**Abbreviations:**

**F:** Facilitator

**R:** Respondent

I: So, as I said the idea is to learn from health care workers their experience during the COVID-19. **S**o, talking about covid-19 patient uhh during this period how has your work been related patients or have you worked in covid wards at some points?

**R: So yes uhh our department internal medicine was I would say was the whole department that was responsible for all covid-19 patients admitted to Queens, so during the initial period when the pandemic had just started when we started seeing cases uhh we were admitting our severe covid-19 patients in ENT that was one of the wards that was designated then to accommodate the covid-19 patients, so as a department we were actually in fore front because that was like our slow progress to cover covid patients. So since the pandemic started I would say that we had to make a few adjustments because from the normal routines that I have said now we had to include covid patients from that (??), so our schedules actually had to adjust because we then had to cover our normal wards and we had to cover covid patients as well so yes that was incorporated on our Rotas depending on where you were so you would either have to do your ward your normal ward and then you had to see the covid patients as well like right now we still have covid patients, and right now I’m in the covid ward so my day actually starts with seeing patients that are there,**

I: Yeah.

**R: and then I have to go and see my patients in the ward (??)**

I: Ok.

**R: so it was quite an adjustment since it was we had more patients to see apart from the normal duties that we had, we had more.**

I: More patients now that might be one of the changes that has happened because of COVID.

**R: Yes that was one of the changes and I think we also talk of how our wards were carrying out issues, previously I think we never used to wash hands as so often as we do now, we never used to wear all those personal preventive clothes that we wear now, so I would say that was another change that we actually noticed.**

I: Yeah

**R: On admissions in our wards, I wouldn’t say that admissions had changed,**

I: Umm.

**R: we actually saw the same numbers actually**

F: Same numbers.

**R:** **we even saw more because during this pandemic period we had stopped seeing our patients in the clinics for some time because we had closed because we were actually (??) expose our patients even ourselves as health care workers so since most of the patients weren’t attending clinics they ended coming up whilst they were ill so we actually even saw that we had a lot more admissions then so yeah we still had a lot more to do in the wards (??).**

I: Ok, so that’s one question I wanted to ask you later but I think because you have raised out we will talk about it here that in cases of such epidemics there’s normally required that or recommended that you do reverse triage or you see very few patients only those that are very sick,

**R: Yes.**

I: and as you said you closed some of the clinics, did you see that working in our local context?

**R: So I would say that uhh, by closing the clinics yes it worked because patients were not showing up,**

I: Ok.

**R: at the clinics but these are clinics like BP clinic, hypertension clinic, that usually they are chronic patients they need our support, they need drug refills and all that, so I guess most of the patients were still coming to the clinic for drug refills, when they are supposed to get drug refills they are supposed to have documentations on whether a nurse or a doctor in the clinic to write for them so that they can get refills from the pharmacy,**

I: Ok.

**R: so most of them who would actually come in maybe they would have high BPs or they would have high sugars so the nurse wouldn’t actually do all that so we ended up seeing those patients in the accidents and emergency departments rather than in the clinics because the nurses ended up referring. So yes to some extent it worked for the stable patients but for the patients who had uncontrolled sugars and BPs I think we still saw them, and I thing during this period we also saw a lot of complications like in terms of stroke and diabetes as I said admissions had increased not that I have the data but since I actually see the wards every day, we actually noted that we get to see a lot of stroke patients cause my feeling is since we ended closing up hypertension clinics that was one of the effects that we actually anticipated,**

I: So they came in mostly as emergencies.

**R: as emergencies and at the end of the day we still had to admit them in our wards.**

I: Ok, alright. Are you able to explain to me as a hospital the pathway that was put in place or was there for covid patients?

**R: Ok, so as a hospital one of the measures that they took was to screen people right at the gate, so for staff coming in as well as patients, so if you are coming in say on a vehicle you were screened whilst in the vehicle right at the gate while patients they were required to bypass and go through the tents, so in the tents usually they would screen they would ask for the common symptoms that covid patients have fevers, coughs and exposure to any confirmed case or suspected case. If at all they think the patient has symptoms that are suspicious of covid-19 they would take a sample and actually hold the patient in the tent before sending them to ATC. So the clinic patients as well they would screen if the patient has no symptoms that means they were going to go in,**

I: Ok.

