

COVID-19 Impact on Healthcare and Education Workers: A Phenomenological Case Study in West Africa

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Abstract

Inaccuracies and misrepresentation of facts and fiction about the coronavirus disease of 2019 (COVID-19) has continued to create fear, frustration, and anxiety among citizens. The World Health Organization (WHO), alongside other bodies such as the Centers for Disease Control and Prevention (CDC) and the governments of countries around the world, therefore created guidelines on how to navigate the uncertainties of COVID-19, stop the spread, and support the infected. This paper presents a case study of two sectors involving healthcare and education workers in three countries of West Africa, namely Cameroon, Ghana, and Nigeria. This phenomenological case study employed a convergent mixed methods, cross-sectional survey design, consisting of a 27-item questionnaire, distributed electronically via Survey Monkey. Supervisors and Employees from the two professions were sampled ($N = 311$) for comparison purposes, where services were brought to a halt in the education sector and deemed essential in the healthcare system. Pearson r reveals a significant relationship between self-care and profession ($p < .01$). The t -test revealed a large effect size ($d = .837$) and significant differences in mental health knowledge when comparing professions (healthcare vs. education, $p < .001$). Additional data analysis sought to determine the most trusted source of information on COVID-19, and the television news emerged at the top. The WHO was deemed more trustworthy by study participants than information from the CDC and friends/social media were more trusted sources of information than governments. Implications for practice are discussed.

Keywords: COVID-19, healthcare, education, WHO, CDC, self-care, mental health.

Introduction

This paper presents the results of a phenomenological case study derived from a preliminary study conducted by the African Sisters Education Collaborative (ASEC, 2020) in ten African countries. The initial study showed that some countries and ministries of women religious were more negatively impacted by the current phenomenon of the coronavirus disease of 2019 (COVID-19) than others. In assessing ASEC's stakeholders' experiences of the COVID-19 pandemic, people working in healthcare and education ministries were found to be more negatively and significantly impacted compared to other ministries under scrutiny in the same study (ASEC, 2020). This was specifically the case for countries in West Africa, where Nigeria had the highest number of cases of COVID-19 amongst those under study, according to data collected and reported by the World Health Organization (WHO, 2020b). Even though the continent of Africa continued to report less

cases than other continents of the world, the rate of increase continues to grow with additional unprecedented outcomes (WHO, 2020b). These included increased cases of depression, suicidal ideations, divorce, teenage pregnancies, social isolation, and unemployment.

Purpose of the Study

The purpose of this study was to examine and present the experiences of participants currently experiencing the common phenomenon of the COVID-19 pandemic. The choice to engage in a case study involving three countries of West Africa, which included Cameroon, Ghana, and Nigeria, provided insight into how participants in this region are navigating the pandemic. Special interest is paid to investigate how workers in the healthcare and education sectors were adhering to the WHO's guidelines for managing the pandemic. Although particular interest was given to workers providing services at institutions operated by Catholic women religious in the three countries, the study intentionally widened its scope to also include laity (men and women) serving in the same workplaces across the countries selected.

Central Research Questions

The study aimed to address three central research questions:

1. Is there a relationship between self-care and the nature of work (healthcare or education) during the COVID-19 pandemic?
2. Is there a relationship between self-care and mental health?
3. Is there a relationship between mental health and field of work?

Significance of the Study

This study is significant in that no prior research has focused on the comparison of the impact of COVID-19 on healthcare and education workers in West Africa. Results of this study will provide guidance to organizations wishing to provide specialized support to those serving in healthcare and education fields in West Africa during the COVID-19 pandemic.

Related Literature

As of August 17, 2020, the WHO (e) reported that amongst the countries under study, Nigeria had the highest incidences of COVID-19 with 48,770 cases and 974 deaths, followed by Ghana (42,210 cases, 231 deaths), and Cameroon (18,469 cases, 401 deaths). In addition, all three countries were classified by the WHO as having community transmission. The WHO's COVID-19 Strategic Response Plan for the African Region (2020a) outlines recommended public health and humanitarian actions to combat COVID-19 on the African continent through December 2020. In this document, the WHO (2020a, p. 34) provides five critical actions for African countries, these include: (a) prepare, protect, and be ready, (b) find, test, and isolate all suspect cases and contacts, (c) prevent, suppress, and slowdown transmission, (d) provide safe and effective clinical care, and (e) maintain core health services and systems.

Furthermore, the WHO has provided the public with general advice to keep healthy during the COVID-19 pandemic, including but not limited to: the importance of self-care, how to cope with stress, how to obtain accurate information, and the need to keep in close communication with loved ones (WHO, 2020c). Other important points of reference include demonstrating care and compassion for those suffering from the virus, anti-discrimination efforts, and how to prevent and address social stigma of the infected (WHO, 2020c).

