**Abbreviations:**

**F:** Facilitator

**R:** Respondent

F: Alright, so as I have said our focus is to understand views if healthcare workers over strategies that have been put in place for COVID-19.

**R: Uhh so umm we had as a unit uhh both obstetrics or maternity as well as the gynae part uhh we did face quite a number of challenges in the uhh with COVID-19 pandemic starting with ourselves we had a number of cases that were diagnosed in the unit and those were confirmed cases and a number of suspicious cases.**

F: Amongst staff that is.

**R: Uhh that is amongst patients as well as staff, so yeah some members within the department within the unit starting with Registrars, uhh Interns uhh in the unit some of them were diagnosed to have COVID, and fortunately all of them they had mild symptoms and they recovered well and midwives as well in the unit some of them had tested COVID positive and both cadres had to stay away from work for quite some time and from work perspective I think it not directly on my part but I think on the nursing side I think it crippled the them, uhh because and this occurred right at the beginning when if someone was diagnosed then the contacts had also go into isolation until they are proven to be COVID negative by two tests, so that meant that the number of staff that were within the department tremendously decreased coz if for example in the uhh we have ten midwives working in for example labor ward and one of them is diagnosed COVID positive it means the other nine also had to go,**

F: Into isolation.

**R: yeah into isolation and for two weeks and it’s not like we do have a lot of nurse and midwives within the unit so it meant if those nine, if those ten are in isolation then quite a few remained on the ground the same with interns and Registrars and the interns we already have been having a shortage, closure of the medical college meant the calendar was shifted eeh new we didn’t meet our time lines in terms of graduating a new set of doctors,**

F: Ok.

**R: yeah so we don’t have a cohort of interns to replace the existing ones so usually we do have two cohorts that sort of meet and supplement each other the numbers are quite high but right now we do have like five interns within the unit.**

F: Ok.

**R: yeah and it has been like that for most of the time so if one intern was COVID positive possibly one more was a contact then it meant numbers reduced to three which did put pressure on those three the same with Registrars yeah. So it meant everyone had to step up,**

F: Yeah.

**R: first thing we had to share the work uhh equally and then the other part is we had to scale down operations within the unit so we suspended all clinics, all outpatient clinics except antenatal care services because I mean those, uhh pregnant women can’t be managed conservatively forever they have a time limit but for gynae clinics we sort of suspended all gynae clinics we were only running only two antenatal clinics per week. And another thing is we did close our private unit or private ward 1A, not necessarily closing the ward but it was uhh, it’s operations shifted it was our unit for COVID positive pregnant patients so it means other patients couldn’t go in that ward, yeah so that’s how work within the unit was affected.**

F: Affected.

**R: Yeah.**

F: Ok.

**R: Sure.**

F: I’m not sure if you are able to explain to me how the hospital managed COVID patients in the hospital,

**R: Ok.**

F: the pathway that they went through from the time they came to the hospital and the different stages that they go through,

**R: Ok.**

F: and what happens in those stages at the point of whether they are discharged or died.

**R: Aha, (clears throat), so all patients would come to the tents at the gate uhh having been screened they would be identified as uhh whether as being positive or negative if they screened positive they were isolated to the tents and if COVID test was done whose results would come within 24 hours of obtaining the sample, uhh once the result was out then they were referred to one of the COVID wards so either in the 3A,**

F: Ok.

**R: to ENT or if they were a maternity pregnant woman they would be referred to 1A as I already said. Uhh 1A we were as a unit we did make sort of amends because sometimes we the understanding is sometimes patients pregnant patients would be referred in an sort of emergency condition they wouldn’t necessarily stay at the gate so we had sort of within the unit we had a second place where we were doing only for pregnant women.**

F: Ok.

