MONITORING THE HUMAN RIGHTS IMPACT OF COVID-19 AND RELATED EMERGENCY MEASURES ON PERSONS WITH DISABILITIES IN SOUTHERN AFRICA

'[PERSONS WITH] DISABILITIES' LIVES MATTER TOO'*

JUNE 2022

Centre for Human Rights
UNIVERSITY OF PRETORIA

OSISA
Open Society Initiative for Southern Africa

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Monitoring The Human Rights Impact Of Covid-19 And Related Emergency Measures On Persons With Disabilities In Southern Africa

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* Quote from a respondent with a physical disability from Namibia.

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ACRONYMS AND ABBREVIATIONS

ACERWC	African Committee of Experts on the Rights and Welfare of the Child
ACRWC	African Charter on the Rights and Welfare of the Child
	African Disability Protocol Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities
AT	Assistive Technology
COVID-19	SARS-CoV-2 (Coronavirus)
DPOs	Disabled Persons' Organisations
NHRIs	National Human Rights Institutions
NPM	National Preventative Mechanism
OPCAT	UN Optional Protocol to the Convention Against Torture
OPDs	Organisations of Persons with Disabilities
PPE	Personal Protective Equipment
PWDs	Persons with Disabilities
UNCRPD	United Nations' Convention on the Rights of Persons with Disabilities
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

TABLES, GRAPHS AND MAPS

1. INTRODUCTION

This survey gathered quantitative and qualitative information on the experiences relating to emergency government responses to COVID-19 and its impact on persons with disabilities (PWDs) from seven countries: Botswana, Eswatini, Lesotho, Malawi, Namibia, Zambia and Zimbabwe. The data was obtained from 352 respondents, inclusive of PWDs, family members and carers of PWDs. The survey sought to gather the respondents' experiences of the COVID-19 pandemic to obtain a regional understanding of consequences of government responses experienced by PWDs, or those who support them, during this unprecedented humanitarian emergency.

Due to the consequences of government regulations as a response to mitigate the impact of the pandemic, PWDs experienced heightened stigma, discrimination and human rights violations. This status quo is a global finding from the COVID-19 Disability Rights Monitor which surveyed the responses from 134 countries, of which 34 were African.[1] The Southern African country response rate was low, aside from a high response rate from South Africa. Accordingly, a need for obtaining data from the seven countries in this survey was identified.

1 COVID-19 Disability Rights Monitor 'Disability rights during the pandemic: A global report on findings of the COVID-19 Disability Rights Monitor' (2020) 19 https://covid-drm.org/en/statements/covid-19-disability-rights-monitor-report-highlights-catastrophic-global-failure-to-protect-the-rights-of-persons-with-disabilities (accessed 04 May 2022).

2. BRIEF LITERATURE REVIEW

The literature review identifies a few key themes. These are state obligations and the roles of stakeholders such as NHRIs and NPMs, as well as DPOs. Thereafter rights violations identified in the literature and measures needed to address these are discussed, including in relation to the rights to access healthcare, accessible information, access to sufficient nutrition, and access to justice. Next, literature on the availability, accessibility and inclusivity of protective measures for PWDs is described, followed by the impact of the pandemic on specific groups of PWDS, such as those with psycho-social disabilities and children with disabilities. The review focuses primarily on literature from the selected countries, as well as on guidelines from international and regional law, treaty monitoring bodies (TMBs) and other international stakeholders.

2.1 State obligations and the role of stakeholders

2.1.1 International and regional guidelines on appropriate state measures for PWDs

International and regional bodies have sought to identify standards and guidelines on addressing the impact of the pandemic and other humanitarian disasters on PWDs. These relate to issues such as access to PPEs, medication, education, justice and access to adequate nutrition and water. Some of these guidelines are identified next. In particular, the impact of rurality in measures for PWDs is discussed.

At the outset of the pandemic various bodies issued guidelines to countries on how to mitigate the disproportionate impact of governmental restrictions on the lives of PWDs.[1] International agreements such as the United Nations' Convention on the

1 UNOHRC 'COVID-19 and the rights of persons with disabilities: Guidance' (2020) https://www.ohchr.

Rights of Persons with Disabilities (CRPD)[2] and Agenda 2030 towards Sustainable Development[3] provide a blueprint for action to address some of the challenges brought by the humanitarian crisis and its impact on PWDs. Article 11 of the CRPD requires states parties to take all possible measures to ensure the protection and safety of PWDs in the national responses to situations of risk and humanitarian emergencies. These measures include those that protect their right to access the highest attainable standard of health, prevention of infectious diseases such as COVID-19, and measures to protect PWDs against stigmatisation and isolation arising from the pandemic. The 2030 Agenda, similarly assists countries in identifying measures to meet targets that respond to epidemics, including in relation to access to medicine and vaccines, and promotion of mental health and wellbeing. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities (the African Disability Protocol) will offer further context-specific guidance to states, once it comes into force, on how to mitigate the impact of the pandemic or similar humanitarian disasters on PWDs residing in Africa and it reinforces, particularly, the existing state duty to provide access to healthcare to PWDs on an equal basis to those without disabilities.[4]

Rapid deinstitutionalisation of PWDs in some instances, with closed off institutions in other instances, and restrictions of freedom of movement of those persons residing in the community, as well as limited or no access to services, including healthcare, meant that the daily living of PWDs within communities (and those in institutions) brought many challenges to the fore. Article 19 of the CRPD, however, recognises the right of all PWDs to live in the community with choices equal to others. States parties therefore have a duty to take 'effective and appropriate measures' to facilitate the exercise of this right and their full inclusion and participation in the community.[5]

TMBs such as the African Committee of Experts on the Rights and Welfare of the

org/sites/default/files/Documents/Issues/Disability/COVID-19/COVID-19_and_The_Rights_of_Persons_with_Disabilities.pdf (accessed 04 May 2022); 'Joint statement: Persons with Disabilities and COVID-19 by the Chair of the United Nations Committee on the Rights of Persons with Disabilities, on behalf of the Committee on the Rights of Persons with Disabilities and the Special Envoy of the United Nations Secretary-General on Disability and Accessibility' UN Media Centre 01 April 2020 https://www.ohchr.org/en/statements/2020/04/joint-statement-persons-disabilities-and-covid-19-chair-united-nations-committee?LangID=E&NewsID=25765 (accessed 04 May 2022).

