# ASEC **COVID-19 Impact Report**

## Stakeholder Engagement Survey

**ASEC Research**

**May 2020**

ASEC
AFRICAN SISTERS EDUCATION COLLABORATIVE

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# Abstract

The purpose of this study was to seek an organizational understanding of stakeholders' experiences and coping mechanisms during the phenomenon of the coronavirus disease of 2019 (COVID-19) pandemic. The African Sisters Education Collaborative (ASEC) operates in ten countries of Africa south of the Sahara, through partnerships with 24 institutions of higher education, 39 consultancy groups, and 10 national associations/conferences of women religious. ASEC facilitates four core programs: the Higher Education for Sisters in Africa (HESA) program, the Sisters Leadership Development Initiative (SLDI), the ASEC Two-Year Scholarship program and the Service Learning program. In addition, ASEC's Institutional Capacity Building (ICB) program is being piloted under SLDI and it's Visiting Scholar Fellowship is run in partnership with the Center for Applied Research in the Apostolate (CARA) at Georgetown University under ASEC's Research Initiative. This research study utilized a mixed methods, cross-sectional survey design. The target population from all of ASEC's stakeholders was approximately 3,800, from whom the study obtained a 40% response rate ($N$ = 1,529). Pearson's r reveals no relationship between personality type with work/ministry, emotional, and coping skills, but a strong relationship was found between work/ministry, emotional, and coping skills $p$ <.01. The pandemic has negatively impacted the stakeholders' ministries and practice settings, leading to significant influence on personal experiences of loneliness, fear, anxiety, and lower performance. Recommendations for practice have been made to help the organization implement interventions to provide data-driven planning for future organizational operations.

*Keywords*: COVID-19, stakeholders, Africa, coping skills, mechanisms

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# Introduction

Organizational relationships and team building are part of everyday planning and engagement of stakeholders. During unprecedented times, team cohesion and check-in play an important role in keeping such engagements and organizational relevance in place. The announcement of the outbreak of the coronavirus disease of 2019 (COVID-19) has presented individuals, organizations, and nations with a global challenge of its own kind. Therefore, continuously evaluating stakeholder coping mechanisms during the COVID-19 pandemic is imperative to maintaining successful partnerships and organizational cohesion.

The African Sisters Education Collaborative (ASEC) operates in ten countries of Africa south of the Sahara, through partnerships with 24 institutions of higher education, 39 consultancy groups, and 10 national associations/conferences of women religious. Collaboration is a core value of ASEC and is vital to the organization's success in achieving its mission to "facilitate access to education for women religious in Africa that leads to the enhancement and expansion of the education, health, economic, social, environmental, and spiritual services they provide" (ASEC, 2020). ASEC operates four core programs: the Higher Education for Sisters in Africa (HESA) program, the Sisters Leadership Development Initiative (SLDI), the ASEC Two-Year Scholarship program and the Service-Learning program. In addition, ASEC's Institutional Capacity Building (ICB) program is being piloted under SLDI and the Visiting Scholar Fellowship is run in partnership with the Center for Applied Research in the Apostolate (CARA) at Georgetown University under ASEC's Research Initiative.

As ASEC prioritizes strong relationships with partner institutions, understanding the impact of devastating events such as the COVID-19 pandemic on its stakeholders is central to providing effective interventions that will ensure the continuation of its programs long term. For these reasons, in May 2020 ASEC initiated an internal study to assess its stakeholders' experiences and coping mechanisms during the COVID-19 pandemic. It was hoped that results of this study would initiate a proactive response to the pandemic at an organizational level.

## Purpose

The purpose of this study was to seek an organizational understanding of ASEC stakeholders' experiences and coping mechanisms during the COVID-19 pandemic. In addition, the study endeavoured to provide a proactive response to an unprecedented worldwide phenomenon at the organizational level.

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## Central Research Questions

1. How has the COVID-19 pandemic impacted ASEC stakeholders at an individual/emotional level and in their place of work/ministry?
2. How are ASEC stakeholders coping with the COVID-19 pandemic?
3. In what ways can ASEC best support its stakeholders during the COVID-19 pandemic?

## Hypothesis

$H_o$: In crisis management, there is no significant relationship between personality type (extrovert/introvert) and disposition to the impact on stakeholders' ministries/work, emotional experiences, and coping skills.

$H_a$: In crisis management, there is a significant relationship between personality type (extrovert/introvert) and disposition to the impact on stakeholders' ministries/work, emotional experiences, and coping skills.

## Significance of the Study

This study is significant in that it assesses the current status of ASEC's stakeholders, assists in prioritizing their needs, and informs ASEC operations during the unprecedented COVID-19 pandemic. This study presents the current stance in personal development in risk assessment, investment, disaster mitigation, and crisis management, which will be used to inform decision making processes to meet the growing needs of ASEC. Furthermore, this study is highly relevant as it will add to the growing body of literature available on the impact of the COVID-19 pandemic and provides unique insights into the challenges faced by both lay and religious individuals throughout Africa south of the Sahara.

# Related Literature

Academic literature on the impact of COVID-19 is currently evolving as the pandemic unfolds throughout the globe. However, many researchers are focusing their efforts in this area and the initial results of numerous studies have been released for public consumption. Available preliminary literature on the impact of COVID-19 in the areas of emotional, work, and effective coping strategies provided the bases from which this study was designed.

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As of May 27, 2020, the World Health Organization (WHO, 2020) reported 83,913 cases of COVID-19 and 2,287 deaths from the disease in the African region alone. Community transmission within the African region continues to increase with cross-border transmission mainly through truck drivers and other illegal movement across borders (WHO, 2020). In African countries served by ASEC there has been varying degrees in the severity of number of identified cases: Nigeria (8,344), Ghana (6,964), Cameroon (5,436), Kenya (1,348), Zambia (920), South Sudan (806), Tanzania (509), Uganda (341), Malawi (101), and Lesotho (2) (WHO, 2020). In general, the West African region is experiencing the highest proportion of cases. Nigeria has also sustained the largest number of healthcare worker infections, with 606 infections attributed to this group (WHO, 2020). In addition, as of May 27, 2020, the United States has recorded the highest global impact from COVID-19 with 1,634,010 cases and 97,529 deaths. Containment and testing measures vary greatly by country, contributing to various degrees of impact on individual mental health, ministry/work, and coping abilities.

Based on modeling analysis, strict quarantine measures, or the movement restriction of asymptomatic people, in African countries may be an effective measure in decreasing the spread of COVID-19 (Ryan, Mazingisa, & Wiysonge, 2020). However, it is also important to consider that seven out of ten Africans perform informal work, which may contribute to defiance of such restrictions and increased negative economic/mental health impact (Ryan, Mazingisa, & Wiysonge, 2020). For these reasons, consideration of the context of each African country has been found to be imperative to COVID-19 mitigation efforts.