**R: Yeah, so anyone who is identified as a suspect they wouldn’t go to the tent they would go straight to 1A,**

F: Ok,

**R: until the test said either they are positive they would go to a general ward,**

F: Ok,

**R: in 1A the good thing is a ward which was already demarcated so they need to have some sort of their own private space and we had put facilities for delivery in case a woman was in labor and delivery had to happen there actually I think three, four patients delivered there**

F: COVID patients

**R: COVID positive patients.**

F: Ok.

**R: and I think we’ve had one death of a pregnant woman from 1A also COVID positive. Yeah so the general pathway for all the patients was the gate screened to the tents wait for the result if negative they would go and access the rest of care if positive they would go to one of the wards where continuation of, if they were not eligible for admission they would be advised on management and (??) at home but for patients that were coming within the hospital premises were getting admitted that’s how they would flow, I should say, yeah.**

F: Alright, so if you look at that pathway both the general patients and pregnant women,

**R: Yeah.**

F: are there specific things that you would uhh point out and recommend the hospital that it did well uhh positive things and or again are there specific things that, areas that the hospital could have improved?

**R: I think uhh the one thing that uhh the things that I think the hospital did well was to set up places where COVID suspects patients are isolated before mixing with the general population within the unit, I think that’s one commendable effort it’s not easy uhh to do such within, uhh in Malawi, or within the hospital uhh premises here at Queens, uhh we do have huge influx of patients number one and huge influx of guardians which I think the hospital tried to cartel both uhh the number of patients coming in and the amount of guardians I look at it tremendously wealth another thing as a unit I think we did prepare before and to say if eventualities come we should have a backup plan just as a unit I know as a hospital we had a plan, a general plan but as a unit we also prepared our own because I mean yes we can say a pregnant woman we can isolate at the tent whilst waiting for the result but things can happen that’s why we said we should identify a place within the premises that if there’s some emergency at least we should continue general care because care doesn’t stop because someone is COVID positive but for example if they are bleeding then we need to address the bleeding because they might die from the bleeding and not necessarily from COVID, so going a step further I think it was a good thing and it worked out well in the end that uhh we had a place where women could be isolated and care given and not much was missed uhh within the unit. Another thing we did well I think I already pointed out is restraining, reducing of guardians, yeah I think even before COVID I think there was a general outcry that the number of guardians within the hospital was just too much,**

F: Umm.

**R: yeah, and working well with the community, sensitizing the community as well as putting measures restrictive measures I think the hospital really I think uhh should commend that effort because it’s not easy in Malawi, it’s we are different kind of people but the hospital really tried to address it without actually raising conflict,**

F: Ok.

**R: umm,**

F: Ok.

**R: Sure.**

F: And what you feel could have improved in that process managing patients.

**R: Uhh, umhuu, I think at the very beginning I think there were so many uncertainties regarding management of COVID patients. I think yes people did get trained but as we were uncovering cause COVID was out there and we didn’t have any recorded cases in Malawi we had started preparing but we didn’t really know to what extent would the problem would really be when we face it. I think one of the things that was kind of overlooked was our support staff, the cleaners the maids only when the cases started trickling in that’s when we discovered that actually we should have included these people,**

F: The front line.

**R: yes they are front line, uhh that’s but we quickly and responded most of them were trained and the trainings are happening actually now**

F: Ok.

**R: yeah, but I think as a response I think we overlooked that aspect, yes we did good training all doctors, all midwives, and all doctors and nurses, clinicians they did get good training and yeah we were able to see and respond and whatever but then other things surrounding I mean we have managed COVID patients I think there was one example where in this unit there was a patient who came as a referral from another unit,**

F: Ok.

**R: yeah I think one of the district hospitals, had another condition but also was a suspect for COVID and went to gynae ward that time gynae ward we had very few numbers of manage so we could manage to isolate her in one of the sides wards**

F: Ok,

**R: uhh she was very sick and she quickly deteriorated and passed away luckily later on her COVID test was negative but within the time that this event had occurred the patient came was resuscitated and successful one died, the nurses came the doctors had come to do the resuscitation the after the patient’s death was confirmed the nurses came to wrap the body referred to the mortuary actually was referred back to the facility the ambulance was called back and referred back to the facility then it was time to clean the room,**

F: Ok.

