F: So once again I welcome you to this interview so in this interview uhh we have about uhh four broad questions so the first one we are looking at the general clinical management of COVID-19 cases and then we are going to look at COVID-19 preparations and any response strategies that are used by Queens and the perspective of health care workers or the thoughts of health care workers in rationing care and attitudes towards COVID-19 perception of risk, but uhh before we can go into details if you can just explain to me your position and your responsibilities or how your day is like when you report for work?

**R: Ok I am working here the treatment centre for covid-19. My duty is to counsel all people who come on COVID-19 issues and others who are coming here at the hospital for other issues. My other duty is to screen because the patients who come here are just suspects, anyone who is coming here who has covid-19 signs like coughing, difficulty breathing, fever or diarrhea is a suspect so my duty is that when the patient come here, we help to manage those signs, for example if he has fever we will give him medication,**

F: So you just manage the signs.

**R: yes those signs because we aren’t sure by this time that it can be COVID-19.**

F: Alright, you’ve said that you attend to suspects,

**R: Umm.**

F: so, can you explain to me the planned pathway that was put in place by management in either suspected or confirmed covid-19 cases, so this is from the time a client or patient arrived at the hospital to the time he is discharged from the hospital

**R: Ok, as I have already explained when the patient arrives, if the patient has one of the signs I have mentioned he is supposed to pass by the tent, after he passes through the tent, we give general care that we could have given to any other patient because a Malaria patient may have symptoms of covid-19, someone with pneumonia may have the same symptoms, so we give treatment according to those. The first thing we do when he arrives here is for the lab technicians to come and take samples, since here we operate 24 hours.**

**After taking the sample it is taken to the lab straight away while we are providing general care for the symptoms, if the results come back negative and the patient is not completely healed, he goes through normal floor to ATC and then he will be put either in 3B, or 4A, or 5A or 5B, if the results are positive we have special place for the patients.**

F: Ok.

**R: Before, we had ENT, but they closed it, now we have 3A, so if patient is positive, we will follow all the procedures and take him to 3A. At 3A they continue the care.**

F: Ok, you have clearly explained, but before all this, what was the plan like, I remember people were saying some do go to Kameza.

**R: Ok, what you are saying is true. At first this was not a treatment center,**

F: Ok.

**R: It was just for, screening only, when results came out positive, the Blantyre DHO was responsible for treatment and not Queens,**

**That’s why when a patient came out positive they were being referred to Kameza for treatment, we could either call for an ambulance to come pick the patient.**

F: Ok.

**R: So since the staffs at Kameza were not getting allowances Kameza was closed,**

F: Ok.

**R: now, here we are still screening, the patients are still coming out positive, what should we do with these patients? The hospital management of Queen Elizabeth Central hospital, decided that COVID-19 patients should be treated at ENT, that’s why treatment was moved from Kameza to Queen Elizabeth Central hospital and we still doing that up to now.**

F: Ok, alright so we can say that it was just a concern by Queen central hospital or the DHO asked for help as things were not working out there?

**R: I am not sure on that.**

F: Ok, the whole pathway you have explained from the arrival of patient, screening, positive, admission, where do you think the system was working better, or if we can have a higher number of COVID-19 cases where do you think the system can work better?

**R: Mmm I can say now things are working better unlike in the past,**

F: Ok.

**R: Why am I saying this? At first we were not operating 24 hours here, we were only working during the day,**

F: Ok.

**R: because of shortage of equipment so that the nurses and doctors could work through the night till the following day, so I can say now the system is working better because we are at least able to track many cases that are coming, whether they will come at night still the patient will report here first.**

F: Ok. Alright. Where do you think the system needs some improvements so that the system can work better or so that in future the system should work better?

**R: maybe to also sensitize the general public,**

F: Ok.

**R: about COVID-19,**

F: Ok.

**R: some people out there maybe coughing but they don’t come when they hear about COVID-19, out of fear.**

F: Yeah.