Cameroon

The first case of COVID-19 was identified in Cameroon on March 6, 2020 and subsequent “lockdown” measures (i.e. curfew, closure of schools, mask wearing enforcement) were instituted beginning March 17, 2020 (Nkwayep, Bowong, Tewa, & Kurths, 2020). Due to negative impacts on Cameroon’s economy, many of these containment mandates were lifted on May 1, 2020 and schools were permitted to reopen on June 1, 2020. A study of the basic reproduction number of COVID-19 in Cameroon by Nkwayep et al. (2020) indicated that without the re-implementation of effective control measures, such as mask wearing and social distancing, the disease will continue to persist within the country.

Ghana

The Ghana Health Service has focused its COVID-19 response efforts on “tracing, testing and treatment” since identification of the first case on March 12, 2020 (WHO, 2020d). As of July 2020, Ghana has also been able to boost its tracing efforts by conducting pooled Polymerase Chain Reaction (PCR) testing and increasing the number of facilities able to carry out testing from one to nine. A qualitative study ($N = 38$) on the cultural and educational impact of the pandemic in Ghana found that cultural beliefs have played a significant role in the propagation of misinformation regarding COVID-19 (Adom, 2020). Specifically, the initial popular Ghanaian belief that “the virus was immune to the black gene” and that preventative measures were unnecessary because “God will protect them” allowed the virus to spread within the country. However, Serwaa, Lamptey, Appiah, Senkyire, and Ameyaw (2020, $N = 350$) found that in Ghana feelings of preparedness toward the COVID-19 outbreak are closely linked to higher levels of education and health care occupations.

Nigeria

Health officials identified the first case of COVID-19 within Nigeria on February 27, 2020 (Adegboye, Adekunle, & Gayawan, 2020). Government imposed lockdown measures to prevent the spread of COVID-19 subsequently caused economic ramifications such as widespread hunger throughout Nigeria (Kalu, 2020). A study of knowledge, attitudes, and practices of those residing in North-Central Nigeria toward COVID-19 ($N = 589$) revealed that 99.5% reported having “good” knowledge of COVID-19, with sources of information predominately being internet/social media (Reuben, Danladi, Salah, & Ejembi, 2020). In the same study, a significant relationship was also found between more COVID-19 knowledge and positive attitude towards preventative measures.

Methodology

This phenomenological case study employed a convergent mixed methods design, collecting quantitative and qualitative data at one point in time, followed by a comparison of the outcomes (Creswell & Creswell, 2018). A phenomenological approach was utilized to allow for the description of the participants' shared experiences of the COVID-19 pandemic. The study was designed to utilize those identifying as working in the healthcare field as a control variable, where participants were essential workers, and those working in the education field, which came to a complete halt during lockdown, as a comparison group.

Participant Selection

Participants were selected using purposive sampling (Patten & Newhart, 2018) from three West African countries— Cameroon, Ghana, and Nigeria. The West African region was chosen based on prior research, which indicated these countries had experienced the greatest negative impact of the COVID-19 pandemic (ASEC, 2020). The inclusion and exclusion criteria (Creswell & Creswell, 2018) was based on the field in which participants were employed, predetermined as either those working in healthcare or education sectors alone. No other types of employment were considered in this case study. The purpose of this criterion was to determine the extent to which workers were impacted by the pandemic as individuals, their workplace, and their immediate families. Individuals who identified as either religious or laity (men and women) were included as participants in the study.

Data Collection Methods

Data was collected through a survey developed specifically for this study. The survey consisted of 27 items including 26 quantitative and 1 qualitative question. The survey was distributed to participants through ASEC's in-country staff in Cameroon, Ghana, and Nigeria via email and WhatsApp. Survey responses were collected through an electronic link supported by Survey Monkey.

Data Analysis

Data was analyzed using procedures typical of studies using a mixed methods case study design. Distinct methods of analysis were used for quantitative and qualitative data. Quantitative data was analyzed using IBM SPSS Version 26. Responses to the single qualitative, short answer item were analyzed using the constant comparative method as recommended for case studies ((Merriam & Tisdell, 2016). NVivo Pro 11 software was utilized to complete the open coding process and placement of the codes into themes. Matrix coding was also implemented to compare healthcare and education worker responses.

Validity Issues

The use of a cross-sectional survey design, as opposed to a longitudinal survey, minimizes the threats to internal and external validity of data in this study (Creswell & Creswell, 2018). The survey design in addition removes threats to internal and external validity as would be the case in

experimental designs. Such threats would include but are not limited to: regression to the mean, attrition, maturity, and past experience with instruments of study (Creswell & Creswell, 2018). Selection of participants, while purposive sampling was employed (Patten & Newhart, 2018), did not give any participants advantage over others. All education and healthcare workplaces were considered, and all participants had equal opportunity and access to participate in the survey either as supervisors or staff.