**R: but the cleaner was like I am really scared because I don’t know how to handle such a situation,**

F: Yeah.

**R: because she knew that this patient is a COVID suspect and genuinely she had genuine concern and you could see how you are faced with oh doctor can’t do cleaning of the room, nurses can’t do cleaning of the room it’s still the duty of the cleaner but she had genuine concerns and I think that’s when we started realizing oh you know I think we did miss these things,**

F: Umm.

**R: yeah so that’s just one example there could be many more but one area probably we didn’t emphasize as much was that. In terms of other management of patients I think uhh I think it was generally ok.**

F: Yeah.

**R: Yeah.**

F: Trust me because those are some if the issues when I talk to the patients attendants and the like,

**R: Yeah.**

F: they are also raising about being involved in the process.

**R: Umm.**

F: Yeah you talked about training uhh I suspect that those trainings included letting staff know about maybe guidelines or protocols that were being introduced to staff,

**R: Yeah.**

F: about how the hospital will go about managing the patients,

**R: Umhuu.**

F: uhh are you aware where those guidelines or protocols came from or where they were developed too?

**R: Uhh I can speak of the protocols for this unit as an obstetrics and gynae unit because some of us were involved in inputting and developing the protocols**

F: Ok.

**R: so there’s a grouping of consultants through the head of department was tasked with developing guidelines, uhh for managing pregnant women with COVID,**

F: Ok.

**R: yeah, so we had to sit and review and send contributions I mean we did adopt some of the guidelines that were being done somewhere else UK, uhh some from WHO, and staff like that so in the end we developed a guideline presented to the ministry of health and I think they adopted it and I think that’s the one that is being used nationally.**

F: Ok.

**R: In terms of the other guide lines I really would lie if I know who actually or what was the process like,**

F: Umm.

**R: but I know that Dr. xxxx was heavily involved I don’t know if she is the one who actually drafted the guideline but I would actually lie if I were to comment. I can confidently**

F: (Laughs)

**R: about the unit, yes.**

F: Ok.

**R: Yeah.**

F: So speaking about your unit if as you said most of those were adapted internationally or from WHO,

**R: Yes, yeah.**

F: implementation did you feel that they fit within the or how did they suit the ideal context looking our resources and capacity?

**R: Yeah, so yeah I think one of the challenges was developing a guideline that would suit and not only Queens but also suit uhh a health sector setting in the remotest part of Malawi, so looking at some of the things infection prevention protocols they can actually follow uhh basic IP protocols they can follow and IP equipment they can have for them to be safe and for patients to be safe I think that’s we were sort of we were looking for, so most of the guidelines like from UK obviously some of the things were a little high end,**

F: Umm.

**R: but some things were basic like washing hands, making sure mum and baby are not separated you know conducting a delivery if you do have a suspect for covid separate room and not mixing with other patients, but then it’s easy to do it here at Queens but if you have a health center where the labor and delivery room is just one open space with four beds and there are no other spaces we were kind of challenged so we sort of did advocate for the ministry to sort of have isolation facilities tents etcetera in those health center so if they do have who they are suspecting could have COVID and is in labor can deliver safely at that facility,**

F: And isolated.

**R: isolated not mixing with other patients and then the baby can also be with her, I think those are the things that we were mainly looking at that’s just one example, so yes we did adopt international but international guidelines but most of them didn’t fit Malawian context, when I say Malawian context I’m not just looking at Queens, actually Queens was taken to be, maybe we can try some of these things but we didn’t consider things like health centers, district hospitals etcetera, yeah.**

F: Alright. The level of knowledge among staff not level of knowledge, access being able to follow those guidelines what has been your general experience?

**R: So general experience uhh it’s been a mixture,**

F: Umm.

**R: at the very beginning there was good I can say upwards to 90 percent adherence to infection prevention procedures and protocols,**

F: Umhuu.