In April 2020, 35 research centers across the globe collaborated to conduct an international survey to assess the mental health and emotional well-being impact of COVID-19 social distancing measures (Ammar et al., 2020). The initial results of the study ($N$ = 1,047), including 40% respondents from Africa, suggest that home confinement had a significant negative impact on mental well-being, mood, and feelings. From these results, Ammar et al. (2020, p. 14) encourage “crisis-oriented interdisciplinary interventions” and an “Active and Healthy Confinement Lifestyle (AHCL)” to mitigate these negative impacts.

Further, Frissa and Dessalegn (2020) posit that sub-Saharan Africa is particularly at risk for negative mental health impacts caused by the COVID-19 pandemic due to weak healthcare systems, as evidenced by previous studies conducted on the 2014-2016 Ebola epidemic. It is suggested that effective interventions should be contextualized, with implementation of safeguarding measures for social, cultural, and coping resilience factors (Frissa & Dessalegn, 2020). The researchers also propose that community workers should be trained to provide basic

mental health education and counseling services in their various localities to diminish negative mental health impacts.

# Methodology

This study employed a mixed-methods methodological approach, utilizing a cross-sectional survey with majorly quantitative questions with the addition of one qualitative short answer response item. Quantitative results were triangulated with qualitative outcomes to provide a complete depiction of stakeholder impact. It was determined this design would best allow for the investigation of the study's central research questions and fulfill the study's purpose.

## Participant Selection

The study population was sourced from the organizational master lists of all stakeholders, utilizing a purposive sampling technique (Patten & Newhart, 2018). To reach as many participants as possible on the grassroot, the assistance of ASEC country directors and coordinators was also employed to contact participants who may not have recorded their current email address in the organization's central repository database.

## Data Collection Methods

Data was collected online over a period of two weeks through an electronic link supported by Survey Monkey. The Survey Monkey link was distributed to ASEC partner representatives utilizing the email link distribution feature within Survey Monkey. All other stakeholders (e.g. program participants, visiting scholars, ASEC staff) received the Survey Monkey link via Mail Chimp, Gmail, or WhatsApp. The survey link was accessed most often through the Mail Chimp, Gmail, and WhatsApp distributions according to the Survey Monkey data collector analysis.

## Data Analysis

Data was analyzed using common recommended techniques for both quantitative and qualitative analysis. A detailed description of this analysis is included below.

### Validity Issues

The survey tool had not previously been tested for internal consistency and reliability. However, the large pool of participants ($N$ = 1,529), gave the study enough statistical power to generalize the quantitative results to the entire stakeholder population (Mertler & Reinhart, 2017). Cronbach's

Alpha reveals high internal consistency and reliability of the study's survey tool. The ministry/work related scale produced a Cronbach's Alpha of .520, the emotional scale produced a Cronbach's Alpha of .714, and the coping skills scale produced a Cronbach's Alpha of .644. The recommendation for the alpha level holds that "the probability of a Type II error decreases when the sample size increases" (Mertler & Reinhart, 2017, p.12). For the qualitative responses, threats to internal and external validity were eliminated by the choice of cross-sectional survey design, to collect data at one point in time (Creswell & Creswell, 2018).

## Quantitative Analysis

Quantitative data was analyzed using IBM SPSS version 26. The large pool of data served well for generalization of quantitative results at a level of 95% confidence and +/-.05 confidence interval, where the minimum number required was 349 participants (Raosoft, 2020). The survey obtained a 40% response rate (*N* = 1,529).

Data screening identified various levels of missing cases but there were no outliers. The missing cases did not pose any undue influence on data analysis based on the outcomes of the standard deviations measured through z-scores, skewness, and Kurtosis. Therefore all the missing cases were retained in the analysis.

Additionally, the scales were coded to provide a measure for ministry/work related items, emotional experience related items, and coping skill related items. The scale for work related items consisted of five questions rated on a Likert-type scale (1 = *strongly disagree* to 4 = *strongly agree*). The range therefore was 5 - 20, where scores of 5 - 12 were considered low impact and 13 - 20 high impact. Emotional impact was measured with five items as well and coping skills had three items, all also rated on a Likert-type scale (1 = *strongly disagree* to 4 = *strongly agree*). The range was 3 - 12, where scores of 3 - 7 were considered low impact and scores between 8 - 12 were considered high impact.

## Qualitative Analysis

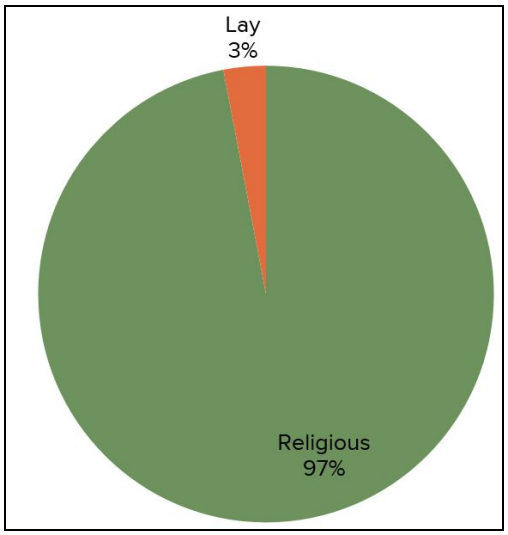
Qualitative data was analyzed using an inductive constant comparative method with the assistance of NVivo Pro 11. A large number of survey participants responded to the single qualitative item (*N* = 1,529), allowing for clear saturation of responses. Participants were asked to provide a short answer to the question, "In your opinion, how can ASEC best support you and your institution/organization during the COVID-19 pandemic?" Given this survey item's qualitative origin, it was determined that the constant comparative method was most appropriate to derive themes from the rich, descriptive data provided (Merriam & Tisdell, 2016).

Utilizing Merriam and Tisdell's (2016, p. 204) constant comparative method for analysis, "open coding" was first conducted based on purely descriptive categories. The open codes were then reviewed and through interpretation, grouped according to similarity (i.e., analytical coding), effectively placing them into themes (Merriam & Tisdell, 2016). From this process, seven overall themes emerged from the data, each of which are described in the findings section of this report.

# Findings

## Participants

The study attracted stakeholders from all targeted programs, with 97% (*n* = 1416) identifying as religious and 3% (*n* = 44) identifying as laity. All participants were required to provide their informed consent prior to completing the survey, 34 participants declined consent and were automatically disqualified from the survey.




Largest participation came from current residents of Kenya, Tanzania, Nigeria, Uganda, and Ghana, each country recording more than 100 participants. The country with the least participation was South Sudan, recording only two participants. Thirty-one participants reported their current country of residence as "Other" due to changes in religious assignments and job placement. Countries of residency described as "Other" included Argentina (1), Central African Republic (1), Ethiopia (1), France (1), India (2), Indonesia (1), Italy (1), Republic of Benin (1), Rwanda (1), South Africa (2), Togo (6), United Kingdom (2), and Zimbabwe (11).