**R: but if the patient they that feel the patient has symptoms maybe the patient has symptoms that I have mentioned then they will hold them in the tent. So once they find that they have a positive result then the patient don’t have to go through ATC it means they have to go straight if they are very severe they have need an admission whether they will go to ENT or 3A, if the patient is not very severe then I guess the DHO would actually take over and try and do all the surveillance that they usually do to take care of the patient but for us since we dealing with the severe cases then they would go straight to the ward.**

I: To the ward.

**R: So everyone was screened before coming into the hospital. In our wards as well since sometimes they would miss patients after screening, uhh it happens and sometimes we would have results that were actually were confirmed negative right in the admission but still with the presentation of the patient in the ward sometimes we would have our doubts and think that maybe something is missed,**

I: Yeah.

**R: tests were repeated in the wards as well. If the patient now is found to have COVID in the ward we had quite a few number of cases that a patient is already on the bed and now is confirmed uhh that they have COVID.**

I: So that’s in 3B?

**R: In 3B and in 4A whereby the patient is in 4A (??) whereby the patient is on normal bed beside other patients is screened,**

F: And has been confirmed.

**R: and is confirmed that they have COVID and we transfer them. So earlier on just as the pandemic started, before we started admitting patients at Queens at ENT and uhh 3A, patients would go to Kameza so then that made us create an isolation ward right in the ward so that once we had either a suspected case or a confirmed case we would actually transfer them into isolation whilst they either waiting for transportation to Kameza or afterwards after we had opened ENT and 3A then we would transfer them to the designated wards.**

I: Ok, if you look at that pathway, what do you think worked, was working and what areas do you think needs improvement?

**R: Alright so what was working basically is that at least we never missed most of the patients as I said earlier on it was hard because before the screening started that’s when we could get those cases in the wards,**

I: Yeah.

**R: but after the screening had started we would only get maybe confirmed cases that were we say false negatives and then we will redo the testing and get the positive so atleast most of the patients and most of the people that were coming into the hospital were screened and uhh I think earlier on uhh it also tried to control traffic at the end of the day because Queens is the only admitting hospital in Blantyre, free hospital that is,**

I: Yes.

**R: so for us we were trying to reduce admissions as much it possible and to reduce traffic in the hospital as much as possible. So with the screening it still helped somehow,**

I: Yeah.

**R: because some the severe cases were actually sent to some of the health centres for management so atleast that worked, but I will say that the system was failing mostly on the lab part,**

I: Ok.

**R: because it would take ages at first to get the results, so if you would have patients staying in the tents for longer period patients who are severe maybe they need medical attention, and they spent time in the tents 48 hours and then the tests come back negative and the patient is already,**

I: Deteriorating.

**R: deteriorating uhh so that was one of the setbacks for the system that they had made available the screening system at the tents I think that’s the major short fall as well as missing out some cases and I’m thinking that one of the major shortfalls was control of guardians**

I: Umhuu.

**R: but I think they had been trying to control traffic in terms of who comes in to see patients but you still find that all those community groups, the church,**

I: (Laughs)

**R: religious people, communities,**

I: They still want to come in.

**R: they still want to come in and see their patient so it was still challenging because those people you would still meet them in the corridors of the hospitals coming to see patients and moving around, so somehow it worked but I think we still failed mostly on the part of guardians,**

I: Yeah.

**R: and even in the wards uhh bed space was still the same there was no distance in our beds so nothing much really changed a part from the fact that the patient were screened right at the entrance.**

I: Ok, so those are the normal wards, the other wards spacing was still,

**R: Yes but for the COVID wards that’s where we tried (??)**

I: Ok, were there particular protocols for treating patients with covid that the hospital developed and used especially for wards.

**R: Yes, so I think we had reviewed uhh papers written on management for severe covid patients,**

I: Yeah.

