**Abbreviations:**

**F:** Facilitator

**R:** Respondent

F: So welcome once again,

**R: Thank you.**

F: and this interview we got about four sections, the first one we are interested to know the clinical management of COVID-19 cases at Queen Elizabeth Central Hospital and then the COVID-19 preparation and the response strategy that was put in place and also looking at the perspective of health care workers in rationing care and lastly your attitudes towards COVID-19 cross section of risks. So maybe before we go further, can you explain to me your position and responsibilities here at hospital?

**R: Here at hospital I work as a nurse**

F: Ok, Interesting.

**R: Thank you.**

F: Now, in terms of the clinical management of COVID-19 cases at Queen Elizabeth Central Hospital, can you explain to me the planned pathway which was put in place for suspected cases and also confirmed cases? So we are looking at when a patient arrives at the hospital and which stages was he or she goes through.

**R: Mostly when patients arrive at the hospital, the hospital designed the place whereby the screening is done. So the entry place of the hospital we have the place where they are screening the patients and before you get into the main entrance. So when patients are here they have to be screened first, every person was supposed to be screened and once the patient is screened, if one is found with COVID-19 symptoms then they take the sample. If they don’t have any symptoms then they are allows to go to the wards because they do not have symptoms of COVID. So there a patient waits for the results, at first the results were within 24 hours and when the results are out and its confirmed they are positive, the patient now receive care right at the screening point before transferring to the COVID ward, because they planned that this is screening area that is entry point than after screening the patient the patient goes to COVID ward specifically for COVID patients. So if you are the suspect, now it happens to have contacts with other people maybe you travelled; so at the screening you are given counselling through the health education about the prevention that you should self-isolate at home. If you cannot manage some people where opting to go at Kameza by then so that they should self-isolate there. But mostly they were saying I can self-isolate at home then they were being advised to come back at hospital after some day’s maybe seven days or ten days to review them. After review some would be found that they are ok and some it would be found that they got some signs of COVID and they are want to be admitted then they would be admitted. Yes, so in short as a hospital we have what we call the screening point as well as the ward**

F: Alright, so all these stages of the pathway which you would you say was working good or can work best to any illness that can be an outbreak?

**R: In any pandemic, we need to properly prepare unlike this time around because everyone didn’t know that we would be hit with COVID but this time around is like an eye opener for us that every time we have to prepare for pandemics. So I would prefer personally the screening point should always be there because that’s a starting point,**

F: Umm.

**R: Yes.**

F: Ok, so now in this case or how the plan was do you think there were some problems at the screening point?

**R: Yes, problems were there especially at first people were afraid so we had inadequate human resource yeah that’s why they placed a carrot and stick; carrot and stick is like we are giving carrot to an individual that after eating the carrot you should hit him. So what I mean is offering some job to people that at the end they will get paid.**

F: Ok.

**R: So when they did that and people started receiving allowances, human capital a bit improved and the risk allowance but the challenge is people did not understand, awareness amongst the community flow to the hospital there was a misunderstanding; because people complaining of being screened every time they are entering the hospital and you are delaying me, but gradually people started understanding the importance of being screened.**

F: So, all these processes did the hospital have recommended guidelines and protocols that people were using?

**R: Yes.**

F: And how were they developed?

R: At first, the guidelines we were using were general guideline, when some would say general guidelines; you just know that when you want to screen a patient you would just say ok, i have to triage (??) things not specifically for COVID but after sometime people sat down to come up with guidelines whereby they demarcate the whole screening area, that this should be our lab where people will be taking samples. This will be our short stay ward,

**F: Ok.**

R: this should be our clinicians and consultation room, this should be our mortuary in case someone has passed on; this one should be our stove and the like. So because of that they came up with guidelines now, that when a patient has been screened this side before he is been identified as a suspect they have to be reviewed. So when he or she has been confirmed as a suspected a clinician will review him, then he will be given the counselling following guideline. There afterwards they will give him optional; are you willing to be quarantined at Kameza or at home (??). With that the patients, then what happens is after reviewing the patient the clinician, the clinician has to call the senior, especially maybe the consultant, so the consultant was also confirming the case and approve that lets proceed, so they would check him; that is after the results are out.

F: So, they were doing all this following guidelines that they developed?

