**Abbreviations:**

**F:** Facilitator

**R:** Respondent

F: First, I would like to understand your responsibilities or how your day goes like when you are at work.

**R: Ok, the first thing is we do handovers, if I’m working in the day shift then I do the handover with those working the night shift. If I’m working night shift then I have to handover to the day duty staff, from there I go to assess the patients that I will be interacting with for that day.**

F: So like I said before this study is to do with COVID-19. So at first we will discuss about clinical management of COVID-19 cases, so I would like to understand when a patient arrives at this hospital what is the pathway like?

**R: In relation to COVID-19?**

F: Yes.

**R: Ok, the first arrive at tent, at the tent they do screen, right? Then they triage and afterwards if they are exhibiting signs and symptoms of COVID-19, according with screening then they are tested for COVID-19 and if they are positive for corona-virus they are referred to COVID ward, of course it is not for every case that is referred to COVID ward it depends on the symptoms, on whether the case is mild, moderate or severe, if it is moderate to severe those are the ones that are brought to the ward, when it is mild or moderate but they do not have the signs and symptoms they are sent back home, but the most cases we receive are people with comorbidities and maybe they need hospital care maybe they are desaturating and the like.**

F: Ok.

**R: Sure.**

F: You are saying they are being sent to ward, I don’t know when did start, I would like to understand how it was way before the ward; how was it happening?

**R: Before the ward then people were just being screened and then tested but mostly the hospital was not admitting people, They were being sent to Blantyre DHO centre that is at Kameza, if someone has tested positive for COVID-19 that person was being taken to Kameza Isolation Centre by then we did not have a Covid-19 ward. Of course I think it was the paediatrics only that was first to admit but previously was none. So I think it started, because the ward that was created then it was for staff only not for everyone. I think first patient was staff who was admitted for Queens to say we have a COVID ward that was June it should be 16 or 17 June, it is when COVID patients started being admitted here at Queens.**

F: On all the strategies for a patient to be admitted to COVID ward, where do you see that the pathway is good or you think it will improve in the near future? And the reasons that make you think so?

**R: Of course, it will be hard to answer for the other wards because i have not served there but i have worked in COVID ward right? Then when they are coming from tent to get at COVID ward, they were taking the person here on a wheelchair and another person will be holding a cylinder and they would walk from that side to ENT of which to me it wasn’t ok, because some where very sick. It could have been better had it been we were using an ambulance as somewhere feeling dizzy and now ferrying that person on a wheelchair and to arrive here. To me i felt like there should be a change on that one, or maybe as right now COVID patients being kept at 3A ward but still it is not alright to get them there on a wheelchair and an ambulance cannot get there. But that time when we only had ENT it could have been better if the patients were being ferried on ambulance rather than a wheelchair. So to me I felt like that was a problem.**

F: Ok, what protocols were there on management of patients on the stages? If they were there, where developed from?

**R: On the protocols, it would be hard for me to say where they were developed from but there, there was a team that was responsible for the setup of the ward. So they developed some protocols and somewhere just adopted as time was going by. Would you remind me the question?**

F: The protocols which were being used, i should say if they were there were I would like to know the source.

**R: I remember some, the problem is you don’t know where some people are coming from and so on, but I don’t know is it Dr. XXX brought some protocols, I don’t know if they were developed by government or Welcome Trust of somewhere else, but they could just bring them and say maybe on pronation of patient’s maybe we should do it in some way, or maybe on we have brought these so that discharge or admission criteria of patients should be done in this way like the protocols would just come whilst you are taking care of the patients like when they observe a problem. Maybe on sugar monitoring and the like they would just bring the protocols, i don’t know where they sourced them from if or maybe they surfed the internet but they were just bringing us the protocols to use.**

F: Ok, but were the protocols working?

**R: Of course, I would say some were working because when they were bringing them they would not just copy and paste but they would look at our set up. I would say that some were working and some were not working as not all would work over time, right?**

F: Yeah.

