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An Emergency Strategy for Intersectoral Local Government Responses to COVID-19 in Long-term Care Facilities in Western Cape Province, South Africa

RESEARCH

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ABSTRACT

Context: There are growing numbers of long-term care facilities (LTCFs) in low- and middle-income countries (LMICs). In 2020, a network of academics and stakeholders developed the CIAT (Coordinate, Identify, Assess and Targeted support) Framework, an emergency COVID-19 policy guidance that sought to address specific needs of LMIC government agencies responsible for LTCFs.

Objective: This paper reviews the South African COVID-19 response experience, with particular reference to Western Cape Province, and assesses the degree to which policy responses conformed with the CIAT Framework.

Methods: The paper draws on an opportunistic, improvised research design, based on the establishment of a pragmatic partnership between the authors and local government stakeholders. This entailed proactive engagement and informal discussions with policymakers as the pandemic unfolded, as well as privileged access to official documents.

Findings and implications: Responses to the pandemic, especially in the early months, did not follow the CIAT Framework. They were hindered by government departments' poor coordination, weak information systems, and dysfunctional engagement with LTCFs. These problems dated back to before the pandemic and require structural reform to long-term care policy.

Limitations: The lack of data on LTCFs in South Africa (though itself an important finding) prevents analysis of policy effects at the level of individual facilities.

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INTRODUCTION

Until recent years, the number of long-term care facilities (LTCFs) in low- and middle-income countries (LMICs) was thought to be very small compared to most high-income countries (Lloyd-Sherlock, 2002). There has since been a rapid increase due to heightened levels of demand and shifting cultural norms about caregiving (WHO, 2015; Feng et al., 2020; Fernandes et al., 2021). In high-income countries, there is a substantial body of evidence that LTCF populations were the most at-risk group for COVID-19 mortality (Comas-Herrera et al., 2020; Cousins, 2020). South Africa saw the largest COVID-19 outbreak in Africa, with 296,000 excess deaths recorded between the start of community transmission in May 2020 and the end of January 2022 (Bradshaw et al., 2022). Of these excess deaths, it is estimated that 85% could be attributed to COVID-19 and 73% have been among people aged 60 or more–an age group that accounts for only 9% of the total population (Moultrie et al., 2021).

Globally, conditions in LTCFs vary considerably, both within and across countries. Since the onset of the pandemic, evidence has emerged that not all LTCFs were equally affected by COVID-19 mortality. Studies in the USA report higher COVID-19 mortality in facilities with poor quality ratings, more crowding, and higher shares of residents who were not white (Li et al., 2020; Weech-Maldonado et al., 2021). The limited evidence about LTCFs in LMICs indicates that the quality of facilities is often poor due to limited resources and weak government oversight (Lloyd-Sherlock, Penhale & Redondo, 2019; Feng et al., 2020; WHO, 2015). In 2021, it was estimated that South Africa contained 1,150 LTCFs for older persons (Mahomedy, 2021). At the start of the pandemic, there was therefore understandable concern that LTCFs in South Africa and other LMICs would be hard hit, and that there was an urgent need to develop effective policy responses.

This paper examines the responses of different South African government agencies to the risks posed by COVID-19 to LTCFs. These responses are assessed with reference to a set of policy guidance produced by an *ad hoc* network of academics and stakeholders specifically for LMIC contexts at the start of the pandemic: the CIAT Framework (Coordinate, Identify, Assess and Targeted support) (Lloyd-Sherlock et al., 2020). Initial global responses to the COVID-19 pandemic included the rapid development of emergency guidance for infection prevention and control (WHO, 2020). However, these were primarily informed by what was known about LTCFs in high-income countries. Some LMIC experts were concerned that their local contexts differed substantively from those in high-income countries and that this called for differences in approach. For example, many LTCFs in LMICs only offer multiple-occupancy dormitory accommodation, rather than individual rooms (Roqué et al., 2016). This reduces the feasibility of managing infection risk by isolating suspected cases among residents in specified rooms with bathrooms. Simultaneously, there is a high level of informality in the sector, with a rapid increase in numbers of largely unregulated and unregistered private providers (Mexican National Institute for Older People, 2020). A context of weak institutional governance and a lack of historical engagement between LTCFs and government agencies represented a major barrier to epidemiological surveillance, as well as to the capacity of governments to offer support.