**R: from my experience on my stay here, some may come but since people have known that if you go to Queens and you say you are coughing or you have fever they will take you to the tents, number 1, now they also have that mentality to say when they come here at the tents they won’t be helped, the reason they are coming here is just for us to know if they have COVID-19 or not it’s like we are doing nothing here.**

F: Ok.

**R: Yeah.**

**R: So maybe if we can sensitize them that, when they come here even if they have come here as suspects they will still be receiving general care that any other patient will receive even if he first reported at the general, and some cases may be found at the wards so when coming here he won’t say he is coughing he will just say he is feeling pain somewhere, he will lie because he knows when he tells the truth he will come here, something like that**.

F: Alright, you are explaining more on how the system is working right now, but what was the plan when a patient arrives here before the screening, before installing the tents?

**R: Firstly the management had to design and after noting how other countries were handling it, what is it that they are doing in their hospitals, so they organized trainings on Covid-19, sensitizing the general public on COVID-19 before it came, explaining to people that we know that the disease is spreading in many countries and that many people travel, so at the same time they had to design the tents, they mentioned about the tents during trainings, they said we will install the tents and this is what will be done we will be screening people this way but not treating COVID-19 as.**

F: Per se.

**R: Yeah.**

F: Ok. I get the point, uhh do you have any recommended guideline or treatment protocols that you are using?

**R: Yes for now we have, we had some trainings so looking at the causes of COVID-19, how do patients present,**

(..)

F: Ok so we were discussing about protocols, guidelines, another question cab be, how were these developed?

**R: I can say that the protocols were clearly designed,**

F: Umhuu.

**R: but the draw back that I see, since COVID-19, is a communicable disease, so what was happening was that , and this is how other countries were doing, let’s say this is a ward, you were not supposed to frequently enter into the ward because in doing so it was increasing the risk of contracting the disease, so the nursing area was divided into blocks, so for example here at ENT, they could only enter once to provide care till the next morning, so the drawback is that we could have sugar patients, and COVID 19 was not tolerating with sugar patients, those with sugar, the condition was worsening and many who have died had sugar, so only attending to them twice sugar monitoring was compromised since sugar monitoring is two hourly.**

F: So do you think the guidelines were suitable here with how the situation is?

**R: They were suitable, that’s the only shortfall I noticed.**

F: Ok, now let’s look at level of staff knowledge or access to the guidelines, were people told about the guidelines and were the guidelines readily available to any staff to access them and read?

**R: Yes, I will say yes because the things we learnt were not completely knew, it’s the same thing we leant in college and we do them here at the hospital, only that you need to be more careful and vigilant, whether it’s in terms of monitoring the disease, it’s something whether a nurse or a doctor learnt in school all what is needed now is putting them into practice.**

F: Alright. Let’s now discuss about COVID-19 preparedness and response strategy that were put in place here, so if you can explain to me how prepared you as an individual you were and the hospital to respond to high numbers of COVID-19, so assuming, well I’m saying assuming because now that we had COVID-19 cases but they were few cases, but assuming there was a high number of COVID cases how prepared were you as an individual, or how prepared was the hospital to handle higher numbers of COVID-19?

**R: As an individual.**

F: You should start with before we started having cases then you should compare it with the time we started having cases, as an individual how prepared were you?

**R: Before we started having cases it was scary, as we could hear from our friends, we had an image that once the disease is here the same thing will happen, so preparedness wasn’t easy we just accepted it that anyway we will see how things will go, but then as time went by we just said it’s a pandemic we need to accept and see how we can help people.**

F: So do you think the hospital was prepared for higher numbers of COVID-19?

**R: Yes.**

F: How prepared was it?

**R: Uhh I already mentioned earlier on to say on the hospital plan, during the training times we started with the tents, the plan to have space where to treat COCID-19, patients was also there, for example there were areas that were suggested like the eye but in the end they ended up settling for ENT department for treating COVID-19 patients. But during June and July we had high number of cases so what the hospital did was again to cancel 3A ward so to accommodate more and more patients, so I can say that the hospital did a,**

F: Recommendable job.