**R: Sure.**

F: Ok, another thing i would like to know is access of the staff to the protocols that were there or guidelines; did they know where to find them?

**R: Before opening ENT, we had a training of course, it was on critical care training on how we were to care for patients because we anticipated that the patients who will be admitted will be the ones that are in critical condition. We had to go critical care training, of course it was just an orientation right?**

F: Umm.

**R: When we have new guidelines, it was like just explaining to us. They would explain on the new guidelines on how to use them that is to the team that is present. Then that team would impart the knowledge to other teams on what the contents of the new guidelines. I remember some day we were told about the protocol on how to adjust oxygen whether to increase or decrease. It was a certain doctor who came and called some of us who were on duty and explain to us on how it is done. Then pasting the guidelines on the walls.**

F: In your case you were present when he was explaining about the new protocol, how about others who were not present?

**R: We were explaining to them.**

F: When they come.

**R: Yes.**

F: Aha..

**R: Sure.**

F: Ok, alright. I would like also to know the strategies that were used in preparedness of COVID-19, that were used here or the ones that are expected to be used. So if you can explain to me as a health care worker how you got prepared on COVID-19 and how the hospital as an institution got prepared to deal away with COVID-19 pandemic?

**R: I would say we did prepare despite being delayed, because we started being busy when the country has already registering cases of which we should have prepared way before that. That is what lead to shortage of some materials because we didn’t prepare like face masks; which could have been a different case had it been we prepared where the hospital could have only been giving the materials needed to be used.**

F: How about now?

**R: Sometimes maybe due to resources right?**

F: Yeah.

**R: Because maybe we are a poor country that is why we always say we didn’t prepare even if we take an example of a mother, she knows she should give clothes to her baby but due to poverty she fails. But I feel that when the resources are available you don’t need to tell the person. So anyway right now the situation has improved we could see that they are able to provide us with the A95, gowns are available in the wards. Welcome Trust donated gowns to the hospital of which you can see that on PPE’s we have improved, it is better now.**

F: Ok.

**R: Sure**

F: How about on trainings or expertise on prevention or I should say infection prevention and control practices on COVID-19, how was that area fairing or how is it in that area?

**R: The thing is, at first since everybody was trained on what is COVID, prevention, IP; things like that. Everyone was told but hearing is one thing, implementing is another and implementing would be problematic sometimes. But i would say at ENT we were trying our best that we should prevent, we were barring guardians to check patients inside. It was only workers that were permitted to go inside to help patients. The guardians would only pass us whatever they want to give to the patients and we would give the patients, but still there were glitches as the people bringing food to the patients were coming from home and most use minibuses, so it’s like there was a risk of infection. Fine, they were putting on masks but you can’t guarantee that they were putting masks all the time when they are travelling to the hospital. So we are saying these are family members who are coming with food and later they would take their plates or baskets and would use minibus going home. But we had some measures put place like labelling some places like red zone, yellow zone; which meant in some places we could go without masks and others it was mandatory to put on a mask. And that was perfect to me.**

F: How about the availability of PPE’s before we started recording cases and during the period when we were recording cases, so availability of PPE’s to health care workers. Where they readily available or what difference was there?

**R: In relation to COVID ward or any ward?**

F: No, we should just say here at the hospital in general or?

**R: Ok, in general in the wards N95 were not available. You would find that they are using surgical mask, right?**

F: Hmm, hmmm.

