



Disability Inclusion and Pandemic Policymaking in South Africa: A Framework Analysis

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RESEARCH



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ABSTRACT

A growing body of research demonstrates the disproportionate effects of the COVID-19 pandemic on people with disabilities. Existing inequities, especially in healthcare, were deepened during this period, highlighting the need for policymakers to consider the specific needs of people with disabilities during crises. We conducted a framework analysis of health-related policy in South Africa during 2020, investigating the extent to which the country's pandemic response was disability-inclusive. Our findings demonstrated the limited conceptions of disability reflected in decision-making, and the general failure to consider people with disabilities in lockdown and other measures. One government department made positive statements about disability-inclusive services and support, but these were unactionable in the context of existing infrastructure and resources. In spite of South Africa's ratification of the United Nations Convention on the Rights of Persons with Disability, this study demonstrated the inadequate buy-in and capacity across government to implement disability inclusion.

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People with disabilities continuously experience health inequities (WHO 2022) and this is often exacerbated during pandemics. This is partly because people with disabilities are more likely to have underlying health conditions and to live in congregate settings such as care homes and mental health institutions, but their vulnerability is often more complex. People with disabilities are more likely to live in poverty than people without disabilities (Banks, Kuper, and Polack 2017), and are more likely to find healthcare providers' skills and facilities inadequate when reaching out for care (Kuper & Heydt 2019). Fifty percent of people with disabilities cannot afford health care and are more likely to suffer from catastrophic health expenditure (WHO 2020; WHO 2022). Globally, this group is three times more likely to be denied care and four times more likely to be treated badly in health settings (WHO 2020). This makes people with disabilities particularly vulnerable to health systems' weaknesses and failures, a reality which is being documented in a growing body of literature about the impact of COVID-19 and pandemic-related factors on people with disabilities around the world.

One way of avoiding disproportionate impact of health emergencies on people with disabilities is to prioritise disability in health systems strengthening efforts and to make specific provision for the needs of people with disabilities in all health-related policies. However, significant concerns have been raised internationally regarding the inclusiveness of governmental policies and decision-making during the COVID-19 pandemic. Various authors have presented analyses of COVID policy responses in specific countries and regions, with respect to their consideration of people with disabilities (see for example Colonna-Cabrera et al. 2021; Sakellariou, Malfitano & Rotarou 2020). The purpose of our study was to conduct a similar desktop analysis of South African government responses to COVID-19 during the initial year of the pandemic, with a specific focus on health-related decision-making.

South Africa is a middle-income country with a high degree of income inequality and unemployment (Blecher et al. 2021). Although in certain aspects (and certain geographical areas), South Africa shares characteristics with high-income countries, large sections of the population still live in significant poverty, with limited access to basic services such as water and sanitation, decent housing, and healthcare (McKinney, McKinney & Swartz, 2021). According to census data, people with disabilities comprise 7.7% of the South African population, although this excludes children under five years old, people living in institutions, and people living with mental illness, making this a significant underestimation of actual prevalence (Statistics South Africa 2021). People with disabilities are considered a designated group in legislation and policy aimed at redressing historical disparities and inequities, including the Employment Equity Act (Department of Labour 1998), and the Promotion of Equality and Prevention of Unfair Discrimination Act (Government of South Africa 2000). The South African government ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007, but this has yet to be fully domesticated in law or practice. The most significant local policy document in this respect is the White Paper on the Rights of Persons with Disabilities (WPRPD), passed in 2015 (Department of Social Development 2016). This policy guides the development of standard operating procedures for mainstreaming disability and stipulates norms and standards for the removal of discriminatory barriers that exclude persons with disabilities from society. The WPRPD further tasks duty-bearers with protecting the rights of persons with disabilities as an at-risk group for compound marginalisation, and with building an equitable state machinery for persons with disabilities, amongst other directives.

The Ministry for Women, Youth and Persons with Disabilities (DWYPD) reported in 2022 that although awareness of the WPRPD was increasing, implementation of policy directives remained limited (DWYPD 2022). Thus, South Africans with disabilities continue to face similar but often more severe challenges compared to their counterparts from high income countries in relation to civil participation, access to healthcare, economic opportunities, and other rights-based liberties (Moodley & Ross 2015; Mutwali & Ross 2019; South African Human Rights Commission 2017; Vanderschuren & Nnene 2021). According to Moodley & Graham (2015), people with disabilities in South Africa are also worse off compared to their compatriots without disabilities in terms of education levels, employment participation, and income levels, while black women with disabilities experience the greatest degree of marginalisation. Exclusion and discrimination experienced by persons with disabilities were laid bare during the recent pandemic, particularly as health system failures increased the barriers they face to accessing healthcare (McKinney et al. 2021; Ned et al. 2020; Ned et al. 2021; Wickenden et al. 2022).

The first case of COVID-19 in South Africa was diagnosed on March 5th, 2020, and a State of Disaster was declared on March 26th, giving the government extended powers to pass regulations and directions with the aim of managing the crisis [Supplementary File 1, item 2.1.1.]. The initial government response was a hard lockdown which confined everyone but essential workers to their homes for a period of five weeks [Supplementary File 1, items 2.1.3. & 2.1.9.]. Even as these regulations were eased, the government maintained a high degree of control over population movement and activities, and the State of Disaster was only lifted two years later, in April 2022. Significant criticisms have been raised regarding the rationality and transparency of government decision-making during this period, especially given the severe economic and social impact of lockdown measures (Ministerial Advisory Committee on COVID-19 2020; Blecher et al. 2021; Venter et al. 2022).

