely personal attributes but were enacted through caring practices adapted to local conditions.

These caring practices were continuously challenged by structural and environmental conditions beyond nurses' control, as reflected in the theme "Sailing through Barriers: Challenges in Coastal Health Delivery." Geographic isolation restricted timely access to healthcare, a constraint widely reported across coastal and geographically isolated health systems (Babawarun et al., 2024; Collado, 2019; Tejero et al., 2022). The absence of on-site diagnostic facilities also required specimens to be transported to mainland facilities, with results sometimes taking several days to return and consequently delaying clinical assessment and decision-making (Bayhakki et al., 2024; Collado, 2019).

In addition to these structural constraints, sea travel during adverse weather created a safety-critical hazard specific to coastal settings. Strong waves and sudden rainfall made the primary mode of transportation less safe and reliable. This finding is consistent with reported gaps in primary healthcare nurses' preparedness for climate-related hazards (Ward et al., 2024) and concerns regarding safety in rural and remote practice without adequate institutional support (Pham, 2022). Disruptions in access are particularly concerning for coastal populations with existing health vulnerabilities (Murray et al., 2024). Participants' accounts suggest

that hazardous travel affected not only their occupational safety but also their perceived ability to provide timely and appropriate care.

Workforce shortages left some facilities critically understaffed, requiring nurses to manage multiple service areas with limited equipment and professional support. This finding is consistent with evidence from geographically isolated primary care settings, where staffing deficits have been associated with increased service demands, greater task delegation, and difficulties in care coordination (Parial et al., 2024). These challenges may be further compounded by inadequate compensation and difficult working conditions that contribute to difficulties in recruiting and retaining nurses in remote areas (Park & June, 2022; Tamata & Mohammadnezhad, 2022).

Participants also described delays in seeking formal healthcare when some residents initially consulted traditional healers. This finding should be understood within the local sociocultural context, in which community relationships, beliefs, and support systems may influence decisions concerning healthcare access and utilization (Jose et al., 2024). Together, geographic isolation, resource limitations, workforce shortages, and local healthcare-seeking practices shaped the conditions under which nurses attempted to maintain care delivery.

These structural and sociocultural barriers shaped the adaptive strategies described in the theme “Keeping Heads Above Water: Adaptive Coastal Nursing Strategies.” Rather than representing coping behaviors alone, these strategies reflected nurses’ efforts to sustain essential services under resource-constrained conditions. Participants described administrative personnel assisting with basic tasks, such as monitoring vital signs, during periods of high patient volume. Similar forms of task redistribution have been reported as responses to nursing workforce shortages (Loft et al., 2025). However, the informal delegation of clinical tasks may create safety concerns when personnel have not received appropriate training, competency assessment, supervision, or clearly defined responsibilities (Blay & Roche, 2020).

Another adaptive practice involved stabilizing patients before transfer to a higher-level healthcare facility. This finding is consistent with evidence that nurses in remote settings often undertake broad generalist responsibilities involving acute, chronic, and emergency care when access to specialized services is limited (McCullough et al., 2022). Such responsibilities require sound clinical judgment, clear referral procedures, appropriate professional support, and recognition of nurses’ scope of practice to protect both patient safety and professional accountability.

Beyond adaptations undertaken within individual facilities, partnerships with local government, social welfare offices, referral centers, and national health programs extended support to the wider community. These collaborations are consistent with evidence that interprofessional and intersectoral partnerships enable resource-limited healthcare facilities to participate in broader systems of care (Perron et al., 2022).

Participants described a facility-owned transport boat that provided no-cost transportation to mainland healthcare facilities for laboratory procedures and patient referral. This institutional resource addressed both geographic and financial barriers to care. Unlike findings from settings where nurses relied on small boats or rented vessels to reach patients (Bayhakki et al., 2024), the facility-owned transport described in this study reduced dependence on individually arranged transportation. This support was particularly relevant in low-income coastal communities, where the cost of transportation and diagnostic services may intensify barriers associated with geographic isolation (Azzeri et al., 2020; Collado, 2019).

Taken together, these findings may be interpreted in relation to Watson’s (1979) Theory of Human Caring. They illustrate how participants attempted to maintain caring relationships through relational support, material assistance, clinical adaptation, and collaboration in resource-constrained coastal settings. Rather than demonstrating that resource scarcity strengthens caring, the findings show how nurses sought to preserve caring practices despite conditions that could compromise their safety, well-being, and capacity to provide care.