**R: so much so that we actually noted that one of our very bad outcomes had actually dropped we do have quite a lot of post caesarian infections but we noted that uhh we had a drop in infections,**

F: Umm.

**R: within the time that the restrictions came in yeah so we knew that we were doing something right whether, we didn’t know what it was actually whether it was just reducing congestion within the hospital or us doing the hand washing every time or which of those two we still don’t know up to now, but we actually noted that infection had tremendously reduced,**

F: Ok.

**R: same schedules, same environment, same everything but the only things that had changed were only those two.**

F: Ok.

**R: So we know that people were very adherent to infection prevention measures, uhh as we are going on and on it sort like getting used as numbers of COVID patients have reduced I think people are sort of getting used uhh we still have maybe 40, 50 percent adherence (??) totally I would say adherence to infection and prevention measures but it’s not as much,**

F: Umhuu.

**R: so things have (??).**

F: Do you think has influenced or is influencing those

**R: In my opinion I think uhh I think getting used to or getting, how can I describe it? Getting used or getting comfortable,**

F: Ok, comfortable,

**R: Yes, yeah I think that’s the way things have been sort of going on, uhh we are not facing, we are not having as much cases of COVID as we used to have in July, August, uhh so now people are now sort of relaxing and ,**

F: Those are your views I thought people getting comfortable.

**R: oh it is quite dangerous (Laughs)**

F: (Laughs)

**R: that’s what, when this group of students cause MBBS 4 group started uhh on Monday,**

F: Ok.

**R: that’s what I was telling them you see you still have to be safe,**

F: Yeah.

**R: no matter what you see out there so you find in the wards people have not put on masks, people are not washing hands or they are back to their practices but you shouldn’t copy that always be safe and whenever you are conducting a delivery or you are assisting conducting a delivery put on a face shield because vaginal delivery an also generating event, yeah someone is pushing so you still have to emphasize on that practice and yeah I still struggle to say I don’t know what people would actually say yeah.**

F: Ok. What’s your comment about your availability on PPE both in your unit or generally in the hospital?

**R: Yeah, so availability of PPE I think in my opinion and this Is being honest PPE has always been there I mean with COVID not as always as in the hospital has always had PPE but when COVID came there were purchases or donations that were made for PPE, the problem was I think at the very beginning people were so afraid and I think, I mean we were all exposed to external media we were seeing the kind of PPE that sort of doctors in the UK were putting or doctors in the US are putting just working in the normal ward they are putting N5 etcetera, so I think the expectation that people had or staff within the hospital had was really or the government had that PPE for everyone, that understanding although the training did emphasize on what kind of PPE can you put on, on what occasion, people sort of I should say ignored that and just went about demanding PPE for inappropriate situations so I’m just going to labor ward to do a ward round there’s no reason for me to put on a mask I mean N95 mask I can put a normal surgical mask and that will be fine,**

F: Ok.

**R: surgical mask, apron, boots that’s fine and we did have that within the unit and I cannot speak for the other wards but at least know for sure this unit has that but uhh people’s demands**

F: The expected to have full gear.

**R: they expected to have N95 masks (??) suits or anything which was kind of ridiculous but I think we had to maneuver through that we had to negotiate and make people understand that actually you don’t need all that when slowly people understood and actually accepted that these are appropriate for appropriate scenarios, yeah, yeah, but I really don’t think maybe I’m not, I’m not front line in management but I don’t think there was a day when we didn’t have appropriate PPE maybe the hospital might not have had PPE but as a unit we had some well-wishers that had donated related PPE for the unit so that if we don’t have any from the hospital we can use that as a backup so this was kept by the matrons so if maybe there was no PPE from main pharmacy they would realize that but there wasn’t any interruption in supplies for PPE appropriate for the situation.**

F: Ok.