**R: Yes.**

F: Specifically at Queens,

**R: Yes, at Queens, yeah.**

F: Do you think they did this because there were cases being recorded, or maybe they developed before the cases or maybe they developed from other guidelines?

**R: Ok, what happened was, when news about COVID just broke out, then people gathered resources,**

F: Resources.

**R: Then start brainstorming, what if this happens to us at Queens?**

F: At Queens.

**R: At Queens, what will we do? So they started developing the what? So they adapted other guidelines from WHO and even the partners. So they adapted those guidelines and make their own now, when they saw that maybe these cannot suit our environment and then they changed other modalities.**

F: Other things, yes. Ok, so now, uhh looking at the guidelines the way they were developed, do you think they were suiting the setting of Queens, as some of them were developed by WHO?

**R: Yeah, (??)**

F: Do you think they were working in our setting?

**R: Yeah, at first it was very difficult for us to understand those things but after some time now we are hearing other countries what they are doing, so they come up to narrowing them down to our specifics at Queens. So after sometime people started commenting on guidelines that were not ideal for us and recommending to change them according to our environment, so it started changing gradually so that they adapt our environment but the challenge was you know when there is a change people sometimes resist, so that was the challenge but eventually people understand now that ok, because this is COVID lets do this as well.**

F: Alright, but, now in terms of level of awareness,

**R: Yes.**

F: to people who are supposed to use the guidelines, what can you tell about the people’s knowledge about or where people able to access the guidelines to use?

**R: Ok, the guidelines were accessible were accessible to everyone because they were pasted on various departments and people were trained, that this time around we are going to use this guidelines, when someone has COVID lets do a,b,c,d following the guideline, so the rest we can say that were accessible, though you know people just say ‘I can’t do this’ you know in Malawi; everyone was understanding this disease in his own (??).**

F: So, what approaches do senior medical doctors or nurses apply to support staff to use the guidelines?

**R: Ok, for the seniors what I have noted is that they were trying their best that we have to work as a team, you can’t work in isolation when it comes to COVID cases, so we work as a team including them, we partnered as well so that we have to adhere to the guidelines, so that the care should be optimal, otherwise if they could have said everyone should work in isolation that means there could have a problem but mostly the seniors were there that we have to follow the guidelines**

F: So, before we had COVID cases at Queens or in Malawi,

**R: Yes.**

F: we had a lot of cases happening in other countries, how prepared were you as an individual working in the hospital?

**R: Yes, it was very difficult;**

F: Umhuu.

**R: frankly speaking it was very difficult looking at our health system setup because we don’t have enough resources.**

F: Yeah.

**R: Uhh, in terms of resource mobilisation even financially it wasn’t easy for us but individually I was thinking ‘if this comes to Malawi what will we do’,**

F: Yeah.

**R: because level of understanding in Malawi is a challenge, but when the country started recording some cases of COVID people started understanding gradually, resources come in despite being inadequate. So to me it wasn’t easy to understand on what i will do because hearing that our colleagues in other countries are what?**

F: Are dying.

**R: Are dying, so we had that picture that here in Malawi we will literally die because we don’t have everything but eventually people comes in, we started, then,**

F: How about general preparation for the hospital?

**R: Ok, general preparation for the hospital, each department and each individual at the hospital were involved in terms of the working environment will change because of COVID, so what they did was involving partners and involving workers to make sure that all the resources should be channelled to response of COVID, so when they started that we saw that there was preparation although there were some challenges. The challenges were like 1; there was understanding amongst us health workers was insufficient, attitude towards the disease even the knowledge deficit was there, so the coming in of trainings on how to manage COVID people now gained the knowledge, then it turned out that we have started doing the preparations on a right track but the challenge the community comes now, people are coming at hospital we have put in place news procedures not the ones they got used to, so people were expressing discomfort with the new measures but little by little we saw a change.**

F: Alright, on the same issue on preparation, do you as an individual and then to the hospital at large, assuming that we have a high number of cases. How prepared were you or how prepared was the hospital?

**R: Ok, fine. Individually I was prepared, ok? So the fear was there of course but I was prepared because everybody will die someday. So we need to assist our friends who have been found with COVID but there was a challenge whereby the management wanted some people to work at COVID ward, but unfortunately people were refusing to volunteer,**

F: Volunteer.