## Implications for Practice and Future Research

The findings have implications for nursing practice, education, research, and policy. Healthcare institutions serving coastal communities should strengthen staffing, diagnostic capacity, referral coordination, transport safety, and access to essential equipment and supplies. Context-appropriate telehealth services may also be considered to support consultation, follow-up care, and referral coordination when travel is delayed, provided that connectivity, data privacy, staffing, and professional scope-of-practice requirements are adequately addressed.

Nursing education may incorporate simulation scenarios reflecting coastal emergencies, severe weather, transport delays, limited diagnostic resources, workforce shortages, and inter-facility referral. These learning activities may help nurses develop clinical judgment, culturally responsive communication, emergency preparedness, and adaptive decision-making for geographically isolated and resource-constrained settings.

Future research should examine coastal residents’ perspectives on nursing care and healthcare access. Ethnographic studies may clarify how culture, community relationships, and local healthcare-seeking practices shape care experiences. Longitudinal studies could examine the effects of environmental hazards, occupational stressors, and resource limitations on nurses’ well-being, retention, and professional practice. Research

should also evaluate the feasibility, safety, and effectiveness of telehealth, sea-based patient transport, task-sharing arrangements, and other service-delivery strategies in coastal communities.

At the policy level, priorities include workforce capacity building, equitable compensation, sufficient resource allocation, safe transport systems, diagnostic infrastructure, and context-specific emergency protocols. These measures are needed to support sustainable healthcare delivery while safeguarding the well-being of nurses serving coastal communities.

### Limitations

This study involved ten nurses recruited through purposive sampling from selected coastal healthcare facilities in a single province. Therefore, the findings represent a context-specific range of experiences and may have limited transferability to coastal settings with different geographic, infrastructural, organizational, or sociocultural conditions. Interviews were conducted face-to-face, by telephone, or online and ranged from 20 to 90 minutes; these differences may have influenced the depth of participant accounts and the availability of nonverbal information. The findings were also based on nurses' self-reported experiences and did not include the perspectives of patients, administrators, or other healthcare workers. In addition, quality of care was explored through nurses' perceptions and was not assessed using objective clinical or service-quality indicators. Despite these limitations, the detailed participant accounts provide context-specific insights into nursing practice in coastal and resource-constrained settings.

## CONCLUSION

This study described the lived realities of nurses providing care in coastal community settings in Bulacan, Philippines. Participants reported that their practice was shaped by humanistic and altruistic values while being challenged by geographic isolation, hazardous sea travel, workforce shortages, inadequate diagnostic resources, and local healthcare-seeking practices. They responded through resourcefulness, patient stabilization, transport arrangements, referral coordination, and collaboration with government and community institutions.

The findings reflect nurses' perceptions of care delivery rather than objective evidence of clinical effectiveness. Personal financial assistance, informal task-sharing, and individual resilience should not be regarded as sustainable substitutes for adequate staffing, resources, infrastructure, and institutional accountability. Strengthening diagnostic capacity, safe transportation, workforce support, referral systems, and intersectoral collaboration is necessary to support equitable healthcare access while protecting nurses' safety and well-being.

### Author Contributions

Conceptualization: Ma. Desiree L. Apdujan; Methodology: Alecxis Russelle M. Garcia and Fatima Vincent Mogarte; Data Collection: All authors; Analysis: Ma. Desiree L. Apdujan and Blessierine Keiyth N. Quetua; Writing – Original Draft: All authors; Writing – Review & Editing: Ma. Desiree L. Apdujan, Regie P. De Jesus.

### Data Availability Statement

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

### Conflict of Interest

The authors declare no conflicts of interest related to this study.

### Acknowledgments

The authors sincerely thank the participating nurses for their time, trust, and willingness to share their experiences. The authors also acknowledge Dr. Yanga's Colleges, Inc.–College of Health Sciences for the institutional support provided during the conduct of this study.

### Funding

This research received no external funding.

### Declaration of Use of AI in Scientific Writing

In the conduct of this study, the researchers employed Microsoft Copilot, an artificial intelligence (AI)-based tool, to facilitate the identification of relevant literature and potential sources during the review process. The tool was used exclusively to support and expedite the literature search. All retrieved sources were subsequently subjected to independent verification, critical evaluation, and selection by the researchers based on their relevance and methodological soundness.

The researchers assume full responsibility for the interpretation, synthesis, and presentation of all literature incorporated into this study, as well as for the accuracy and integrity of the manuscript.

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