**R: Yeah.**

F: Alright, so I want to take you into an imagination because the way things turned out to be it was not the way people had projected to be,

**R: Sure.**

F: but in case we had a high number or an increased number of case just as we have seen in other countries,

**R: Umm.**

F: uhh what do you think could have had happened in reality in the hospital?

**R: Uhh I don’t think anything much would have changed uhh we would have scaled down and uhh that’s about it uhh,**

F: What do you mean when you say (??)

**R: like we did with uhh when we were embracing for impact so he said let’s scale down numbers will increase let’s scale down we should just focus on the very sick patients those that need attention, I think that would be the same I don’t think that things would have been managed differently maybe the only thing would have been to increase the number of hospital staff so that we should be rotating, uhh, the one thing that we sort of noted when transmission among staff sort of was noted then we started working in the units or firms so one unit could be working this week,**

F: Ok.

**R: and then resting the other week and the other week would start reason being you don’t want these two to be mixed if they get exposed to one to a COVID patient then they shouldn’t expose the others,**

F: The next team.

**R: yeah.**

F: Ok.

**R: I think that would have been the same, I think that strategy was generally adopted I think in a lot of countries and most countries when they saw that the numbers were quite huge they recalled their staff only isolating those that were positive or sick.**

F: Ok, but how supportive do you think these infrastructure could have been to an increased number of patients?

**R: Mhuu, yeah that’s the real problem I think in terms of space we don’t have enough uhh I know there were plans to open not plans but we had opened a unit in conjunction with Blantyre DHO at Kameza but again there were some challenges there. Uhh even if they were no challenges of the payments etcetera the unit was not well prepared it didn’t have beds, it didn’t have it wasn’t built as a hospital so I mean it’s a makeshift kind of structure you would expect some challenges within the structure, so I think problems like that would have risen drugs and uhh procurement of supplies that would have been a challenge uhh I know we do have oxygen (??) in the wards in some wards but not like the way 3Ais that every bed has 100 percent oxygen so if we needed, if the numbers were huge and numbers that needed to be on oxygen increased that would have also been a challenge because uhh consumption of oxygen would have increased and I don’t think there’s enough uhh I should say enough uhh (??) plan or to have all the wards fitted with oxygen uhh if we were to order from across the road Afrox that would also have been very expensive uhh those challenges would have also come along.**

F: Ok.

**R: Yeah, sure.**

F: You earlier talked about scaling down in what in other cases is referred as reverse triage those that are not sick,

**R: Umm.**

F: can be quickly sent home and only take care of the very sick do you think that could work in our context in our Malawian context that people are discharged home to continue home care and if you look at the conditions in our local,

**R: So talking of covid patients or all patients?**

F: Talking about all patients.

**R: all patients, yes I know,**

F: Ok.

**R: yeah, yes from my perspective it works, I know it works because if a patient is able to take drugs uhh orally is fit enough to walk to the bathroom and back I mean without any sort of discomfort or is post-operative there’s nothing more that we can do within the hospital, I think that patient should go home,**

F: Ok.

**R: no from some perspective when I look at from the patient’s perspective so people have expectations when they go into the hospital so if so if someone comes with a mass a big mass on the chest or abdomen the expectation is I have gone to the hospital I should have assistance and go back home feeling assisted,**

F: Yeah.

**R: that sort of satisfaction reduces if you reverse triage if you know the mass is there but you know it’s giving you pain here’s some panado to alleviate the pain yes it takes away the paid but it doesn’t take the thought that I mean I have a mass inside me and it should come out, so patient satisfaction might reduce or it does reduce say if you,**

F: (??)

**R: yeah, so you find that yes people comply to go home but within a week they are back, so eventually what you could see is you see the same patients over and over again frequenting the hospital,**

F: Umm.

**R: yeah.**

F: There were these who came here because of covid because Mwaiwathu and Seventh day SDA couldn’t take them,

**R: Yeah.**

F: do you think that just getting up perception, do you think this could have been managed differently, could have been special arrangement for such kind of people?