**R: Ehe, a recommendable job.**

F: Ok.

**R: Yeah.**

F: So in terms of knowledge and skills, you mentioned about trainings in regards to infection prevention, do you think staff, you as an individual you were more knowledgeable and you had enough skills in terms of infection control?

**R: For me I would say yes because the people were trained, yeah, but then despite being trained some may live carelessly,**

F: Yeah.

**R: Yeah, so for me I would say everybody was trained and even now, the trainings are ongoing, refresher courses they are ongoing now.**

F: Ok.

F: How readily available are PPEs? If for example staffs need them.

**R: PPEs are available but sometimes we do have shortfalls especially in the use of the masks and the like, another shortfall is to know when I should use PPE. I will give you an example the HSAs who are there, you may find they are putting on the PPEs from head to toe which is not necessary, but those are special for procedures, maybe when you want to handle COVID death that’s when you use that, but simply you can just put on a mask.**

F: Ok.

**R: So maybe because sometimes people misuse, you may find that they are quickly running out because we are not using them properly.**

F: Ok, alright.

**R: Ofcourse I can’t say it’s because of misuse sometimes we just face challenges in supply.**

F: Ok, alright. How do you see it when people are using the PPEs, are staff able to use the recommended infection prevention measures? How is it now when you compare with the past?

**R: Repeat the question.**

F: Are staff able to use the recommended infection prevention measures, for example the hand washing we talked about or proper disposal of the PPEs do you think people are now more knowledgeable, or they are more able to do that because of COVID, how is it now?

**R: People have the knowledge,**

F: Umhuu.

**R: but now people are becoming negligent because we are not having more cases of the disease, so some are taking advantage of that not to maintain strict measures of washing hands, wearing masks,**

F: Yeah.

**R: unlike in the past.**

F: Ok, alright, uhh, imagine we had higher numbers of COVID-19, although you mentioned that the hospital had to sit down to see how to manage, but in general, how supportive is the infrastructural set up at this hospital to support high numbers of COVID-19 if we had them.

**R: No, we could have more challenges,**

F: Umhuu.

**R: the issue was also raised that if we have high number of cases we will face challenges**

F: So which areas do you think can have more challenges?

**R: Infrastructure, where will we put the patients,**

F: Umhuu.

**R: Yeah.**

F: Ok. Uhh, how about in terms of staff?

**R: Yeah the same with staff.**

F: Or maybe you feel like there are adequate enough to handle?

**R: No, no they are not adequate enough since I should say it’s not all staff who accepted to help COVID-19 patients,**

F: Umm.

**R: maybe some since we have lower number of cases and also looking at the impact of the disease in Malawi it cannot be compared with how it was in other countries we were better off, but it could have been a difficult situation.**

F: What about medication that were used on COVID-19 related case, how readily available were they?

**R: I can’t say how readily available were they, but they were available.**

F: Ok, they were available any time you need them.

**R: They were available.**

F: Ok.

**R: Yeah.**

F: What can be the key barrier in current issues that are affecting COVID-19 response here at Queens?

**R: Repeat the question.**

F: Imagine we expect to have higher numbers of COVID-19, what do you think could have been a barrier to implementation of response strategies here at Queens?

**R: The same issue of number of staff to work, I can also say resources since the higher the number of,**

F: Cases.

**R: yeah it also means you need more resources to use.**

F: Ok. Still on the imaginary question, what if we had higher numbers of COVID-19 cases, so we would like to explore your thoughts around the potential need to ration care, assuming, so rationing care is let’s say we have three hundred patients at once, how can care be managed? So rationing care is making sure everyone is receiving care.

**R: Firstly we need to have enough staff, secondly we need to have enough space from where to keep the patients, yeah, uhh.**

F: Or I should say in reality if it can happen that we have three hundred cases how can it be managed?

**R: And all need admission?**

F: Umm.