**R: yes, so myself I said I will go, that is when we started being discriminated by our fellow workers alleging that we will die, so anyway we said lest move on, ‘if we refuse the people who are sick who will help them?’**

F: Alright, in terms of knowledge and skills in infection prevention and control, as managers of COVID-19, how do you rate yourselves in preparation for handling?

**R: (??)**

F: Cases of COVID-19? In terms of knowledge and the skills do you think staff and care workers have sufficient knowledge?

**R: Uhh, ok let me say in this way, uhh, for me as individual because I really utilise the infection prevention measures or the guidelines because I know the person I’m to handle already,**

F: Is infected.

**R: is infected, so I have to make sure that I should protect myself before handling any patient, so that should be a priority, so yeah the knowledge was there because we were sharing the knowledge and checking what others are doing in comparison with what we are doing and what is WHO doing? So we narrowed it down to see what others are doing and see if we would manage doing the same considering our resources, looking at our financial muscle, so by the end we would only adopt what we could manage, so it was very important to us and we agreed as a team that infection prevention should be a priority. We got to an extent that before you see a patient your colleagues have to verify that you are well dressed because they knew once you get infected you will transmit to the others, so for that we were (??)**

F: Ok, you mentioned about having challenges in terms of resources that infection prevention measures is (??) so how readily available were the Personal Protective Equipment?

**R: Ok, I will talk much because I work in the COVID ward, what happened with the partners, we should commend that it wasn’t difficult because had it been they just left it to government then there could have been some hiccups here and there, but coming in of Welcome Trust, John Hopkins, so it made things be easy and PPE it was enough,**

F: Ok.

**R: It was readily available for the whole staff, so because of that people we started being encouraged that we can work because the resources are there.**

F: Now in terms of people’s ability to use those resources, how was it like?

**R: Yes, ability was there, yes, people were using every time and then, resources were used and the system that was brought by Welcome Trust, I think they are continuing with it, of making these gowns, that they should be washed and are recycled, it helped because we didn’t have situation when they were in short supply and people were very eager to use those resources.**

F: Alright, and looking at the increased number of COVID-19 cases again, how supportive is the infrastructural setup in managing these increased cases of Covid-19, if you look at Queen Elizabeth Central Hospital?

**R: Ok, uhh it wasn’t easy. I remember that was end of June, July up to end of August early that was very very difficult time whereby the cases were shooting like, yeah, so that time it got to the extent that at Kameza as a Quarantine Centre has been closed, so the whole Blantyre and the southern region was relying on Queens, so the ward I was working at first was only for staff; the staff means those that are within Queens campus including partners. So what happened after Kameza’s closure is that we were under big pressure because the whole Blantyre even Mwaiwathu declared that they are not handling COVID cases even Adventist Hospital said the same thing, so numbers skyrocketed. So our infrastructure was meant for only staff which is maximum to twenty,**

F: Oh, ok.

**R: yeah, it was twenty, but I think partners, I think the Queens Management they said ‘no, let’s utilise the several infrastructure’, so they came up with other beds, we opened up other beds, increasing forty. So the capacity doubled, but it was getting occupied to the capacity but the challenge was health workers now were few, because at first we were only handling staff and we did not expect that we can need a lot of staff, so finally, we thank God that the people that were there we managed the patients because that time to find another team so that we should be on shifts, it proved futile because everyone was scared and they were refusing.**

F: So, how could have it been if the cases got to numbers like 200?

**R: That could have been a big problem, by the way that time problems were there because we were few but since we were already committed to it we carried on, but if it happened that it got to 200 then the infrastructure could have been in chaos, 2: the resources could have still been insufficient,**

F: Yeah, yeah.

**R: because there could have been cases of people refusing. So to my surprise now, it turned out that the people who were mocking us, they are getting COVID right at the ward, us this side we are safe. Why? Because they were saying ‘all COVID patients are going that side, us here we are safe’, so any way it was a hard time for us.**

F: So, you mentioned about at first people were being sent at Kameza,

**R: Yes.**

F: and we heard that at first Queens did not want to admit any COVID-19 case.

**R: That is.**

F: So what happened for it to change?

**R: The thing to change is uhh, at first Queens was interested to have its screening area, and short stay ward, so that when a patient has been found they should manage him or her and later send the patient to Kameza.**

F: Kameza.