South Africans with disabilities were affected more severely and intensely than the general population by COVID-19 restrictions imposed to curb the spread of the virus. Inadvertent discrimination materialised against people with disabilities under lockdown restrictions when disability services were initially not classified as essential (McKinney et al. 2021). Lockdown regulations also presented increased barriers to persons with disabilities when the public was only allowed to leave their homes for limited periods, and persons with disabilities had to navigate further restrictive and inaccessible public transport systems to reach shops or health services (McKinney et al. 2022). People with certain disabilities endured higher risk of contracting the virus due to, for example, their need to use touch to navigate spaces, or when utilising structures or equipment for support with mobility impairments (ibid).

RESEARCH METHODS AND DESIGN

We conducted a policy review of the South African government's pandemic response using a framework analysis approach. Framework analysis is a structured method of qualitative data analysis, using an *a priori* set of themes or concepts (in contrast to the inductive methods more typical of qualitative research) (Ritchie & Spencer 1994). It is commonly used in policy analysis, and several recent papers have adopted this approach in interrogating the disability-inclusiveness of pandemic responses in different countries (e.g. (Colon-Cabrera et al. 2021; Sakellariou, Malfitano & Rotarou 2020).

We devised a thematic framework based on two key documents on disability-inclusive COVID-19 response produced by the UN and the World Health Organization (WHO) respectively (United Nations 2020; World Health Organization 2020). This framework focuses specifically on health- and healthcare-related policy, and its nine elements are described in Table 1.

METHODOLOGICAL THEME	KEY ELEMENT FOR DISABILITY-INCLUSIVE RESPONSE TO COVID-19
Ensure accessible public health information	Provision of all information in accessible formats, including sign language translation, Braille script, captioning, and easy read. Ensuring that information is up to date.
Implement protective measures against COVID-19	Access to appropriate WASH facilities. Providing protective measures for those supporting people with disabilities. The distribution of personal protective equipment to persons with disabilities needs to be tailored to their impairment.
Ensure accessibility to services	Facilitating access to health services, especially essential services. Removal of financial barriers to care. Measures taken to ensure equitable access to healthcare, including measures addressing disability-based discrimination.
Ensure non-discrimination in the allocation of scarce medical resources	Mitigate the risk of discriminatory decisions in resource allocation that put people with disabilities at a high level of disadvantage.
Make mental health interventions inclusive of persons with disabilities	Mental health and psychosocial support need to be accessible and not discriminate against persons with disabilities.

Table 1 Thematic framework.

(Contd.)

METHODOLOGICAL THEME	KEY ELEMENT FOR DISABILITY-INCLUSIVE RESPONSE TO COVID-19
Ensure the continuity of support services	Develop and implement service continuity plans, particularly for people with disabilities with high support needs, as well as measures to reduce potential exposure to COVID-19 during the provision of services.
Reasonable accommodations for persons with disabilities	Adjustments to public health measures to accommodate the needs of disabled people, including flexibility in restrictions on movement in public spaces.
Consideration of the needs of persons with disabilities who face multiple exclusions	Measures taken to protect disabled people who are at increased risk of social exclusion and poverty, such as women, children, homeless people, and prisoners.
Protection of people living in residential settings	Measures taken to ensure people living in residential care are protected from infection.

DOCUMENT SEARCH AND SELECTION

The thematic framework guided our search and selection of policy documents. Documents were included that:

- Had bearing on the national government's COVID-19 response with respect to health and healthcare;
- Either made direct or indirect provisions for people with disabilities
- Or addressed a significant issue reflected in the analytical framework, whether or not any consideration of people with disabilities appeared;
- Were produced by government departments and bodies (i.e. not disabled people's organisations or other civil society groups);
- Were produced between March and December 2020.

Although the Department of Health (DOH) was our starting point, the elements of the framework involved action from several other departments as well. The core set of regulations governing the national lockdown were issued by the Department of Cooperative Governance and Traditional Affairs (COGTA), which was the ministry designated to lead the disaster response. Other relevant departments included the Departments of Social Development (DSD), Transport (DOT), Telecommunications and Postal Services (DTPS), and Employment and Labour (DEL). We excluded documents dealing specifically with education and educational institutions due to time constraints.

We began by searching the national government's official coronavirus website, and the sites of specific ministries relevant to our research question (see Supplementary File 2: Websites Used in Document Search). We screened all available policy and related documents from the inclusion period and downloaded the selected material for analysis. We also cross-referenced document lists appearing on different sites to ensure comprehensive coverage. Some of the included documents referenced further material not identified through our search, and these were then sourced where possible. All sources were accessed in their original language, which was English.

A range of document types were found in our search, with differing degrees of legal status. The Disaster Management Act ([Government of South Africa 2002](#)) empowered the government to make regulations and issue directions to deal with the pandemic. Regulations were legally binding on all citizens, government departments, and organisations, while directions were confined to the specific remit of the issuing Cabinet minister ([Government of South Africa 2002](#)). Guidelines further fleshed out how regulations and directions should be implemented, but were not legal imperatives. Speeches and media releases had no legal status but added to our understanding of the overall government discourse and gave some information on actions taken.

Regulations and directions did not cover all of the elements of the thematic framework. We therefore extended our search to documents not necessarily issued directly by government, but likely to shape action in key areas. For example, the issue of telehealth during the pandemic was addressed primarily by guidelines from the Health Professions Council of South Africa, the statutory body regulating the registration, conduct, and practice of health professionals. We also chose to include documents produced by the Ministerial Advisory Committee on COVID-19

(MAC), a group of leading scientists and clinicians appointed by government to interpret emerging evidence on the pandemic and inform decision-making. Even though advisories from the MAC had no regulatory power, they provided insight into the rationale behind some government decision-making.