Results

Results of this study indicate that the impact of COVID-19 had similar patterns across sectors regardless of their unique operating status, continuous service, or no service due to closure. Pearson r , revealed a significant relationship between self-care and the workplace, with participants who work in education showing a slightly better sense of self-care compared to their counterparts in healthcare.

Central Research Questions Results

Three central research questions were designed to test the nature of relationship amongst the three variables considered for this study.

1. *Is there a relationship between self-care and profession?*

The first central question under study was based on testing if workers were mindful about their self-care during the pandemic. A Pearson correlation reveals that there is a positive significant relationship between self-care and profession categorized as healthcare or education ($r(281) = .164, p < .01$).

2. *Is there a relationship between self-care and mental health?*

However, for the second question which sought to determine if there is any relationship between self-care and mental health, there was no significant relationship found ($r(265) = -.070, p > .05$).

3. *Is there a relationship between mental health and profession?*

The third and last question sought to determine if there is a relationship between mental health and profession. Pearson correlation found a negative but significant relationship between mental health and profession ($r(266) = -.315, p < .01$).

Additionally, tests were conducted to compare between the fields (i.e. healthcare and education workers). The t -test reveals that there were significant differences between the knowledge and experiences of mental health between healthcare workers ($M = 3.69, SD = 1.06$) compared to education workers ($M = 4.53, SD = .99$), ($t(266) = 5.410, p < .001$) and a large effect size was found ($d = .837$).

From this study, participants in the healthcare field ($M = 2.83, SD = .986$) were less likely to spend time on self-care compared to their counterparts in education ($M = 2.48, SD = .798$). This outcome

aligns with the result for the *t*-test reported earlier which revealed a large effect size in the significant differences found in mental health knowledge when comparing professions - healthcare ($M = 3.69, SD = 1.06$) and education ($M = 4.53, SD = .99$), ($t(266) = 5.410, p < .001$).

Demographics

This case study attracted a total number of 311 respondents from the healthcare and education fields. Demographics data collected for this case study revealed that participants' mean age is 40 years ($SD = 8.78$), the median age being 40 and the mode 32 years. The survey was distributed to healthcare and education workers in three countries of West Africa only. In total, 7% of participants were from Cameroon ($n = 19$), 25% were from Ghana ($n = 73$), and the largest proportion of participants were from Nigeria 68% ($n = 195$).

The majority of participants were from the education field (81%, $n = 234$) and the representation of participants from the healthcare field was 19% ($n = 54$). This statistic is based on participants who are either supervisors or staff from institutions sponsored by women religious in their respective country. On the demographic information pertaining to marital status, 12% identified as single. The least number of participants was for those who identified as married at 6% ($n = 18$), while the largest proportion consisted of women religious, constituting 82% of the response rate ($n = 239$).

Responding to the question on the gender participants identify with, 14% ($n = 40$) identified as male while those identifying as female were 80%. A small proportion of participants preferred not to indicate their gender (6%, $n = 17$). Participants were also asked to state their position, where 57% ($n = 149$) serve in the role of staff and 43% ($n = 111$) consisted of supervisors.

Additionally, demographic data from broad categories of participants reveals minimal differences in self-care which did not go below a mean of (2.54; +/- .847) or above (2.57, +/- .860). The mean differences for mental health were consistent throughout the demographic data in this broad category (4.37; +/- 1.06). The table below presents this information.

Table 1. Comparison of Means Based on Participants' Broad Category Demographics

Demographics	Self-Care			Mental Health		
	<i>f</i>	<i>M</i>	<i>SD</i>	<i>f</i>	<i>M</i>	<i>SD</i>
Gender	284	2.55	.849	265	4.37	1.06
Position	256	2.57	.860	242	4.37	1.03
Ministry	283	2.55	.847	268	4.37	1.06
Marital Status	287	2.55	.851	270	4.37	1.05
Cameroon	19	2.74	.933	18	4.06	1.21
Ghana	72	2.47	.888	69	4.13	1.14
Nigeria	192	2.55	.824	181	4.50	.992

Moderating Variable Mean Comparisons

Descriptive statistics are presented below based on a comparison of means aligned to the other moderating variables such as participants' profession, position, marital status, and gender. These descriptive statistics compared the experiences of participants on self-care and mental health outcomes during the pandemic.