The most commonly reported current age of participants was 40 years, with an overall average age of 41 years ($M$ = 40.74, $SD$ = 9.60). In addition, participants ranged in ages from 23 years to

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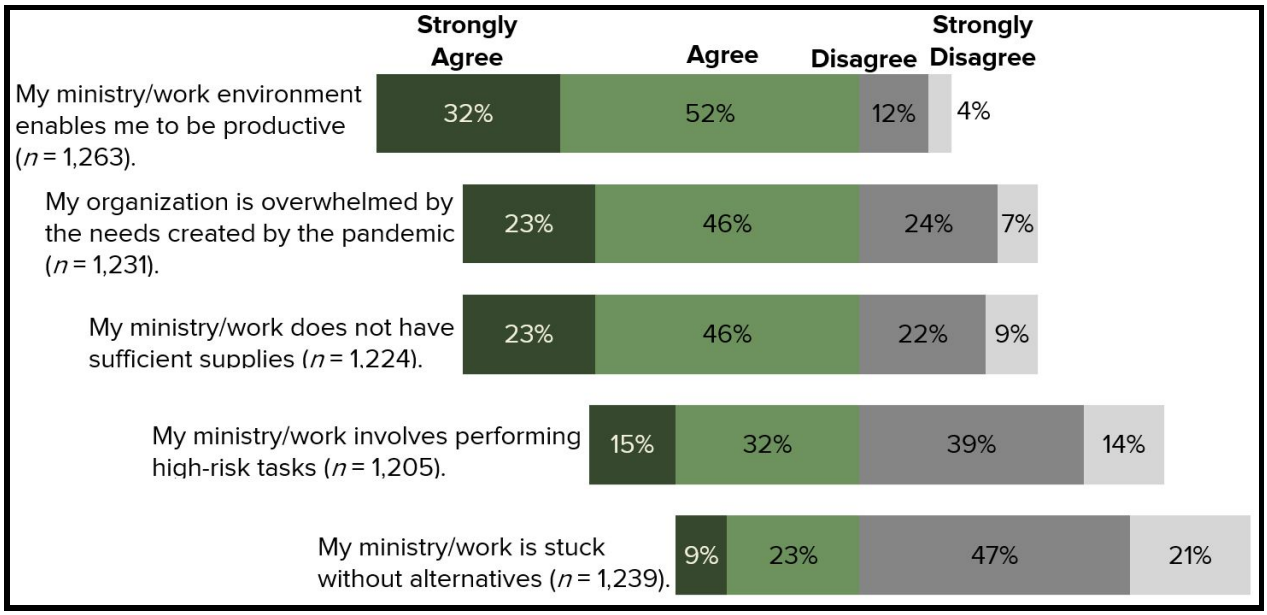
79 years. Participants were also asked to report the number of years they have served in their current ministry/place of work. Most commonly, participants reported they had served in their ministry/place of work for three years, with an overall average of ten years ($M$ = 10.40, $SD$ = 8.86).

## Quantitative Findings

### Ministry/Work Impact

First, the impact of the COVID-19 pandemic on stakeholders' work/ministry, emotional experiences, and ability to cope was assessed. To measure these variables, a research tool consisting of 24 quantitative items was formulated. The quantitative scale items consisted of a total of 13 questions, divided into three areas of analysis: ministry/work impact, emotional experiences, and a coping skills assessment. All participants in this study agreed that the pandemic had negatively impacted their work, emotional experiences, and coping skills within the same range. The mean score, as earlier reported in the scale for ministry/work related items, fell within the upper limit of the scale 13 - 20 ($M$ = 13.04, $SD$ = 2.84).




Overall, these outcomes suggest that participants experienced high negative work impact. However, their high coping skills enabled them to navigate their emotional experiences, which fell within the lower side of negative emotional impact during the pandemic. At the same time, the study considers there could have been other moderating variables that were likely to influence this outcome differently. Therefore further analysis of data examined the level of work/ministry impact, emotional impact, and coping capacity for participants under different

categories and variables in this study such as profession, vocation status (i.e. religious vs. laity) and personality type (introverts vs. extroverts).

## Professional Occupation Outcomes

Secondly, analysis was conducted to determine if there were any significant differences between stakeholders' work impact, emotional experiences, and coping skills between professional occupation categories. The scores for the work/ministry scale was predetermined at two levels of equal categories (5 - 12) would mean low negative impact and (13 - 20) as high negative impact on work/ministry. Table 1 below shows mean scores for participants according to their identified ministries.

**Table 1**

***Differences Among Overall Scale Means by Professional Occupation***

| Profession | Work/Org. | | | Emotional | | | Coping | | |
|---|---|---|---|---|---|---|---|---|---|
| | *f* | *M* | *SD* | *f* | *M* | *SD* | *f* | *M* | *SD* |
| Administration | 218 | 13.07 | 2.91 | 215 | 11.67 | 3.30 | 216 | 8.66 | 1.94 |
| Education | 294 | 13.10 | 2.54 | 295 | 12.03 | 3.02 | 297 | 8.68 | 1.81 |
| Healthcare | 100 | 13.63 | 2.52 | 102 | 11.06 | 2.94 | 103 | 9.03 | 1.48 |
| Pastoral Work | 50 | 13.96 | 3.22 | 51 | 12.59 | 3.14 | 50 | 8.56 | 1.97 |
| Social Work | 52 | 12.40 | 3.31 | 53 | 11.55 | 3.95 | 52 | 8.75 | 2.11 |
| Finance/Accounting | 120 | 13.33 | 2.94 | 121 | 12.16 | 3.51 | 120 | 8.98 | 1.67 |
| Student | 348 | 12.64 | 2.98 | 347 | 12.15 | 3.05 | 352 | 8.68 | 1.68 |
| Other | 55 | 13.24 | 2.38 | 53 | 11.70 | 3.02 | 53 | 8.91 | 1.76 |

Note. Higher work/ministry mean scores (13 - 20, high impact) indicate higher negative work/ministry impact, higher emotional mean scores indicate higher negative emotional impact, and higher coping mean scores (8 - 12, high impact) indicate a higher ability to cope.

A few significant differences were found in this category based on some occupations, the impact on their work/ministry, and emotional experiences. Health workers and pastoral workers had significant differences in their emotional experiences from the independent samples *t*-test, (*t* (151)

= -2.965, $p$ <.01). When healthcare workers were compared with those in finance/accounting, significant differences were also found ($t$ (221) = -2.505, $p$ <.05). From the mean scores, results suggest that those in pastoral work were more likely to experience emotional distress than healthcare workers, even though the means fall within the low risk range of 5 - 12 mean scores (see Table 1).

When it came to work/ministry related items, two significant differences were found between healthcare workers and social workers ($t$ (150) = 2.546, $p$ <.05). Social workers were less likely to be experiencing high negative work/ministry impact compared to their counterparts in healthcare ministries. Healthcare workers in the practice setting reported high negative impacts from the pandemic (see Table 1). Similarly, work/ministry related differences were found between participants who identified as students and those in education ($t$ (640) = -2.079, $p$ <.05). These results suggest that those serving/working in the field of education had high negative impacts in their work/ministry from the pandemic, compared to those who identified as students (see Table 1).

## Personality Type Correlations

The Pearson correlation coefficient outcome was used to test the hypothesis which sought to understand if there is any relationship between personality and crisis management.

> $H_o$: In crisis management, there is no significant relationship between personality type (extrovert/introvert) and disposition to the impact on stakeholders' ministries/work, emotional experiences, and coping skills.