**R: Of which sometimes, you would find that a patient is brought here and has tested positive and now if the people here are not protecting themselves then it means they are putting themselves at risk of COVID-19, from what they are doing. So to me, i would say sometimes they were unavailable of course previously in the other wards would also be hit with shortage of the same. But with the COVID-19 we were supposed to put on N95 because you are putting yourself at risk with a COVID patient. So COVID-19 ward mostly they were prioritising it, they were providing us with masks. When they are unavailable it was happening that when you report they would assess because there were people from Welcome Trust, John Hopkins like a set up right? They could help in some way maybe they would say ‘’we have them, come to collect’. But i would say the PPE’s in COVID ward was not an issue but in the wards you would find that they don’t have N95, the gowns were available but the N95 to protect themselves.**

F: How about strategies on infection prevention, its adherence. You have said you demarcated some places like red zone. Now in general, how were people adhering to infection prevention strategies like washing hands or wearing PPE’s or proper disposal of equipment?

**R: On that you would know, if I do this I would infect myself right. The disease was scary so you knew that you are going to be in contact with a COVID patient so mostly you would be conscious to protect yourself because if you are not protecting yourself then you are also putting others at risk. So we would check each other to see if everything is fine, you are wearing shield, you are wearing head gear, apron or gown that you are fully covered then you will go in there. Sometimes you would find some people who are just relaxed maybe it’s their nature. You would find that they are crossing over things that you agreed of course that happens everywhere but at most we could remind each other and correct where there is a problem but all in all we were trying our best even in disposing, we had bins you would know that when i take them off i should throw them here and afterwards a maid would come to get rid of them.**

F: If it happens that we have high numbers of Covid-19, do you think the hospital has enough support systems to manage Covid-19 cases?

**R: (..)**

F: If Covid-19 cases surge,

**R: Umm.**

F: Does the hospital have the capacity to handle the cases?

**R: I think it does not.**

F: Umhuu.

**R: I think it does not, mostly i think staff**

F: Umhuu.

**R: Maybe since capacity is thirty something so perhaps better because census would get to twenty, twenty five. That means at RHDU there are other patients, so in cases that now we have one ward the other wards are closed. I don’t know if we have high cases if they will open again but as of now with the capacity of thirty if we have high cases, but to me i would say the space is there but maybe staffing, the challenge is staff. When the cases skyrocket there is a problem of staff because people were working three nurses against 17 nurses; which the patients didn’t had guardians and they are very sick; burn out could occur because you are overworking.**

F: Now on treatment of Covid-19 patients on the same question that we should assume we have high cases that those we had a while ago, the treatment of VIP’s or those with higher social status how do you would it be? That it is we have cases of people who are VIP’s and some average citizens, do you think the treatment would be same or.

**R: When caring patients we are supposed to treat them equally despite social status of the individual but when we have many cases, those with high social status wants to have better care. But us when we are working we work depending on staff and the number of patients. But with their social status you find that they are used maybe at Mwaiwathu were there is one to one ratio, now to them they feel that they are not being cared for but in your case you are going to attend to them, but because you are overwhelmed because there has never been a case of one to one ratio treatment in public health facilities. So I would say that the care will be provided but it would depend on the number of staff available but talking from previous experience, it would be a disaster.**

F: Since you have ever worked at COVID ward.

**R: It would be a disaster; you could have patients let’s just say you have time that when we arrive in the morning, we go in at 8 o’clock. If we went in at 8 o’clock with doctors then it means we would get back there at 11 then maybe 3. Now when the cases increased it was happening that when you go in at 8 o’clock you would get out there at 1 o’clock. At 1 o’clock not that you were only attending to one patients, it means you would check the vital signs and write downs the patient’s problems. Now there were some people who were not critically sick that you are supposed to stick around, but it was that you were helping other people; now the other ones would complain to doctors that ‘nurses are not attending to us’. Not necessarily that a nurse is sitting down but she is there or he is there but he is attending to other patients. So because everyone wants to be helped, now that’s where some people were complaining not necessarily nurses are not working but because you are short staffed. So with VIP’s and a large number of people I would say eh (laughs). That would be a disaster.**

F: Now on COVID-19 and its risk to you and how Queens as a hospital prepared to deal with it or how you are prepared to deal with COVID-19. If you would explain to me you thoughts on that and the risk that you think you can contract COVID-19, so risk do you think is there?