The next section sets out the wider context of this study, including the origin of the CIAT Framework, and research methods. The paper then assesses the nature of engagement between South African government agencies and LTCFs in the period before the pandemic. This is followed by a review of policy responses during the pandemic, and the extent to which these corresponded to actions recommended by the CIAT Framework. The final section relates South Africa's experience to those of other countries, with a particular focus on LMICs, and discusses the usefulness of the CIAT Framework for LTCF policy as it moves on from the COVID-19 pandemic.

STUDY DESIGN AND METHODS

This study emerges from an unorthodox and initially improvised research design, developed in the heat of the early months of the COVID-19 pandemic. Two authors had participated in the rapid development of the World Health Organisation's technical guidance for LTCFs (WHO, 2020). At the same time, they were informally liaising with local government departments in different LMICs. From April 2020, these activities become linked to a wider network of experts and stakeholders interested in promoting rapid knowledge transfer of good practice, with reference to COVID-19 and older people in LMICs (https://corona-older.com/). Interactions across this and other networks prompted concerns about specific forms of vulnerability facing LTCFs outside high-income country settings. In response, members of the network rapidly developed the first iteration of the CIAT Framework (Lloyd-Sherlock et al., 2020).

The CIAT framework drew on existing knowledge about LTCFs pre-pandemic to identify aspects of vulnerability that were thought to be especially pronounced in LMIC settings. Its target audience was local and national government agencies with related responsibilities, for whom it offered a set of pragmatic actions. These actions fall into four areas: (1) coordinating responses, (2) identifying LTCFs, (3) assessing their vulnerabilities, and (4) offering targeted support (Box 1). Between June 2020 and July 2021, two revised versions of guidance were produced, taking into account emerging evidence and the changing pandemic situation. For example, the third edition of the CIAT Framework includes a substantial new section on providing COVID-19 vaccination in LTCFs and managing staff risks (Lloyd-Sherlock et al., 2021a).

Box 1 Key components of the CIAT Framework.

Step 1: COORDINATE

- Any strategy must be led by an inter-agency and inter-disciplinary Task Force, with seamless coordination between health and social agencies.
- The Task Force must have backing from the highest levels of government (such as the president's or mayor's office).
- The Task Force must urgently develop a basic and feasible set of guidance, suited to the realities of local LTCFs.

Step 2. IDENTIFY

- The Task Force must develop specific strategies to locate and develop constructive engagement with all LTCFs in their area: registered, unregistered, and de facto ones.
- The Task Force should be empowered to offer all facilities some form of "amnesty" for past and ongoing infractions of official LTCF standards, on the condition that they cooperate with the CIAT Strategy.

Step 3. ASSESS

- The Task Force should conduct an emergency survey of local LTCF preparations and vulnerability to COVID-19.
- This survey information can be used to:
  Identify LTCFs at greatest risk, based on simple criteria.
  Identify specific issues of concern for all LTCFs (equipment, information, space limits, hospitals dumping infected patients, etc.), to prioritise local actions.

Step 4. Targeted support

- LTCFs identified as high-risk should be given priority status for targeted support.
- Focus on cooperative support rather than punitive measures.
- It may be necessary for high-risk LTCFs to be put under direct control of the Task Force if their management is very weak.