**R: from different countries, the countries that had experienced it first,**

I: Sure,

**R: so here I think for the first patient that we had admitted we actually tried and followed those guidelines so it set as a set point for us a learning point to get an idea of how we can manage them what works and what doesn’t work so at the end of the day soon after we had managed that first patient we actually had uhh guidelines uniform guidelines that we that we used (??) covid patients that we had ofcourse patients are different,**

I: Sure.

**R: So even though we had guidelines we made adjustments for individual patients depending on what they presented but for a normal covid patient without other morbidities we actually had considered then we use those guidelines that were set in managing patients.**

I: But how do you look at, as you have said maybe based on papers or experience from other countries but how did you look at applicability of those guidelines and protocols in our local context?

**R: So in our local context for Queens it worked because our guidelines were (??) because other countries were ventilating patients haven’t (??) a severe patient who need ventilation they were done in other countries,**

I: Yeah.

**R: but for Queens we said we are not doing that basing on the fact that 1: we only have 4 ventilators the hospital is quite big (??) whole of the southern region so if we were to say we will be ventilating all covid patients it means we would fail in managing other cases, so for us ventilation was a no go, for us what we managed to do was provide oxygen high oxygen flow luckily enough I think MLW had assisted us with an oxygen plant so that made it easier for us because the wards that used to manage uhh the covid patients both ENT and 3A they had oxygen plant installed so it was easy,**

I: Ok.

**R: we could get up to 150Litres of oxygen for our patients, for Queens that was an easy thing to do even in terms of medication because we use uhh antibiotics heparin and dexamethasone of course on the heparin side as a hospital we were also on the lower side of supply but with support from MLW I think some of the consultants assisted in supplying us with the heparin so most of the patients were actually managed during this time when the protocols had been set we managed to do most of what we were required to do for them as a hospital.**

I: Yeah.

**R: But I’m not sure how other districts managed because as I’m saying for Queens we were actually lucky that this time around MLW had (??)**

I: (??)

**R: so for most of the districts even here before that we would use oxygen cylinders which usually run out fast and if you look at the concentrators we only got about 5Litres it’s only the cylinder, the plant that can go to 50 Litres of which most of the districts that I’ve been to we usually have concentrators in other districts hospital maybe with 5 concentrators, and maybe the O2 cylinders are only available in theatre so my thinking would be they were highly incapacitated maybe ventilation and the heparin as I'm saying if Queens would have a shortage of heparin I’m not sure how the other hospitals were dealing with that, but for dexamethasone and (??) they are readily available both in districts, health centres as well as central hospital. So I think our main challenge is the (??) as well as the ventilation part.**

I: So basically what you are saying is in adapting those guidelines you made sure that you considered what would be applicable and suitable in our,

**R: Yes, yes.**

I: in our context.

**R: Umm.**

I: Alright, but how did you, have you seen, you’ve already said that patients differ but how have you seen your fellow health workers abiding and making sure they understand and use those protocols?

**R: So uhh I think since for the people, who worked in the covid ward,**

I: Umm.

**R: initially they were overwhelmed we had several departments but what was actually emphasized was of cause as I said earlier on that covid-19 is (??) is a medical disease,**

F: Ok.

**R: of which it was supposed to be managed by the internal medicine department but then looking at the pandemic and staff shortage that we usually encounter we had discussed that actually not just anesthesia and medicine should manage them other departments were incorporated,**

I: Ok.

**R: but what was actually emphasized was that apart from we would have a roaster whether maybe we would have a consultant from (??) or one from obs and gynae (??) but still they had to be someone from medicine to cover or to see and actually try and assist if the other departments had issues.**

I: Ok.

**R: So we would actually have atleast a medical registrar or a medical consultant on each day.**

I: and every day.

**R: available to cover, so for us we had already been oriented with the guidelines we knew actually what to do so for most of the patients even with different consultants from the same department the only difference that was made as I’m saying is maybe the patient had maybe the patient produced factors that would actually put at a risk of developing say pulmonary (??), if the only difference would be maybe on the dosage of medication that maybe someone attends to this patient is actually at more risk let’s have (??), or let’s reduce the risk but apart from that we all knew that if we are giving (??) then it has to be for seven days if we are giving dexamethasone whilst the patient is in the hospital then we have to go this far when the patient is still sick then we continue and so on and so forth. So at least we were ensured that there was uniformity in managing such cases plus we would also have meetings departmental meetings where we would do so (??) so there will still be ongoing discussions if people noted that maybe there were loopholes or scenarios where patients weren’t managed accordingly then we would have a discussion on how to move forward and do things in the right way.**

I: So there was senior support throughout the process.