There was no significant relationship between personality type and ministry/work related items, emotional experiences, and coping skills. For personality type, the following was found: personality type and ministry/work ($r$ (1180) = .046, $p$ = .114); personality type and emotional experiences (r (1176) = -.016, $p$ =.586); and personality type and coping skills ($r$ (1181) = -.010, $p$ =.735). An additional correlation on the question *Are you religious or lay?* revealed no significant relationship with personality type ($r$ (1215) = -.021, $p$ =.468), and lastly there was no significant relationship between participants' occupations and personality type ($r$ (1203) = -.019, $p$ =.504). These outcomes suggest that regardless of personality type and/or religious status, all people are impacted similarly when faced with a crisis like the COVID-19 pandemic. Therefore this study fails to reject the null hypothesis. Organizations would do well to look at individuals' needs, while considering other needs that are work/ministry, coping skills, and emotional experience related.

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Even though Pearson r did not reveal a relationship with the three variables under scrutiny and personality type, the *t*-test reveals that extroverts ($M$ = 11.68, $SD$ = 3.10) were less likely to be negatively impacted emotionally compared to their introverted counterparts who had a slightly higher score ($M$ = 12.13; $SD$ = 3.16); ($t$ (1082) = 2.405, $p$ = .016). Although this result is significant, it still falls within the lower level of negative emotional impact for both groups.

## Other Relationship Impacts

Next, the study sought to further determine other forms of relationships that could have impacted participants during the pandemic. Pearson correlation found a weak but significant relationship between profession (i.e. education, administration, health) and work/ministry ($r$ (1235) = -.061, $p$ = .033). As earlier discussed in the outcome for the scores of work/ministry related items, participants reported high negative impact scores ($M$ = 13.04). Most participants for instance reported their organizations had been stuck without alternatives, they worked in high risk situations, and were overwhelmed by their work. Thus the high self-reported scores emerged clearly in the case of healthcare workers, as well as participants in the education profession whose means were on the higher side (see Table 1).

Work/ministry had a weak but significant relationship with vocation status (religious vs. lay) the correlation is ($r$ (1248) = -.121, $p$ = .000). Other significant relationships were found between ministry/work and emotional impact ($r$ (1224) = .392, $p$ = .000). A positive correlation was also found in coping skills and work ($r$ (1229) = .107, $p$ = .000), which seems to explain the balance between the negative impact in participants' work/ministries and the high coping skills that probably enabled them to cope with the pandemic.

The outcome for relationships also revealed that while work was negatively correlated with vocation status (religious vs. lay), coping skills had a positive significant relationship with vocation status (religious vs lay ($r$ (1254) = .115, $p$ = .000).

## Emotional Experiences

The scale for emotional items is based on five questions related to the emotions experienced by stakeholders. The range for this scale thus is 5 - 20, where (5 - 12, is low impact) and (13 - 20, high impact) negative impact on emotional experiences. Emotional experiences had no significant relationship either with occupation or vocation status (religious vs. lay).

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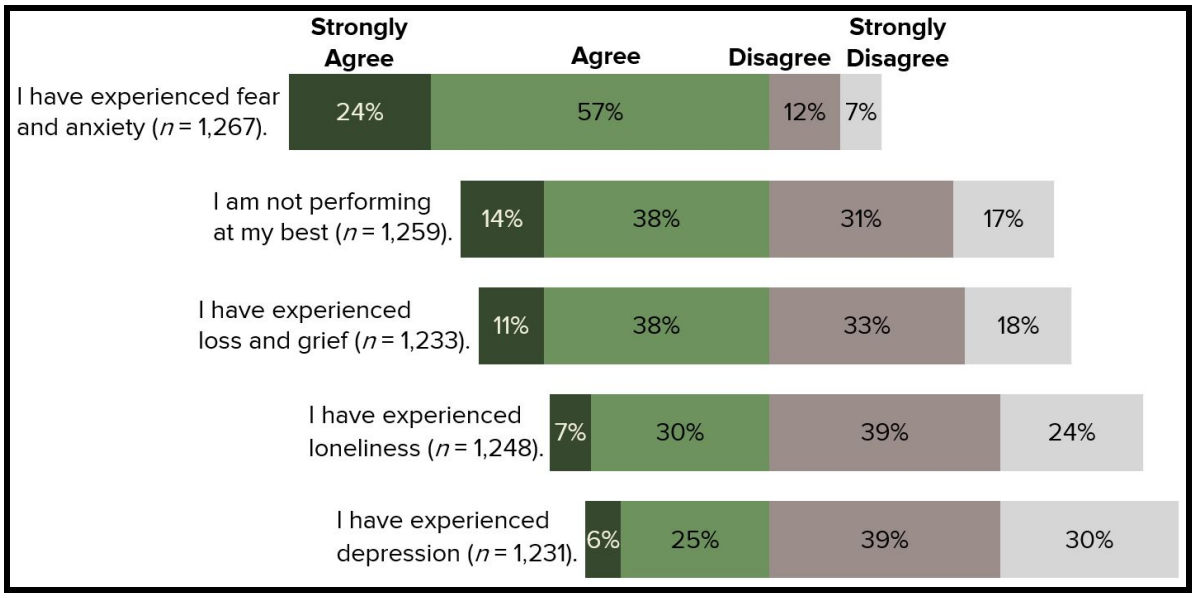



The scale for emotional experiences had five questions as well, the mean was within the lower limit of negative impact (*M* = 11.92, *SD* = 3.18). This reveals participants had a lower negative impact on their emotional experiences different from the high negative experienced in their work. All countries reported high scores of the items of experiencing fear and anxiety and that they were not performing at their best. In spite of the lockdown majority of participants (63%) did not identify with the feeling of loneliness. By the time of this study, nearly half had experienced loss and grief (49%) within the first three months of the outbreak of the pandemic.