Document search and review were undertaken by two researchers independently (one after the other), to ensure comprehensive coverage. Uncertainties about inclusion were discussed and resolved together, with no disagreements noted. Table 2 below summarises the documents finally included in the study.

DEPARTMENT	REGULATIONS AND DIRECTIONS	GUIDELINES, ADVISORIES, AND CIRCULARS	NOTICES AND WEBSITES	SPEECHES AND MEDIA RELEASES	ALL
Health (DOH)	9	30	1	15	55
Cooperative Governance and Traditional Affairs (COGTA)	18			7	25
Transport (DOT)	18	1		3	22
Social Development (DSD)	8		3	6	16
Telecommunications & Postal (DTPS)	6		2		8
Employment and Labour (DEL)	6			1	7
Public Service and Administration (DPSA)		2		1	3
Presidency				3	3
National Treasury (NT)				1	1
Water & Sanitation (DWS)	1				1
Totals	67	33	3	37	141

Table 2 Summary of included documents.

DATA ANALYSIS

Our analysis broadly followed the five steps outlined by Ritchie and Spencer (1994), namely familiarisation, identifying a thematic framework, indexing, charting, and mapping. As explained above, we began with the thematic framework and used this to guide our document search. Familiarisation then involved an initial reading of all of the documents. The next step was indexing the documents' content against the thematic framework, followed by charting, in which we extracted specific data against each theme. This allowed us to identify gaps and overlaps in the themes, leading to further clarification of the thematic framework and some additional sourcing of material. The last stage, mapping, identified the further themes and patterns across the data.

ETHICAL CONSIDERATIONS

This research forms part of a larger study for which ethical clearance was obtained from the Stellenbosch University Social, Behavioural and Education Research Ethics Committee (REC: SBE), Project Number 15244. No specific ethical issues were identified in the document review, as all data is in the public domain and involves no personal or sensitive information.

RESULTS

This section presents the findings according to the nine elements of the thematic framework.

1. ENSURE ACCESSIBLE PUBLIC HEALTH INFORMATION

Regulations issued by DTPS assigned responsibility for disseminating information about COVID-19 to various role players in the sector [Supplementary File 1, item 5.1.1]. Accessibility provisions in these regulations were limited. All licensed broadcasters were required to receive

and disseminate information about COVID-19, “in all local languages as well as sign language” [Supplementary File 1, item 5.1.1:6]. South African Sign Language (SASL) interpreters were used when speeches from the President were broadcast, but not consistently across other programming. Closed captions and subtitles were not made available, and the primary language in which key information was communicated was English.

All local websites were required to display a link to the official government coronavirus website, which posted up-to-date information relating to the virus and the lockdown [Supplementary File 1, item 5.1.1]. This included all regulations, directions, and guidelines promulgated under the Disaster Management Act to date, as well as fact sheets and links to other information sources. The site has no evident accessibility features, although documents can be downloaded in PDF format. Most of the information is provided in English, although some basic fact sheets appeared in other languages. No content was adapted for easy reading. The site did include a disability section, which consisted almost entirely of links to websites of local and international organisations sharing disability-specific information about the pandemic [Supplementary File 1, item 4.3.1]. We found no government documents or sources which presented public health information specifically for people with disabilities.

Access to public health information was facilitated by the zero-rating of the official website, as well as a number of local health and education sites [Supplementary File 1, items 5.1.1 and 5.1.5]. Data costs are a significant barrier to information access for many in South Africa, alongside access to internet-enabled devices, electricity, and network coverage (especially in rural areas) (Faloye & Ajayi 2022).

Further major barriers to accessing online information are literacy and English proficiency, which could exclude people with low educational attainments, visual impairment, or print disabilities, as well as speakers of the other ten official languages of South Africa who were not fluent in English. Again, this would have most affected rural populations, which tend to be poorer and subject to multiple forms of exclusion (StatsSA 2022).

Municipalities were also assigned responsibilities in local dissemination of information [Supplementary File 1, item 2.1.3], but no detail was given to ensure people with disabilities and other marginalised groups were reached.

2. IMPLEMENT PROTECTIVE MEASURES AGAINST COVID-19

Access to adequate water and sanitation (WASH) was a recognised barrier to infection prevention and control (IPC) measures in many underserved communities [Supplementary File 1, item 6.1.1]. We found two documents addressing this issue. The first dealt with the responsibility of municipalities to provide communities with the means to prevent the spread of COVID-19, including drinking water and adequate sanitation [Supplementary File 1, item 2.1.3]. The other established the National Disaster Water Command Centre, centralising the coordination of WASH rollout for communities deemed to have inadequate access [Supplementary File 1, item 6.1.1]. No mention is made in either document of specific subgroups within target communities that might be prioritised, nor of ensuring services are accessible to people with disabilities.

Provision of personal protective equipment (PPE) and hygiene supplies was included in directions for schools, workplaces, health facilities and other institutional settings [Supplementary File 1, item 3.1.3], but we found no documented intention from any government department to supply these for personal use. Instructions for institutions made no mention of the specific needs of people with disabilities. The DOH’s Draft Manual for the Implementation of the IPC Strategic Framework [Supplementary File 1, item 1.2.1] gives detailed instructions for health facilities, but the only disability considerations concern the safe placement of sanitiser dispensers (with reference to vulnerable populations such as children and mental healthcare users), and the provision of at least one accessible toilet for patients.