Immediately after the online publication of the CIAT Framework, an emergency funding proposal was submitted to deploy, verify, and refine the framework, with reference to three specific settings: the Western Cape in South Africa, Mexico City, and the Brazilian state of Bahia. Funding was awarded in October 2020. The project placed a strong emphasis on collaborative partnerships with local government agencies, entailing a hybrid of policy engagement, knowledge coproduction, and opportunistic research (Redman et al., 2021). This pragmatic–but unorthodox–research strategy presented opportunities, challenges, and limitations. Opportunities included direct access to stakeholder deliberations as the pandemic unfolded and, potentially, an ability to inform these deliberations. Challenges included obtaining and maintaining good access to local government agencies, gaining their trust at a time of unprecedented pressure on their staff, and the impossibility of in-person meetings. Limitations included the degree to which local government staff were willing or permitted to share information relevant to the study, and whether this information even existed. Experiences varied across the three study sites. In the case of Bahia state, a high level of collaboration was possible with several government departments. In Mexico City, collaboration was restricted to the local department of social assistance and was discontinued after the senior member of staff was replaced. In Western Cape, collaboration with the Department of Social Development (DSD) began in mid-2020 and continued until the end of 2021, with more limited interaction with the Department of Health (DoH).

This collaborative strategy yielded a number of different forms of research data which are deployed in this study. It was not feasible to conduct research-specific interviews, since key informants had no time for these during the pandemic. However, the research team were permitted to attend and participate in a series of online meetings with these agencies during 2020 and 2021, from which detailed written notes were made and key official documents were shared. This privileged information was supplemented by material in the public domain and discussions with other stakeholders, including NGOs and service providers.

The findings of the each of the three case studies represent a rich, complex, and diverse set of experiences. To date, these have been analysed individually, and sister studies conducted in Mexico City and Bahia state have been published elsewhere (Duarte et al., 2021; Lloyd-Sherlock et al., 2023). This paper focusses on the Western Cape experience, albeit with some international comparative discussion. Ethics approval for the study as a whole was obtained by the School of International Development Research Ethics Committee in the University of East Anglia. Permissions for this specific case study were obtained from the University of Cape Town Health Research Ethics Committee and the Department of Social Development Western Cape's Research Ethics Committee.

GOVERNMENT AGENCIES AND LTCFs IN SOUTH AFRICA BEFORE THE COVID-19 PANDEMIC

Information about LTCFs in South Africa on the eve of the COVID-19 is limited. It was estimated that the country contained over 1,000 LTCFs for older people, of which only eight were directly operated by government agencies (Malherbe, 2021). The remainder were operated

by private providers, on either a for-profit or philanthropic basis, with 417 of the latter receiving part of their funding from subsidies paid by the Department for Social Development (DSD).

In South Africa, roles and responsibilities for LTCFs are shared between the Department of Health (DoH) and DSD. As the custodian of the Older Persons Act of 2006, the DSD has a mandate to fund and oversee long-term care for older persons, although the DoH is responsible for providing facilities with medical consumables, such as incontinence pads. Additionally, the DoH has lead responsibility for overseeing those facilities offering specialist dementia care, as part of the Mental Health Care Act. The interconnected roles of DSD and DoH called for close collaboration, but there was evidence that this was far from ideal. For example, the DSD did not employ health professionals and therefore lacked the technical capacity to assess whether LTCFs met health standards. Rather than liaise with the DoH, provincial-level DSD departments resorted to outsourcing this duty to external private sector agencies.

Despite having overall responsibility for LTCFs, the DSD did not possess an accurate database of facilities at the start of the pandemic. In 2015, DSD conducted a national survey of registered facilities which identified 418 LTCFs, containing 27,623 older people (Department of Social Development, 2021). The 2015 DSD national survey was not updated before the pandemic, since LTCF registration was managed by provincial DSD offices which did not routinely share these data with the central office. As well as not being updated for five years before the pandemic, it was widely reported that the majority of South Africa's LTCFs were not registered with DSD and therefore not included in survey. In 2015 the lead author of a South African Human Rights Commission report (SAHRC, 2015) claimed:

> "We don't know precisely how many [unregistered LTCFs] there are out there, but we know that people have a tendency of opening their houses and converting them into residential homes for older persons…In Pretoria there are about six places operating within a very small radius from one another and they are functioning without control … We are saying that these places need to be registered so they comply with standards" (Mkhwanazi, 2015).

A more recent study by Human Rights Watch acknowledged the existence of large numbers of unregistered LTCFs, but it was not able to provide an estimate (Human Rights Watch, 2023). A business survey by a private sector agency estimated there were 1,150 LTCFs in 2021 (Mahomedy, 2021).