**R: Yes, yes.**

I: Ok, in terms of preparing to respond to covid-19 what are some of the measures that the hospital had put in place in preparation for covid-19?

**R: So my thinking in terms of preparation, I wouldn’t say much coz I’m not in the hospital management team but what I’ve observed in terms of preparation I think basically it was on infrastructure because initially as you know we don’t have any ward that is said designated or kept for say pandemics or special outbreaks we don’t have that at Queens so I think it was a matter of management discussing which wards to actually set aside and reserve as possible wards for covid patients, so as I mentioned we used ENT, so initially the hospital had actually transferred out all patients in ENT and the ENT theatre is actually restructured to accommodate uhh covid-19 patients as well as 3A, 3A is usually a ward that was used for TB patients and in 3A we have HDRU which is basically for medical respiratory patients and other severe patients but we had to actually withhold those admissions and reserve it for covid patients so in terms of the infrastructure that was well covered. In terms of human resource I would say that was a bit of a short fall because as I said uhh it was still the same people on the ground,**

I: Yeah.

**R: so there were no readjustments that were made even in hiring new staff I think you might have already heard health care workers sitting in and doing all sorts of stuff because even initially the PPE that was available initially wasn’t adequate, so I think it was right after now that people had actually staged (??) then PPE became available but in terms of staff working like on the medical officer the clinician side I don’t know about nurses but on the clinician side I would say that there was still a bit of a short fall even in the financing department I still note that it still wasn’t adequate as we would want it to be the only thing is that yes it worked for us but I still feel that was one of the problems even I think preparation in terms of medication for the heparin that we actually were using. Uhh I would still think that there was little that was done,**

I: Ok.

**R: in trying to purchase it for the hospital for some of the patients that we actually encountered and other issues I think maybe in terms of resources.**

I: Sorry maybe before you go to the resources so were there times when the hospital could run out on medications?

**R: So not necessarily run out, run out yes maybe in our pharmacy,**

I: Yes.

**R: but as I said since we have a lot of partners within,**

I: Sure

**R: then yes the hospital could run out of medication**

I: Yes

**R: the partners would come in**

I: Come and support.

**R: (??) until we get the drugs and then later on we would pick up to the extent where we (??)**

I: Ok, and talking about resources.

**R: Yes on the resources I was actually I wanted to emphasize on other on basically things that can enable us to investigate, covid is a respiratory disease respiratory disease (??) So initially I think as Queens the only trailer we have is the one that everyone uses so we couldn’t actually (??) our covid patients (??) I think it still had to take our partners as well to come in to bring in a mobile respirator which was used in one of the wards which was ENT.**

I: Ok.

**R: so even right at the beginning for you to get samples to the lab you still had to go through a bit of issues which show that we still weren’t really prepared on that part as to how we will be managing such parents so I think those are some of the issues that weren’t really done well apart from the fact that maybe on the infrastructure side the ward was allocated, yeah.**

I: Ok, you earlier talked about trainings that were also (??) as staff attended training,

**R: Umm.**

I: if you look at the way trainings were structured and the content that was delivered is there anything that you would recommend for improvement in the delivery of those trainings to all staff in preparation for covid?

**R: So I think for starters those trainings even for the trainings I wouldn’t say there were actually prepared in the right way because if they were done right after the people the staff from Queens had actually done the sit in because they said no covid patients will be coming in but we haven’t been trained so that’s when I think the hospital administration rushed in to,**

I: Prepare the trainings.

**R: prepare the trainings, the trainings yes, so I guess the trainings, uhh since the trainings were basically capturing everyone, nurses, clinicians so I still thought that if at all we recovered after the pandemic things could be done differently cause clinicians and nurses yes at the end of the day you are going to do uniform things in managing patients but there’s still other things that one cadre has,**

I: Cannot to do.