2 UN General Assembly, Convention on the Rights of Persons with Disabilities: resolution adopted by the General Assembly, 24 January 2007, A/RES/61/106.

3 UN 'Transforming our World: The 2030 Agenda for Sustainable Development' UN Doc A/Res/70/1 https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf (accessed 04 May 2022).

4 I Mgijima-Konopi & M Auma 'Health emergencies post COVID-19: What guidance can Africa's Disability Protocol provide?' (2020) 8 African Disability Rights Yearbook 253.

5 Such measures include: '(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement; (b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community; (c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.'

Child (ACERWC) identified the knock-on effect of 'temporary' school closures on food security of children and particularly for children with disabilities.[6] The ACERWC urged states parties to adopt measures to address the harmful effects of the pandemic on children, particularly children with disabilities, and ensure the continuation of essential services, including access to safe water and adequate nutrition.

International bodies such as UNESCO sought to identify best practices for government responses to the pandemic for PWDs.[7] Those best practices, however, sometimes ignore African contexts such as rurality. The UNESCO document favours the solutions that can be offered by 'cities [as they] are at the forefront of the social dimension of any crises, social policy response and service delivery'.[8] This survey's findings show that PWDs residing in rural or remote areas are under-served by interventions during the pandemic, including access to information, PPEs and other protective measures. Issues such as the high transport costs and inaccessibility of rural areas for PWDs, as well as lack of sustainable transport options has been explored.[9]

A study of official government measures in relation to COVID-19, found that only half of the countries reviewed from five world regions 'created and implemented specific measures for PWDs to contain, mitigate or supress COVID-19'.[10] Lugo-Agudelo et al commended Zambia's efforts in obtaining a multi-sectoral response to the COVID-19 early on at the onset of the pandemic, which included reference to the vulnerabilities that PWDs face, and identified government undertakings to mitigate the impact of the virus on this population.[11] Particular emphasis is placed, by the Republic of Zambia in its companion document on the socio-economic response to the virus, on the effects on PWDs.

More recently, states sought to investigate and assess the impact of the pandemic on PWDs and those studies point to a disability inclusive response and the need for the participation of and consultation with PWDs.[12] This call for participation is informed by the fact that PWDs are not just 'users' of services, but also 'partners and consultants'.[13] Furthermore, participation of PWDs is considered a 'pre-condition' of

6 ACERWC 'Guiding note on children's rights during COVD-19' (8 April 2020) https://www.acerwc.africa/guiding-note-on-childrens-rights-during-covd-19/ (accessed 04 May 2022).

7 S Bhan et al 'Disability inclusive COVID-19 response: Best practices' UNESCO New Delhi, United Nations Partnership to Promote the Rights of Persons with Disabilities (2021) https://unesdoc.unesco.org/ark:/48223/pf0000378354.locale=en (accessed 04 May 2022).

8 UNESCO (n 8) 9.

9 R Kuhudzai 'SADC e-Mobility outlook: A Zimbabwean case study' SAIIA Occasional Paper 318 (March 2021).

10 LH Lugo-Agudelo et al 'Countries response for people with disabilities during the COVID-19 pandemic' (2022) 2 Frontiers in Rehabilitation Sciences https://doi.org/10.3389/fresc.2021.796074 (accessed 04 May 2022).

11 UN Zambia 'United Nations' Covid-19 Emergency Appeal: Zambia' (2020) https://reliefweb.int/sites/reliefweb.int/files/resources/ZAMBIA_%20COVID-19_Emergency_Appeal.pdf (accessed 04 May 2022).

12 Department of Women, Children and Persons with Disabilities 'COVID-19 and rights of persons with disabilities: The impact of COVID-19 on the rights of persons with disabilities in South Africa' (2021) https://southafrica.un.org/sites/default/files/2021-10/DWYPD%20COVID-19%20REPORT%20Interective%20%281%29.pdf (accessed 04 May 2022).

13 LB Mzini 'COVID-19 pandemic planning and preparedness for institutions serving people living with disabilities in South Africa: An opportunity for continued service and food security' (2021) 9 Journal of

the CRPD as '[a]ctive and informed participation of PWDs in decisions that affect them is consistent with a human rights-based approach, free from stigma and ensures good governance and accountability'.[14] Globally, government COVID-19 measures that are not disability inclusive, have 'compounded' the marginalisation of PWDs.[15]

2.1.2 The monitoring role of NHRIs and NPMs

Studies that monitor the experiences of PWDs and research on the impact of COVID-19 pandemic on various aspects of community and institutional living of PWDs have gathered momentum over the last two years.[16] The role of NHRIs has been touted as crucial to assist in monitoring the situation on the ground for PWDs and advising governments on appropriate measures to meet their obligations to PWDs during the pandemic.[17] Research on outcomes from such NHRI monitoring in relation to PWDs in Southern Africa has not yet been conducted. This study sought to obtain the perspectives of NHRIs in the selected countries but no official responses were received.

