**Abbreviations:**

**F:** Facilitator

**R:** Respondent

F: Uhh, so the process of this discussion, we will start with general introduction, so I would love if you can explain to me your position and the responsibilities that you have at the hospital. So how does your day look like?

**R: So on a normal day we do handovers in the morning around 8,**

F: Umhuu.

**R: and then I see patients in the morning and then normally in the afternoon I have clinics or I’m attending eminent classes,**

F: Alright, so we will go now into details of Covid-19 preparedness and management strategy that Elizabeth Central Hospital, but I have to admit we planned to conduct these interviews or to conduct these interviews actually before Covid-19, before Queens started registering Covid-19 cases. So I think I will be asking both your initial thoughts about the preparedness and the current thoughts.

**R: Ok.**

F: Yeah, so if you can just explain to me the planned pathway for managing suspected and confirmed cases of Covid-19? So from the time the patient arrives at the hospital to the time they get discharged, how does the pathway look like?

**R: The planned or what actually happened?**

F: So, I’m interested at what was planned and then later on you can share what actually happened.

**R: Alright, so what actually happened is that initially the plan was that patients will be going, when they come to Queens they will be screened, ok. And if we think they might have COVID then they will be taken to COVID tents at Queens and then if they have the sample taken in the tents. And then they will go to Kameza Isolation, ok. That was the original plan and then the plan was that we won’t have COVID patients at Queens because we thought we would manage the COVID patients at Kameza and doctors from here would just be going to Kameza and see patients at Kameza but then what happened is that we had problems getting patients from here to Kameza. So sometimes the patients come to Queens, we think they might have COVID they end up in the wards, in the Queens wards instead of going to Kameza. And sometimes as they end up in the wards and they have to wait for transport because transport was a bit of a problem.**

F: Ok.

**R: Uhh, so we kept having problems like that and also from my experience it seems there were a lot of patients dying from that side,**

F: at Kameza?

**R: at Kameza,**

F: Ok.

**R:** **so then we had to change the plan to adapt and say ok, patients that have COVID when they come to Queens they should stay in the COVID wards until they get their results,**

F: Ok.

**R: and when they get their results that’s when we will decide if they have Covid they go straight to the COVID ward. If they don’t have COVID then they can go back to the normal back way.**

F: Ok.

**R: Yes, so then that means we have both screening and triaging happening in the tents uhh, before there is a mixture between COVID patients and non-COVID patients.**

F: So from that pathway, the way you have explained. Which area worked better and why do you think?

**R: So, I think what worked better was admitting patients to Queens. One, because logistically its was easy to get the samples taken and if they are negative then they will go through the normal care pathway.**

F: Yeah, yeah.

**R: So I think what worked better was saying patients shouldn’t be managed in another unit, if they have COVID but patients should be admitted here at Queens. So logistically it made life easy for I’m sure the management team and also us the doctors and then another thing that made a big difference was then we were able to get results quickly. So they get a sample and then we have a result and we can decide in terms of the management of the patient.**

F: So, learning from that experience which area need to be improved because it seems the first plan failed and then you had to come with a second plan

**R:** **Uhh, to be improved in terms of**?

F: In terms of preparedness and like in case we have any. other future pandemics or

**R: So, from my opinion,**

F: Yeah.

**R: is that, we struggled in terms of the logistics and transport because we were not prepared; there was zero preparedness for any sort of epidemic. So one, there was no say money in reserve like for things like transport. And the unit at Kameza, it wasn’t anything fancy but at least it was there and i understand it was meant for Ebola. But, at least there was a unit somewhere that could handle emergencies.**

F: Yeah, yeah.

**R: So, I think if we were to go back and change what should have been done differently is that we could have an emergency unit around here because logistically, transport wise it’s a problem here in Malawi. So, then the Ideal will be to have a unit that is closer to Queens or maybe in Queens; like a well-structured unit that has water, because even when the tents were erected the issues with water, the issues with electricity as what happens after 6pm, so I think the main thing that could have been done different is having an emergency isolation unit here at Queens outbreak or no outbreak but we need this isolation unit.**

F: Ok,, and based on what you have just explained did Queen Elizabeth Central Hospital have any recommended protocols that were being followed at each and every stage of the pathway and if they did or if you do have how were they developed?