**R: has to learn more about and then the other ones can’t actually do, so for the content of training it was yes relevant but I still think that they should have divided at some points ‘kuti’ to say this is only for clinicians, and this is just for the nursing team the content for us clinicians it was good,**

I: It was good.

**R: but you would had some other cadres complaining that no this is not actually for this is for clinicians, so you may end up over loading (??) they don’t (??) at the end of the day, the duration because it had to take us asking for the training when it should have been done as soon as the pandemic actually started,**

I: Started.

**R: yes,**

I: So these were the trainings that combined you in.

**R: so they combined us and I think, they had to combine us since it was also done I think since it was done I think since it was done promptly uhh they ended up putting a lot people to say at the same day so some people had to leave trainings to go and cover wards and all that cause it was a bit hard you can’t leave patients,**

I: And trainings.

**R: and the trainings so you could actually miss other stuff,**

I: Yeah.

**R: so I guess that’s one of the other things that maybe they will be people have to take into consideration (??) in case there’s another outbreak.**

I: Alright, you briefly talked about PPE but what is you view about availability of PPE in the hospital during this period?

**R: Uhh so during this period for our department I would say that we had adequate,**

I: You had?

**R: adequate,**

I: Ok.

**R: both in the covid wards, ENT, even in the normal wards I can say we had adequate PPE gloves, masks, face fields and everything, so I would say that on the PPE side I think basically because of the I think it’s (??) the gowns that they have been washing right at laundry place, they have been supplying them consistently so you will never come to a point where you have run out of them mostly in the covid wards, supply of PPE has been consistent.**

I: Yeah, so you are talking about covid wards that,

**R: even in the main wards,**

I: even in the main.

**R: Yes.**

I: Ok because there’s other people that have complained that I think the focus was only on the covid ward

**R: No.**

I: neglecting that the other cases were found in other wards.

**R: So what was done was, as I said in the hospital we have different cadres we have nurses we have clinicians, for us clinicians gowns were there for everyone they were at the common side,**

F: Ok.

**R: nurses clinicians could access gowns there, we are the ones (??) supplies in terms of masks and shields, for us masks we would actually (??) so clinicians we would have our departmental head to get masks for us so that everyone going to the ward you should get a mask,**

I: To get a mask.

**R: for the nurses as well the matron could actually supply them adequate masks for that day just to make sure that people are you know some people were actually getting masks for their family members and what have you,**

I: That’s true.

**R: so to prevent that the matron would actually hand out masks to individuals to say this is what you should use for this week. So for masks I think on our part if someone complained that I’m not sure ‘kuti mwina for them’ to say maybe for them the masks were a bit hard but for us this side I can say that it worked cause even for the shields each one of us was supplied with a shield that you should keep it and at the end of the day you going clean it you can even leave it in for sterilization so that you can have it the next day.**

I: Ok, you talked about procedures for infection prevention like washing hands and the like that seem to be newly introduced because there has never been,

**R: They never emphasized.**

I: they never emphasized on that.

**R: Yes.**

I: but how did you look at health care workers abiding to those procedures during this pandemic period?

**R: Well for those that I actually had a chance to work with I would say people were abiding to that coz then you would have your sanitizer say alcohol or spirit when doing your rounds you can have your gloves such that when you are actually examining patient to say with one pair of gloves you would actually sterilize your hands with spirit and you get clean hands for the next patient, I think it was initially you were supposed to do that for each patient infection prevention for both you and the patient,**

I: That’s true

**R: but this time around I think what inspired most people was protecting themselves so it was not,**

I: Than the patient (Laughs)

**R: about you and the patient so you ended up washing hands not that because you are not afraid that you are going to pass the infection from this patient to this patient but because you are thinking oh I need to wash hands at first so still though the reason wasn’t very good but it helped because for that the people I worked with I noted that, that actually worked, I think during this period we have seen it in the wards as well the hospital took an initiative to prepare (??) so yes people were washing hands we actually (??) placed soaps liquid base soaps in most of the stations so even right before you enter the ward you had a bucket and water so where you change your gowns you had water as well so it’s like everywhere you go you had water and soap now it’s easy.**

I: Ok, alright if you look at our, our hospital and infrastructure set up do you think it’s supportive enough in case we experienced very high numbers of patients.