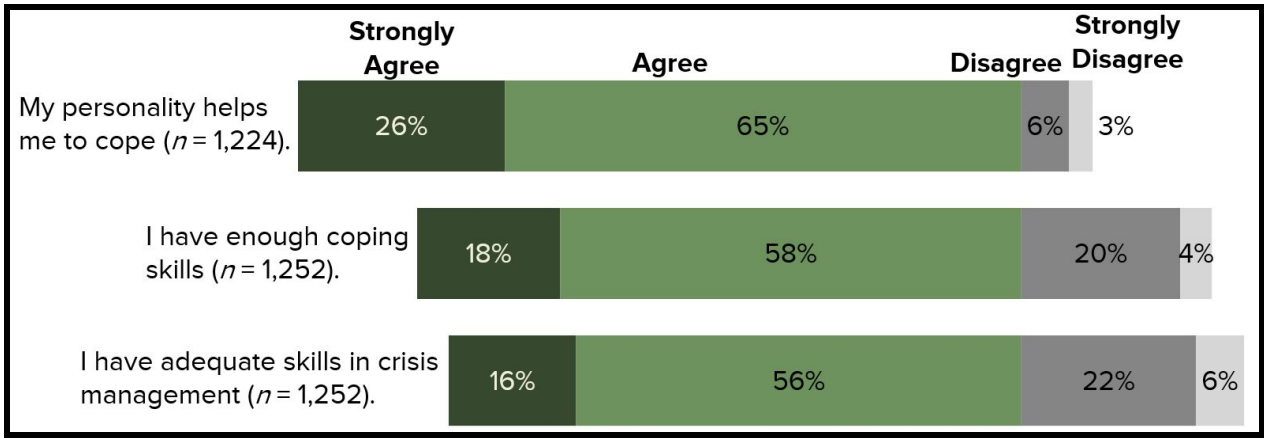
**Table 2**

***Differences Among Overall Scale Means by ASEC Affiliation***

| Country | Work/Ministry | | | Emotional | | | Coping | | |
|---|---|---|---|---|---|---|---|---|---|
| | *f* | *M* | *SD* | *f* | *M* | *SD* | *f* | *M* | *SD* |
| ASEC Staff | 50 | 9.02 | 1.52 | 51 | 11.65 | 2.78 | 50 | 11.38 | 2.98 |
| HESA Liaisons | 68 | 8.44 | 1.86 | 71 | 12.94 | 2.32 | 72 | 12.21 | 3.48 |
| Partner Institution | 79 | 9.25 | 2.23 | 77 | 12.29 | 2.32 | 79 | 10.95 | 3.08 |
| National Conference | 20 | 8.45 | 1.79 | 20 | 13.35 | 2.18 | 20 | 11.85 | 2.48 |
| Program Participant | 1039 | 8.71 | 1.74 | 1031 | 13.17 | 2.87 | 1028 | 12.00 | 3.19 |
| Religious | 1219 | 8.71 | 1.78 | 1213 | 13.10 | 2.83 | 1211 | 11.94 | 3.19 |
| Lay | 37 | 9.92 | 1.66 | 37 | 11.08 | 2.49 | 38 | 11.08 | 2.69 |

Note. Based on five survey items, (5 - 12, low) and (13 - 20, high) higher mean scores indicate higher self-reported incidences of negative ministry/work impact (e.g. unproductive, stuck, overwhelmed, insufficient supply, high risk). Coping skills score is based on 3 items (3- 7, low and 8 -12, high).

## Coping Skills Assessment




The coping skills scale revealed high crisis management mechanisms among participants (*M* = 8.75, *SD* = 1.78). Scores of 3 - 7 would be low coping skills and 8 - 12 high coping skills. The outcome in the mean of the group reveals that participants had high coping skills. The highest

contributor was their self assessment on their personality where 91% agree or strongly agree their personality helped them to cope. Their professional skills were also highly rated at 76% and 72% of those who agree or strongly agree that they felt prepared. A sizable number of participants felt less confident in the same areas.

## Country Differences

**Table 3**

***Differences Among Overall Scale Means by Country***

| Country | Work/Ministry | | | Emotional | | | Coping | | |
|---|---|---|---|---|---|---|---|---|---|
| | *f* | *M* | *SD* | *f* | *M* | *SD* | *f* | *M* | *SD* |
| Cameroon | 83 | 8.66 | 1.56 | 83 | 13.36 | 2.58 | 81 | 12.99 | 3.28 |
| Ghana | 112 | 8.97 | 1.44 | 113 | 12.73 | 2.98 | 111 | 10.96 | 3.00 |
| Kenya | 293 | 8.48 | 1.87 | 288 | 12.66 | 2.90 | 291 | 11.65 | 3.04 |
| Lesotho | 15 | 8.80 | 1.86 | 17 | 12.82 | 4.05 | 17 | 13.35 | 2.64 |
| Malawi | 70 | 8.16 | 1.77 | 71 | 13.45 | 2.94 | 70 | 11.69 | 3.77 |
| Nigeria | 174 | 9.22 | 1.61 | 170 | 12.81 | 2.59 | 175 | 11.24 | 2.70 |
| South Sudan | 2 | 9.00 | .000 | 2 | 12.00 | 2.83 | 2 | 11.00 | 1.41 |
| Tanzania | 225 | 8.87 | 1.89 | 221 | 13.51 | 2.80 | 218 | 12.75 | 3.45 |
| Uganda | 153 | 9.03 | 1.69 | 156 | 13.34 | 2.69 | 157 | 11.72 | 3.15 |
| United States | 16 | 9.56 | 1.79 | 17 | 10.47 | 1.74 | 17 | 12.59 | 3.28 |
| Zambia | 85 | 8.13 | 1.85 | 85 | 13.40 | 2.42 | 82 | 11.89 | 2.65 |
| Other | 28 | 8.32 | 1.76 | 27 | 13.00 | 4.14 | 28 | 13.64 | 3.35 |

Note. Higher work/ministry scale means indicate higher negative impact (5 -12, low) and (13 - 20, high), higher emotional scale means indicate higher negative impact (5 - 12, low) and (13 - 20, high), and higher coping scale means indicate a higher ability to cope (3 - 7, low) and (8 - 12, high).

There were significant differences across countries based on the three variables under study: ministry/work related items, emotional experiences, and coping skills. This outcome affirms the

Pearson correlation which revealed that all the three variables have a relationship. The group means also vary from country to country (see Table 3).

While holding country of residence variability in place, a second set of comparison was employed to determine the experiences of participants within the same geographical region under three unique situations: countries in total lockdown, partial lockdown, and no lockdown. This was the case for the three East African countries (i.e, Uganda, Kenya, and Tanzania, respectively). For the Uganda (in total lockdown) and Tanzania (in no lockdown) comparison, the only significant difference found was on their emotional experiences. Uganda ($M$ = 11.72, $SD$ = 3.42) and Tanzania ($M$ = 12.75, $SD$ = 3.43); ($t$ (373) = -2.966, $p$ <.01). This result suggests that participants from Tanzania were more likely to experience emotional distress compared to their counterparts from Uganda who posted a lower score self-rating for emotional impacts. However, both groups fell within the lower limit of negative emotional impact from the pandemic.

The significant outcome for Uganda and Kenya had both coping skills: Uganda ($M$ = 9.03, $SD$ = 1.69) and Kenya ($M$ = 8.48, $SD$ = 1.86); ($t$ (444) = 3.003, $p$ <.01) with a moderate effect size $d$ =.305. The second significance was found in work related items: Uganda ($M$ = 13.34, $SD$ = 2.69) and Kenya ($M$ = 12.66, $SD$ = 2.90); ($t$ (442) = 2.432, $p$ <.05) with a small effect size $d$ = .240. Participants from Uganda had a high negative impact on their work/ministries compared to those from Kenya. A possible explanation for this outcome is that the total lockdown could have had a higher negative impact on work/ministry than for those in partial lockdown.