**R: So, the protocols were developed when the outbreak was already here, so there were several meetings happening and mostly it was Queens administration,**

F: Yeah.

**R: and I understand there were heads of department that were involved. So I think the only challenge with the protocols was that it was developed by certain individuals, it felt like they were multiple committees happening and this one would have their own protocols, the college guys would have their own protocols and then the affiliates maybe,**

F: Ok.

**R: the MLW, John Hopkins, it felt like they also had their plan. I feel like the main challenge is that there were so many committees and so many protocols happening and so execution of the protocol was a challenge because then the affiliates would say we want to do this, the college guys would say they want to do this, the ministry says we want to do this, but I think maybe if we were to go back what made things even different was when people started working together the college, the affiliates, ministry of health coming together, coming up with one thing protocol that we work all as a team that would have maybe a big difference right from the start**

F: Ok, so because you mentioned about different affiliates partner organization, they all had their own protocols.

**R: Yes.**

F: I believe Queens had its own protocol, but they all wanted to work together,

**R: Yes.**

F: towards the same patient, so were these suitable for the context, the protocols from other institution.

**R: Yeah, I think, at the end of the day the interest is the same for we want the best thing for the same patient, the difference is that it felt like the affiliates have a bit of money so they can come with protocols and execute them,**

F: Ok.

**R: the ministry felt like they have power but they didn’t put in money, so then it felt like the power play that the people who had ability to execute things didn’t have the power and the people who had power didn’t have the ability but at least at the end of the day the outcome was the same. So things started to improve when somehow they started working together.**

F: Ok, how about the levels of knowledge or access to these protocols for people who were on the ground implementing them?

**R: we would have done better than what we did,**

F: Ok.

**R: so fine it’s an outbreak so nobody prepares for it, so as far as knowledge is concerned it felt like because of the same thing I said different committees**

F: Yeah, yeah

**R: came with protocols and then there was confusion because say the government had their own recommendations and protocols and the college, so it brought confusion you don’t know even those that had access to the protocols they didn’t know which ones to follow, ok?**

F: Yeah.

**R: and to be honest, it didn’t feel like the protocols were spread to the people on the ground. They were made on paper but maybe we could have done better in terms of making sure that they are accessible. I don’t think they were accessible.**

F: Ok, alright, so the next set of questions is on preparation and the response strategy, so if you can explain to me how prepared you were as an individual or you are as an individual, and the hospital at large to respond to a high number of Covid cases? If we had high numbers of COVID (laughs)

**R: Uhh, as an institution there was a plan that would start with ward ENT, if there is an overflow of patients we could open up our thermology unit. If there is an overflow we open 3B, so yes there was a plan a well laid out plan but that was well in the middle of the crisis as an individual I didn’t really have a plan I was just taking each day as it comes. Yeah, I didn’t had any plan .**

F: But didn’t you feel like you had sufficient knowledge and skills in terms of infection prevention.

**R: At the beginning I didn’t.**

F: Ok.

**R: I didn’t and that’s what got us scared and then eventually when we got the knowledge like how to use the PPE appropriately and all these infection prevention and understanding the disease then I felt ready,**

F: Ok.

**R: Yeah, so I think it took a bit of time like there were trainings that were organized I think by ministry of health when the training came in and I got equipped, knowledge wise. That’s when I was able to confidently say I think I can see a COVID-19 patient,**

F: Ok.

**R: but at the beginning without any knowledge I did not had any plan, it felt too risky even coming to work.**

F: Yeah sure, ok, and in terms of the institution making availability of the PPEs, were they available like both pre and after we had some few cases? I think you can take the call if it’s important.

**R: Uhh, no.**

F: Alright.

**R: Uhh, provision of PPE to be honest it was frustrating and disappointing because we were actually had to do a certain dos even if we didn’t have PPE. On paper we were told that we have PPE but access was difficult. They will tell you that every ward has PPE but when you go to the ward, you don’t have it, ok. So for the affiliates to be honest they did a good job, like they offered tents, they offered PPE’s, offered teaching but as far as the ministry is concerned I felt a bit let down. I felt like we didn’t prepare and there was so many politics involved because even when people had the sit-in, there were threats that were being made instead of sitting down with people and reasoning with them. So yeah mean, the bright side was that there affiliates to bail us out and they were not involved in the politics.**

F: Ok, now with the support that was there from the affiliates, we are also interested to know how the staff were using the PPEs, so if we are trying to compare before we had cases and at the moment or during the time that we had some cases. How do you look at the use of the PPEs by the staff or any prevention measures, if they are followed?