A review of NHRI activities elsewhere proposes that the issuing of advisories by NHRIs can assist governments in developing more inclusive responses to the pandemic; and that the use of NHRI complaints mechanisms can contribute to greater accountability.[18] The monitoring role of NPMs as set out in the UN Optional Protocol to the Convention Against Torture (OPCAT)[19] should have set the tone for appropriate governmental measures in detention facilities – but these bodies' access to detention facilities was restricted.[20]

2.1.3 The role of DPOs

Participation of PWDs in public and political life is guaranteed in article 29 of the CRPD, including in relation to their participation through forming DPOs.

Intellectual Disability - Diagnosis and Treatment 11, at 11.

14 UNESCO (n 8) 10.

15 D Colon-Cabrera et al 'Examining the role of government in shaping disability inclusiveness around COVID-19: A framework analysis of Australian guidelines' (2021) 20 International Journal for Equity in Health https://doi.org/10.1186/s12939-021-01506-2 (accessed 04 May 2020).

16 Disability Advisory Group (FCDO-UN SBC) & UNDIS Interagency Working Group on COVID-19 Humanitarian Response and Recovery 'Tip sheet for monitoring a disability-inclusive response to COVID-19 in humanitarian settings' (2020) https://www.un.org/sites/un2.un.org/files/28_sept_disability_inclusive_monitoring_framework_within_hpc_final.pdf (accessed 04 May 2022).

17 E Skhiladze 'Rights of persons with disabilities during COVID-19: How have NHRIs responded?' European Network of National Human Rights Institutions 18 December 2020 https://ennhri.org/news-and-blog/rights-of-persons-with-disabilities-during-covid-19-how-have-nhris-responded/ (accessed 04 May 2022).

18 Common Wealth Forum of National Human Rights Institutions 'Protecting disabled people's rights during COVID-19: Good practice from across the Commonwealth' (2021) https://cfnhri.org/wp-content/uploads/2021/03/Protecting-disabled-peoples-rights-during-COVID-19.pdf (accessed 04 May 2022).

19 UN General Assembly, Optional Protocol to the Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment, 9 January 2003, A/RES/57/199.

20 L Muntingh et al 'Criminal justice, human rights and COVID-19 - A comparative study of measures taken in five African countries: Kenya, Malawi, Mozambique, South Africa and Zambia' (2021) 31 https://acjr.org.za/acjr-publications/combined-covid-19-report-13-10-2021-final.pdf (accessed 04 May 2022).

A regional DPO identified the need to respond to the pandemic by developing a response plan and activities to meet gaps in provision of services to PWDs. One of these is a media literacy campaign (to train the media about inclusivity and accessibility requirements of information on COVID-19) and a need to have better ICT infrastructure.[21] A national DPO developed guidance for the state to ensure disability-inclusive responses.[22]

DPOs can, of course, offer insight into the lived reality of PWDs and the gaps in service provision. This monitoring role of the impact of COVID-19 is crucial to feedback to the relevant government departments for disability inclusive responses.

2.2 Rights violations

2.2.1 Access to health, rehabilitation and habilitation and assistive devices

The right to health of PWDs generally was severely impacted by the government restrictions during the pandemic.[23] Article 25 of the CRPD requires states parties to recognise the rights of PWDs to enjoy the highest attainable standard of health without discrimination on the basis of disability. Such recognition requires states to take appropriate measures to ensure this access to health services in a gender-sensitive manner, including for health-related rehabilitation. The CRPD elaborates on these measures.[24] Article 26 stresses the right of PWDs to habilitation and rehabilitation including in the areas of 'health, employment, education and social services'.

The reallocation of resources that accompany this pandemic has meant that states need to be reminded to continue to support the provision of rehabilitation and habilitation and Assistive Technologies (ATs) as disruption to those supports and services prejudiced PWDs.[25] Article 20(b) of the CRPD requires states to put in

22 Lesotho National Federation of Organisations of the Disabled (LNFOD) 'Strategy for COVID-19 and persons with disabilities' (2020) http://www.lnfod.org.ls/uploads/1/2/2/5/12251792/lnfod_strategy_for_covid19_.pdf (accessed 04 May 2022).

23 E Hulland 'COVID-19 and health care inaccessibility in sub-Saharan Africa' (2020) 1 The Lancet Healthy Longevity E4-E5; R Swindle & D Newhouse 'Barriers to accessing medical care in Sub-Saharan Africa (SSA) in early stages of COVID-19 Pandemic' (2020) 38 Poverty and Equity Notes 1.

24 '(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes; (b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons; (c) Provide these health services as close as possible to people's own communities, including in rural areas; (d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care; (e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner; (f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.'

25 UNICEF 'COVID-19 response: Considerations for children and adults with disabilities' (2020) https://sites.

place effective measures to ensure the personal mobility of PWDs to foster their 'greatest possible independence', including measures to facilitate their access 'to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost'.

Access to assistive technology (AT) including services such as repairs has been disrupted by the pandemic. A multi-country study into the experiences of assistive technology-users (AT-users) during the pandemic recommends that government responses should be AT-user inclusive and should recognise AT as essential health products and services. The study also recommends broad-based consultation with stakeholders such as AT-users, their families, providers of AT, and DPOs[26] to promote AT use.

Worldwide, measures to address COVID-19, including the use of science and technology, have excluded the participation of PWDs. This includes inaccessible vaccine testing kits, lack of interpreters or captioning when using telemedicine, for example, inaccessible vaccination registration sites for the Blind or those with visual impairments.[27] But for many PWDs in Southern Africa, access to at-home testing kits and telemedicine is still a pipedream.