**R: No, so if we experienced high numbers of patients it would mean that other conditions would have to suffer as I have said already we had closed ENT and we had to transfer patients in 3A, and TB ward and send them somewhere else if the pandemic had hit us hard I would say our hospital would actually wasn’t the infrastructure alone wasn’t set to accommodate a large number of covid cases.**

I: Ok, apart from the infrastructure how would you because I think the way things turned out it’s not what people expected but in case that we had very high numbers of cases just as other countries as we have seen in Europe, what do you think could have been a reality in the hospital? Considering all factors what could have happened.

**R: Disaster, honestly speaking if we had been hit hard I would say it would have been a disaster because then I’m thinking that 1: capacity because as I have said yes we have those oxygen plants that have been installed but if we were to have a lot of numbers, cases then it means that we would actually transfer most of the patients say in 3B or 4A we could have to transfer them somewhere and even patients, non covid patients without the requirements would have suffered, so it wouldn’t be just about covid deaths alone yes we could get a lot of covid deaths if that was the case because as I mentioned we had no ventilating capacity already and the spacing space is already inadequate even the O2 spacing that is available though we have the plant but still it’s inadequate so to say to support a lot of people,**

I: Yeah.

**R: so yes we would have seen a disaster both in covid patients and non covid patients so it wouldn’t have worked for us if at all we had a large number of covid patients who were severe.**

I: Yeah, but still as health care workers you could have could have been required to come and provide care,

**R: Yes, yes.**

I: and how would you see the hospital health care workers providing equitable care to high numbers of patients, that everybody wants care is able to get that.

**R: Already with small numbers people were exhausted even I, I was exhausted because it was exhausting people were at it so even with the small numbers because we were already,**

I: Just speak up a little bit.

**R: yes with the few numbers that we have already have a few numbers of health care workers in our hospitals,**

I: Yeah.

**R: where it’s not enough so even with small outbreak that we had in Malawi people were still tired and all that so I would assume that if we had a lot more of covid patients people would have been exhausted and you should also add in the fact that some health care workers were actually affected had symptoms and they received it could also affected people in that way because people had also to go for quarantine for 14 days still making the numbers available less,**

I: Less.

**R: so 1: people would have been tired, people would try yes to come and deliver but at the end of the day a tired person well, you really don’t think can deliver, you really can’t deliver adequately so I’m thinking it could have been a disaster (laughs) both delivery wise, health wise,**

I: Yeah.

**R: even psychologically people would have been affected.**

I: Talking about psychologically were there I read one of the guidelines that staff are likely to experience burn out and anxiety, fear were there any plans that the hospital had put in place to support staff who are experiencing that?

**R: Not that any was formally communicated but people were only discussing that oh maybe people should actually try and go they should be seen by psychologist or psychiatrist,**

I: Yeah.

**R: but nothing formal was actually,**

I: Communicated and implemented.

**R: communicated so I wouldn’t actually really say that the hospital had implemented this to cover the psychological aspect of the health care workers.**

I: Ok, during this period people did not go to Mwaiwathu with covid cases, so there were a number of VIP cases that came here just getting your views do you think the hospital could have prepared to treat or attend to VIPs in a special way?

**R: So with covid I don’t think so,**

I: Umm.

**R: because basically what we did for everyone was simply the same unless people wanted maybe wanted to have space where they would have say a self-contained room,**

I: Laughs.

**R: which Queens doesn’t have already,**

I: Yeah.

**R: so at the end of the day even VIPs or other patients everyone was managed equally at the end of the day I think, I think it was only one time but then I think that’s the only time when they had opened the 3A, HDRU,**

I: HDRU.

**R: which is a better space,**

I: Yeah.

**R: they had opened it now to be a covid side, so then I think some of the people who were considered as VIP, I just heard some would be admitted there but then even the other normal patients who didn’t (??) could actually also go there since the monitoring there is a bit different and it’s actually a nice space so to say.**

I: Yeah I have seen it it’s very nice (laughs), alright, so coming to work every day during that period how was your perception of being at risk how did you feel as an individual now?

