Australian Nursing and Midwifery Federation

SUBMISSION TO THE HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH, AGED CARE AND SPORT INQUIRY INTO LONG COVID AND REPEATED COVID INFECTIONS

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial, and political interests of more than 320,000 nurses, midwives, and carers across the country.

Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in all of these settings, fulfil their professional goals, and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

The ANMF welcomes the opportunity to provide feedback to the House of Representatives Standing Committee on Health, Aged Care and Sport Inquiry into Long COVID (LC) and Repeated COVID Infections (RCI). Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF is pleased to submit evidence in relation to the terms of reference of this inquiry.

1. The patient experience in Australia of long COVID and/or repeated COVID infections, particularly diagnosis and treatment.

1.1. Although there are various definitions for LC, ongoing or recurrent multi-organ symptoms following SARS-CoV-2 infection have been widely reported. Various longitudinal studies conducted in the United Kingdom (UK) show between 7.8%, and 17% of participants reporting symptoms for 12 or more weeks,[1] with symptoms including, but not limited to, weakness, general malaise, fatigue, concentration impairment, and breathlessness.[2] Although evidence continues to emerge, these symptoms of LC are associated with a range of sociodemographic and clinical risk factors. Those most at risk appear to be people who are of female sex, belonging to an ethnic minority, socioeconomically deprived, smoke, and are obese.[3] Evidence also indicates the proportion of individuals reporting ongoing symptoms increases with age.[1] Further, evidence suggests that vaccination only offers partial, not full, protection against LC, and cannot be relied upon to reduce the long term health impact following SARS-CoV-2 infection.[4] Although those who experience a RCI may be at less risk of developing symptoms of LC.[4] In Australia, ongoing COVID-19 monitoring has reported 29.0% of adults with confirmed or suspected COVID-19 experienced symptoms more than 4 weeks after contracting the disease.[5] Of those, 22.5% suggested the symptoms impacted their ability to carry out day-to-day activities. The most common symptoms included tiredness and weakness. Those who were experiencing ongoing symptoms after 4 weeks reported the lowest quality of life compared to those who had contracted COVID-19 but had not experienced LC, and those who had not contracted COVID-19.[5]

1.2. With evidence still emerging, the impact and experience of LC and RCIs is so far not completely understood. Long COVID can affect people who initially had mild illness which was managed at home as well as those who had a hospital admission. Some people are at increased risk of developing LC including those who are over 35 years of age, female, have some pre-existing conditions such as diabetes, or had severe illness during their COVID-19 infection. The symptoms can be varied and for this reason multidisciplinary care is required.

1.2.1. ***The ANMF recommends that there must be effective and ongoing data collection, analysis, linkage and reporting regarding COVID-19, LC, and RCIs, including for healthcare staff in order to understand, track, and model the progress of the pandemic and its long-term impacts.***

1.3. New empirical (i.e., quantitative and qualitative research) and non-empirical (i.e., subjective and observational repots and theoretical modelling) evidence is constantly emerging regarding Australian patients' experiences of long COVID and RCI. A significant body of evidence of both types is also generated overseas and is relevant for gaining an accurate and comprehensive understanding of the scale, nature, and implications of the impact of LC and RCIs on the Australian population, particularly from other countries with similar contexts and factors at play.

1.4. People who have been affected by COVID-19 and LC face an array of challenges, including an invisible but no less formidable foe: mental health burden, in the form of anxiety, depression, mood disorders, post-traumatic stress disorder (PTSD) and more. These issues are often entwined with physical issues. There is strong emerging evidence that the mental health implications of the pandemic will continue for many years. Those that suffer from LC are likely to be much more at risk of long-term mental ill health.

1.4.1. ***The ANMF highlights that all treatment needs to be multidisciplinary with the inclusion of best practice and accessible psychological support where indicated.***

1.5. To build an appropriate, feasible, and effective response to mitigate the widespread and damaging impacts of LC and RCIs on the Australian community, and particularly its most vulnerable members, evidence-based policy and decision making is urgently required. Methodologically rigorous and suitably targeted evidence synthesis approaches (E.g., systematic reviews, scoping reviews utilising best practice methodologies) are recommended to supplement broad community (i.e., patients/ health consumer) and stakeholder (i.e., healthcare staff, employers, peak bodies) consultation and information gathered through the present inquiry. By ensuring evidence-based policy, planning, and decision making, more effective and consistent interventions and approaches, including for infection prevention and control, can be scaled across Australia's healthcare system and community to better support Australians from diagnosis to treatment for LC and RCIs.