**R: Mhuu, well (laughs),**

F: (Laughs)

**R: it’s a very, it’s a very tricky,**

F: Question.

**R: question.**

F: Ok.

**R: Yeah I believe that every person have, I mean doesn’t matter what we are we have the same right, we have the same freedoms and probably same privileges, the ministry of health in Malawi provides health care for free for every Malawian uhh so it doesn’t matter whether I have a billion kwacha in my bank account or I have zero kwacha in my bank account, if I come to this unit I should access the same service as everyone else,**

F: Umm.

**R: but now it becomes a challenge because if the head of state is sick and goes to the hospital they would, obviously they would be treated differently and that’s the same with everyone else, society ranks people uhh and the ranking that you receive from the society also puts you at an advantage or disadvantage depending on the situation. So for example I have a lot of friends at road traffic, if I go there they just say uhh**

F: ‘Tabwelani’. Come over

**R: ‘a dokotala tabwelani’ doctor come over, I don’t stand on the queue,**

F: Yeah.

**R: it’s uhh, it’s sort like,**

F: Not like natural.

**R: it just looks like natural but from someone I know they are people that go there at 6 o’clock,**

F: That’s true.

**R: start waiting and I go there at 10 by 10:30 I’m done; I’m going back so I mean it’s a disadvantage,**

F: That a society has learnt.

**R: yes but yeah, so it’s very hard to put to say could have there been managed differently, I really don’t have an answer (laughs),**

F: (Laughs)

**R: but I guess that’s how things are, sure.**

F: Ok. My last sets of questions,

**R: Yeah.**

F: it’s about your concerns and your certainties,

**R: Umm.**

F: if you look at the level of preparedness for covid-19 at the hospital and in case we are start experiencing an increase in the number of cases again,

**R: Yeah.**

F: what are you most worried about as far as providing the required care is concerned?

**R: My main concern if we get rise of cases again,**

F: Umm.

**R: is that we will go back into the same cycle where uhh because like I said IP procedures have sort like declined and with that I can foresee if number of cases become higher now the affected staff members will increase probably more than what we had before,**

F: Umhuu.

**R: yeah that’s my main concern, uhh in terms of preparedness,**

F: Umm.

**R: uhh I will take you back I think as a hospital Queens tried to go within its means to maneuver within its own means they beg from here tap funds from there,**

F: Umm.

**R: to try to prepare for this pandemic, but I think and this is purely my personal opinion,**

F: What do you think the hospital can do to get that required support from the ministry?

**R: Yeah, so eeh I can only hope that they can re-negotiate and people listen making realistic demands I don’t think it’s anything that is out of reason no, uhh and those realistic demands uhh as for me my concern is that people don’t get enumerated no, my concern is that people are not safe. One of the things that people were demanding for example during the strikes was yes one part was the pay, the incentives but for me my concern really is all these people they work so hard if they get covid and god forbid they get covid and they are so sick or they pass on you know it’s end of life,**

F: Umhuu.

**R: most of them they are not ensured, they are not on medical aid these are the things that the government should sort of prioritize putting a health worker sometimes it’s so concerning and so you know sad to see your fellow health worker they are so sick now they can’t access any, they have to access this type of health and you tell them you have to access this service buy this drug privately and they can’t afford because they don’t have medical aid, yeah so certain things like that uhh need to be addressed, lobbying for better services and space and you know quality things in this unit is I think this is the time we had to lobby for such I know that there’s been an outcry for improvements at Queens some of them have happened but some of them seem to some sort of gotten into but this was the time to negotiate for better quality services at Queens.**

F: Ok.

**R: Yeah.**

F: Alright, staff willingness to provide the required (??) especially at the very beginning when it was just starting,

**R: Umm.**

F: how did you see willingness among staff to say ok we are there we will provide the care and support required?

**R: You know it was difficult, it was difficult and people were genuinely concerned about their safety,**

F: Umm.