**R: The risk is that one, we are not strict, and maybe we are out of electricity we are allowing a lot of people to continue coming here at hospital. They said currently we are not allowing visitation of patients but i wouldn’t say that is applying now. You can see that five people of the same family have been allowed to come into the hospital compound then you would see them there chatting and they are not wearing face masks though we are saying one guardian one patient, when they are done chatting there they would get inside and they would not put the mask on despite our constant reminders that people should be wearing face masks. They will be now seeing the patients in turns lying to us that I’m the guardian and now with the guardian tags, they exchange them. So to us that puts at big risk that means physical distance is being broken and these meetings we can call them social gatherings right? (??) so they gather there a large group of people, today maybe because this is lunch hour, they have gone to have their patients have meals. So they gather there not wearing face masks and they sometimes get close to us, and sometimes maybe because of work pressure we overlook that. We put on PPE’s yes, but still that puts us at risk.**

F: So how has that affected the way you execute your duties due to the Covid-19 pandemic?

**R: How has it affected my work?**

F: Umm.

**R: That’s what i have just explained.**

F: No, i mean knowing that you are at risk of contracting COVID-19.

**R: Most of the times, if you don’t have a mask you fail to go to the ward to work because you are aware that there is Covid-19 and you never know if the person you are treating has Covid-19 or not. So if you don’t have the necessities to work inside let’s say mask because previously sometimes we would not have a face mask but you would go inside and work but now with the Covid-19 you can’t go inside without a mask.**

F: So if you are working whilst wearing a face mask do you think you are protected enough to Covid-19?

**R: God is the one who protects (laughs), anyway at least when you are wearing the PPE’s you feel that you have protected yourself and you work freely comparing with when you have not. When you are working you just do your part maybe you will wear an apron, gown, gloves, you feel that you have protected yourself. The other part you know it’s not your part it’s God who takes care of that.**

F: So what is your biggest risk when you are working, which you identify as the big risk regarding COVID-19?

**R: I don’t get the question.**

F: For example, maybe that you can get infected with COVID-19 when you are at hospital or maybe when you get home being side-lined.

**R: Can infect others.**

F: Or infecting others.

**R: Yes, true. You find that you are refraining a lot maybe there would be a gathering but would just remember that you worked in COVID-19 and you would not go there. And the fear that not everybody puts on a mask in gathering especially family gatherings you find you are the only person wearing a face mask and its awkward. So turned out that socially you were affected and even here you find that after work you sometimes fear that you have got infected with COVID-19 because you were in contact with COVID-19 patients. I remember this other day it happened that we didn’t have the N95’s. I told somebody to get the N95 but i later forgot that i was not putting on N95 mask i was wearing this other mask, so i had to go in; by then the other person was not around because we were just us two. So i got surprised, i was testing a patient for vital signs, on my shield i could smell odour so i realised i was not putting on an N95 mask i was wearing a surgical mask. I tell you it was not easy to accept what happened (laughs).**

F: You thought you have got infected with COVID.

**R: I was thinking that i have got infected with COVID, now anything i would fell i was concluding that it was the illness. So we were there to help people but it wasn’t nice to health workers.**

F: There was the issue of risk allowance, what was the relationship between receiving money incentives and reduced risk to the disease?

**R: Umm.**

F: Because people were demanding that risk allowance should be revised upwards.

**R: Umm.**

F: So what is the relationship between the money incentive and reduction of risk to,

**R: COVID-19**

F: COVID-19 pandemic?

**R: that maybe we will be complaining that we will not receive risk allowance anymore.**

F: No, because some say when you receive an allowance you forget a bit about the risk because you have received money. So what do you think about the relationship on risk allowance or do you see anything? There is no change?