Table 2. Comparison of Means Between Moderating Variables

Moderating Variables	Self-Care			Mental Health		
	<i>f</i>	<i>M</i>	<i>SD</i>	<i>f</i>	<i>M</i>	<i>SD</i>
Healthcare	54	2.83	.986	52	3.69	1.06
Education	229	2.48	.798	216	4.53	.992
Female	227	2.55	.845	214	4.39	1.04
Male	40	2.60	.955	37	4.27	1.19
Prefer not to say	17	2.53	.624	16	4.38	.957
Supervisor	108	2.64	.826	102	4.34	1.02
Staff	148	2.52	.884	140	4.34	1.02
Single	35	2.77	.910	31	4.19	1.17
Married	18	2.72	.752	17	4.12	.857
Religious	234	2.50	.845	222	4.42	1.05

Taking a closer look at the fields reveals that healthcare workers spent more time caring for others than they did for their own needs. Similarly, participants who identified as single spent more time on others than they did on themselves. Participants who identified as supervisors spent more time on others compared to participants who identified as staff. Participants in the healthcare field were more likely to deal with mental health issues in their work compared to their counterparts in the education field. Based on their individual ratios in the two professions, 52 healthcare participants and 217 education participants, healthcare workers were more knowledgeable on issues of mental health (71%, $n = 37$) compared to their counterparts in education (26%, $n = 57$). A *t*-test revealed a significant difference between healthcare workers ($M = 2.40$; $+/- .869$) and education workers ($M = 2.79$; $+/- .857$), ($t(272) = 2.937$, $p < .01$). When the two groups were combined 65% ($n = 176$) responded that they do not have a professional background in mental health problems/issues. However, the two groups of participants (i.e. healthcare and education) did not show any significant differences on the question of asking if *more mental health cases were reported in their local area during the pandemic*. The majority of participants responded with a *no* (40%; $n = 115$) or *not aware* (43%; $n = 125$), compared to a small proportion of those who responded *yes* (17%, $n = 48$).

Lived Experiences of COVID-19

Mental Health

During the COVID-19 pandemic a diverse range of lived experiences, such as mental health issues and other unprecedented outcomes, have been explored and continue to be studied. In this study specifically, participants were asked to identify if increased mental health issues had been reported in their local area. The responses were nearly half and half, where those who either *strongly disagree* or *disagree* constituted 42% ($n = 134$) and those who *agree* or *strongly agree* were 46% ($n = 152$). The rest of participants did not identify with any position in this study. This question was followed up with an additional item, rephrased to corroborate and mine data that could inform the meaning and understanding of mental health in Africa south of the Sahara. The paraphrased question stated *mental health issues are not common in my workplace*. Slightly more than six in ten participants *agreed* or *strongly agreed* with the statement (64%, $n = 178$), compared to 36% of those who *strongly disagreed* or *disagreed* ($n = 101$). An additional question that provides for triangulation of this data was based on the identification of participants' understanding of mental health problems/issues. More than six in ten (65%, $n = 176$) identified as not having any professional background in mental health issues and only 35% responded *yes, I have a professional background in mental health problems/issues* ($n = 96$). This outcome compared to results of the study stakeholders' experiences during the COVID-19 pandemic conducted by ASEC (2020) reveals issues of mental health may not be understood in the same way in Africa. The understanding of mental health might not mean the same thing as is understood in the West or compare at par with the Eurocentric meaning of mental health. This outcome supports the view of scholars who postulate that a more culturally-sensitive approach to mental health is necessary (Frissa & Dessalegn, 2020).

COVID-19 Beliefs

In the care for patients with COVID-19, the WHO recommends that the virus should not be associated with any ethnic group or race and social stigma/discrimination should be avoided (WHO, 2020c). To examine the experiences of participants in the three countries of West Africa, participants responded to selected questions. The majority of participants did not believe COVID-19 was real in spite of the stringent measures that were put in place by governments to curb its spread. This was seen in the high response rate among those who *agree* or *strongly agree* (72%, $n = 198$) that COVID-19 was viewed by the general public as an abstract idea. Only about three in ten (28%) believed the general public saw COVID-19 as a real public health problem. However, 53% of participants also *strongly disagreed* or *disagreed* with the view that COVID-19 was viewed as more prevalent for some ethnic communities than others in their region. Nearly half of participants (47%) *agreed* or *strongly agreed* with that statement.

Institutions

The COVID-19 pandemic in different parts of the world saw many governments shutdown their economy, work, international trade, and everyday services apart from those that were considered essential services. Healthcare systems remained one of the only operational activities, while the majority of other businesses were closed. Organizations therefore took on the adjustment of their work schedules to meet needs under the new circumstances. Participants in this study indicated

that the highest form of adjustment adopted by their institutions was working remotely (39%, $n = 125$), while some organizations shut down all together (29%, $n = 92$). In addition, 25% reported that their organizations worked in shifts and 30% remained the same due to providing essential services. Most organizations adjusted their schedules dependent on the mitigation measures taken by leaders of their countries. The majority of organizations found the adjustment of schedules as *somewhat successful* to *very successful* (73%, $n = 195$), compared to 15% who found the adjustment to be *only a little successful* or *not at all successful*.