When Tanzania was compared with Kenya, which was in partial lockdown, significant differences were found for all three variables. The major difference between Tanzania and Kenya was in the area of ministry/work related items: Tanzania ($M$ = 13.51, $SD$ = 2.80) and Kenya ($M$=12.66, $SD$ =2.90); ($t$ (507) = -3.346, $p$ < .001) with a small effect size $d$ = .298. There were also differences found between Tanzania and Kenya emotional experiences: Tanzania ($M$ = 12.75, $SD$ = 3.43) and Kenya ($M$ =11.65, $SD$ = 3.04); ($t$ (507)= -3.805, $p$ < .001). A moderate effect size was found $d$ =.342. Lastly, differences for coping skills in Tanzania and Kenya were also found: Tanzania ($M$ = 8.87, $SD$ = 1.89) and Kenya ($M$ = 8.48, $SD$ = 1.87); ($t$ (516)= -2.298, $p$ < .05) with a small effect size, $d$ =.208. These results suggest that participants from Tanzania were negatively impacted in their work/ministries falling within a high impact level, compared to those from Kenya who were in partial lockdown. The same was true of the emotional impact, even though they did not experience high negative impacts, but Tanzania had a higher score within the scores considered low (5 - 12) range.

However, in terms of coping skills, participants from Tanzania had higher coping skills compared to those from Kenya. An exploration of aspects surrounding emotional experiences for Tanzania

were further examined and the major factors were associated with their responses to the questions on loss and grief (*M* = 2.62, *SD* = .893) where 86% (*n* = 222) identified with this experience during the pandemic. The highest concern was fear and anxiety (*M* = 2.92, *SD* = .895) where a total of 88% participants (*n* = 228) identified with this experience. The major concerns for participants from Uganda were associated with the feeling of not performing at their best (*M* = 2.53, *SD* = .912) and their highest concern was fear and anxiety (*M* = 3.02, *SD* = .756). This was similar to the situation of those from Kenya, whose major concerns were associated with not performing at their best (*M* = 2.52, *SD* = .982) and the experience of fear and anxiety (*M* = 3.03, *SD* = .824) as the highest concern.

## Religious and Lay Grouping

This variable answered the question, *Are you religious or lay (also referred to as vocation status)?* A significant difference was found in the relationship between work/ministries and vocation status (religious vs. lay). The items for work/ministries were negatively correlated with vocation status (religious vs. lay).

The *t*-test identified significant differences in the two variables as well where the coping skills were: religious (*M* = 8.71, *SD* = 1.77) and lay (*M* = 9.92, *SD* = 1.66); (*t* (1254) = -4.088, *p* <.001). Work/ministry impact: religious (*M* = 13.10, *SD* = 2.83) and lay (*M* = 11.08, *SD* = 2.49); (*t* (1248) = 4.292, *p* <.001). These results suggest religious participants had a high negative impact in their work/ministries and less coping skills, compared to their laity counterparts. On emotional impact, both groups fell within the low level, acknowledging their emotional well-being enabled them to cope well during the pandemic (see Table 2).

## Greatest Support

Study participants were also asked to identify their greatest sources of support during the COVID-19 pandemic (*n* = 1,222). The largest group of respondents identified spirituality as a coping mechanism (i.e. personal prayer, spiritual support), with 84% selecting personal prayer and 64% selecting spiritual support as their greatest comforts. This was followed by social coping mechanisms (i.e. community/family, social media, co-workers, organizational communication), with 69% selecting community/family and 47% selecting social media as sources of comfort. Lastly, a small portion of respondents (8%) reported that access to counseling services was a source of support during the pandemic.

Slight variances between participants' countries of residency and ASEC relationship were found when assessing sources of support, which highlights the importance of contextual factors. When controlled for the country of residency, those from the United States selected community/family

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most frequently as their greatest source of support, not prayer, which ranked second. The same was true for those who identified as laity in comparison to those who were religious. Access to counseling services was also cited most frequently by residents of Tanzania in comparison to all other countries (including the United States). This may correlate with the finding that residents of Tanzania experienced less impact on the emotional experience scale. ASEC staff ranked coworkers as their third most common source of support, which differed from all other ASEC relationship groups, who were more likely to cite support from social media.

## Qualitative Findings

A single qualitative question was asked to determine how ASEC can best support its stakeholders during the COVID-19 pandemic. This question was vital to achieving the study's purpose, as it allowed for collection of specific measures ASEC may take to better serve its constituencies. Seven themes emerged from the data, each of which are described below in order of frequency.

### Material Support

Most commonly, survey respondents indicated that the best way ASEC could support them during the COVID-19 pandemic was through provision of material items ($n$ = 510). Overwhelmingly, material support was most often requested by religious participants, with only seven laity participants requesting such support. Assessing responses based on identified ASEC relationships provided additional insight as 42% of all HESA liaisons, 34% of ASEC program participants, and 26% of all ASEC partner institution staff requested ASEC's support through material items. Indicating ASEC partners, especially higher education institutions (HEIs), may need ASEC's focused support in this area. Often material support was described generally but in some instances these requests could be further broken down by the type of supplies requested.

Nearly half of all material requests ($n$ = 225), were related to medical supplies (e.g. personal protective equipment, sanitizer, soap, thermometers, ventilators). Information and communications technology (ICT) was also cited frequently ($n$ = 146), with data bundles, internet access, and laptops being the highest priority. As a Ugandan HESA participant reported:

> Getting data for knowing what is happening around you is a problem. We were given some course works (sic) to do during this pandemic but because of lack of data, we are unable to do…affording data is still not easy because of the nature of the communities we are coming from.

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Furthermore, a significant portion of respondents (*n* = 56) referenced the need for food supplies and the dwindling sustenance available in their various communities. This was exemplified by the account of a HESA participant in Cameroon, "Especially where I live, lot (sic) of people can not provide food, people are suffering, and dying. Hungry are killing people, because they can not provide for their daily basic food, due to lock down."

## Additional Skills Training

A large proportion of qualitative respondents (*n* = 374) indicated that the best way ASEC could support them was through the provision of additional skills training. Based on ASEC relationship, 33% of HESA Liaisons, 26% of ASEC program participants, and 23% of national conference/association of religious representatives requested additional skills training. The most common requested training was in the area of mental health (*n* = 124) including coping skills and counseling methods, tailored to the impact of the COVID-19 pandemic. This was closely followed by general COVID-19 training (*n* = 117), as many respondents conveyed a desire to more fully understand how to prevent transmission of the virus, identify its symptoms, and direct those infected to proper treatment resources. In addition, a small portion of respondents (*n* = 33) stated that they required crisis management training (e.g. disaster relief skills, risk assessment) in order to better serve their communities.

When discussing the provision of additional skills training, respondents often requested that the training be facilitated through alternative methods such as online webinars, distributed printed materials, and discussion boards. Another thread of commonality amongst respondents was the overall need for accurate, practical information. In the words of a Ghanian HESA Participant, "Provide us with authentic information about the virus since we have lots of information on the media, and also some logistics in case we have cases."

## Financial Support

A fairly sizable proportion of stakeholders (*n* = 249) requested ASEC's financial support at the congregation, ministry, and/or individual level. This form of requested support was less common among ASEC staff, HESA liaisons, and ASEC partner institution representatives, than material and/or training support. However, national conference/association of religious representatives and ASEC program participants reported financial support at a similar priority level as material and/or training support.