**R: Umm, we can say there is a relationship and we can also say there is no relationship because risk is not only COVID-19. There are so many risks we have TB, hepatitis, all those are risks that here at hospital we have but it is just that it came under spotlight due to COVID-19, of which the risks have always been there even in the society of getting COVID-19. So we could say that there is relationship or there is no relationship but still the relationship is there in some way. So right now we are demanding risk allowance because the risk has now soared as a lot of people come here at hospital and social distancing cannot work here between a patient and doctor**

**F: So do you think that if you have received the money as risk allowance the fear that was there will subside a little?**

**R: That what?**

F: The fear about risk.

**R: No, that is not true; the fear will not subside due to money. What we were receiving when we were there was like an allowance, you were assured that the money will come in but still you had the fear to enter the COVID ward. But still we had no choice but to get in there to help the patients, so the fear was not plummeting due to the fact that you will receive the money, no it is still the same on how anyone else will fear. Of course, people were saying we are entering because we are receiving money,**

F: Money.

**R: Because I remember a colleague right?**

F: Umm.

**R: It was said that when one was handling a suspect and has got infected, that person will be receiving the risk allowance, then people were interested to work there. When later it was said that only those working at treatment centre will be receiving the risk allowance someone said ‘I will never go in there again’ right? So that is why I said maybe there is a relationship because the people were interested to work because they knew they will get paid even if i get sick, it will be after I have got paid. Sure.**

F: alright, how about on testing COVID-19, what is your experience using the nasal prongs?

**R: (Laughs) It’s irritating.**

F: What can you say?

**R: It is irritating, of course people we perceive things differently but nobody ever expressed satisfaction with them, everybody complained even myself I ever got tested it was irritating.**

F: What if there is a testing procedure that uses saliva or other fluids from the body?

**R: That would be better, especially the nasal prong, the mouth one is better off but the nasal prongs is painful.**

F: Alright

**R: (Laughs)**

F: Finally I would like to get your priority recommendations, what would they be on improving the level of preparedness or putting in place strategies to deal away with the pandemic or similar pandemic in the near future what should the hospital do? What do you think is very crucial to do?

**R: I think maybe there should be a preparedness team, right? That should be concerned with pandemics that are in other countries let’s say South Africa has been hit with some strange illness then that the team should start drawing strategies before the pandemic is even close like on what should we do and what we should keep in stock. Things like that are helpful because should the pandemic get in the country then it would be easy to implement the developed strategies and trainings started when COVID was already here, of which it wasn’t right to do it that way. People were supposed to get trained even before.**

F: When it just started.

**R: The country recorded cases, that people was proper for people to learn about Covid-19. That when the pandemic is here, people have already internalised, but here we got trained when the pandemic was already here and maybe initially the training was supposed to be long but here we didn’t have all that time. And by then people were scared already because had it been the pandemic was not here then people could have gone to the training with their minds at ease as it was with Ebola. People got trained on Ebola but the disease didn’t get here in Malawi.**

F: Alright, what do you think made authorities at first to say there won’t be any admission at Queens, what do you think were the reasons behind that? And what lead them to change their mind?

**R: At first they thought the disease was very infectious right? Now here there was no space to keep the people and they say this is referral hospital, right?**

F: Yeah.

**R: Of which they don’t handle anything to do with disaster management, right? Disasters are supposed to be handled by the DHO. At first that was their explanation and later it turned out that the cases surged and the DHO boycotted the work, now that meant either the patients should continue staying there or go home. And on the other side they realised that they not supposed to manage people who are very sick, us here are the ones to handle very sick people as mostly people who were critically sick with COVID-19 happened that they had other comorbidities, of which those people were supposed to be treated at what?.**

F: Referral hospital.

**R: Central hospital, so I think they even realised that the death toll was skyrocketing because the people working there are not used treating such cases, the consultants are here at Queens. So the most crucial care was supposed to be provided at tertiary.**

F: Alright, thank you so much.

**R: (laughs) Thanks.**