Measures to protect specific vulnerable groups from COVID-19 infection focused on those considered at high risk for severe COVID-19 disease, based on emerging clinical evidence. Regulations from the DEL defined vulnerable employees as “employees with known or disclosed health issues or comorbidities, or with any condition which or may place such employees at a higher risk of complications or death than other employees if they are infected with COVID-19” [Supplementary File 1, item 3.1.6:5]; or “employees above the age of 60 years who are at a higher

risk of complications or death if infected with COVID-19” [Supplementary File 1, item 3.1.6:5]. The DOH produced concomitant guidelines for managing vulnerable employees [Supplementary File 1, item 1.2.4], which provided for detailed employee risk assessment and adaptation to job roles and requirements where possible. Provisions were also made for paid incapacity leave where risk reduction was not possible. Interestingly, these guidelines expanded the definition of vulnerable employee to include those who “reside with or care for persons that are at high-risk for severe illness from COVID-19 (including family members, aged parents etc.)” [Supplementary File 1, item 1.2.4:1]. This could have provided secondary protection for people with disabilities whose family members are formally employed, but was not found in any other document.

Another group for whom specific protective measures were created was people living in residential care, including old age homes and facilities for people with disabilities. The measures included banning of all visits and in-person family interaction, and a temporary embargo on releasing or discharging residents into the community [Supplementary File 1, item 4.1.2]. Directions for applying IPC measures and handling suspected cases of COVID-19 in mental health institutions were also included in a Department of Health guideline on provision of mental healthcare services during the pandemic [Supplementary File 1, item 1.2.6].

The most specific protection measures for people with disabilities were the arrangements for disability grants and old-age pensions to be collected on a separate day from other social grants (e.g. child support grants) [Supplementary File 1, item 4.2.1]. Disability grants are means-tested income support payments for people unable to work due to a disability, and not receiving any other income. In 2020, the grant was approximately US\$106 per month, which even pre-pandemic was inadequate to meet the costs of living with a disability in South Africa (Hanass-Hancock et al. 2017). Grant pay-points are typically crowded, and the risk of infection therefore high. Public transport regulations were also relaxed on those days to allow collection [Supplementary File 1, item 8.3.1].

3. ENSURE ACCESS TO SERVICES

We found no evidence of attempts to make testing and treatment services for COVID-19 accessible to people with disabilities. Existing DOH policy does not enforce universal design or access considerations in health facilities, and pre-existing barriers in the built environment would have been compounded by COVID-related restrictions on accompanying family members or personal assistants. Further, many disability-specific services, including rehabilitation, assistive technology, and sign language interpretation, were cancelled as non-essential during the pandemic (McKinney 2021; van Biljon & van Niekerk 2022). This meant that many people with disabilities lost the supports they needed to function and to access services over this time.

Transport poses a major barrier to accessing healthcare for many people with disabilities, as the vast majority of public transport in South Africa is not accessible, and the hire of private transport can be prohibitively expensive. During lockdown, public transport was restricted in hours of operation and loading capacity (down to 50% occupancy during the initial lockdown [Supplementary File 1, item 8.1.1., see also items 8.1.4. and 8.1.5]), which made it less likely that transport drivers would make the extra time and effort to assist a person with a disability (McKinney et al. 2022). No specific transport provisions were made for people with disabilities during this period, except for increasing permitted hours of travel on the days when grants were to be collected [Supplementary File 1, item 8.3.1].

Basic primary healthcare services are free at clinic level for all public healthcare users and charged on a means-tested sliding scale at higher levels of care. People who receive disability grants are entitled to free healthcare at hospitals as well (DSD 2016). This meant that in theory, access to COVID-19 testing and treatment was available to many at low or no cost, but in practice, public sector services were over-subscribed and difficult to access. Private sector services offered better availability and quality of services, but were unaffordable for the majority of the population without medical insurance. For the minority of the population who were insured, COVID-19 was declared a Prescribed Minimum Benefit condition, obliging all insurance schemes to cover COVID-related testing, treatment, and rehabilitation [Supplementary File 1, item 1.1.3], thus reducing financial barriers to healthcare.

The DOH made no specific provisions to ensure access to COVID-related services for people with disabilities. However, the DSD included the following in its first set of directions:

“There must be universal access for Persons with Disabilities in a prescribed manner, to all service points, infrastructure and any other essential service and products that are related to COVID-19.” [Supplementary File 1, item 4.1.2:5]

We found no further documentation of the “prescribed manner”, nor specifics of what facilities were to be rendered accessible or who was responsible. These regulations further stated:

“Persons with Disabilities must have access to personal assistance at all service points, hospitals, screening, testing facilities, supermarkets and any other available facilities which are appropriate” [Supplementary File 1, item 4.1.2:6]

Again, there was no detail provided on how this was to be done, nor (crucially) who would be responsible for providing personal assistance at the various facilities named. These statements from DSD were not found to be translated into directions or guidelines from any other departments.

4. NON-DISCRIMINATION IN MEDICAL RESOURCE ALLOCATION

Three key issues in medical resource allocation arose during the period under study, namely, access to COVID-19 testing, allocation of scarce intensive care unit (ICU) resources, and planning for vaccine rollout.

By mid-2020, the demand for COVID testing overwhelmed capacity. The MAC was asked to produce a strategy to prioritise use of available tests, which identified high- and medium-priority groups for testing. The high-priority group included hospital inpatients and staff, while the medium-priority group included other essential workers, isolation facilities, and care home residents and staff [Supplementary File 1, item 1.2.12]. People with disabilities were not included, other than those residing in care homes.