**R: Ok, so what we did as most departments we would not come to work everyday so we gave each other shifts,**

I: Ok.

**R: so the shifts were introduced because we were thinking that if all of us came at the same time and say all of us are exposed and all of us are down then no one could (??) so we had divided ourselves into two teams so atleast if one member from one team is infected then we still have people to see patients. So for me well (laughs) I wouldn’t say that it actually affected me because much as we were drained cause for that work that we were working it really worked,**

I: Ok.

**R: because we could see a lot of patients apart from the turn that I explained earlier on so the turn is on my side and then you have turn as soon as we split meant that we would see twenty patients per day, so if you see twenty patients it could happen that maybe you are on call you have to be admitting patients you have to do that as well, and if you are on call sometimes you could actually be on your call but you still had to cover a covid ward.**

I: Ok.

**R: So it really was very,**

I: so you had to see twenty patients, you are on call.

**R: and if that time we had about fifty patients so it means you had to see those patients as well and you had to be in call if at all your Rota actually appeared in that way on that day you had to do that. So it was very stressing when you are working on that (??) because even post call because usually when you work 24 hours you need to rest the other day.**

I: Umm.

**R: but during this period since the numbers were small we had already divided they you still had to see patients every day so it was exhausting the only good thing was after that week you had the following to rest which was a bit better for us only that we still had our classes going on so we still had to attend those classes even though were on holidays.**

I: To go and attend classes as well.

**R: but at least we could rest but yes it was very tiring but on my part fearing that I will get covid and I will be infected,**

I: Umm.

**R: I don’t think that was one of my worries because I think I was just I was optimistic I guess that even if I get covid I wouldn’t have severe covid so for me that worked.**

I: Even from the very beginning.

**R: From the very beginning I didn’t fear that I will get severe covid.**

I: That’s a very few that I have heard from.

**R: I was optimistic I don’t know why, but yeah that was me. So yes I even think I had a chance to manage one of the patients that were admitted I think I was one of those I was in the team that was managing the very first cases so for me I really wasn’t afraid of getting infected but just being (??).**

I: Did you feel that the fear from other health care workers?

**R: The fear of getting infected?**

I: Yeah.

**R: Yes some of the health care workers were actually were afraid, mostly those that have kids,**

I: Yeah.

**R: and maybe I stay alone so it was ok for me I know I will be alone I wouldn’t have transmit my infection to anyone maybe if I was staying with parents or say my relatives who are older or who have other comorbidities but for me staying alone was like eish I stay alone (??), but some people who stay with parents or with other comorbidities people were actually worried during that period.**

I: Ok, alright, are there particular times where you raised a concern in terms of managing covid cases to your superiors or supervisors,

**R: From me?**

I: Yes and how it was addressed.

**R: Umm, no I think from the time that I had started managing, from the time that we had been included on the Rota the only issue I think we raised was that initially as I said that we were supposed to cover the covid ward when you were on call so you would start to go to the covid ward then you will go to see your patients so with more numbers in the covid ward it got full (??) so then that’s when we noted that actually we go there at 8 finishing at 11 by the time you are going to ATC, you would find that it was full people are waiting for you so the only recommendation we made then was that if you are covering a covid ward there has to be a different Rota that is covering the covid ward and the different ward which was implemented and things changed even now we are using the same Rota the different Rota for covid ward and there’s another one for,**

I: ATC.

**R: ATC.**

I: Ok, alright. One of the recommendations for emergencies and epidemics is that hospital should be able to make some emergency drills was that something was done in the hospital prior to covid do you remember that happening?

**R: I am not sure.**

I: You are not sure?

**R: Yes, for that I’m not sure.**

I: Ok, alright are there any uncertainties or areas that you don’t understand about covid and you would love to know more about as far as covid is concerned?

**R: I think for now what is of interest basically for most people and most clinicians is the issue of I think re infection,**

I: Yeah.

**R: people are still interested to learn whether the people that had covid actually get re infected after some time considering the fact that I think in Malawi most have asymptomatic covid,**

I: Umm.

**R: but I’m still not sure as to whether those people actually developed quite strong immunity now that they have actually preventing them from getting covid-19, so I think those are some of the questions that people still have in mind as to whether are we in to get another surge,**

I: Yeah.