**P: Before we had COVID, it was quite difficult to get hold of PPE, yeah it was quite difficult, like even in the wards there was a few functional sinks, we didn’t have gowns most of the times. So then PPE started coming in but at that point there was some PPE’s coming in but knowledge was not there. So, i felt like there was then an abuse of PPE because we didn’t know which ones to use as when to use the correct ones N95, and when to use a simple AP1 (speaks on phone)**

F: Again on the increased number of cases of COVID-19, let’s suppose we had more cases of Covid-19, do you think the hospital had the capacity in terms of the human resource or in terms of other resources to manage the cases?

**R: I don’t think the hospital would have managed uhh even two months of high number of cases, so 1: the PPE that we had had to be rationed because it wasn’t enough and 2: we didn’t have the human resources because the second percentage I don’t know how much but that is contributed by students, because we have limited number of nurses and they have the nursing students and medical students and they help do some of the jobs. And then there other institutions like nursing schools, so these help quite a lot. When there was COVID they withdraw their students for safety, so then there were limited number of people on the ground. And then there were people who were on upkeep who were also withdrawn because they were given very little money, so they didn’t think it was worthy it coming to work when they were making very little amount of money. So it was just a matter of time before the system was overwhelmed but I’m sure even if we had 100 cases plus at any point we could have been overwhelmed because we didn’t have the capacity to manage those large number of cases.**

F: Alright, so another section is on perspectives of health care workers on rationing care, so this is an imaginary section. So in the event of the epidemic measures such as reverse triage, so this is whereby you look at patients who had cases of large numbers of COVID-19 cases. How can we ration care, how can we manage the reverse triage? Making sure that those who get better they get discharged so.

**R: Reverse triage, you say?**

F: Yeah, reverse triage.

**R: Ok.**

F: So, this is like you know the triage that happen in the hospital, you prioritise those who are very sick. So this is reverse triage in cases we have large numbers of COVID cases

**R: So you are focusing on the ones we can save?**

F: Yes, and then at the same time having in mind rationing the care,

**R: Yes.**

F: So if we would like to explore your perception around the potential need to ration care assuming we had this large numbers of COVID-19 cases. What do you perceive happening in real world at Queens?

**R: At Queens?**

F: Yeah.

**R: Uhh, if that happened, that we have so many patients and then you are trying to explore the idea of uhh**

F: How do you ration the care and then to make sure that those who get better go home like in as quick as possible so that everyone can?

**R: Uhh, that one is tricky, it is tricky in the sense that from human point of view, from doctor point of view. I would want to allocate resources to the patients I can save, so I mean children, these maybe people as in young people like in their twenties in their thirties we can save and you will think they will go back and contribute to the society. So, I’m for the idea of putting resources where they will bring the most outcome; save the most number of people, ok?**

F: Yeah.

**R: As opposed to having, giving everyone the same resource even if it means some will die regardless of what you do.**

F: Yeah.

**R: But then the problem comes in when this one who is sick is a family member, now this is the human point of view, if this one is like my mother or my professor, I would want them to get treatment.**

F: Yeah, that’s true.

**R: But from the epidemiological point of view or from a doctor point of view, I’m of the idea of focusing resources on people you can save.**

F: Ok.

**R: Yes.**

F: And now how about, could this be different in terms of if you have VIP patients or those who have social status in the society in this context?

**R: So for me, I’m not really for the VIP idea, because 1: most of these people who are in coats VIP feel like they have won the power to change things and two, they have the resources, financial resources to make things better but they didn’t. So I do not think that anybody deserves VIP treatment, I think at the end of the day it’s about rationing care to people who are likely to recover and who will contribute more to the society**

F: Ok, alright, uhh in terms of attitudes towards COVID-19 and perception of risk, I think mainly it’s about uhh the protection to you as an individual and also protecting others. So uhh if you can explain to me your attitude and perceived risks to COVID-19 infection has your work changed due to COVID-19?

**R: So, risk to be fair at the beginning, I was very scared even to work even to come to work.**

F: Yeah.