2. The experience of healthcare services providers supporting patients with long COVID and/or repeated COVID infections.

2.1. In this submission, the ANMF utilises the term 'healthcare services' to refer to the diverse contexts and sectors where our nurse, midwife, and personal care worker/assistant in nursing members (and other healthcare and support staff) work. This incorporates aged care, maternity care, disability care, mental health, First Nations health, schools/universities, correctional facilities, the defence force and others.

2.2. The impact of LC on healthcare service providers is multi-faceted, with LC affecting not only people from the community, but also healthcare staff who have experienced episodes of acute COVID-19. Estimates from the UK suggest that in 2021 those working in health and social work were the occupational group most disproportionately affected by LC.[6] In managing LC, guidelines suggest management and support should be multi-disciplinary,[7] with many European countries establishing a means of addressing LC, such as 'Long COVID Clinics' that operate as multi-disciplinary hubs and points of contact for individuals experiencing LC.[8] In Australia, similar clinics are opening in major cities.[9] Patients gain access to the clinics via referral from a medical practitioner, and on accessing the clinic are reviewed by the clinical team, which develops a plan that provides appropriate support and rehabilitation to help the individual manage their ongoing care.

2.3. As above, new evidence of a variety of types and from a range of sources is emerging constantly regarding the experience of healthcare services providers supporting patients with LC and RCIs. Likewise, this evidence should be synthesised and considered alongside that which is collected through consultation and the present inquiry to build a comprehensive and detailed picture to inform evidence-based policy and decision making.

2.4. It is critical to recognise the human face and experience of healthcare service providers who are also members of the Australian community and thus directly and indirectly impacted by COVID-19, LC, and RCIs. Working with and after COVID-19, particularly in high-risk, high-pressure contexts including healthcare, aged care, maternity care, disability care, and mental health care etc. is rendered considerably more challenging if one is dealing with new or lingering COVID-19, LC, and RCI symptoms and/or informally caring for others (e.g., children, family, loved ones) who may also themselves be impacted. Many healthcare service providers have exhausted their leave balances and are now struggling to cope, both in terms of looking after their own health and wellbeing and that of their family/loved ones, but also that of their patients/clients. Lack of sufficient leave and the revocation of mandatory isolation periods and payments means that many staff are put in a position where they must choose whether to work or not. This can put both them and patients/clients at risk of detrimental health impacts due to the possibility of transmitting COVID-19 to others and working while still recovering or suffering from LC.

2.5. Another concern in terms of the experience of healthcare services providers supporting patients with LC and RCI is that after around three years of the pandemic, many staff are already burned out and suffering as a result of the immense pressure, strain, fear, and secondary trauma of working throughout the pandemic. This impacts both staff who provide care directly to people with COVID-19 and those that do not, due to the wide-ranging and flow-on effects of the pandemic on every aspect of healthcare (and other industries and sectors) in Australia.

2.6. It is well reported that in Australia and worldwide, many healthcare workers have had enough and want to leave their jobs, the sector, or the professions entirely as a result of the burden of the COVID-19 pandemic. The pandemic represents a powerful and detrimental compounding factor on top of a range of pre-existing factors that place undue burden and risk on our valuable and vulnerable staff working across Australia's healthcare services and sectors. It is critical to understand that many healthcare service providers faced considerable burdens even before the pandemic reached Australia; the aged care sector has been in crisis for decades and hospitals and other services, particularly mental health, maternity care, regional and remote health, First Nations health, and disability care have also experienced long term pressure and funding and workforce shortages. Without adequate and sustained policy and practical reforms, the pandemic is likely to be a significant blow to workforce attraction/recruitment, retention and wellbeing that will persist for years and result in widespread negative consequences for the effectiveness and sustainability of Australia's healthcare system and wider community health and wellbeing outcomes.