2.2.2 Accessible information

The state obligation to make information accessible, including ICT and broadcasting is found in article 9(b) of the CRPD which requires states to take appropriate measures to ensure that PWDs have access, on an equal basis with others, to information, communications and other services, including electronic services and emergency services. Furthermore, article 25(b) of the CRPD requires states to take all appropriate measures to ensure access for PWDs to health services (and information) that are gender-sensitive, including health-related rehabilitation. Article 21 of the CRPD promotes the freedom of expression and opinion and access to information for PWDs. Accordingly, states parties have to take appropriate measures to do so, including through the provision of information in accessible formats and technologies appropriate to diverse disabilities; and utilising the use of sign language, Braille, Augmentative and Alternative Communication (AAC) and other accessible means, modes and formats of communication utilised by PWDs. Furthermore, private entities that provide information to the general public, including through the internet are to be urged to provide such information and services in accessible and usable formats. States parties are also obliged to encourage the mass media (including internet based media) to make their services accessible to PWDs.

unicef.org/disabilities/files/COVID-19_response_considerations_for_people_with_disabilities_190320.pdf (accessed 04 May 2022).

26 N Layton et al 'Access to assistive technology during the COVID-19 global pandemic: Voices of users and families' (2021) 18 International Journal of Environmental Research and Public Health 11273.

27 L Weber 'Pandemic medical innovations leave behind people with disabilities' Kaiser Health News 14 March 2022 https://www.fiercebiotech.com/medtech/pandemic-medical-innovations-leave-behind-people-disabilities (accessed 04 May 2022).

Article 19(2) of the African Disability Protocol will require states to put in place policy, legislative, administrative and other measures to ensure these rights, on the basis of equality, including requiring private entities, such as telecom and television companies, to provide information and services in accessible and usable formats for PWDs.

Lack of information about COVID-19 and inaccessible formats is a refrain in the literature. In Zimbabwe, for example, only one national television station broadcast information on COVID-19 and it was not provided in accessible formats for the Deaf or simplified formats for persons with intellectual disabilities.[28] A successful lawsuit brought by Zimbabwean DPOs in April 2020, forced the state-run broadcaster to provide accessible information on the Coronavirus for Blind and visually impaired persons and Deaf and hard of hearing persons. The court ordered the provision of subtitles/captions for pre-recorded programmes and sign language interpretation for main news bulletins, as well as sign language interpretation for live announcements (where they have sufficient notice), and to progressively increase provision of sign language interpretation for all live programming including news bulletins. Various government departments were ordered to produce pamphlets in Braille and large text on information about the virus, its prevention, and where to access healthcare facilities and emergency contacts.[29]

Mhiripiri and Midzi compared the suitability of information publicised in the mainstream media in Zimbabwe, the United Kingdom and New Zealand and traced activism by PWDs on the issue. The authors conclude that PWDs 'demand information on public health issues [such as COVID-19] in a crisis time as a matter of life or death'.[30] Svongoro & Matende considered access to information for disadvantaged communities in Zimbabwe and identified the information gap in the mainstream media. More than 60 per cent of COVID-19 messages communicated in Zimbabwe's mainstream media do not cater for the needs of these disadvantaged groups. Brochures, videos and infographics, for instance, appear in English, yet English proficiency amongst the Zimbabwean population is significantly limited. With regard to the Deaf community, videos, conversations and interviews with health specialists which also includes Zimbabwean Sign Language interpretation, were analysed which rarely appear in mainstream public media.[31] The use of communications that employ plain language, Easy Read and other formats should be promoted to ensure access to information for persons with intellectual disabilities.[32]

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28 International Disability Alliance 'When Accessible information is far from a reality: Zimbabwe during Covid-19' (16 April 2020) https://www.internationaldisabilityalliance.org/covid19-story-zimbabwe (accessed 04 May 2022).

29 Centre for Disability & Development v Zimbabwe Broadcasting Corporation Holdings (Pvt) Ltd HC2175/20 Zimbabwe High Court (Harare) http://www.veritaszim.net/sites/veritas_d/files/Final%20order%20against%20ZBC.pdf (accessed 04 May 2022).

30 NA Mhiripiri & R Midzi 'Fighting for survival: Persons with disabilities' activism for the mediatisation of COVID-19 information' (2021) 178 Media International Australia 151, at 165.

31 P Svongoro & T Matende 'Covid-19 information gaps among the disadvantaged communities: The case of the Deaf and Limited English Proficiency communities in Zimbabwe' (2021) 26 Communitas 86.

32 TA Samboma 'Leaving no one behind: Intellectual disability during COVID-19 in Africa' (2021) 64 International Social Work 265.

Governmental websites do not often provide accessible information for PWDs. For example, even though the Zimbabwean website outlines COVID-19 measures implemented by the government in plain language, the same information is not translated into other languages.[33] Sign language during television broadcasts is a good practice, except for countries where access to television is limited such as Eswatini.[34] Some other good practices have been spotlighted, such as the printing of Information, Education and Communication booklets concerning COVID-19 for Blind persons and those with visual impairments.[35]

2.2.3 Access to sufficient nutrition

Access to food was restricted for most population groups during the lockdown periods, including for PWDs.[36] Particular sub-groups suffered disproportionately as a result of food insecurity – women and children with disabilities.

2.2.4 Access to justice

Article 13 of the CRPD guarantees access to justice for PWDs on an equal basis with others, which requires provision of procedural and age-appropriate accommodations in legal proceedings, as well as training for stakeholders involved in the administration of justice (police and prison staff too).