Unemployment

The lockdown was associated with other unintended consequences such as widespread unemployment and economic challenges. When participants were asked about their experience with unemployment, 37% ($n = 101$) of respondents did not experience the problem of unemployment within their families, compared to 31% ($n = 91$) of participants who reported that one to two family members lost their job. Some 20% of the respondents had three to four people in their family lose their jobs ($n = 54$) and another 10% had more than five members of their family lose their jobs ($n = 27$).

Communication

While in lockdown, regardless of mitigation level, the WHO (2020c) also recommended that people try to stay in constant communication with their family and employing organizations. Participants also responded to the mode of routine communication provided by their employing organization. Social media platforms were the most commonly used (64%, $n = 205$), telephone communication was used by 50% ($n = 161$), email communication was used by 22%, and video conferencing was used by 16%. A small percentage of respondents (6%, $n = 20$) indicated that they did not have routine communication with their employing organization.

Participants in this study also responded to a question on modalities provided for communication from the organizational to the individual level of communication. The most common mode of communication that employing organizations provided for their staff was through WhatsApp (71%) and Zoom conferencing (42%). Google Meet (17%) and Skype (4%), were the least commonly used platforms. Participants from some organizations ($n = 26$) reported that there was no online platform provided for communication and 18 participants reported using other forms of communication.

The frequency of communication was also examined, where participants reported communicating at least three days or more in a week (36%, $n = 101$). The second level of frequency was noted among those who communicated two days per week (24%, $n = 68$). Participants who communicated twice a month and once a month were slightly more, 14% and 13% respectively. One in ten (10%, $n = 27$) indicated that they did not have routine communication and therefore did not record any frequency of communication.

Participants were asked to indicate how often they have been communicating with family/loved ones during the pandemic. The highest response was found among those respondents who communicated everyday and two to three days per week with each category obtaining 28% (n

=81). Those who communicated once a week constituted the second highest category of 27% ($n = 78$). Other respondents comprising less than one in ten communicated once a month (9%), less than once in a month (1%), and those responding every fortnight, and six days a week were both at (5%).

Other Unprecedented Outcomes

To determine the nature of unprecedented outcomes of the lockdown, participants were supplied with a list of those that had been reported in parts of the world that were not sampled in this study. The highest impact of the lockdown was cited as increased need for beneficiaries without increasing funding to meet that need, impacting negatively 55% of respondents ($n = 176$). As a result, 34% of the respondents ($n = 108$), found it necessary to reduce the services provided by their institution and also a similar percentage lacked personal protective equipment ($n = 109$). Others responded by closing down the services provided by their institution (31%, $n = 99$). Other impacts included reduced employee motivation and morale (32%, $n = 103$), inadequate communication from leadership (8%), and fear of employees/beneficiaries of the institution contracting COVID-19 (3%). Interestingly, 6% ($n = 20$) did not experience any of the challenges named above.

The study sought to explore other unprecedented outcomes that negatively impacted people in their locality. The highest response was associated with fear of people going to hospital for other ailments not related to COVID-19 (81%, $n = 258$). Instances of isolation and stigma associated with COVID-19 constituted another outcome, where nearly half of respondents (46%) identified that as happening in their local area ($n = 147$). Teenage pregnancies also impacted communities as identified by 40% of respondents ($n = 129$) and domestic violence was reported by 37% of participants ($n = 118$). Three in ten participants (30%) reported that people in their locality were afraid of those recovering from COVID-19 ($n = 96$). Less than 5% ($n = 6$) of respondents reported that there were no unprecedented outcomes reported in their locality.

Obtainment of COVID-19 Related Information

During the onset and throughout the pandemic there has been a great spread of misinformation about COVID-19 (WHO, 2020a). The general public therefore has not been in a position to determine the most dependable source of information regarding the pandemic. This study identified that the most trusted source of information regarding COVID-19 was television, cited by nearly six in ten participants (59%, $n = 189$). The second most trusted source of information was social media, cited by 53% of participants ($n = 168$). In addition, the WHO was selected by 48% of participants ($n = 152$) as being a trustworthy source of information. The Centers for Disease Control and Prevention (CDC) was selected by 34% of respondents and the government by 33%. Furthermore, slightly higher than that of the CDC, friends were considered a more trustworthy source of information (35%). Based on this information seeking behavior, participants revealed that they sought COVID-19 related information *very often* or *often* at a high rate of 75% each day. While 24% of respondents searched for COVID-19 related updates a few times a day and 2% did not search for updates at all ($n = 5$).

Positive Lessons Learned

The survey instrument also asked study participants to provide the single most important lesson they have learned from the COVID-19 pandemic thus far. Analysis of the qualitative responses ($n = 279$) revealed seven key lessons learned (in order of frequency) – (a) spiritual growth, (b) greater appreciation or awareness, (c) increased cleanliness/hygiene, (d) importance of preparedness (financial, crisis/disaster), (e) improved vibrance in community living, and (f) technological innovation/creativity.