2.7. Government planning for the longer-term impacts of COVID-19, in particular LC, not only for an individual but the impact on the healthcare system and workforce is vital. This is necessary given more and more people will become infected with COVID-19, thereby increasing the disease burden and the initiatives governments must take in ensuring a health care system that is sustainable and can meet demand. We suggest that the full effects of LC and RCIs are yet to be felt and the management and treatment for this condition will greatly impact the recovery from COVID-19.

2.7.1. Given the current paucity of data relating to LC, ***the ANMF recommends that the Federal Government include LC in the publicly reported database, where LC is a notifiable condition. We recommend that The Federal Government amend the National Health Security Act 2007 to allow the Communicable Diseases Network of Australia (CDNA) National Notifiable Diseases Surveillance System's Notifiable Diseases List to be amended to include LC (or post-COVID-19 condition) with case definition. We recommend that the guidelines should then be endorsed by the Australian Health Protection Principal Committee to include mandatory public reporting.***

2.8. This will provide the legislative framework to allow for more effective future research and public health responses. This is in line with a recent independent report that has also recommended that governments improve data collection, linkage and sharing arrangements to enable governments to more easily share de-identified data with other jurisdictions and research organisations.[10]

2.9. From a workers' compensation perspective, Australian states and territories differ in terms of how Workcover arrangements are managed. For example, Queensland differs from New South Wales, which has a presumptive Workcover arrangement. Given Queensland's Workcover arrangements, the ANMF Queensland Branch (Queensland Nurses and Midwives Union (QNMU)) anticipates it will be difficult for employees to prove that they had developed LC from an exposure that occurred at work. Consequently, it will be difficult for these employees to be eligible for workers' compensation and for worker representative organisations like the QNMU to collect data about members' experiences of LC via this mechanism. The ANMF recommends that Workcover arrangements be reviewed for fitness of purpose to ensure that with rising cases of LC and RCIs staff who work in high-risk areas (e.g., with people with confirmed COVID-19 infection) are well supported.

3. Research into the potential and known effects, causes, risk factors, prevalence, management, and treatment of long COVID and/or repeated COVID infections in Australia.

3.1. While ongoing research and evidence relating to LC and RCIs continues to emerge internationally, in Australia there is limited evidence into potential and known effects, causes, risk factors, prevalence, management, and treatment, specific to Australia.[11,12] Internationally however, several government level research programs are underway. The National Institute for Health and Care Research in the UK has launched a series of studies that seek to examine the underlying mechanisms and symptoms of LC, and test potential treatments.[13] Similarly, the United States (US) government has launched a national research plan that seeks to accelerate the delivery of evidence and data across seven research domains relating to LC, including those looking at causes, management, and treatment.[14]

3.2. While it is vital that infection rates for COVID-19 (including RCIs) must be minimised as much as possible to protect particularly the most vulnerable community members, Governments balance economic, political, and health priorities when setting policies. As governments reduce restrictions and no longer require that positive tests are reported, there will likely be more COVID-19 infections and greater prevalence of LC and RCIs in the community. Reducing the prevalence of LC and RCIs will be largely determined by the extent to which governments' balance these competing priorities and the community's response. As new evidence emerges, we will be able to develop a more detailed and comprehensive picture of the potential and known effects, causes, risk factors, prevalence, management, and treatment of long COVID and/or repeated COVID infections in Australia. Without effective data collection, linkage, analysis, and translation however, we are unlikely to be able to develop a timely and accurate picture. It is likely that LC and RCIs are being under-reported both in Australia and abroad, due to the limited understandings we currently possess regarding their scale, nature, and impacts.

3.2.1. ***The ANMF recommends that the Government must direct targeted and ring-fenced funding to support high-quality research into the potential and known effects, causes, risk factors, prevalence, management, and treatment of long COVID and/or repeated COVID infections in Australia as a matter of priority.***

3.3. Many other countries, including the United States and the United Kingdom, are advancing research into these areas and Australia must do likewise or risk falling behind. Until LC and the impact of RCIs become better defined, with the development of appropriate diagnostic criteria, we expect that people who have LC symptoms will encounter similar challenges as others experiencing even well-established, but relatively poorly understood diseases like Chronic Fatigue Syndrome, where obtaining an appropriate diagnosis and accessing appropriate treatment can be difficult. The ANMF highlights that there needs to be clear, evidence-based diagnostic criteria for LC as well as communication with health practitioners, especially General Practitioners and Nurse Practitioners, so that those experiencing LC symptoms are efficiently, appropriately, and effectively diagnosed and addressed.