Many ASEC program participants reported an inability to finance their ministerial operations, as one Tanzanian SLDI participant wrote:

> I request ASEC to support me financially. Because for these two month (sic) all our workers haven't got their salaries due to the temporary close of the schools because of COVID-19 pandemic. As headteacher am (sic) worried because of their families and I have no way to assist them.

Ideas in which ASEC could support its stakeholders financially included options to apply for small grants directly through ASEC and/or assisting in connecting stakeholders to other potential donors.

## Prayer and Spiritual Support

Continued prayer and spiritual support was also referenced frequently (*n* = 228) in short answer responses. Again, this was most commonly stated by those who identified as religious (99%) than those who identified as laity. This finding suggests that ASEC's continued prayer offerings have not gone unnoticed by its stakeholders and is an important factor in creating solidarity amongst partners. As a Nigerian SLDI and HESA participant wrote, "ASEC can support me by joining with me in the networking prayers for God's intervention to heal and to save his people."

## Continue Offering ASEC Programs

Although only a small fraction of total respondents (*n* = 123) directly reported a need for ASEC to continue to offer its programs, this theme included the second highest response category for HESA liaisons (33%), ASEC partner representatives (19%), and ASEC staff (18%). Respondents that fell within these three relationship categories were more likely to experience job/ministry hardship, should ASEC need to suspend its programming due to the COVID-19 pandemic. By continuing to offer its programming, ASEC provides economic support to those it partners with and employs. This finding is indicative of the widespread importance of ASEC's operations, even outside its direct service to its program participants.

## Encouragement and Moral Support

Continued encouragement and moral support (*n* = 86) was cited majorly by ASEC program participants, with no national conference/association of religious representatives and a limited number of other ASEC relationship categories referencing this support area. ASEC program participants often reported a need for support in this area in conjunction with additional support areas, it was rarely listed independently. However, given ASEC's value of reverence as an organization, it is important to note that it's program participants explicitly stated their

appreciation of ASEC's encouragement and moral support and reported a need for this to continue, especially during this period of uncertainty.

### Increased Communication

Lastly, a theme of increased communication (*n* = 85) among ASEC and its stakeholders emerged from the qualitative analysis. Although this was the least commonly referenced theme overall, this need was the highest reported theme amongst ASEC staff. In regards to increased communication, one ASEC staff member wrote:

> Availability, guidelines and especially the staff meetings being held online after every other week. My suggestion is we continue with these meetings because this is the only platform that we can exchange the best practices during this difficult time.

This response outlines ASEC's staff members' prioritization for clear guidelines and connectedness throughout the COVID-19 pandemic.

## Interpretation of Findings

The findings of this study must be interpreted through the context in which each stakeholder found themselves including social, spiritual, economic, cultural, technological, and political influences. Each of these factors shapes the ability of the individual to experience a locus of control, which contributes to the self-reported rating of the impact of the COVID-19 pandemic on participants' emotional well-being, ministry/work status, and ability to exert effective coping skills. During the time of administration of this study, ASEC's countries of operation experienced great variation in degree of social distancing precautions. Some countries, such as Uganda, were under government order for total lockdown (i.e. shelter in place), while others, such as Tanzania, were still allowing free movement amongst its citizens.

## Differences in Quantitative and Qualitative Findings

Slight differences were found between qualitative and quantitative responses. For example, in the qualitative survey item 374 participants requested additional skills training in the areas of mental health, COVID-19, and crisis management. While in the quantitative responses for coping skills, the majority of participants *agreed* or *strongly agreed* to already possessing similar skills (i.e. *I have enough coping skills*, 91%, *n* = 1,268; *I have adequate skills in crisis management*, 72%, *n* = 1,269; *my personality helps me cope*, 76%, *n* = 1,270). However, participants often explained in their short answer responses that the coping skills training they required was not for themselves

but rather to better serve others in their community. As an SLDI participant from Cameroon wrote, "I think if we can be trained in order to cope with this new reality, so as to help those in danger, it can be helpful." This is indicative of the difference between being able to personally cope and having to assist others in coping effectively through a straining situation. In addition, the smaller set of qualitative responses cannot be generalized to the larger population, but inform practice and the need to network more locally to provide such training through institutions.

## Limitations

As in all qualitative studies, the qualitative findings of this study cannot be generalized to the larger population. However, this study acknowledges the value of the data collected through the single short answer response, particularly to the direct practice of the organization. The qualitative results assisted in triangulation of data collection and were used to assist in interpreting the quantitative data. The qualitative findings were strengthened by the quantitative responses regarding the study variables, which revealed that in general stakeholders in this organization feel relatively well prepared in the area of personal coping skills.

Given the global nature and magnitude of the COVID-19 pandemic, there was no known preexisting scale that could have been utilized to fit the exact needs of this study. Therefore the survey was researcher-designed and had not been tested for internal consistency or reliability prior to this study. This limits the outcomes of this study and an adoption of the scale could be utilized after several tests to confirm the Cronbach's Alpha produced in this study are validated through additional studies. The survey also relied on self-reported responses, which indicates results may only be subjective stances which are likely to change if participants took the same survey at a different time. Participants may not have been well disposed to articulate their experiences and needs due to the fluid situation of the pandemic and looming anxiety was accelerated by the fear of the unknown.

# Conclusion

The purpose of this study was to seek an organizational understanding of ASEC stakeholders' experiences and coping mechanisms during the COVID-19 pandemic and to provide a proactive response to this unprecedented phenomenon at the organizational level. This study is part of many steps ASEC has proactively made to stay connected with its stakeholders. Messages were also distributed to show solidarity with the suffering world from ASEC's United States headquarters in Scranton, Pennsylvania and across the ten countries in Africa south of the Sahara. To ease the negative impact of COVID-19, ASEC's development office has played a

proactive role in facilitating applications for small grants from well-wishers to select ministries of women religious in Africa. The findings of this study suggest that the pandemic has had a significant impact on all stakeholders particularly in their work and ministries. In addition, there are identified areas of need amongst its constituencies, particularly in material support, which ASEC may be able to fulfill through its partnerships, networking abilities, and Africa staff.

## Recommendations for Future Research

It is recommended that this study be replicated within selected sisters' ministries, such as healthcare (i.e. nurses, aides, pharmacists) and education (i.e. teachers), to better understand the specific impact of the COVID-19 pandemic in these sectors. More in-depth case studies could be conducted in these specific ministries to develop a fuller picture of the disease's influence. A case study could also be conducted regarding the impact of the pandemic at the congregational level, utilizing ASEC's most served congregations as references. It is also suggested that the same variables be applied to better determine the differences in experiences between women and men religious and a larger group of laity. Further, a post COVID-19 study amongst ASEC stakeholders would also be helpful in determining the full impact of the situation and the effects of the lockdown in hindsight. This would allow for improved preparation for possible similar situations in the future.