DSD registration of LTCFs was very incomplete for a number of reasons. It was reported that some LTCFs preferred not to seek registration (Cape Argus, 2018). Registration with DSD made LTCFs potentially eligible for financial support from DSD for any residents identified as "frail and destitute". However, the process was often slow, and the value of this support was widely viewed as inadequate to cover real costs of providing care (Human Rights Watch, 2023). It was estimated that LTCFs in receipt of the DSD subsidy typically acquired more of their funding from other sources, such as voluntary donations (The Association for the Aged, 2019). Being registered with DSD required LTCFs to meet its quality norms and standards or face the risk of closure (Lloyd-Sherlock, 2019). These norms and standards were closely modelled on those applied in high-income countries and were therefore unaffordable for many providers (Human Rights Watch, 2023). Those LTCFs which struggled to meet official standards could be offered temporary registration, which still permitted access to DSD funding. In theory, DSD social workers would then support LTCFs in building their quality and capacity. However, this support was very limited due to budgetary restrictions even before the pandemic.

The lack of comprehensive data on LTCFs precludes a systematic description of the sector and the profile of residents. Nevertheless, the available data indicate large inequalities of resourcing and quality between different LTCFs. There were large differences between those facilities mainly reliant on subsidies and those with paying residents, who tended to be much more affluent. Some private facilities provided services that compared favourably to those found in more expensive LTCFs in high-income countries. By contrast, LTCFs reliant on DSD support usually consisted of crowded dormitories, with few bathrooms and high ratios of residents to staff, who were often untrained and poorly paid (Mapira, Kelly & Geffen, 2019). A 2010 DSD audit of 405 LTCFs found that over a fifth never had access to a trained nurse (DSD, 2010). Evidence of poor service quality in facilities funded by DSD included high-profile exposés of elder abuse and the infraction of fundamental human rights. The best-known example of this was the "Life Esidimeni Scandal", which involved the deaths of 94 mentally ill and intellectually disabled people in LTCFs registered with and funded by DSD (Kelly, 2017).

Although data on LTCFs in South Africa before the onset of the COVID-19 pandemic were very incomplete, several facilities appeared to be highly vulnerable to the effects of the pandemic. It is also evident that the capacity of government agencies to rapidly engage with facilities and provide support was very limited.

POLICY RESPONSES IN SOUTH AFRICA DURING THE PANDEMIC

The first confirmed case of COVID-19 in South Africa occurred on 5 March 2020, with a national lockdown implemented three weeks later. Between May and September 2020, these restrictions were gradually

relaxed. At the end of 2020, restrictions were reintroduced in response to a second pandemic wave, continuing until March 2021, which was also when the vaccination programme began. In the middle of 2021, restrictions were reimposed in response to a third wave associated with the Omicron variant, and these remained in place to varying degrees until June 2022. These phases of policy response broadly corresponded with five distinct waves of pandemic infections between March 2020 and June 2022. During this period, there were over 100,000 deaths attributed to COVID-19–by far the largest number recorded in any African country. This section examines policy responses in relation to the high vulnerability of LTCFs to the pandemic, assessing whether there were meaningful changes to previous approaches and the extent to which they conformed to the recommendations of the CIAT Framework.

The CIAT Framework sets out four basic principles to guide policy action, the first of which is to ensure responses between government agencies are effectively coordinated. In South Africa, however, the pre-existing lack of coordination between the DSD and DoH was not addressed in the first months of the pandemic. As in other countries, funding for the DoH was substantially boosted in order to respond to the pandemic. At the same time, funding for the DSD was reduced, since it was not considered as specifically relevant to the public health crisis (Ashwell et al., 2021). The DSD was therefore unable to purchase personal protective equipment (PPE) and other essential materials for LTCFs, and requests for materials from DoH were rebuffed on the grounds that health professionals were the most in need.