**R: You would knock off and go home and you are scared, I mean you have a sore throat you are worried. So yes, I perceived that I was was in serious danger everyday I came to work and saw patients with COVID, but with time especially when knowledge came in and I knew that if you use PPE correctly then it should be fine. So then I still knew that I’m at risk but then my perception towards that risk changed because I knew if I wear my PPE correctly then I should be safe.**

F: Ok.

**R:** **So then my perception changed I think the main thing that made a difference was the fact knowledge and a bit of understand of the disease changed,**

F: Ok.

**R: that’s when I thought like maybe chances of dying are quite low but even up to now I still understand that I’m at risk.**

F: Do you feel like that you had some concerns in terms of being at risk?

**R: Yes.**

F: And how were they addressed if for example?

**R: I had concerns that I’m at risk, uhh so the first part was because there was no PPE, so then we got PPE. And then the second part came in, in the sense that everyone was staying home, so they don’t catch Covid, for us we felt like we were being obliged to work and therefore the risk felt like we wanted to be compensated for the sort of the risk we were putting ourselves on, because it felt like they called it like essential workers where you still have to go to work put your lives at extra risk for no extra compensation.**

F: Ok.

**R: So I think that’s the one thing that I felt like I was never sorted, I felt like it was never addressed, yeah.**

F: And it’s good you mentioned about the compensation and I think earlier on you also mentioned that you had a group of students and other workers that were asking for risk allowance.

**R: Yes.**

F: Do you think there is a relationship between financial incentives and the feeling of reduced risk, or any risk reduction?

**R: So, oh so as in financial incentives and feeling that there is reduced risk?**

F: Yeah.

**R: No, so in my mind,**

F: Yeah.

**R: I don’t think those compensated financially then faces reduced risk.**

F: Yeah, yeah.

**R: What that matters is, I think the financial compensation was in a way is about feeling appreciated,**

F: Umhuu.

**R: and knowing that someone understands your risk and feels you need to be compensated.**

F: Yeah.

**R: I will give you an example of people who clean in the COVID ward, so their risk is the same as us and maybe sometimes more than us, but the sort of compensation they get as in their salary is quite low, now when COVID came even in the minibuses fares went up but these people were expected everyday to come to work. They don’t have cars like maybe doctors,**

F: Yeah.

**R: so at that point I felt like these people needed to be rewarded, ok, because they went an extra mile still going to work even when they have to pay maybe two, three times what they were paying. So my perception was fine, maybe for us it would just be job satisfaction but there were people who really needed the compensation, yeah.**

F: Yeah sure, ok, just some few questions on the testing procedures; testing for COVID-19, uhh this is for health care workers and for patients in general, what has been your experience so far with the nasal prongs or nasal (??)?

**R: Oh, the actual testing procedure or the system?**

F: Like, the actual testing procedures, so we are interested to know what patients say or what do I mean what is your experience with that process or procedure?

**R: Uhh, for me I felt it was uncomfortable, but considering the risk of COVID and not knowing whether you have COVID or not I think it was worth it. So it was uncomfortable but I wouldn’t really complain for most of our patients I feel like they didn’t really complain much because there are several factors.**

F: Yeah.

**R: One, the doctor-patient relationship here is like power-play where a clinician is high up there and a doctor is down here, so it’s like we are doing them a favour we don’t usually complain even when things are not comfortable which is not good, but such is the case.**

F: Umhuu.

**R: So to be honest my interaction with patients who has tested for COVID I never had anyone who complained about the test being uncomfortable,.**

F: Ok, because there was a suggestion or proposal about using other testing means, so for example using saliva, so what’s your views on that one?

**R: So. (laughs).**

F: If somebody comes and say ok, lets now start using saliva to test for COVID-19

**R: If I knew that the sensitivity are specifically the same, then I would go for saliva any day,**

F: Because? (Laughs)

**R: (laughs) it is uncomfortable like I said, so yes, if there was something as less evasive as saliva, urine just comes out and it won’t cause any sort of pain that would be perfect,**

F: Ok.

**R: but then well, maybe its understanding that we don’t have other options that made me not complain much but a less evasive test would have been nice**

F: Nice, ok. Alright, just to finish up; what are the priority recommendation in improving level of preparedness and the strategies for responding to COVID-19 that you may think of?