Access to justice was severely constrained during hard lockdowns, and backlogs since those restrictions were lifted, continue to hamper access to justice.[37] UNODC calls for an analysis of the particular risks for PWDs and adoption of mitigation measures in relation to barriers to access to justice during the pandemic.[38] It further calls for justice systems to provide procedural accommodations for PWDs and to ensure accessibility of legal information and advice to PWDs.[39] Crucially, the availability of complaints mechanisms and legal assistance during hard lockdowns was limited particularly where the justice sector was not considered an essential service. A review of restrictions in the justice systems of countries such as Malawi identifies that backlogs in justice systems caused by hearing limitations continue after initial hard lockdowns were lifted.[40]

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33 Zimbabwean Ministry of Health and Child Care http://www.mohcc.gov.zw/index.php?option=com_content&view=category&layout=blog&id=103&Itemid=743 (accessed 04 May 2022).

34 S Dlamini 'FODSWA assesses COVID-19 impact on PWDs in Eswatini' (22 November 2020) https://covid19.safod.net/questions-answers-new-coronavirus-covid-19/ (accessed 04 May 2022).

35 F Bellumore 'COVID-19, Information in Braille for Blind People in Zambia: Amref: Nobody left behind' Focus on Africa (6 May 2020) https://www.focusonafrica.info/en/covid-19-information-in-braille-for-blind-people-in-zambia-amref-nobody-left-behind/ (accessed 04 May 2022).

36 UNESCO 'Assessment shows persons with disabilities in Zimbabwe experience severe impact of COVID-19' (03 February 2022) https://en.unesco.org/news/assessment-shows-persons-disabilities-zimbabwe-experience-severe-impact-covid-19 (accessed 04 May 2022).

37 UNODC 'Guidance note: Ensuring access to justice in the context of COVID-19' (2020) https://www.unodc.org/documents/Advocacy-Section/Ensuring_Access_to_Justice_in_the_Context_of_COVID-191.pdf (accessed 04 May 2022).

38 UNODC (n 39) 17.

39 UNODC (n 39) 23 & 31.

40 Muntingh et al (n 22) 31.

Domestic courts such as those in Malawi assert the rights of PWDs to be protected during the pandemic, including protection from domestic violence during government imposed lockdowns.[41] Unfortunately, however access to information about rights and redress was a barrier for PWDs in some countries, including Botswana, pre COVID-19.[42] Public participation in the formulation of lockdown regulations, however, has not been found to be necessary by some Southern African domestic courts.[43]

2.2.5 Employment and income generating opportunities

The impact of state regulations on the ability of PWDs to attend work, and generate an income continued to have a knock-on effect even after hard lockdowns were suspended.[44] The impact of the pandemic on informal economy workers was exacerbated by policy responses that exclude the informal economy.[45] The ILO recommends that states formulate gender-sensitive measures to mitigate the impact of the pandemic on the services they render and to impose income support measures such as a universal temporary grant.[46]

2.2.6 Adequate standard of living, social protection and social security

Article 28 of the CRPD recognises the right to an adequate standard of living and social protection for PWDs, which includes adequate food and housing. The CRPD further requires states parties to recognise the right of PWDs to social protection, as well as measures to ensure access to clean water, 'appropriate and affordable services, devices and other assistance for disability-related needs', and assistance with disability related expenses for persons living in situations of poverty and public housing.[47]

Good practices such as emergency cash transfers which offer beneficiaries opportunities to survive have been identified.[48] A review of cash transfer practices in SADC shows that the impact of cash transfers for poverty alleviation is immediate.[49] Social protection measures in Botswana, previously fragmented, have been streamlined during the pandemic into a more coherent offering, however monitoring and evaluation gaps

41 R (oao Kathumba) v President of Malawi (Constitutional Reference 1 of 2020) [2020] MWHC 29 (3 September 2020) para 10.2.2.3. But See Law Society of Kenya v Hillary Mutyambai Inspector-General National Policy Service [2020] EKLR where a similar challenge was unsuccessful.

42 S Mukhopadhyay & E Moswela 'Disability Rights in Botswana: Perspectives of individuals with disabilities' (2020) 31 Journal of Disability Policy Studies 46.

43 Esau v Minister of Co-operative Governance and Traditional Affairs 2020 (11) BCLR 1371 (WCC) para 129; Esau v Minister of Co-Operative Governance and Traditional Affairs [2021] 2 All SA 357 (SCA) (South Africa); and Law Society of Kenya v Attorney General; National Commission for Human Rights (Interested Parties) [2020] eKLR (Kenya) paras 9, 11, 81 and 88.

44 UNESCO (n 8).

45 ILO 'The impact of the COVID-19 on the informal economy in Africa and the related policy responses' (2020) https://www.ilo.org/wcmsp5/groups/public/---africa/---ro-abidjan/documents/briefingnote/wcms_741864.pdf (accessed 04 May 2022).

46 ILO (n 47) 6.

47 Art 28(2)(b), (c) and (d) of the CRPD.

48 UNICEF 'In Zambia, a second chance at life with COVID-19 emergency cash transfer' https://www.unicef.org/zambia/stories/zambia-second-chance-life-covid-19-emergency-cash-transfers (accessed 04 May 2022).

49 T Fundira & I Frye 'Review of current social cash transfer programmes in SADC and global social protection responses to Covid-19' Studies in Poverty & Inequality Institute (2021) http://spii.org.za/wp-content/uploads/2021/04/SPII02-REVIEW-OF-SADC-STATE-SCT-PROGRAMMES-OSISA-REPORT-PRINT-FINAL.pdf (accessed 04 May 2022).

remain.[50] Extension or new beneficiary creation in social assistance as a 'shock' response in the form of vertical and horizontal cash transfers during the pandemic was offered by some countries such as Malawi.[51]

However others, such as Zambia, were reluctant to expand existing social protection programmes.[52]

2.3 Availability, accessibility and inclusivity of protective measures

Lack of access to affordable PPEs, and sanitisers and soap is a major concern for PWDs.[53] A study by UNESCO on COVID-related measures for PWDs in Malawi identified that not only barriers to access PPEs (affordability) and accessibility (for example mask use impacts on lip reading for the Deaf or hearing impaired persons), but also access to water and soap to exercise hygiene and the challenges with practising social distancing for some PWDs (those who use personal assistants or require help with self-care).[54] As will become clear, this study's findings are in line with the UNESCO report.