The national government produced a range of general public health regulations through the pandemic, corresponding to different lockdown levels. However, the DSD was slow in communicating how these should be interpreted by LTCFs. By early 2021, neither the DSD, DoH, or any other national agency had provided comprehensive national COVID-19 guidelines for LTCFs. The lack of government action during the first wave of infections led some civil society organisations and LTCFs to develop and share their own sets of guidance (SIFAR, 2020). At local government level, only Western Cape's DSD and DoH co-developed a guidance document and established systems to communicate directly with key contact people within facilities. This guidance, published in late May 2020, addressed some specific local issues, such as the widespread sharing of rooms (https://coronavirus.westerncape.gov.za/resources). However, other specific concerns, such as limited local availability of PPE, thermometers, and other equipment, went unmentioned. The guidance included elements which were unrealistic for many facilities, such as daily screening of staff and residents and a minimum of 1.5 metres social distancing between residents.

As the pandemic continued, some limited forms of coordinated activity emerged. For example, in August 2020, DSD reported that 199 nurses from LTCFs were trained by DoH to screen and test for COVID-19 (DSD, 2020). However, poor coordination and joint planning between DoH and DSD hindered the process of finding out about and participating in training (DSD, 2020). At the national level, the National Institute of Communicable Diseases collaborated with both the DoH and DSD to establish an epidemiological surveillance programme of 45 residential facilities, including 19 LTCFs for older people and 11 assisted living facilities (Arendse et al., 2022). However, this initiative was limited to collecting information on COVID-19 cases and deaths. It did not have a mandate to gather information from other LTCFs registered with the DSD or to collect data regarding the effects of the pandemic on facilities.

The CIAT Framework observes that a second type barrier to effective government engagement with LTCFs is the very poor quality of available information about them. In the case of South Africa, where pre-pandemic information systems and registers of providers were substantially incomplete, this represented a substantial challenge. As part of its pandemic response, the national DSD proposed to validate and update the 2015 national LTCF database and to identify unregistered facilities (DSD, 2020). It is unclear what this validation process entailed, especially for those facilities which were not already on the national database or were waiting for their official certification to be approved. As of early 2024, there was no evidence that the 2015 database had been updated.

Once all local LTCFs have been identified and effective communication with local authorities has been established, the CIAT Framework calls for relevant information collection and monitoring to identify those facilities at greatest risk, as well as more general problems affecting all LTCFs. This was not done at the national level in South Africa, although there are examples of initiatives taken by local government agencies. For example, in July 2020 Western Cape's DSD (WC DSD) introduced weekly epidemiological surveillance of confirmed COVID-19 infections and deaths in LTCFs. Of the 300 facilities WC DSD was aware of by this time, around half participated in this surveillance system. This was the full extent of efforts to monitor infections and deaths in LTCFs in Western Cape or at the national level, and these data are not publicly available. Surveillance did not take into account that many facilities lacked access to COVID-19 testing kits, especially during the first year of the pandemic. As such, there are no data or even estimates on overall rates of infection or the number of older people in LTCFs who died from COVID-19.

As well as offering general support and guidance, the CIAT Framework calls for proactive identification and targeted assistance for those facilities that appear to be most at-risk. It advocates that, rather than focusing on enforcing pre-existing standards, engagement between government agencies and LTCFs should focus on contingent guidance and protocols that are realistically achievable. In

the case of South Africa, a large number of informal facilities that did not meet DSD or DoH norms and standards were unregistered at the start of the pandemic. Consequently, those facilities with greatest vulnerability to the pandemic were more likely to be invisible to public agencies. The COVID-19 pandemic further eroded the capacity of many LTCFs to fully comply with official standards, to which were then added new Covid-19 protocols. Expenses increased at the same time as income fell due to the deaths of existing residents and restrictions on new admissions. Yet, in some South African provinces, DSD subsidies to LTCFs were cut or delayed during the pandemic forcing some LTCFs to close down (Govender, 2022; Francke, 2021; Western Cape Parliamentary Monitoring Group, 2023).