**R: It can be a difficult situation.**

F: (Laughs) What is it that can be challenging?

**R: All three hundred have been found at once?**

F: Yes, you have said they first come here and then if they are positive and have severe symptoms that’s when they will go there.

**R: I need to be honest most patients can die.**

F: Why?

**R: Firstly, if the patient is to be properly taken of it means those to take of him are available, two proper place where to keep the patient and medication because if we have more cases at once the medication may not be enough for everyone to be taken care of, so it’s 1: enough health care workers, 2: isolation space 3: yeah things like those.**

F: Whilst we are in the same situation that is we have high number of cases and we have VIP patients that have social status in the society, how can care been managed?

**R: The way I look at it, in most cases VIP are treated with respect, the can be given a special, than.**

F: Ok.

**R: That’s how I look at things.**

F: Ok.

**R: There situations that you have to attend to an MP you give him special attention, things like those.**

F: Ok, so now we will talk about attitudes towards COVID-19, and perception of risk, so considering the level of preparedness you have talked about for you as an individual uhh and the hospital as an institution uhh if you can explain to me your attitude or your views on risk to COVID-19, infection. How do you think your risk was?

**R: As for me I can say I was at high risk,**

F: Umm.

**R: because we were a few of us who were working here, at first people were refusing to come here, we were just a few who dedicated ourselves so you being exposed everyday despite we were handling suspects, but in June out of ten one was negative the rest positive, tomorrow out of eighteen, fifteen positive, so we were continuously being exposed, so it wasn’t a good thing.**

F: So, how has that changed your work or the way you work due to the COVID-19, so you are free to describe changes you think as important for patients as well as yourself. The risk that you were so you were exposed to COVID and you think you are much much uhh at risk to being affected by COVID, how has that changed your work, the way you work, you can explain in terms of uhh importance of patients as well as yourself, your team of the institution and the like?

**R: As for me I dedicated myself to come here so it didn’t really affect my work because I was trained so it was through the training and the guidelines they taught us I was following to say ok, if I do this I am safe, if I do this for my patient it means is also safe. So I was just vigilant when carrying out my duties,**

F: Ok.

**R: To make sure that I shouldn’t be infected.**

F: So do you feel that you are sufficiently protected from getting COVID-19, in the hospital, if working here, do you feel like you are protected?

**R: Yes.**

F: Ok, why? (Laughs). Do you feel like you agree that you were at higher risk because you were seeing COVID cases like larger numbers, so I’m asking do you feel like there is enough protection to you while working here? Because despite (??) that you are at risk you still work. Or maybe the question (laughs). Or maybe I should say at the moment or maybe before COVID, did you have any other fears uhh in terms of risk of COVID-19, infection.

**R: Yes I had fears.**

F: How about now?

**R: Uhh, for now I don’t have fears.**

F: So what has changed, for you not to have fears now?

**R: Yeah it’s because the time when uhh, COVID 19, cases were at peak and on everyday basis I was being continuously uhh being exposed to more cases.**

F: Umhuu.

**R: We could get tested and the results could come out negative, now we have fewer cases you can have three days, negative cases so while maintaining strict measures of infection prevention I feel like I’m at lower risk.**

F: Ok.

**R: Yeah.**

F: So at first, uhh before you started screening of COVID cases did you have any concerns for example when you were told that ok, now you will be based at the tent and you will start screening for COVID cases, did you have any concerns?

**R: Yes concerns were there.**

F: And what were your concerns, and possibly how were they addressed by the hospital if you had any concerns.

**R: My concerns were that I can contract the disease,**

F: Umhuu.

**R: yeah but the hospital was there plus the trainings, plus supplying enough PPE, so you say, ok, ok let me go and work because of those things.**

F: Ok, so my next question is it’s concerning uhh, risk allowance. Do you think uhh there’s any relationship between uhh getting risk allowance or financial incentives and risk reduction, so risk reduction in terms of if I get allowances then I will have reduced risk of contracting COVID-19 or any infectious disease, do you think there’s that relationship?