The allocation of critical care resources (including ICU beds, ventilators, and high-flow nasal oxygen) was not mentioned in any of the documents we identified in our main search. A national guideline produced by the Critical Care Society of Southern Africa [Supplementary File 1, item 1.4.4] was the main reference document in use around the country, although some provinces produced their own policies, largely based on the same principles.

Controversially, the guideline’s decision-making algorithm included use of the Clinical Frailty Scale (CFS) to identify patients most likely to benefit from treatment. The CFS was developed for use with elderly patients, and scores individuals on their physical activity and functional independence prior to admission (Rockwood et al. 2005). Used with the general population, the tool disadvantages people with disabilities, who may be scored as frail for functional reasons, and yet be no less likely to benefit from intervention than able-bodied individuals (McKinney, Swartz, & McKinney 2020). This guideline was amended in May 2020 to state that patients with long-standing but stable disabilities should not be classified using the CFS, but rather assessed individually for medical frailty [Supplementary File 1, item 1.4.4].

In practice, during peak infection periods the demand for critical care far outstripped availability, and many patients who were eligible according to the guideline could not be given care. According to ICU staff in one government hospital, teams had to adapt triage methods continually to cope with this harsh reality (D. Bishop, email, 09/06/2023).

Vaccines were not yet available during 2020; however, the MAC was requested to propose a strategy for when these became available [Supplementary File 1, item 1.2.27]. The suggested allocation framework prioritised “persons with co-morbidities and at risk for morbidity and mortality” [Supplementary File 1, item 1.2.27: Annexure A], which included people over 60 and those living with various medical conditions, as well as “persons in congregate or overcrowded settings” [ibid] such as prisons and care homes. Health workers and essential workers (which could include carers in institutions and schools accommodating people with disabilities) were also given priority. These groupings are similar to those in the testing strategy described above, with the familiar emphasis on age and comorbidity. People with disabilities as such were not mentioned.¹

¹ When vaccines were rolled out for the public in 2021, it was simply by age cohort. Frontline health and essential workers were the only group otherwise prioritised.

5. MAKE MENTAL HEALTH INTERVENTIONS INCLUSIVE OF PERSONS WITH DISABILITIES

The DOH produced a guideline on mental health interventions during the pandemic in March 2020, an early acknowledgment of the mental health challenges likely to ensue from the situation [Supplementary File 1, item 1.2.6.]. The guideline emphasises mental healthcare as an essential service and focuses on its continuation during lockdown. Alongside usual primary mental healthcare services, providers are instructed to offer “basic practical and emotional support to affected individuals, staff and families” [Supplementary File 1, item 1.2.6:7]. District specialist mental health teams are expected to provide mental health support to primary healthcare workers.

The guideline offers little detail on how mental health services should respond to pandemic conditions, and none at all on making services accessible to vulnerable groups. We found no further documents from the DOH relating to mental health service provision. The DSD made mention of mental healthcare in their initial regulations [Supplementary File 1, item 4.1.2] which state:

- “(i) Psychosocial Support Services must be provided to all those infected with or affected by COVID-19;
- (ii) Persons with disabilities requiring psychosocial interventions must have access to all prescribed medications and counselling as a minimum requirement for crisis interventions” [Supplementary File 1, item 4.1.2:8]

Once again, these instructions are vague and do not specify who should provide the services stipulated, or how they should be made accessible. The DOH is the primary provider of mental health services (including “prescribed medications”), making this another extra-departmental direction. However, according to a speech by the Minister of Social Development in April 2020, DSD itself deployed 276 psychosocial support teams around the country to provide trauma counselling to people affected by COVID-19, as well as substance abuse treatment at homeless shelters [Supplementary File 1, item 4.2.1].

6. CONTINUATION OF SUPPORT SERVICES

The initial period of lockdown confined everyone to their homes, except for purposes of procuring or providing essential goods and services. The definition of essential services was pivotal to the continuation of support services for people with disabilities. Regulations defined essential services as including “medical, health (including mental health), laboratory and medical services” [Supplementary File 1, item 2.1.4:10] and “care services, social relief of distress provided to older persons, mentally ill, persons with disabilities, the sick and children” [2.1.4:10]. People were also permitted to travel to collect grants or seek “lifesaving, emergency or chronic medical attention” [Supplementary File 1, item 2.1.4:6]. These definitions would seem to protect the continuation of personal care and access to healthcare, rehabilitation, and assistive technology services for people with disabilities, but the practicalities were more complicated. Providers of essential services, including caregivers of people with disabilities or people living with mental illness, had to carry a permit indicating their right to travel, which had to be completed by the head of their institution (with the organisation’s stamp). This entirely excluded informal caregivers (e.g. family members) and those who were privately contracted and not part of a care organisation, even though these categories account for the vast majority of caregiving received by people with disabilities in the country (McKinney 2021).

Care arrangements for many people with disabilities were severely disrupted by COVID-19, not only by lockdown but also by the illness itself, as family members fell ill or needed to isolate (Ned et al. 2021). Caregiving services were mentioned in two DSD documents. Firstly, the direction concerning access to personal assistance [Supplementary File 1, item 4.1.2.] was followed by a statement that “where it is deemed necessary, [people with disabilities] may be provided with regular caregiving services at their places of residence” [Supplementary File 1, item 4.1.2:6]. Secondly, instructions for care homes and other institutions included a requirement that centres usually offering community services must have caregivers “available to provide the required home-based care services during the lockdown” [Supplementary File 1, item 4.1.2:7]. No detail was provided on what care might be deemed necessary, nor how this was to be organised or resourced. Existing government services do not cover personal care for people

with disabilities, except indirectly where DSD may provide funding to NGO's (including many of the centres referred to in the direction). Very little service infrastructure therefore existed to carry out this instruction.