The DSD in the Western Cape contracted a research institute (the Institute for Contemporary Research Africa) to carry out additional training in LTCFs with higher rates of infection and deaths. Targeted support also included telephone calls with DSD social workers and training on infection control using low-cost measures, as well as liaison about testing with DOH. Similar efforts appear to have taken place in other provinces and all DSD provincial offices submitted a list of priority at-risk facilities to the national DoH. However, this targeted support strategy identified more vulnerable facilities purely on the basis of high COVID-19 infection rates reported to the surveillance system. It did not result from risk assessments, whereby LTCFs with more potential vulnerability were given early support to prevent the virus from entering the facility in the first place. Further, this strategy was founded on an assumption that all LTCFs would conduct testing and share results.

The final iteration of the CIAT Framework recognised the importance of targeted interventions supporting LTCF staff. These interventions should be mindful of staff member's own concerns and, in many cases, their limited prior training, low status, and insecure work status. Fear of losing salary due to limited sick leave benefits and the risk of dismissal can discourage staff testing unless specific guarantees are in place. There is, therefore, a need to guarantee continued salaries during quarantine periods for staff who test positive. In South Africa national legislation was introduced in June 2020 to provide paid leave for employees of any organisation, for the purpose of self-isolation after a positive COVID-19 test. There is no indication that either DSD or DoH communicated this information to LTCFs or monitored compliance.

By 2021, COVID-19 policies had become strongly focussed on vaccination. Ensuring that LTCF residents and staff are prioritised in vaccination roll-out requires that official agencies be already aware of their existence and have established contact with them. It also requires close cooperation between social departments with general oversight of LTCFs (DSD in the case of South Africa) and health agencies managing the vaccination process (DoH). For example, in South Africa, care workers were permitted early access to the Johnson and Johnson vaccination before rollout across the general population between February and May 2021 (Bekker et al., 2022). From May 2021, when older South Africans became eligible for the Pfizer vaccine, specific efforts were made to reach LTCFs. For example, in the Western Cape Province, teams from civil society and the DoH worked to carry out vaccinations at LTCFs between May and August 2021 and booster shots from December 2021. There was, however, no formal engagement with LTCFs by either DoH or DSD to ensure their LTCF care workers and nursing staff would be included. During the early phase of the roll-out, vaccines were only administered at a small number of health care facilities, which reduced access for LTCF staff.

Despite some prioritisation of LTCFs, there have been a number of barriers to COVID-19 vaccination. First, not all LTCFs are known by the official agencies. Also, facilities were asked several times to complete different digital forms capturing information on individual residents and staff, significantly burdening overstretched administrative systems. Some less-resourced LTCFs did not have access to Wi-Fi, creating an additional barrier. Separately, there was some vaccine hesitancy, both among staff and residents (Kelly et al., 2021). A failure to establish information systems for all LTCFs in South Africa means it is not possible to assess the speed and effectiveness of vaccination, and systematic data on coverage of LTCF residents were not collected.

LESSON-LEARNING FROM THE SOUTH AFRICAN EXPERIENCE

Although the CIAT Framework was not specifically developed for South Africa, the available evidence indicates it was often relevant to the specific challenges facing policymakers there. Poor coordination between government agencies hampered efforts to respond to the pandemic, especially during the first wave. As in other countries, LTCFs were not considered to be part of the health sector and, as a consequence, facilities and staff were not prioritised for support. DoH and DSD worked together more effectively in later stages of the pandemic. Nevertheless, cooperation remained limited. Large gaps in data at the start of the pandemic meant neither DSD or DoH were able to rapidly identify facilities and assess their relative vulnerability. Some efforts were made to improve information systems, but these were limited and ad hoc. To date, South Africa still does not have reliable national data on the total number and specific characteristics of LTCFs and their residents. As well as hampering responses to the pandemic, data gaps masked the consequences of ineffective policy: the true toll of the pandemic on LTCFs, their residents, and staff will never be known.

It has been suggested that the pandemic may open a "policy window" for reform due to heightened public awareness and political interest (Béland & Marier, 2020).