**R: Priority recommendations**

F: Yeah.

**R: in what?**

F: In the preparedness or strategies for management of COVID-19 cases, so this is like in case we have increased number of COVID-19 cases or any other future epidemic.,

**R: Ok, so for me what I think, my number one recommendation is that we can’t afford to have people working in clusters,**

F: Yeah.

**R: ministry, affiliates, College of Medicine, Health Sciences because I felt like that what brought like a lot of confusion. So it’s a sort of synergy between these teams to work together, so nobody should say we have the power, we make the final decision**

F: Yeah, yeah.

**R: or if you want to help us just give us the money but we make the final decision. I don’t think it should work like that, so my number one recommendation would be when it comes to coordinating outbreaks or emergencies even another COVID outbreak there should be equal representation by all these stakeholders and if a decision is made by this team that is equally represented then it would be easy to triple down because everyone will look up to their boss.**

F: Yeah.

**R: ok, so we do not just say the ministry of health has said this but say the big guys at ministry of health, the big guys at college, big guys at affiliate organizations they make the same decision and then everyone takes the same message to their people that would make a lot of sense. So I feel like when it comes to management of these disasters, outbreaks or even Covid comes back I feel like the coordination, the decision should not be made by one cluster because they have got power or one cluster because they have got the money,**

F: Yeah.

**R: but they should work hand in hand and then from there share the same message because at the end of the day if you about it think we didn’t get new people coming in to help and then it was the very same people on the ground who just worked different and saved a lot of lives. It was the same resources, the same organisations, the same (??) that worked together, so i think number one thing is decisions should not be made by one side but they should be made by people from both sides, with equal representation and equal say in decision making.**

F: Ok, any other additional issues that you may have on COVID19 preparedness?

R: **(laughs) and then the other thing is, still on the compensation.**

F: Yeah.

**R: I feel like the way they structured the compensation was not good. 1;, they said uhh, allowances will be given to people in the COVID ward, ok, now what that means is if you work in the COVID ward then you get this significant amount of money but then there is patient attendant who is working in ATC, who also gets to see a patient who ends up having COVID.**

F: Yeah, yeah.

**R: So, then at some point then it was bringing division because everyone wanted to go work in the COVID ward and ignore their sort of normal work. And there are some people who worked on patients who had COVID, but were never compensated, ok. So, like a good number of them in the wards i remember like in ATC, I know of patient attendants who got COVID but never got any money because they are not in the actual COVID ward but they saw COVID patients. So, my ,and then the money that was given to COVID ward we only give it to people who work for ministry of health not who work for this, not for people who work for MLW, not for people who work for WHO, not for people who work for COM, John Hopkins so then that was also bringing some division and also there were making, I don’t how much, there were making significant amount of money, I don’t know if the government would sustain that for five months, eventually I know they are going for a lot of money and then they are going to get in deep trouble.**

F: Yeah, yeah.

**R: If I were the one in charge, this is a big if, if I were the one in charge if people when people were asking for risk allowance I felt they were going to say distribute fairly among all these people like everyone who is still providing care during that time because there are drivers who are carrying patients, but they are not in COVID ward and I feel like they deserve some sort of compensation. So if they just said ok, maybe there’s going to be this addition for everyone so then we know 1: they are appreciate the people who are still working during an outbreak.**

F: Yeah.

**R: And also there isn’t any division to say why is this one getting more when the risk is the same,**

F: Yeah, yeah.

**R: ok because it is one of those things, I remember there was a time there was blood on the floor the COVID ward a nurse was asking a maid to come and clean, ok so she was like, you know, she said in passing, I don’t know if the nurse heard but she implied that the risk is the same and I’m being exposed to more, then some are going to make more money from this which made sense. So, I feel like this whole thing of just saying we are going to give people this amount of money 1; it is not sustainable we don’t know how long COVID is going to last, and 2: knowing government will eventually is going to start bringing confusion. So maybe, when a time there sit-in the people from all cadres, they could just give anyone the same sort of allowance, know this one is a doctor should get ten times than this one while the risk is the same, I felt like if it were me. I would want, if the risk is the same; people should get the same sort of allowance regardless of their salary their salary can stay the same, but these are extraordinary times.**

F: Yeah.

**R: Yeah.**

F: Thanks so much, this is the end of our discussion.