**R: So what happened was people now asked ‘if a member of staff has been infected, how are handling those cases? Will they also be sent at Kameza?’.o that’s when people said ‘no, lest do something’. If the staff is within Queens campus**

F: Yes.

**R: ‘Let’s open up a what?’**

F: A ward.

**R: A ward, so we need volunteers, so us we volunteered ourselves, the ward was designated and everything was planned, so after;**

F:

**R: I think around mid-September, then the management decided that lets now open a ward for everyone, so they opened up a ward in 3A now with the support from Welcome Trust.**

F: So looking at all that what do you think is or what do you see as the key barrier to the management to the management of Covid-19 cases, or barrier to the response of Covid-19?

**R: Ok, fine, the key barrier it might be our health system in terms of services delivery because now the health systems we don’t have the change, when new things arrive for us to swiftly change due to our system there are challenges. Our system needs to change to adapt things that are there like currently we have COVID, we need response towards COVID; of course the response was there but at slow pace yeah, whereby even the government itself how it was handling its affairs, things like closing the borders and others all that was delayed, as a result people started flocking in, even the wearing of masks had it been we started way back at the beginning, I’m not denying that we could have not registered cases but maybe they could have been few and awareness in the areas was not robust. You know what, the awareness was only done in the cities, in the villages it did not happen whilst people in remote areas people are living like a normal life. So i think the awareness is being carried out now at the end and people are surprised because the cases are reducing, so now what’s benefitting. So, we need to strategize once we have a pandemic or a disease that is affecting us let’s hastily change our system then we move on doing the other things. Another thing is what we have talked about like the resources,**

F: Were insufficient.

**R: yeah, mobilisation was few despite partners coming in but as Queens alone it was clear that there were many loopholes when it comes to resource mobilisation.**

F: So, again I would like to ask about an imaginary question if we had an increased number of COVID-19 cases. You mentioned about opening a ward specifically for the staff,

**R: Yes, yes.**

F:but eventually you kept having increased number of cases so juts imagine if the number of cases continued to increase then on the other hand the ward for staff was quite open. What would happen if you had a VIP or if a VIP who has COVID, people with high status in the society?

**R: I think I should say once they opened there was nothing like staff, they closed Kameza.**

F: Kameza.

**R: then it was like open to everyone but still it was not meeting the demand. I remember it got to the point that others who wanted VIP care, they said ‘no, what I will do is, I can’t stay here. I will go home I will just call you guys on phone you tell me what to do,**

F: Yeah, yeah.

**R: or else one of you guys will come’. Then we asked ourselves that ‘yes, of course that is they will be at their place’ but we are understaffed.**

F: Yes.

**R: ‘Should we leave the them here? Because of their status?’ They would do what they were proposing but you would hear they died, that has been happening, but talking about imaginary**

F: In reality.

**R: In reality that they are still coming, our capacity was not sufficient, let’s be honest.**

F: Do you think the provision of the care would be different between the VIP and the others?

**R: Yes, it could have been different because the workload could have been overwhelming, the staff could have been burning out therefore the care could not have been impressive, maybe had it been the cases are continuing to maybe they could have opened other wards but if you have wards and continuing to demarcate that ‘this is COVID ward, this is COVID ward, this is COVID ward’. What about the other diseases then that could have been a great predicament, but this time around that is an eye opener that this time around we need to make strategies, long term plan now. That maybe we can have a big area to demarcate mostly for COVID, I think with Cholera they know that this is rainy season lets establish a camp, so we can buy the ideas that we should have a large place even if it is out of this premises, they can make a temporarily thing that in case of COVID people should go this side.**

F: Ok.

**R: Yeah.**

F: Ok, so uhh, considering the level of preparedness that was there or maybe that was put in place for you as an individual once again and the hospital as an institution, can you please explain to me your attitude and the perceived relation of Covid-19? What did you think as the (??) of Covid-19? What did you think about it?

**R: Uhh, all the mechanisms put in place on the paper we are very good but now the implementation,**

F: Yeah.