**R: yeah like they said one issue was the misunderstanding about the required PPE the other issue was incentives and personal safety, so willingness really was at a minimum to provide required care I think, that’s what led to the sit-in that the ministry intervened and people were back to work,**

F: Umm.

**R: Yeah.**

F: Ok.

**R: Umm.**

F: And community responses to prevention measures do you feel that it is an area of concern as well?

**R: Yes. Uhh community response has been a problem,**

F: Ok.

**R: has been a problem uhh we are lucky that we are not getting as many cases,**

F: Yeah.

**R: community response has generally been a problem uhh I think a lot of people sort of still think covid is over exaggerated uhh it was a time low when elections were sort of coming to close because people thought it’s a campaign gimmick to scare people away from you know uhh and then the general response hasn’t been as good as I thought it would, uhh I was sort of proud to see that one of the first movers were the shoppers that they put buckets,**

F: Yeah.

**R: and churches, put buckets restricted the number of people and encouraged everyone sort of turn back and some are still doing that now turning back people that are not putting on masks and I think that has sort of it is not just coming from us in the hospital but also from you know where people get access and then people have slowly transitioned into the culture putting on masks, sanitizing before the shop,**

F: Umm.

**R: yeah it’s sort of improved but in general not so much,**

F: Not to the expected standard.

**R: not to the expected standard but maybe I’m also not, maybe I’m underplaying the impact because I know uhh that uhh one of the key players in the country it’s the church some churches are being very strict with covid control measures**

F: That’s true.

**R: yes I know there are some churches they make announcements every week that don’t relax,**

F: Umm.

**R: put on a mask, if you don’t wear a mask you won’t enter the church and they have sort of put measures to restrict the number of members going into the church and etcetera, etcetera, inverted other ways of evangelizing, yeah, so it might not be my, every rounded opinion but the general community response hasn’t been as good, I know a few friends of mine that have still be going clubbing, drinking which is,**

F: (Laughs)

**R: yeah.**

F: (??) covid is no longer there.

**R: (Laughs)**

F: (Laughs) my last question,

**R: Yeah.**

F: the recommendations the hospital management,

**R: Umm.**

F: regarding their level of preparedness,

**R: Umm.**

F: what will be your priority it you were to make two or three priority recommendations what would those be?

**R: I will really be skewed towards my area of expertise,**

F: Ok.

**R: uhh firstly as I said I think involving every player,**

F: Umm.

**R: not ignoring the sorry to use this, but the least of us the ones that we consider uhh they don’t mind patients but those have proven to be actually tremendous front line work actually some of the maids we have trained them so that they conduct screening**

F: Ok.

**R: instead of a nurse or a doctor being at the screening table so we trained them and they are there doing the screening uhh instead of a doctor I think that’s one area that in future they should consider that. Training should not only be for these,**

F: Nurses and doctors,

**R: nurses and doctors but for everyone and we’ve seen this and we know this but I think sometimes it just passes by, it’s in every situation whether we want to reduce maternal mortality if you, if your maid doesn’t know the importance of running to the lab and getting blood,**

F: Umhuu.

**R: you just waste your time, because you will not get your outcome right because you can’t do everything yourself,**

F: Ok.

**R: so that’s one area and I hope the lessons learnt during this time can’t be extrapolated to other scenarios,**

F: Umhuu.

**R: one of the things that have come out well for the in our department atleast is that we have worked out way in which we can streamline activities so we have increased the number of gynae clinics, we have increased a number of antenatal clinics so that for each antenatal clinic patient numbers are reduced but we are effective that way that we see them quickly effectively addressing the (??) concerns by the morning everything is done and they are going them and you are going to do other activities.**

F: Ok.

**R: Yeah.**

F: Alright, that brings us to the end of our discussion I really appreciate,

**R: Thank you, thank you,**

F: it’s not easy talking for close to an hour (laughs)

**R: yeah (Laughs)**

F: I really found this discussion to be very valuable and

**R: Aha.**

F: and it will greatly contribute to our study.

**R: Uhh thank you.**