In the case of South Africa, reforms might include a more institutionalised, less *ad hoc* system of collaboration and joint responsibility between DSD and DoH. There are some examples of incremental steps in this direction, including a new Older Persons Amendment Bill that aims to strengthen implementation and compliance measures in LTCFs. In 2022, the DSD initiated consultations civil society organisations to support a five-year National Strategy on Ageing. At the time of writing this paper, the current draft of this strategy included a specific objective to enhance LTCF registration and management (DSD, 2022). In parallel, the DoH is in the early phases of developing a National Strategy on Healthy Ageing. The current zero-draft of this document calls for improved coordination between DSD and DoH, with clearly defined roles. Yet, the draft goes on to say that LTCF registration and monitoring should be led by DSD and "supported" by DoH, without defining what this entails in practice (DoH, 2022). Though both of these strategy documents set out broad aspirations and have been shared between the two agencies, they lack specifics. Moreover, the fact they are being developed separately demonstrates the barriers to integration. In the meantime, funding from DSD for LTCFs has not been increased, despite inflation and rising costs. No proposals to improve funding are currently under discussion, which does not bode well for the sector's capacity to offer older people an acceptable standard of care.

This brings us to the questions: to what extent was the South African experience substantially different to that of other countries and, by extension, to what extent would the CIAT Framework have offered them useful guidance? Poor coordination between government agencies responsible for LTCFs had been reported in many other countries prior to the pandemic (The Kings Fund, 2016; Lloyd-Sherlock, Penhale & Redondo, 2019; Feng et al., 2020; Lloyd-Sherlock et al., 2021b). Studies from Canada, Chile, and the USA report that these weaknesses in coordination obstructed responses during the pandemic, including surveillance, ensuring PPE and vaccination priority status to LTC staff, and avoiding the discharge of hospital patients into LTCFs without testing or suitable precaution (Dawson et al., 2021; Béland & Marier, 2020; Browne et al., 2020).

The scale of information gaps in South Africa due to under-registration of LTCFs and a failure to update records exceeds the experience of most high-income countries, but similar gaps have been reported for other LMICs, including Thailand, Argentina, Mexico, and Jamaica (Lloyd-Sherlock et al., 2021c; Lloyd-Sherlock et al., 2023; Govia et al., 2021; Mexican National Institute for Older People, 2020). The COVID-19 pandemic drew momentary attention to this significant failure of public policy. However, there are no reported examples of LMICs substantially enhancing data gathering on LTCFs, either during the pandemic or since. Where information systems were weak, the capacity of government agencies to assess the needs of LTCFs and provide targeted support was inevitably very limited.

In many countries, as in South Africa, state engagement with LTCFs before the pandemic often focussed more on policing compliance with norms and standards rather than on working with providers to improve quality (Mor, 2014). LTCFs might therefore seek to limit regulatory oversight by keeping government agencies at arm's length and, especially in LMICs, remain unregistered and effectively invisible to the state. During the pandemic, when LTCFs faced additional barriers in meeting standards, concerns about punitive responses by government agencies may have inhibited cooperation (Lloyd-Sherlock et al, 2021b).

Lastly, South Africa's experience of a momentary increase in public and policy-maker interest in LTCFs, but a failure to sustain this interest or translate it into substantial reforms is arguably a global phenomenon. The issues identified in the CIAT Framework transcend the pandemic context and could be used to guide reforms of state stewardship of this complex sector. Reforms should include, as a minimum, the establishment of clear competencies, effective communication, and compatible shared information systems between all responsible agencies. Quality assurance policies should be realistic about what is achievable in low-resource settings, reflecting dialogue and partnership with providers. All countries, even LMICs, should aspire to complete registration of LTCFs, with reliable data shared between agencies and provided to the general public in suitable forms. An initial step towards promoting this reform agenda would be its recognition by international agencies, including different United Nations organisations and non-governmental organisations, and by national civil society networks. As numbers of LTCFs continue to increase, especially in LMICs, this has become a major global issue of concern, and one that remains largely ignored.

DATA ACCESSIBILITY STATEMENT

The data that support the findings of this study are available from the corresponding author, PLS, upon reasonable request.

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COMPETING INTERESTS

The authors have no competing interests to declare.

AUTHOR CONTRIBUTIONS

PLS, LG, and GK all made substantial contributions to data collection and analysis. PLS drafted the paper and LG and GK made substantial contributions to further drafts.

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