2.4 The impact of the pandemic on some sub-groups

The disproportionate impact of the pandemic and state measures to mitigate the impact of the virus on PWDs and a general lack of disability specific or inclusive measures at a global level is undeniable.[55] Some groups of PWDs are further prejudiced by this situation. These groups include persons with psycho-social disabilities and children with disabilities.

2.4.1 Children with disabilities

Children with disabilities are at higher risk for COVID-19, particularly due to their

50 S Devereux 'Social protection responses to COVID-19 in Africa' (2021) 21 Global Social Policy 421.

51 Oxfam 'Shelter from the storm: The global need for universal social protection in times of COVID-19' (2020) https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621132/bp-social-protection-covid-19-151220-en.pdf (accessed 04 May 2022); Cf H Zandam & FM Gardiner 'Building back to leave no one behind: Disability-inclusive COVID-19 response and recovery in Africa' (2021) Harvard Africa Policy Journal 73.

52 L Gronbach & J Seekings 'Pandemic, lockdown and the stalled urbanization of welfare regimes in Southern Africa' (2021) 21 Global Social Policy 448 https://doi.org/10.1177/14680181211013725 (accessed 04 May 2022).

53 UN Eswatini 'An inspirational fight against Covid-19 in the Disability Community' (2020) https://eswatini.un.org/en/40338-inspirational-fight-against-covid-19-disability-community (accessed 04 May 2022).

54 UNESCO Regional Office for Southern Africa 'Rapid impact assessment of COVID-19 on persons with disabilities in Malawi' (2021) 29, https://unesdoc.unesco.org/in/documentViewer.xhtml?v=2.1.196&id=p::usmarcdef_0000376053&file=/in/rest/annotationSVC/DownloadWatermarkedAttachment/attach_import_fb9e39cf-5744-4eff-b0cb-1b085074c522%3F_%3D376053eng.pdf&locale=en&multi=true&ark=/ark:/48223/pf0000376053/PDF/376053eng.pdf#Report%20Rapid%20Impact%20Assessment%20Of%20Covid-19%20On%20Persons%20With%20Disabilities%20In%20Malawi_Final.indd%3A.222374%3A2080 (accessed 04 May 2022); Cf TA Samboma 'Leaving no one behind: Intellectual disability during COVID-19 in Africa' (2021) 64 International Social Work 265.

55 T Shakespeare, F Ndagire & QF Seketi 'Triple jeopardy: Disabled people and the COVID-19 pandemic' (2021) 397 The Lancet https://www.thelancet.com/action/showPdf?pii=S0140-6736%2821%2900625-5 (accessed 04 May 2022).

heightened experiences of poverty, limited access to healthcare and few educational opportunities.[56] Some children with intellectual disabilities struggle to wear masks and require access to PPEs.[57] A higher care burden is felt by families and caregivers of children with disabilities during the lockdown periods.[58] Children with disabilities residing at or using residential facilities and schools were severely impacted by consequences of regulations such as school and facilities closure, or the absenteeism of caregivers or teachers, and access to adequate nutrition.[59]

Studies recommend the need for psycho-social support to these families and for material provisions such as food and PPEs.[60] Olivia et al in their Zimbabwean study found that children with disabilities in the Chiredzi area did not obtain meaningful assistance from the government and NGOs during the pandemic and experienced barriers to basic education and health. The study recommended inter alia the introduction of subsidies to assist children with disabilities in schools.[61]

Article 24 of the CRPD identifies the state measures that need to be put in place to respect and promote the rights of children with disabilities to education.

2.4.2 Women with disabilities

Women with disabilities suffer compounded marginalisation during the COVID-19 era and their rights to freedom from violence and access to sexual reproductive health rights were compromised as well as their ability to generate an income.[62]

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56 MO Hearst et al 'Rapid health impact assessment of COVID-19 on families with children with disabilities living in low-income communities in Lusaka, Zambia' (2021) 16 PloS one p.e0260486; Better Care Network 'Children with disabilities in Zambia: Health impact assessment of COVID-19 on families with children living with disabilities in three communities in Lusaka' (December 2020).

57 'Children with intellectual disabilities hard hit by COVID-19' NewsdayZim 28 February 2022 https://www.newsday.co.zw/2022/02/interview-children-with-intellectual-disabilities-hard-hit-by-covid-19/ (accessed 04 May 2022).

58 D Sharpe et al 'Mental health and wellbeing implications of the COVID-19 quarantine for disabled and disadvantaged children and young people: Evidence from a cross-cultural study in Zambia and Sierra Leone' (2021) 9 BMC psychology 1. N Singal et al 'Impact of COVID-19 on the education of children with disabilities in Malawi: Reshaping parental engagement for the future' (2021) International Journal of Inclusive Education DOI: 10.1080/13603116.2021.1965804.

59 Mzini (n 15) 11.

60 NHRID Conference 'The perceived experiences of caregivers, children with special needs and people with disabilities during the COVID-19 pandemic in Eswatini' (27 August 2021) https://nhridconference.org.sz/download/the-perceived-experiences-of-caregivers-children-with-special-needs-and-people-with-disabilities-during-the-covid-19-pandemic-in-eswatini/ (accessed 05 May 2022).

61 G Olivia 'The Impact of COVID-19 pandemic on children with disabilities: The case of Chiredzi South, Zimbabwe' (2021) 12 Open Journal of Political Science 46.