R: **It was a challenge. They had nice strategies stipulating what to do in case of different scenarios but now when COVID was here to implement the same it difficult. For example I remember for duty bearers to authorise like drugs from the pharmacy, if you just say ‘I’m from COVID ward, I’m here to collect some medicine’ from the main pharmacy, it was discriminatory, (??) ‘why?’. ‘We will find you there, if you do not finish them do not come back with them here’.**

F: Ok.

**R: So, you can see that, yes the challenges were there on implementation even resources as I have said already without the coming in of partners, I’m telling you it was chaos; because at Queens they could provide us resources and you find that if we put them on twice then you find that they are what?**

F: Worn out.

**R: Worn out, so we were asking ourselves that ‘had it been Welcome Trust doesn’t come in, other partners doesn’t come in, then we could have stopped seeing the patients’.**

F: Ok, yeah.

**R: So to me, yes on paper the strategies were very nice, very articulated but the issue was implementation was a problem. In terms of financially when funding comes in, government politics you find that they have signed for them but for the resources to get down to us, it was taking long, so I blame the system that is it.**

F: So with all that do you feel that you are at higher risk of Covid-19 infection and how has that changed your work like the way you do your usual?

**R: Yeah, with all the things, I think we were at higher risk but...**

F: So your working environment has changed?

**R: Our working has changed, especially some few months ago, but now we are more like going back to normal as cases have now reduced; but the change is so great as every patient that I have been treating I was regarding him or her as a suspect. Up to now, I’m treating every patient as if they have COVID, why? I have seen with my own eyes how a COVID patient is like when you say he is at critical stage, so I vowed to myself that I should be taking every patient as a COVID suspect, why? Currently we have relaxed because the cases have reduced but you never know even now as the cases are dwindling you may find to be infected now.**

F: Yeah, sure and do you feel that you are sufficiently protected while working at the hospital like protected from getting Covid-19 with all measures in place?

**R: Yeah, during that time when we uhh,**

F: Either during that time or before the cases or now.

**R: Ok, before we had COVID cases (??)**

F: You felt like you are not sure?

**R: Yes, but now during the cases yes.**

F: Why do you feel more protected now?

**R: Ok, protected now because you know what? We are following infection prevention measures unlike before the cases but when we have cases now it’s when we are more serious about hand washing, everything putting all head to toe protective wear, so this time around we have learnt oh let’s do this PPE is very important, lets follow all the procedures and do all those things.**

F: Ok, now there was an issue of risk allowance.

**R: Yes.**

F: That people started demanding for risk allowance and then there is this issue of being at risk of getting Covid-19. So, what’s the relation between risk reduction and getting financial incentives so in form of risk allowance?

**R: In any pandemic, whereby people are afraid coming to work because of the pandemic, when anything is coming don’t forget people take advantage. And on our previous complaints we were not being helped when it comes to money thing, people now take advantage that this is the right time to put forward our concerns that they should be heard. So comes in to COVID risk can be reduced not only for money but once you are following what? PPE procedures you can reduce the risk of getting what? The risk of getting COVID,**

F: Yeah.

**R: so risk allowance was there because the job you are at danger that you can die anytime, so, people said no, I have to get my share, yes it has helped that health workers should be committed; the government has responded to our concerns. So it helped that people should come out but my fear is there was a duration for it. The government said ‘we are giving you this risk allowance’ back then they said three months, later they said let’s wait for two months. So the fear is if government says the cases are going down and remove the risk allowance which will create chaos.**

F: Ok.

**R: Because the chaos will be people will no longer respond to any disease, pandemic or an outbreak; they will refuse. They have to think of pull resources for the system so that it should remain as it is at the moment because truth has to be told health workers were committed responding to the illness despite the challenges that were there, because for example at Queens people were not entering the hospital anyhow even a guardian and there was a policy that a guardian should see the relatives of the patient outside the ward, which brought some sanity. This time around the environment changed due to COVID-19 and government was also saving on some things like food and it was made work easy for us. So the risk deduction for COVID is for if we follow all the precaution measures, the financial motivation was there just to encourage people that lets respond like a team.**

F: Ok, because where it is difficult to understand is before giving the risk allowance,

**R: Yes, yes.**

F: You were afraid?

**R: Yes, that’s it.**

F: But, after giving the allowances people were motivated.

**R: Yes, people were motivated.**

F: But, now should we conclude to say if you give someone like financial incentives or allowances then they no longer fear the risk of infection, Or?