A further mention of caregiving arose in a MAC advisory regarding community uptake issues in the COVID-19 response [Supplementary File 1, item 1.2.23]. Among other concerns, many people were refusing to isolate following exposure or infection, because of their care responsibilities for children, older adults, or family members with disabilities. The advisory suggested community mobilisation and networking with community-based organisations to seek local solutions to the problem, but no further evidence of policy intervention in this regard was found.

While "chronic medical attention" was allowed as a reason for travel, many health facilities cancelled all non-emergency outpatient services, including rehabilitation and assistive technology services (Ned et al. 2021). Even where services continued, public transport and movement restrictions, financial constraints, and fears of infection kept people from accessing needed services (McKinney 2021). A MAC advisory on non-COVID health service utilisation documented significantly reduced uptake of key services (including TB, HIV, and immunisations), as well as widespread problems accessing chronic medications [Supplementary File 1, item 1.2.11].

More effective attention was paid to the continuation of access to social grants, including the disability grant. Grant payment services (which include the South Africa Social Security Agency [SASSA], the Post Office, and a network of pay-point partners such as banks and supermarkets) were classified as essential services from the start of lockdown and maintained as such [Supplementary File 1, item 2.1.4]. As mentioned above, separate pay-out days were designated to protect elderly people and people with disabilities. Temporary disability grants, usually approved for six months at a time, were automatically extended during lockdown [Supplementary File 1, items 4.1.1, 4.1.6, and 4.1.7]. However, new grant applications were not possible between March and July 2020 due to the closure of all SASSA offices during lockdown. Accessing the necessary medical reports for such applications remained a challenge long afterwards because of pressures on the health system. A media release in July 2020 announced that 465 doctors had been employed by SASSA specifically to conduct grant assessments in order to deal with the backlog, which would have included people who acquired a disability due to COVID-19 infection [Supplementary File 1, item 4.2.3].

The government also extended its social grants programme during 2020 to mitigate some of the economic effects of lockdown. This included temporarily increasing existing grants with top-up amounts, including an additional R250 per month for disability grant and old age pension recipients (approximately US\$14) [Supplementary File 1, item 4.1.4]. While helpful, this was only implemented from May 2020—two months into the pandemic—and was inadequate to counter the additional costs and financial pressures experienced by people with disabilities and their households over this time. Economic relief for the general population included a special COVID-19 Social Relief of Distress payment for unemployed adults, but this excluded existing grant recipients [Supplementary File 1, item 4.3.2].

7. REASONABLE ACCOMMODATIONS

Lockdown regulations by COGTA [Supplementary File 1, item 2.1.7] explained the types of directions Cabinet members could issue within their line functions. These included instructions relating to lockdown, action to protect people from COVID-19 infection, and "[providing] reasonable measures for persons with disabilities" [Supplementary File 1, item 2.1.7:5].

However, apart from the broad statements by DSD discussed above, we found very few references to reasonable accommodations for people with disabilities in any of the regulations, directions, or guidelines.

Guidelines for quarantine and isolation were published by DOH, including specifications for quarantine facilities [Supplementary File 1, item 1.2.5]. Listed requirements included "disability access" [1.2.5:9]. The only detail on what this meant appeared as a single item in the facility checklist (Annexure 2), namely, "Lift/disability access [Yes/no]" [Supplementary File 1, item 1.2.5:33]. There was a further reference under considerations for room allocations [Supplementary File 1, item 1.2.5:13] that listed elderly persons and persons with disabilities among those to be prioritised (no further detail provided).

Despite detailed procedures on the running of quarantine and isolation facilities, none considered people who might need additional assistance or the presence of a caregiver. This was similarly an issue for people with disabilities admitted in hospital, where visitors were banned during lockdown. Where hospitals are understaffed and staff may lack skills or capacity to provide disability-specific care, relatives may play an essential role in feeding, assisting, and facilitating communication for many people with disabilities. Excluding visitors therefore had a serious impact on people with disabilities needing inpatient care at this time, especially as staff pressures were even greater under COVID-19.

A rare example of personal assistance being accounted for was found in the regulations on medical evacuation procedures. The initial document [Supplementary File 1, item 1.1.6] stated that no accompanying relative or caregiver would be allowed except for minors, where one parent was permitted to travel with him/her. However, this was later amended to allow a person with a disability to be accompanied by one responsible adult [Supplementary File 1, item 1.1.7].

Official regulations on IPC in public places, including mask wearing, did not mention accommodations for people with disabilities. A MAC advisory on masks for children suggested that those unable to tolerate or manage mask-wearing due to their developmental stage or a disability or medical condition should be exempted [Supplementary File 1, item 1.2.22]. A later advisory on mask-wearing in public places recommended that people with disabilities who found mask-wearing impracticable due to their disability should be allowed not to do so [Supplementary File 1, item 1.2.25]. However, this was only produced in December 2020, and we did not find the recommendation reflected in government directions or regulations. To access such accommodations, people with disabilities may have been required to obtain a medical report, which was extremely difficult under pandemic conditions (Huisman 2020).