62 Institute for Community Development 'The impact of covid-19 on women with disabilities in urban Masvingo'The-impact-of-COVID-19-on-women-with-disabilities-in-Masvingo-icodzim-200512.pdf (kubatana.net) (accessed 05 May 2022). See also, UNFPA 'The health systems we build back after COVID-19 must reach everyone' (03 December 2020) https://botswana.unfpa.org/en/news/health-systems-we-build-back-after-covid-19-must-reach-everyone-15 (accessed 05 May 2022); OCHA 'Pandemic heightens vulnerabilities of people living with disabilities' (2020) https://reliefweb.int/report/world/pandemic-heightens-vulnerabilities-people-living-disabilities (accessed 05 May 2022); P Zulu 'A lady without hands uses feet to run a thriving business in Eswatini' (2021) https://www.aa.com.tr/en/africa/lady-without-hands-uses-feet-to-run-thriving-business-in-eswatini/2437583 (accessed 05 May 2022).

2.4.3 Persons with psycho-social disabilities

Particular groups of PWDs are more severely impacted by both primary and secondary consequences of the pandemic, for example, persons with psycho-social disabilities.[63] Indeed, access to healthcare specifically for persons with psycho-social disabilities were more constrained during the pandemic and the deleterious impact of the pandemic itself and its consequences for daily living on mental health has been noted.[64]

The continued under-prioritisation both politically and fiscally is problematic in Sub-Saharan Africa.[65]

The heightened experience of persons with psycho-social disabilities of social isolation and abandonment by family during the quarantine periods of the pandemic further impacted on their physical and mental health.[66] Scholars call for specific mental health guidelines to be developed by states to address the needs of groups such as PWDs during the pandemic.[67]

2.5 Summary

The brief literature review shows that the international and regional guidance issued point to a duty to formulate disability inclusive responses that foster the participation of and consultation with PWDs and their representative organisations such as DPOs. The disproportionate impact of rurality on PWDs during the pandemic should be acknowledged and contextual measures drafted to ameliorate this barrier. The continuation of basic services provision is identified as crucial, particularly for sub-groups such as children with disabilities. The international and regional law obligations are clear that states parties have a duty to implement protective and safety measures that include promoting the right to health and to protect PWDs against stigmatisation and isolation.

The monitoring role and complaints mechanisms of NHRIs and NPM have been identified as necessary for holding states accountable for their pandemic responses. Similarly, DPOs are well suited to provide strategic guidance to states on disability inclusive responses and to ensure the self-representation and participation of PWDs is at the forefront of these responses.

In relation to state responses that meet the state obligations towards respecting,

63 Pan African Network of Persons with Psychosocial Disabilities et al 'COVID-19 and persons with psycho-social disabilities' (2020) https://dk-media.s3.amazonaws.com/AA/AG/chrusp-biz/downloads/357738/COVID19-and-persons-with-psychosocial-disabilities-final_version.pdf (accessed 05 May 2022).

64 L Ned et al 'COVID-19 pandemic and disability: Essential considerations' (2020) 18 Social and Health Sciences 136.

65 K Molebatsi et al 'Mental health and psycho-social support during COVID-19: A review of health guidelines in Sub-Saharan Africa' (2021) Frontiers of Psychiatry https://doi.org/10.3389/fpsyt.2021.571342 (accessed 04 May 2022).

66 PTT Nwachukwu 'COVID-19 lockdown and its impact on social-ethics and psycho-social support for disability care' (2021) 9 Journal of Intellectual Disability - Diagnosis and Treatment 45.

67 Molebatsi et al (n 67).

fulfilling, promoting and protecting the human rights of PWDs, the literature identified the following shortcomings:

- The rights of PWDs to health, rehabilitation and habilitation and access to assistive devices continue to be constrained during the pandemic and access to COVID-19 specific interventions such as vaccinations remain exclusionary of the needs of PWDs.
- The literature identified a general lack of information about COVID-19, prevention and vaccination and that information was presented in inaccessible formats. Lack of Sign language interpretation, inaccessible websites, unavailability of documents in Braille and large print or Easy Read, and television broadcasts that excluded the Deaf and Hearing impaired was identified. Good practices were identified in some countries such as sign language interpretation during news broadcasts on television but this measure is less impactful in countries with lower rates of owning television sets.
- The right to access justice, including procedural accommodations, was constrained for PWDs. Resultant backlogs remain problematic. General awareness of rights and access to redress is low for PWDs.
- Food security for PWDs, specifically women and children with disabilities was highly constrained.
- The ability of PWDs to generate income and to remain employed, including informal economy workers, was affected by lockdowns and the continued pandemic government restrictions and consequences of the pandemic on the economy.
- Measures to address the need for an adequate standard of living and social protection of PWDs were implemented in some states, including cash transfers. However, some did not implement such measures and excluded PWDs and existing beneficiaries from receiving extra assistance.
- Protective measures to combat COVID-19, including masks and access to soap, clean water and sanitation were generally not available, inaccessible and not disability-inclusive.
- Particular groups of PWDs, including women, children and persons with psycho-social disabilities were further marginalised by government responses which further undermined their access to services, their isolation and such responses are discriminatory. The literature identifies that gender-sensitive, child-friendly and mental health specific responses are needed.