**R: Yeah, ok fine. You can’t conclude in in that way, the sense is that all times people as I was saying that people or health workers use COVID-19 to respond to their grievances, ok, in terms of financially, so it was like an opportunity and when they were granted the risk allowance, they said ‘let’s go and respond to the COVID’.**

F: So now, as an individual what is the one thing that could be done to support you more at this time of the outbreak or at any future of the outbreak, what could be one thing that you want it to be done as supportive at this time of an outbreak?

**R: Ok, during the time of an outbreak.**

F: The one thing.

**R: As an individual yeah, I think if possible they have to train us. I need more knowledge based on the COVID thing, an outbreak. If we have, maybe it would not be COVID, an outbreak lets train people quickly, mobilise resources swiftly, make awareness campaigns quickly; so that when it comes to response it should be that we have all the things in our mind on how to deal with those things.**

F: Ok, let’s talk about the testing procedures, testing for COVID. What has been your experience so far with the nasal prongs, throat sore testing; what do patients say?

**R: No, I once tested because we were working at the COVID ward, I was supposed to test here and then. It wasn’t easy; it was very painful especially the nasal one.**

F: Yeah.

**R: It’s possible maybe they are conducting some research to develop a new procedure of testing.**

F: Yeah, because there are some people are proposing to use saliva.

**R: Yeah, maybe that will be ok. And sometimes because of the nasal thing people were fleeing to test but if they could come up with another modality, another procedure for testing; I think that will be working efficiently because it was very painful and you know in our setting, it is not common for people to be tested like in the nose; its irritating in one way so it wasn’t easy. But we got used because there was no any other way but I think a study should happen on other testing procedures unlike the nasal prongs, the mouth one is ok but the nasal one.**

F: Ok, uhh, Shadreck, just one last question, so what are the priority recommendations that you can make uhh to improving the level of preparedness in preparing for an epidemic for any epidemic in the near future. What could you be your recommendations?

**R: Ok, fine my recommendation would be health systems in Malawi should be looked into, when it comes to pandemic thing and the response.**

F: Yeah, yeah.

**R: Lets come to scene when there is a pandemic; we should be hasty, our decisions should be done quickly to respond, you can see in Malawi for example we heard that it is now in Sub Saharan Region but by then we had no test kit, that’s not good so once we know the diseases is on our way; let’s have our own resources available on the ground,**

F: Yeah.

**R: not at headquarters, they should be on the ground that when we have cases we should treat because we had some cases where people could exhibit signs of COVID but we didn’t have the test kits. So what do we do? We would agree to treat the person as a COVID patient which is bad for the patients because sometimes a person can be exhibiting the same signs when its pneumonia. So resources should be on the ground and I can say that awareness should not only be done in urban setting, yes of course in rural areas it was happening but not in remote areas, every individual has to be trained especially the health workers even to the remote areas, so that people should know. They should demarcate or they should designs systems from up to downwards; so that in remote areas the beneficiary should know that there is COVID, how can I do a,b,c,d. We are doing thing at the end when cases are what?**

F: Reducing.

**R: Reducing, lucky enough we didn’t record many cases but had it been we had many cases then even in the remote areas, or in our urban setting we could have had a lot of people being infected with COVID and maybe because we did conduct mass COVID testing that why we did not register many cases but my recommendation when they are planning of any pandemic, I should start from the top like the ministry and the partners should go out and spread the information so that we can impart knowledge to people.**

F: Thank you so much, this was my last question unless you have anything to add; anything you feel like to talk about.

**R: Ok, fine uhh lastly I think I just want to thank you guys for coming up with this research.**

F: Yes.

**R: I think we will share information to us so that people should act on them.**

F: Yeah, sure.

**R: Uhh, it wasn’t easy working in COVID thing, we thank God that the cases are now dwindling,**

F: Yeah.

**R: but this should not make us be relaxed because you never know that the cases maybe can also resurge.**

F: Yeah they can start rising.

**R: And let me ask that when partners when they want to come in and do their response, please the rural masses will be very important and also if possible if we can start targeting districts; centres should not only be Queens, Zomba, no, no, we can have centres**

F: In districts.

**R: in districts as well and people should be properly trained to combat this pandemic.**

F: Alright.

**R: Sure boss**

F: Alright, uhh thank you so much,