Specific areas where reasonable accommodations would have been meaningful included movement restrictions and access to transport (including for caregivers), as well as facilitated access to health and support services. Unfortunately, no evidence of action in these areas was found.

8. CONSIDERATION OF THE NEEDS OF DISABLED PEOPLE WHO FACE MULTIPLE EXCLUSIONS

The DSD created temporary shelters for homeless people during lockdown and issued directions for psychosocial support services to be provided to this population [Supplementary File 1, item 4.1.4]. While many homeless people are people living with mental illness and disabilities, this was not specifically mentioned.

Gender-based violence (GBV), already endemic in South Africa, reached new levels during lockdown (McKinney 2021). The existing GBV Command Centre (GBVCC) functioned to support victims of abuse during the pandemic and reported dramatic increases in number of calls received [Supplementary File 1, item 10.1.1]. Access to the GBVCC included a toll-free number, call-back facility, a Skype line for persons with hearing impairments, and an SMS-based line for persons with disabilities [Supplementary File 1, item 4.3.3].

9. PROTECTION OF PEOPLE LIVING IN RESIDENTIAL SETTINGS

The original lockdown regulations [Supplementary File 1, item 2.1.2] suspended all visitors to health and social care institutions. Schools and partial care facilities were closed, which meant that learners with disabilities living in hostels were sent home at very short notice, whether or not families were able to receive them.

DSD regulations initially stopped all releases from institutions for the duration of lockdown [Supplementary File 1, item 4.1.2]. This was then amended [Supplementary File 1, item 4.1.4] to allow releases on the recommendation of a social worker, and further stipulated that in the case of a person with a disability, the social worker must “be satisfied with the state of readiness” [Supplementary File 1, item 4.1.4:4] of the place that would accommodate the person being released. Such recommendations for release were to consider “disability needs for persons with severe disability” [Supplementary File 1, item 4.1.4:5], but no further definition or specification was provided in this regard.

Residential and respite facilities (including substance abuse treatment centres, old age homes, and halfway houses) had similar restrictions on visitors, admissions, and releases [Supplementary File 1, items 4.1.2 and 4.1.4].

DISCUSSION

Our analysis revealed that disability inclusion in government policy during the initial COVID-19 period was superficial at best. Policy provisions relevant to people with disabilities fell into three main categories.

Firstly, people with disabilities who were over 60 or had specific comorbidities recognised as increasing their medical risk of severe COVID-19 disease were afforded priority consideration across a number of policy areas. These included workplace arrangements and (recommended) vaccine allocation. Secondly, people living in institutions (including old age homes, mental health facilities, and residential care facilities) were protected by regulations forbidding visitors and releases from care, and recommended prioritisation for testing and vaccines. Thirdly, people with disabilities who received a disability grant or old-age pension were recognised in the DSD arrangements for separate grant payment days and the extension of temporary disability grants.

These three categories encompass the most substantive regulations and directions relating to disability which our search revealed. Each deals with a subset of the population of people with disabilities, from which the majority may be excluded. The provisions based on clinical risk (the first and second categories) reflect the medical discourse guiding policy decisions during this period, where people with disabilities were recognised insofar as their individual physical bodies were vulnerable to disease. The grant-related provisions recognise people with disabilities who are financially dependent on the state. Considered alongside the cross-cutting absence of reasonable accommodations and key access considerations, these categories seem to reflect a construction of disability that reduces it either to medical or to welfare need in the minds of policymakers. A fourth category of policy provisions, covering the statements made by DSD regarding universal access and personal assistance, is no less problematic. While these regulations apparently support the rights of persons with disabilities in accordance with the UNCRPD, their lack of specifics, or even assignment of responsibility, renders them ineffectual. This combination of positive sentiments with the lack of operationalisation or resourcing has been a consistent feature of South African disability policy over many years.

Sakellariou, Malfitano, and Rotarou (2020) acknowledge the common gap between policy and practice but emphasise the importance of disability rights being protected in law, as a starting point for their realisation. South Africa's policy responses to COVID-19 contain little mention of disability from a rights perspective, except from one department. The WPRPD states the central importance of mainstreaming disability, which it explains as "ensuring that disability is at the centre of all development initiatives as a norm and undisputable principle" (DSD 2016:45). Clearly, this is not yet reality, and the government missed an opportunity during the pandemic to demonstrate the meaning of mainstreaming disability as per this White Paper. Most concerning of all is the silence of the Department of Health with respect to people with disabilities, despite its role as a key service provider. This renders people with disabilities not only exposed to the risks of the pandemic, but also the non-inclusive measures taken to address it and their impact.

Our study reflected the range of sectors and ministries involved in health-related action, underscoring the need for coordinated multisectoral efforts to achieve inclusive healthcare. However, it was clear from the data that with respect to pandemic policy responses, disability was 'owned' only by DSD. The need for intersectoral collaboration (ISC) to address social determinants of health for the general population has been well recognised, as have the challenges with making this happen. Schneider et al. (2021) describe how COVID-19 produced new opportunities and imperatives for ISC for health, and how these resulted in improved collaborative governance in parts of South Africa. On the one hand, this offers hope that the pandemic may have shifted the siloed tendencies of government departments. On the other, the same authors caution that the motivation for ISC may dwindle without the stimulus of a crisis.