3.3.1. ***The ANMF recommends that State/Territory and Federal Governments invest in strengthening the capacity of the entire healthcare system.***

3.4. As described above, the healthcare system has already struggled to cope with peaks of COVID-19 infections. Unless governments implement bold, proactive strategies that incorporate the management of LC and RCIs people who experience primary infection, LC, or RCIs will be reluctant to engage with the healthcare system. While the Commonwealth, State and Territory Governments may not necessarily provide all the treatment services for those experiencing LC, they are the only organisations able to plan and implement the public/private infrastructure necessary to effectively respond to this issue. Effective government responses may include continuing to invest in community-based respiratory clinics. Further, Governments must recognise the financial burden for members of the public and healthcare staff associated with purchasing Rapid Antigen Tests (RATs) particularly with many free testing sites now being rolled back. The Government should continue to provide access to effective testing services either for free or heavily subsidised, particularly for people who are on low incomes and/or eligible concession card holders, ideally from easily accessible locations, such as pharmacies, clinics, and general practices.

3.4.1. ***The ANMF recommends that governments must invest in appropriate primary care infrastructure as a treatment gateway which comprises nurses and nurse practitioners. Further, diagnostics and treatment considerations must run in parallel with prospective research and data collection.*** **As there are many unknowns, including with regard to risk factors, we recommend that *governments fund longitudinal research to investigate the impacts of LC and RCIs over the lifespan.* Research exploring the impact of viruses on autoimmune diseases should also include the impact of LC and RCIs on these diseases.**

4. The health, social, educational, and economic impacts in Australia on individuals who develop long COVID and/or have repeated COVID infections, their families, and the broader community, including for groups that face a greater risk of serious illness due to factors such as age, existing health conditions, disability, and background.

4.1. In Australia there is limited evidence for the broader social impact on the individual as a result of LC, however one yet-to-be-reviewed study estimates that in Australia during 2021-22, LC contributed to 5,200 years lived with disability, and 1,800 as a result of acute COVID-19. These findings suggests LC contributes to 74% of overall years lived with disability within the community, and therefore the largest proportion of morbidity as a result of COVID-19.[15] People living with disability report poorer general health, higher levels of psychological distress and have higher rates of modifiable health risk factors such as poor diet and tobacco smoking. Disability and long term health conditions also limit individuals' ability to access and participate in social and physical activities.[16]

4.2. As new evidence emerges, we will be able to develop a more detailed and comprehensive picture of the health, social, educational, and economic impacts in Australia on individuals who develop LC and RCI, their families, and the broader community, including for groups that face a greater risk of serious illness due to factors such as age, existing health conditions, disability, and background. Without effective data collection, linkage, analysis, and translation however, we are unlikely to be able to develop a timely and accurate picture. It is likely that LC and RCIs are being under-reported both in Australia and abroad, due to the limited understandings we currently possess regarding their scale, nature, and impacts.

4.2.1. ***The ANMF recommends that the Government must direct targeted and ring-fenced funding to support high-quality research into the health, social, educational, and economic impacts of LC and RICs as a matter of priority.***

4.3. In terms of the educational impact of COVID-19, LC, and RCIs, the ANMF Victorian Branch has reported that there have been missed/decreased continuing professional development and mandatory training opportunities for student nurses and midwives. This has also resulted in negative financial impacts for students who have needed to repeat subjects due to the pandemic. Lack of face-to-face education has created an isolated cohort of students with limited opportunities to undertake clinical placements and we are unsure of the medium- and long-term impacts of the pandemic on the education and employment outcomes for recent graduates and current nursing and midwifery students. ***Further research and inquiry should occur in this space to enable the development of evidence-based initiatives to help support and grow Australia's future nursing and midwifery workforce by ensuring effective and appropriate transition to practice for students and new graduates impacted by the pandemic.***

4.4. The pandemic and ongoing impacts of LC and RCIs in terms of financial impact include changes in workforce culture with many staff moving from full-time roles to part-time or casual work which increases the cost of the workforce. There are also additional onboarding costs due to higher workforce turnover which detrimentally impact on healthcare services. High turnover and staff shortages also result in a lack of appropriate skill mix which in turn can result in clinical errors and missed care, with linked financial impacts on health services and worse outcomes for patients/clients. Further, there are potential increases in childcare costs, as staff with young children may not be able to work due to LC or RCIs but also may not able to take care of children full time. This could further drive staff away from jobs in Australia's healthcare sector and amplify workforce shortages.