Spiritual Growth

Overall, study participants most commonly reported spiritual growth as their greatest take-away from the COVID-19 pandemic. Spiritual growth included responses such as greater trust in God and increased reliance on prayer. As one participant wrote, “We are nothing but pencils in the hand of the creator. God is indeed supreme over all, therefore man must not claim to know all, because God is the author and finisher of our faith.” Study participants often stated that the pandemic increased their faith despite the inability to gather in-person for religious activities, for example one participant wrote, “We can encounter God even in our private homes.”

Greater Appreciation and Awareness

The second most common lesson learned by study participants was a greater appreciation and awareness for their ordinary lives. For example, one participant said, “The Covid-19 pandemic demonstrate (sic) to me the value of freedom, the freedom to move, to be with those we love, to live in dignity and security, for ourselves and for those around us.” Study participants often cited that by having their freedoms removed due to precautionary measures, they developed a greater appreciation for their ability to engage in various activities during normal country operations.

Increased Cleanliness/Hygiene

The third most common lesson learned was that of increased knowledge of cleanliness and hygiene. Study participants wrote about becoming more health conscious after the initiation of the pandemic, specifically the significance of hand washing was highlighted. This is demonstrated by one respondent, who wrote, “Wash your hands with soap and water always and wear your face masks always because COVID-19 is real.”

Importance of Preparedness (Financial, Crisis/Disaster)

Next, study participants discussed that from the pandemic, they have learned how important it is to always be prepared for a major financial or crisis/disaster setback. Participants stated that going forward they will make a greater effort to develop monetary savings in preparation for a catastrophic event. As one study participant said, “Precautionary measure is best when you have the time...” They wrote about having vigilance for events that may impact their ability to work and serve the community, preparing for unforeseen future challenges, and always having a “Plan B.” Preparedness measures suggested by study participants were to engage more in personal

farming, seek employment through public entities, not depending on the government, and having multiple means of earning wages per congregation/household.

Improved Vibrance in Community Living

Participants also said that the pandemic has taught them the importance of relationships and caring for those in one's community. Having to spend time at home allowed study participants the opportunity to focus on the relationships of those closest to them and develop a more vibrant sense of community living. This was especially true for those who identified as Catholic women religious, who reported developing greater connectedness with their sisters. Study participants often said that it was their close relationships that allowed them to cope with the pandemic and subsequent lockdown measures, for example one participant said, "No matter, the situation one finds himself or herself cordial relationship is the key to breakthrough of difficult moments." Another said, "The most important lesson I learn (sic) during this pandemic is the important (sic) of families' staying together and parents and children getting to bond more."

Technological Innovation/Creativity

Lastly, study participants commonly wrote that the greatest lesson they learned from the pandemic was technological innovation/creativity. Many participants were able to develop their skills in using the Internet, Zoom, social media, Google Meet, and learned how to complete their academic studies online. As one participant realized, "There is the possibility of staying safe alone at home while at the same time, remaining connected with others by the means of media." The pandemic also allowed study participants the opportunity to incorporate technology into their daily lives in innovative and creative ways. For example, one participant's use of technology "inspired an online Faith-based empowerment/coaching program for youths."

Qualitative Healthcare and Education Differences

In comparing qualitative responses between those working in healthcare and those in education, healthcare professionals were more likely to report increased cleanliness/hygiene as their greatest lesson learned, while education professionals were more likely to report spiritual growth. This is possibly due to differences in the nature of work, where healthcare professions require greater emphasis on personal protective measures to prevent the spread of COVID-19. In addition, Catholic women religious comprised a large proportion of respondents serving in the education sector, which contributed to the top response for spiritual growth. Differences were also found among technological innovation/creativity and increased vibrance in community living, as both were more commonly cited by education professionals in comparison to those in the healthcare sector.

Discussion

Interpretation of Results

Participants reported that the greatest lessons learned through the COVID-19 pandemic were spiritual growth and greater appreciation/awareness of their lives. This outcome aligns with the

findings of the previous study: spiritual support and prayer was cited by 99% ($n = 228$) as the greatest source of support reported by study participants ($N = 1,529$, ASEC, 2020). The significant relationships found between healthcare and education sectors align with the nature of work that participants were engaged in during the pandemic, whereby healthcare workers were seemingly disadvantaged due to the nature of their work. They were more likely to experience negative impacts on their self-care due to the overwhelming needs created by the pandemic, compared to their counterparts among participants who identified as education professionals. Healthcare workers continued to provide highly demanded services as essential staff, with no option to follow lockdown procedures and stay home.