**R: I don’t clearly get the question.**

F: (Laughs) Ok, so I want to understand if you feel like there’s a relationship between risk reduction and financial incentives or getting or receiving allowance and being at risk of infection or when you receive uhh risk allowance how about your risk of infection does it reduce or you are still at risk of being infected.

**R: I’m still at risk.**

F: So the reason why I’m asking is uhh there was an issue of risk allowance,

**R: Yes.**

F: which many people said uhh no we are not getting risk allowance so we cannot work in COVID set ups,

**R: Umm.**

F: but when people say that it means when you give them risk allowance they can now start working, so do you see any relationship between giving somebody risk allowance and the perceived reduced risk of being infected.

**R: Yes.**

F: And how can you, I mean what can you explain about that?

**R: The thing is anything which is risky most of the times there has to be risk allowance, despite the control measures, the PPEs and everything it doesn’t mean, it can still happen some of the health workers have been contracting the disease,**

F: Umm.

**R: so it’s something some can get motivated by**

F: So that’s what I was asking to say someone has been motivated to do something he was not able to do because of fear because there was no risk allowance, how do you look at this issue? At first he wasn’t comfortable to work because of fear now we have given him risk allowance then he can go. At first he was afraid of contracting the disease so now what can make him go to say now I can go because I have .received a risk allowance, so do you think he may think because I have received risk allowance then my risk of contracting the disease has been reduced?

**R: Some may go just because there’s risk allowance whilst some may just dedicate themselves to work and risk allowance come later, so there two groups of people here, I don’t know if you are getting my point.**

F: No I understand, so what is the one thing that could be done to support you, uhh to support you more especially at this time of the outbreak, just one thing? If theresn’t any it’s ok

**R: The support is that the risk allowance should continue.**

F: Or maybe it’s not enough?

**R: No.**

F: (Laughs)

**R: (Laughs)**

F: Ok, alright.

**R: It should continue even though the cases are reducing and the risk is low, and they shouldn’t reduce it, because we have a far, I can even contract now when there are fewer cases.**

F: So last section is on uhh your thoughts on COVID-19, testing procedures, so what has been your experience so far with the nasal prones and the oral throat swabs for testing COVID-19? Your experience or you can tell what other people or other patients say about that.

**R: I did it twice and it’s painful, it’s so irritating, ofcourse the first time it’s when it was so irritating and I felt so much pain.**

F: And then the second time.

**R: The second time they did it perfectly so it also depends with the lab technician who is collecting the samples and how they are collecting it. But most people complain that it is so irritating, some may start nose bleeding.**

F: So what are your views if other ways of testing COVID-19 can be found, like using saliva.

**R: That’s a good idea.**

F: Umhuu.

**R: Some of the patients we receive here have experience from their friends and if they fall sick they are coughing, they refuse the nose swabs, we end up counseling them to collect the sample.**

F: Ok, and lastly, what priority recommendations that you can make in improving the level of preparedness or management of COVID disease at this hospital? Like preparing for any pandemic it could be any future epidemic or any other disease, what would be your recommendations?

**R: I feel like we have learnt something from COVID, my recommendation is that Queens as a hospital they should get prepared that any time there can be another epidemic and they should have an already set up space, for example Queens didn’t have these tents, they were just from donations, so they should buy these things so that if anything happens they should immediately implement and not waiting for donations, even these it took time for them to be installed and it took time to start using them. So preparedness 1: in terms of electricity, water, in the past we didn’t have water here.**

F: Ok, alright. Uhh do you have any other things that you want say otherwise this was the last question, do you have anything else to say you are free to say so

**R: I don’t have much to say but what I can say is that I’m happy despite delays in COVID issues, but most organizations like now we have MSF, we have Malawi Liverpool Welcome Trust and many more, these helped for this thing to work, I hope if this can continue in future it can really be helpful.**

F: Ok.

**R: Yeah.**

F: Alright, thank you very much.