4.5. The ANMF notes that there is inequitable access to leave arrangements for employees with COVID-19 across the public and private sectors and this also extends to people who have LC. The private sector is much less likely to recognise the need for pandemic-related leave, with unions having difficulty negotiating for the inclusion of this leave within Agreements. We also note that nurses and midwives have difficulty accessing flexible working arrangements to manage chronic health conditions and we envisage that this will also occur when health professionals with LC attempt to access flexible work. Inequitable access to leave and flexible work arrangements will have social and economic impacts for individuals and governments.

4.5.1. ***The ANMF recommends that the Federal Government:***

4.5.1.1. ***Put the appropriate infrastructure in place*** to diagnose, treat, and support people who experience LC and RCIs through the provision of appropriate welfare and support services. For example, we have observed the treatment of some of Australia's most disadvantaged people through the Royal Commission into the Robodebt Scheme hearings,[17] and we need to ensure that governments provide appropriate financial support to people who are impacted by LC and RCIs. The Australian welfare system is overly harsh and punitive and needs to move to a supportive approach given the likely numbers of those needing resources for LC symptoms.

4.5.1.2. ***Establish effective, efficient feedback mechanisms*** to translate research findings into evidence-based policy making, with a particular focus on the social determinants of health.

4.5.1.3. ***Consider establishing a Health in All Policies (HiAP) framework at a federal level***, similar to the HiAP framework that was implemented by the South Australian government over a decade ago, with a prospective research study focus on quality adjusted life years and disability adjusted life years affects from persons experiencing LC.

4.5.1.4. ***Consider the impact that LC and RCIs will have on family functioning.*** For example, when we have disconnection between the provision of childcare and education services across different jurisdictions, families encounter inconsistencies in the education sector's response to infections. The nursing and midwifery workforce is one of the largest feminised workforces in Australia, the impact of these inconsistencies and disparities in early childhood and school-based policy has a disproportionate effect on employability of female workers, their leave balances (with unpaid leave often a reality due to exhausting sick or carers leave), superannuation balances, and wellbeing. These impacts are not insignificant, and it follows that this will impact on the availability of a responsive nursing and midwifery workforce, its sustainability, and will continue to place significant financial and personal strain on families and communities.

4.5.2. The COVID-19 pandemic has highlighted the pressures on the health workforce and the need for economic investment and re-investment. COVID-19 and LC have the potential to impact on the health workforce by increasing the stress associated with increased infections and increasing staff turnover. Perhaps a silver lining of this pandemic is that these workforce challenges have been identified on the cusp of a crisis, highlighting that running the system beyond capacity pre-pandemic was a result of poor decision-making. A lesson we can learn from the pandemic is that spare capacity urgently needs to be built into the health system. The Government should not allow this opportunity to go to waste.

4.5.3. ***Contrary to the limited Federal Budget (October 2022) spending on managing the impacts of LC and RCIs, the government must make a genuine long-term investment in the development of the nursing and midwifery workforce.***

4.5.4. ***The ANMF urges all major political parties to take a bi-partisan approach to dealing with LC and RCIs,* with the expectation that policy and decision-makers develop long-term plans to prepare for pandemics and the consequences of pandemics.**

5. The impact of long COVID and/or repeated COVID infections on Australia's overall health system, particularly in relation to deferred treatment, reduced health screening, postponed elective surgery, and increased risk of various conditions including cardiovascular, neurological, and immunological conditions in the general population.