The negative and near to zero relationship between self-care and mental health in this research can be viewed from different perspectives and evidence on the ground. Rathod et al. (2017) studied mental health, identifying that approximately 80% of study participants reside in low- and middle-income countries. Rathod et al. also recommended approaches to mental health services that are culturally sensitive. In spite of the large number of participants diagnosed with mental illness, their study found that the number of those who receive mental health treatment is often low (p.2). In a country like Nigeria, about 10.4% patients who had been identified with severe mental illness had received treatment in a span of one year (Rathod et al., 2017). Mental health issues are surrounded with social stigma (Rathod et al., 2017). This could be another explanation of the practice in countries of Africa south of the Sahara, as this study found that only 17% ($n = 48$) of participants responded that more mental health issues were reported in their local area during the pandemic.

Another point of view is informed by the number of participants in this study who responded that they do not have a professional background in mental health issues (65%, $n = 176$). This may be explained by the fact that the area of mental health is understudied in those contexts, which aligns with other studies where participants identified this as an area of additional need for training (ASEC, 2020; Rathod et al., 2017). There is a probability that, during COVID-19, screening for mental health issues may not have been a priority among service providers and so it did not constitute a large part of their practice and care for patients. Religious and cultural beliefs have also inhibited an exploration of mental health issues, which are often explained away by authorities considered culturally competent in the identified problems (Rathod et al., 2017).

Those in the education field were negatively impacted by school and other closures including businesses and borders, among other activities that were not considered essential services. As of May 2020, the WHO (a) reported that the spread of COVID-19 was so rapid that there were “societal and economic disruptions” that had not been foreseen (p.3). This study reported similar outcomes with the highest unprecedented outcome being fear of going to the hospital for treatment of other ailments not related to COVID-19. Isolation and stigma from COVID-19 was reported by nearly half of study participants (46%). When combined with fear of those recovering from COVID-19 (30%), this constituted the second largest negative impact of the pandemic on respondents. Among other top five outcomes associated with the lockdown and school closures were teenage pregnancies (40%) and domestic violence (37%).

Unemployment may have been experienced more by education professionals due to preventive lockdown measures, compared to healthcare providers who continued to provide services as essential workers. Additionally, those in the education field in qualitative responses reported

experiencing increased technological innovation/creativity through the pandemic. This too may be attributed to the lockdown of the education sector, as schools and employees were compelled to explore alternative means of communication. The quantitative results strengthen this finding with reports that organizations commonly used social media for communication and individuals employed WhatsApp and Zoom. Lockdown measures created an opportunity for study participants to learn alternative methods of communication. Going forward, these lessons learned may continue to alter the way organizations and individuals communicate with more common implementation of technological tools.

Limitations of the Study

Addressing issues of self-care and mental health under the new normal and current pandemic which have not been experienced by participants before is challenging to articulate. The study was limited to workplaces managed by Catholic women religious and their staff. No other organizations were considered that could provide further insights into the experiences of supervisors and staff. A comparison of public institutions or organizations not affiliated to the Catholic Church were not considered in this study. The addition of non-religious organizations would have provided broader perspectives and understanding of the items on the survey that were related to the general public.

The majority of respondents were from the education sector compared to those who identified as working in the healthcare sector. This study was not privy to an accurate number of institutions of healthcare providers and education institutions in the three countries sampled in this study. Therefore, the results of this study, while informative, may not be generalized to all institutions of healthcare and education workplaces in West Africa. The selection of participants largely depended on the sponsoring agency collaborators in each country.

Recommendations for Future Research

The study could be expanded to include other healthcare providers in the public sector and non-profits that are not managed by Catholic women religious in each country. This would allow for increased generalizability and greater insight into those who are employed by public entities, which may have experienced greater pressure to perform and increased need for services during the COVID-19 pandemic.

Future studies could also focus on a specific area of COVID-19 and mental health outcomes in the context of Africa south of the Sahara. This study offered general insights into mental health impacts of COVID-19, whereas a future study may delve deeper into specific areas of mental health focusing on study participants with a working knowledge of these issues.

Conclusion and Implications for Practice

This study provides additional knowledge into the high involvement and labor force provided by women religious in much needed services to humanity. From the entire case study of $N = 311$, 82% were women religious ($n = 239$). Education and healthcare services continue to attract a lot of attention among women religious in Africa south of the Sahara even within unprecedented times

of COVID-19. However, when addressing pertinent needs for clients, they are not often included in policy formulations or forums of deliberations on concerns of the community service providers.

Additional knowledge has been generated from this study on the need to engage more in spiritual care support for workers and patients as another area that has not been largely explored for best practices. A recent research and model proposing the inclusion of spiritual care as an interprofessional practice (Puchalski et al, 2020), is supported by the outcome of this study and an earlier study where spiritual activities constituted a great source of support during the pandemic (ASEC, 2020). Policy formulations for screening and serving clients ought to be more inclusive of all the aspects of the human person not only to include social, economic, political, cultural, and technological aspects, but the spiritual aspect as well.