**R: of more cases or are we done with it? And I think most of the things I think most of the things slowed down because now everyone is supposed to wear a mask the issue of social of which (??) cutting down as Malawi but there’s still a question are we really going to experience another surge and as a country we are still not sure as to why we never got severe cases,**

I: (Laughs)

**R: the question is maybe were we getting severe cases and conditions where people were dying and maybe we could assume that well this patient had diabetes or maybe this patient just collapsed it’s so hard to know because we have already a poor health system in Malawi.**

I: That’s true.

**R: So we are not sure as to whether people were dying in the communities we don’t know as to whether people had no covid people truly had no covid we don’t know, as to whether maybe we have particular genes as Malawians (laughs) or as Africans that actually had protected us from getting severe covid,**

I: Yeah.

**R: or maybe the theory that people were saying that most of the countries that were severe hit like the US and Italy have an older population,**

I: Umhuu.

**R: while in Malawi our graph is different we uhh most of the people that we have are young we actually don’t have a greater number of older people,**

I: Umm.

**R: we are not sure as well as to whether yes we have older people in Malawi but then there are people who actually are there in the outskirts in villages where they are not exposed to other people so it could have been that maybe yes we do have old people who just weren’t exposed to covid and were not affected, we don’t have those answers (laughs) as well. So there still a lot of questions.**

I: Questions to be asked and answered, yeah. Alright my last two questions uhh at the moment what is your greatest fear? When, if you look at the way the hospital has prepared to handle covid in case we experience uhh a high number of cases what is your greatest worry I should say so at the moment?

**R: Ok, I think if we are to experience a very like high number of cases,**

I: Umm.

**R: my greatest fear would be I think on the basically on the human resource part,**

I: Yeah.

**R: because I think that’s a big area that people have to look into because it’s the very same people that manage other patients that are expected to manage these patients in case we have a surge of cases,**

I: Umm.

**R: so my fear would be that people would have to work more people would be exhausted, at the time people get exhausted I mean we can’t even I know myself when I’m tired I don’t think,**

I: (Laughs)

**R: so at a point when a health care worker can’t think you actually even put the patient more at risk.**

I: Yeah.

**R: so human resource as well as infrastructure of course we had 3A and ENT but that only covered I think for only twenty or thirty patients, but say we have fifty people that need admission where are we going**

I: To put them.

**R: and how are we going to help the other non covid patients,**

I: Umm.

**R: so it’s the same issue of human resource and,**

I: Drugs.

**R: On drugs well I think that’s something that can be done and it’s easy to get drugs,**

I: Yeah.

**R: it’s easy to plan for drugs and have them supplied but then to get places build up and have proper infrastructure for people to start accommodating,, I think**

I: And staff working in those.

**R: Yes (??) just in case we have a sudden surge for the pandemic.**

I: Were you personally tested for covid during this period?

**R: Yes (laughs), I was actually,**

I: And how was the experience?

**R: I was actually tested twice I actually after my last test I told myself ‘kuti’ to say I’m never getting tested again.**

I: (Laughs)

**R: it was so painful, it was so traumatizing the first one was mostly the one they took nasal, nasal swabs,**

I: Yeah.

**R: that was the worst, the worst part of the test. So initially I think right at the beginning I had the blood sample as well as both the nasal (??) swab scan,**

I: Umm.

**R: that was better but the second one that I had yeah cause that time I had managed a patient,**

I: Ok.

**R: in a ward but later I think after we had tested we found that he had covid so that’s when I had to do the testing but after that I told myself that even if I feel that I have covid,**

I: (Laughs) and maybe that experience is one that would demotivate most people to go for testing?

**R: Yes, yes, cause it’s painful.**

I: It’s painful, ok, no these are the few questions that I had for you I don’t know if you have any comment or anything that you wanted to say that I did not ask.

**R: Umm I think you covered almost everything.**

I: Ok. (Laughs)

**R: I think I’ve answered almost all the questions.**

I: I really, I really appreciate you have given me very valuable information, as I said I think of we are to change our strategies for responding to covid

**R: Ok.**

I: Yeah sure.