Like many studies examining disability inclusion in COVID-related policy in different countries, our research found extensive shortcomings in government responses. Given the historical state of disability inclusion in South Africa, this is not a surprise, but it does highlight the importance

of pre-existing policy and service frameworks on inclusive disaster responses (Shikako et al. 2023a). Analyses from many countries (including high-income nations) describe how existing services for people with disabilities were affected by the pandemic (Brennan 2020; Kuper et al. 2020; Shakespeare, Ndagire & Seketi 2021; Shikako et al. 2023b). While a deterioration in support systems was widely reported, at least some mitigation of the negative impact of COVID-19 was often recorded due to the supports that continued. In South Africa, addressing the vulnerabilities of people with disabilities at this time called for services that did not exist prior to the pandemic (e.g. accessible transport to reach healthcare, formal caregiving services), and this was, practically speaking, impossible under disaster conditions.

The structure and funding of pre-existing services was important for how and whether they continued under pandemic conditions. Colon-Cabrera et al. (2021) discuss how the decentralised 'gig economy' structuring of care services for people with disabilities in Australia made it extremely difficult to manage safe continuance and infection control. In South Africa, home care services are scarce, and where available are usually provided by NGOs. During the pandemic, no targeted support reached organisations of and for people with disabilities, and regulations shifted existing resources (human and financial) to the COVID-19 effort (Hlongwane et al. 2022). In DOH facilities, many rehabilitation workers were also redeployed to COVID-specific activities (van Biljon & van Niekerk 2022). The lack of legal and institutional protection for disability services meant their inevitable erosion during the crisis.

Another example where pre-existing structures (or lack thereof) affected capacity for inclusive responses was public transport. Large-scale providers, especially in developed countries, could feasibly implement altered schedules to reduce infection risk (e.g. lower capacity, higher frequency). However, in South Africa, the vast majority of public transport is provided by privately owned minibus taxis, which depend on their day-to-day takings to remain financially viable. Without the resources and control of a large organisation behind public transport (whether private or state-owned), ensuring compliance with COVID-19 regulations was extremely challenging. While wide-reaching state service provision is controversial, it seems possible that such centrally organised services were better able to respond to the pandemic.

STRENGTHS AND LIMITATIONS OF THE STUDY

Our search strategy may not have included all relevant policy documents, especially those which were not published in the government gazette, and/or did not appear on the main government websites searched. Many decisions and actions by government departments were also internally communicated by circular or memo, and these documents may not be publicly available.

Our study focused on national policy documents and communications, which did not address all issues in detail. Provincial governments in South Africa have considerable autonomy in operationalising national policy for regional implementation, which means that provincial policy may have determined actual disability inclusion at local level. A scan of selected provincial DOH websites revealed that not all did produce local policies and plans, and geographical variation in disability-related action was probable.

A significant limitation of the study was coverage of policy measures affecting school-aged children and youth in higher education. We excluded documents from the Departments of Basic and Higher Education due to time constraints, which would have had bearing on the health of children and youth with disabilities. Future research should focus more specifically on these age groups.

Our search and analysis were guided by first-hand knowledge of the South African context. For example, telemedicine policy change was not mentioned in any regulation we found, but we were made aware of it in our capacity as health professionals. It follows that we may have missed other topics relevant to this study, if they did not appear in documents covered by our search strategy and were not otherwise within our awareness.

The researchers' insight into local context was a strength of the study, supplemented by emerging literature on the experiences of people with disabilities in South Africa during the pandemic. While our focus was on policy and not implementation, the significance of policy content can only be understood by knowing the situation it addresses. This was especially important in identifying gaps in the policy response. For example, the problems with the

IMPLICATIONS OF THE STUDY

The poor state of disability inclusion in South African policy is not a new finding, although this study provides evidence of its continuance under the COVID-19 pandemic. Decades of advocacy by the South African disability sector have called for mainstreaming and inclusive policymaking, with disappointing effect (Hlongwane et al. 2022). These recommendations continue to be repeated in other work on disability from the COVID-19 era (McKinney 2021; Kuper et al. 2020; Mulibana 2020). What remains unknown is why these calls have failed, and what else might be done to bring about their implementation.

In the post-COVID recovery era, there is an urgent need to build disability inclusion into the way services (especially health services) are organised and delivered, even as budgets shrink and the demands on available resources grow. The WPRPD already exists to drive this process, but given the lack of implementation to date, its effectiveness as a force for change while it remains below the status of law seems doubtful.

More positively, the pandemic precipitated a rethinking of systems and services. Many more services have gone online (including telehealth), home delivery businesses have expanded, and working from home has gained acceptability—all of which may benefit people with disabilities particularly. By expanding society's awareness of different participation constraints and stimulating more flexibility, COVID-19 may have made aspects of society more inclusive. The growing body of research on how the pandemic affected marginalised groups (to which this paper contributes) also offers hope of increasing societal attention to how inequity operates, and the strategies which may reverse it.

CONCLUSION

This study examined South African government policy responses to COVID-19 during 2020 in terms of their inclusiveness of people with disabilities. The findings showed the limited conceptions of disability held by policymakers, and consequently how disability inclusion continued to be neglected in planning and implementation. The lack of intersectoral buy-in respecting the WPRPD is apparent, as is the continuing trend for disability policy statements which sound progressive but fail to make real change. More research is needed to understand South African policymakers' continuing failure to address disability meaningfully, as well as to find potential levers to effect change.

This study adds to the body of contextually relevant evidence needed to inform both more inclusive policy and decision-making, and translation of rights-based sentiments into action.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Supplementary File 1.** List of included sources. DOI: <https://doi.org/10.16993/sjdr.1066.s1>
- **Supplementary File 2.** Websites used in document search. DOI: <https://doi.org/10.16993/sjdr.1066.s2>

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