For improved communication and demystifying fiction and facts about pandemics and other important information, organizations need to maximize their use of social media platforms. This study reveals six in ten (64%) participants' organizations adopted social media for routine communication. Social media constitutes a great source of information and opportunity for the majority around the world. It is possible to postulate that under the new normal the adjustment to new ways of communication is the new direction organizational communication might take, as seen in seven out of ten (73%) study participants who found them to be *somewhat* and *very successful*. WhatsApp was rated top (71%) and Zoom (42%) was second as the most used medium of communication by organizations during the pandemic.

An interesting find from this study also shows evidence that social media was a more trusted source of information than participants' governments. This could be a wakeup call to leaders in agencies and governments to keep abreast with their citizens' needs and have knowledge of where people seek information at any given time.

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References

- Adom, D. (2020). The COVID-19 global pandemic: Socio-cultural, economic and educational implications from Ghana. *International and Multidisciplinary Journal of Social Sciences*. doi:10.17583/rimcis.2020.5416
- African Sisters Education Collaborative - ASEC (2020, May). *Understanding stakeholders' coping mechanisms during the COVID-19 pandemic*. African Sisters Education Collaborative Research Initiative Report. Scranton, PA.
- Creswell, J. W., & Creswell, D. J. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). SAGE Publications, Inc.
- Kalu, B. (2020). COVID-19 in Nigeria: A disease of hunger. *The Lancet Respiratory Medicine*, 8(6), 556-557. doi:10.1016/s2213-2600(20)30220-4
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass Publishers.
- Nkwayep, C. H., Bowong, S., Tewa, J., & Kurths, J. (2020). Short-term forecasts of the COVID-19 pandemic: A study case of Cameroon. *Chaos, Solitons & Fractals*, 140. doi:10.1016/j.chaos.2020.110106
- Puchalski, C., Bauer, R., Ferrell, B., Abu-Shamsieh, K., Chan, N., Delgado-Guay, M., Egan, R., Haythorn, T., Jacobs, C., Joseph, D., Kestenbaum, A., Karimi, K., Oberholzer, A., Simha, N., Vandenhoeck, A. Palliative Care and Covid-19 Pandemic. *Briefing Note: Interprofessional Spiritual Care in the Time of Covid-19*. <http://globalpalliativecare.org/covid-19/uploads/briefing-notes/briefing-note-interprofessional-spiritual-care-in-the-time-of-covid-19.pdf>
- Rathod, S., Pinninti, N., Irfan, M., Gorczynski, P., Rathod, P., Gega, L., & Naeem, F. (2017). Mental health service provision in low- and middle-income countries. *Health Services Insights*, 10, 1178632917694350. <https://doi.org/10.1177/1178632917694350>
- Reuben, R. C., Danladi, M. M., Saleh, D. A., & Ejembi, P. E. (2020). Knowledge, attitudes and practices towards COVID-19: An epidemiological survey in North-Central Nigeria. *Journal of Community Health*. doi:10.1007/s10900-020-00881-1
- Serwaa, D., Lamptey, E., Appiah, A. B., Senkyire, E. K., & Ameyaw, J. K. (2020). Knowledge, risk perception and preparedness towards coronavirus disease-2019 (COVID-19) outbreak among Ghanaians: A quick online cross-sectional survey. *Pan African Medical Journal*, 35(Supp 2). doi:10.11604/pamj.suppl.2020.35.2.22630
- World Health Organization (WHO). (2020, May 4a). *COVID-19 strategic response plan in the WHO African region* (Rep.). Retrieved August 24, 2020, from WHO Regional Office for

Africa website: https://www.afro.who.int/sites/default/files/2020-06/SPRP%20BUDGET%200520_01.pdf

World Health Organization (WHO). (2020, May 27b). *COVID-19: Situation update for the WHO African region 27 May 2020* (rep.). World Health Organization (WHO). Retrieved from https://apps.who.int/iris/bitstream/handle/10665/332150/SITREP_COVID-19_WHOAFRO_20200520-eng.pdf

World Health Organization (WHO). (2020, June 4c). Advice for the public on COVID-19. Retrieved August 31, 2020, from <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>

World Health Organization (WHO). (2020, July 31d). Pooling samples boosts Ghana's COVID-19 testing. Retrieved August 21, 2020, from <https://www.afro.who.int/news/pooling-samples-boosts-ghanas-covid-19-testing>

World Health Organization (WHO). (2020, August 17e). *COVID-19: Situation update for the WHO African region 17 August 2020* (rep.). World Health Organization (WHO). Retrieved from https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200817-weekly-epi-update-1.pdf?sfvrsn=b6d49a76_4