### Potential Follow-Up Research Questions

- What is the nature of training for coping skills provided, are they short or full time courses?
- What strategies do stakeholders have for risk mitigation and disaster/crisis management?
- What were the main issue/s associated with stakeholders' fear and anxiety?
- How do members access news and information in your organizations?
- During the pandemic did your organization/ministry receive financial support from the government, independent donors, the Church, or other investments?
- Where you reside, what was the most rigorous level of mitigation efforts imposed by your government (i.e. total lockdown, partial lockdown, no lockdown)?
    - In whichever level you experienced, what did you find to be the most challenging aspect of social distancing during the COVID-19 pandemic?

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## Implications for Practice

This study reveals that ASEC has a solid foundation of professional engagement with stakeholders, which greatly benefits its response to the uncertainty created by the COVID-19 pandemic. The strength is seen in the partnerships and collaboration locally and internationally, as illustrated in the large pool of respondents and the wide geographical scope of participants' as identified by their countries of residence in this study. Additionally, those engaged in the partnerships are staff of established institutions of higher education, seasoned professional consultants, and leaders of respected organizations, all who bring a diverse wealth of skills and knowledge to the collaborative.

Several areas of need were identified by study participants as potential methods in which ASEC can focus its efforts to better support its stakeholders. Particularly in the area of material support, recognizing the ministry/work related strain reported by program participants serving in healthcare and pastoral ministries. In addition, specific to the HESA program, students are in immediate need of internet/data bundles to access online coursework. It is also important to recognize that ASEC's target service population, women religious, may be experiencing added emotional demands given their community's reliance on their ministries. This is especially true for those residing in Cameroon, Malawi, and Tanzania.

To assist in meeting these needs, ASEC might consider including supplemental topics relevant to the context of each country within its existing workshop offerings. Also, create more awareness amongst congregations and participants about existing partnerships and institutions that ASEC networks with for additional training needs, which are not available through ASEC sponsored programs. Above all, it is clear that stakeholders value ASEC's continued engagement and through the balance made manifest in emotional and strong personal coping abilities, they will prevail against the devastation caused by COVID-19.

In organizational and crisis management, the call to respond to human needs in ways that enhance the dignity of the human person without barriers continues to amplify. The outcome of no relationship between personality type and the study variables, serves as an eye opener for interpersonal relationships to overcome barriers and stereotypes. This is further advanced by the no relationship outcome between emotional experiences and vocation status (religious or lay). The impact of a pandemic or any national/regional/global crises as the one posed by COVID-19, is indiscriminate to personality type and/or other associated affiliations. Proper policies and professional standards that promote the dignity of every human person are desirable in all practice settings.

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# Appendix 2. ASEC Stakeholder COVID-19 Engagement Survey

## Data Permission Statement

Your selection below indicates your permission allowing ASEC to use the data collected through this survey for evaluation and/or research. If, for any reason, you do not want to grant permission, you are free to select "No." If you have any questions please contact the ASEC Research Initiative by sending an email to research@asec-sldi.org. Thank you for your consideration of this request.

- ❑ **YES**, I grant ASEC permission to use my deidentified data collected through this survey for evaluation and/or research purposes.
- ❑ **NO**, I do NOT grant ASEC permission to use my deidentified data in this instance and will not proceed in completing the survey.

## ASEC Relationship

In the following questions please select the item that **MOST** describes your position and/or relationship with ASEC:

1. Are you:
❑ Religious
❑ Lay

2. Please select the ASEC relationship that best applies to you **currently** (*please, tick ONLY one)*:
❑ ASEC Staff
❑ HESA Liaison
❑ ASEC Partner Institute Staff (i.e. college/university staff, SLDI facilitator)
❑ National Conference/Association of Religious Representative or Staff
❑ ASEC Program Participant (i.e. currently or previously enrolled in SLDI, HESA, etc.)

3. If you selected ASEC Program Participant, please specify which program(s) you have participated in (*please, tick ALL that apply*):
❑ Sisters Leadership Development Initiative (SLDI)
❑ Higher Education for Sisters in Africa (HESA)
❑ ASEC Two-Year Scholarship Program
❑ ASEC Service Learning Program
❑ Institutional Capacity Building
❑ Other, please specify: _____

4. What is your **current** age? Please write the number of years only. _____

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5. How long have you served in your ministry/ place or work? Please indicate if your answer is in months or years. _____

- ❑ Months
- ❑ Years

7. In which category is your **current** profession (*please, tick ONLY one)*?

- ❑ Administration
- ❑ Education
- ❑ Health Care
- ❑ Pastoral Work
- ❑ Social Work
- ❑ Finance/Accounting
- ❑ Student
- ❑ Other, please specify: _____

8. Please select the country in which you **currently** reside (*please, tick ONLY one)*:

- ❑ Cameroon
- ❑ Ghana
- ❑ Kenya
- ❑ Lesotho
- ❑ Malawi
- ❑ Nigeria
- ❑ South Sudan
- ❑ Tanzania
- ❑ Uganda
- ❑ United States
- ❑ Zambia
- ❑ Other, please specify: _____

## COVID-19 Pandemic Impact

| *Please answer the following questions in relationship to your experience thus far during the COVID-19 pandemic (please select ONLY one):* | **Strongly Disagree 1** | **Disagree 2** | **Agree 3** | **Strongly Agree 4** | **Not Applicable N/A** |
|---|---|---|---|---|---|
| 9. I have adequate skills in crisis management | 1 | 2 | 3 | 4 | N/A |
| 10. I have enough coping skills | 1 | 2 | 3 | 4 | N/A |
| 11. My ministry/ work environment enables me to be productive | 1 | 2 | 3 | 4 | N/A |
| 12. My ministry/ work is stuck and without alternatives | 1 | 2 | 3 | 4 | N/A |

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| | | | | | |
|---|---|---|---|---|---|
| 13. My organization is overwhelmed by the needs created by the pandemic | 1 | 2 | 3 | 4 | N/A |
| 14. I am not performing at my best | 1 | 2 | 3 | 4 | N/A |
| 15. I have experienced depression | 1 | 2 | 3 | 4 | N/A |
| 16. I have experienced loneliness | 1 | 2 | 3 | 4 | N/A |
| 17. I have experienced loss and grief | 1 | 2 | 3 | 4 | N/A |
| 18. I have experienced fear and anxiety | 1 | 2 | 3 | 4 | N/A |
| 19. My personality helps me cope | 1 | 2 | 3 | 4 | N/A |
| 20. My ministry/ place of work does not have sufficient supply to meet the needs of those we serve | 1 | 2 | 3 | 4 | N/A |
| 21. My ministry/ place of work involves performing high risk tasks | 1 | 2 | 3 | 4 | N/A |

## COVID-19 Pandemic Support

22. What has been your greatest source of support during this time (*please, tick ALL that apply*)?

- ❑ Personal Prayer
- ❑ Spiritual Support
- ❑ Social Media Networks
- ❑ Communication with My Institution/Organization
- ❑ Community/Family
- ❑ Co-Workers
- ❑ Access to Counseling Services
- ❑ Other, please specify: _____

23. I am typically considered:

- ❑ An Introvert
- ❑ An Extrovert
- ❑ Do Not Know My Type

24. In your opinion, how can ASEC best support you and your institution/organization during the COVID-19 pandemic?