5.1. Although information regarding the impact of acute COVID-19 on the Australian health system has been widely reported,[18] emerging evidence demonstrating the impact of LC in particular is limited. Although a clearer idea of the cost burden on health systems will emerge as the pandemic continues, a US estimate suggests that the cost of care for an individual with LC is equitable to that of someone experiencing chronic fatigue syndrome, where costs to the health system could meet approximately $9,000 per individual per year. Further costs also arise when considering the number of people who are absent from the labour force due to LC and RCIs, particularly where those individuals are those working in health care service jobs.[19]

5.2. The pandemic has had widespread detrimental impacts on Australia's overall health system, particularly in relation to deferred treatment, reduced health screening, postponed elective surgery, and increased risk of various conditions including cardiovascular, neurological, and immunological conditions in the general population. These impacts are likely to be prolonged due to the ongoing effects of LC and RCIs, particularly in the context of the emergence of a new sub/variant or diminishing effectiveness of vaccines. The compounding impact of other infectious diseases such as influenza is also not well understood.

6. Best practice responses regarding the prevention, diagnosis, and treatment of long COVID and/or repeated COVID infections, both in Australia and internationally.

6.1. Best practice guidelines for prevention, diagnosis, and treatment of LC continue to evolve as more is learnt about the condition. In Australia, the Royal Australian College of General Practitioners (RACGP) provide guidance on how best to treat and manage individuals experiencing LC. The UK's National Institute for Health and Care Excellence (NICE) also provides comprehensive guidance on how best to manage the condition, drawing on up-to-date evidence.[7] It is suggested that given the multi-faceted nature and presentations of individuals with LC, that services designed to support individuals are multidisciplinary and integrated with rehabilitation services.[7] In the US, LC can be categorised as a disability with the intention to protect the individual from discrimination, if the individual is substantially limited by LC in one or more major life activities.[20]

6.2. Best practice responses for the prevention, diagnosis, and treatment of LC and RCIs must be evidence based. With the wealth of evidence already published and emerging continuously for each of these issues, there is an abundance of information and guidance to ensure that Australia implements appropriate policies and practical solutions. Best practice prevention polices incorporate evidence-based approaches for transmission control, so the removal of mandates around wearing face masks would appear premature if the intention is to minimise the risk of further rises in infections. Likewise, diagnosis and treatment of COVID-19 is dependent upon effective testing, so any policies that reduce the accessibility and availability of free RAT or PCR testing is likely to have detrimental impacts on the number of people with COVID-19 in the community.

6.2.1. One ***effective approach recommended by the ANMF is mandating that evidence-based fit testing and checking as well as use (donning, doffing, and disposal of PPE) be implemented across all healthcare sites.*** Currently government policy is ambiguous, so ensuring that both fit testing and checking occur is an important way to improve protection of healthcare staff and patents/community members.

6.2.2. ***The ANMF recommends ensuring widespread and easy access to vaccines in the community to ensure as many people can be vaccinated as efficiently and safely as possible.*** This must go hand in hand with ongoing education on vaccination for the workforce outlining the importance of vaccines, including for aged care and community. Priority access to vaccinations should also be considered as new evidence and next-generation vaccines become available. Further, ***there must be ongoing public health campaigns and community education on the ongoing risk of COVID-19, LC, and RCIs.***

6.3. Long COVID clinics are being created around Australia. In South Australia, SA Health has implemented LC clinics at Flinders Medical Centre, Royal Adelaide Hospital and The Queen Elizabeth Hospital (all metropolitan acute hospitals) outpatient departments. The Women's and Children's Hospital will also provide a specialist service for children if required. The LC Assessment Clinics have specialist input from: Respiratory, Cardiology, Neurology (including Memory), Pain Medicine, Ear Nose and Throat, Rheumatology, Renal medicine, Haematology, General Medicine, Clinical Pharmacology, Rehabilitation medicine, Physiotherapy, Exercise physiology, Psychology and Mental Health teams. Initially South Australia only had one LC clinic and this resulted in long waits for patients. As more clinics have opened patients are being seen sooner which is likely to result in better care and outcomes.

6.3.1. ***The ANMF recommends review into the roll out and uptake of LC clinics around Australia to ensure that all Australians are able to access timely and effective support.*** Special attention should be paid to areas where community members might not have easy access to LC clinics such as regional and remote areas and options for tele/video health services should be implemented.

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