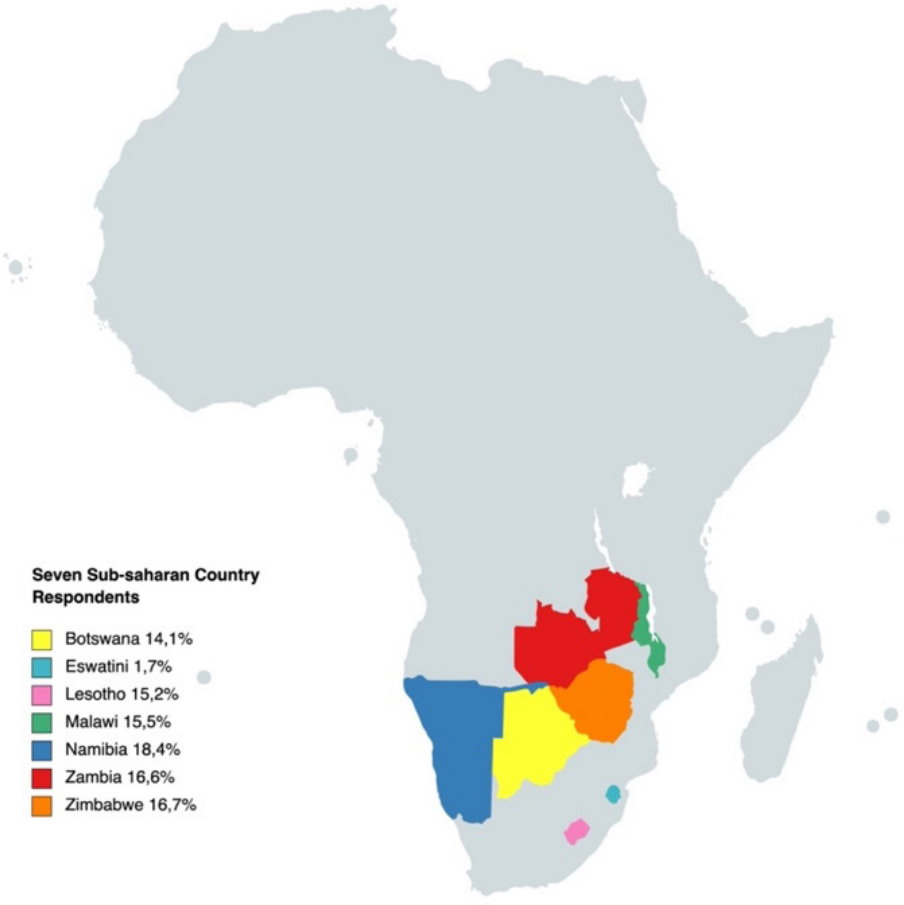
This monitoring project, considered against the background of the international agreements and burgeoning literature on human rights impacts of the COVID-19 pandemic on the lives of PWDs, will provide insight into the specific challenges experienced by PWDs during the pandemic as a result of the responses to the pandemic adopted by specific governments of Southern Africa, as well as provide recommendations for meaningful and equal access and participation during and post-pandemic.

3. METHODS

Descriptive quantitative and statistical analysis was employed for the data from all the questions in the survey and inferential quantitative and statistical analysis was employed for selected questions. Thematic qualitative analysis was employed for the data from all questions.

4. DEMOGRAPHIC INFORMATION

The table below indicates the responses obtained from the seven countries, at an average of 50 responses per country – with the majority being obtained from Namibia, at 18,4 per cent of the responses and the least from Eswatini, at 1,7 per cent of responses



Map 1: Map of Africa depicting the seven countries with their rate or responses to the survey.

The majority of responses were obtained from female respondents (48,6 per cent), with 42,7 per cent of male respondents, while 1,7 per cent of respondents selected to identify as 'other'; another 1,7 per cent identified that they preferred not to disclose, and 5,2 per cent were unspecified.

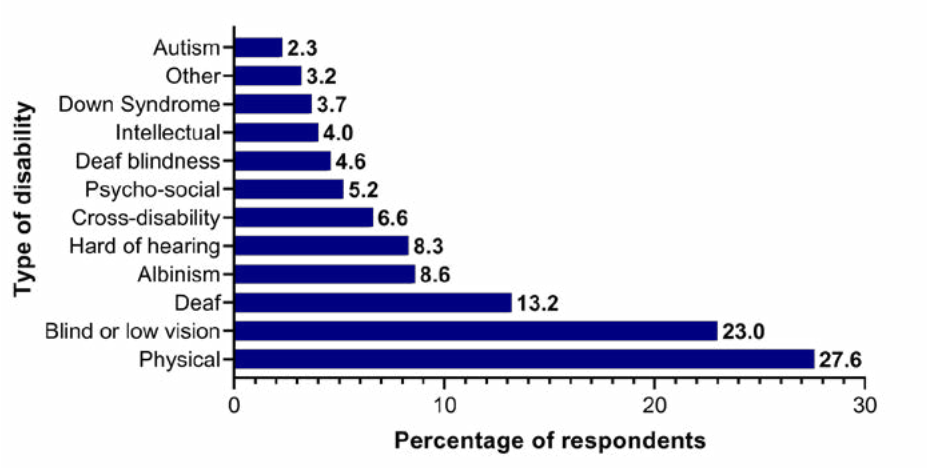
The majority of respondents were PWDs, at 50,3 per cent of total respondents, followed by family members of PWDs and OPDs, at 16,7 and 16,4 per cent respectively. Government body and NHRI participation was generally low, at 5,5 and 2,3 per cent respectively. Only one respondent identified as a NPM. Obtaining buy in from governmental bodies to increase their participation was a challenge particularly in relation to obtaining gate keepers permission.

Disaggregation of disability type identified by the respondents indicates that primarily persons with physical disabilities participated in this survey (27,6 per cent), and blind persons or persons with low vision (23 per cent).

Other categories represented included Deaf persons at 13,2 per cent, with those identifying as hard of hearing at 8,3 per cent of participants, while a relatively high percentage of persons with deaf blindness were identified at 4,6 per cent of respondents.

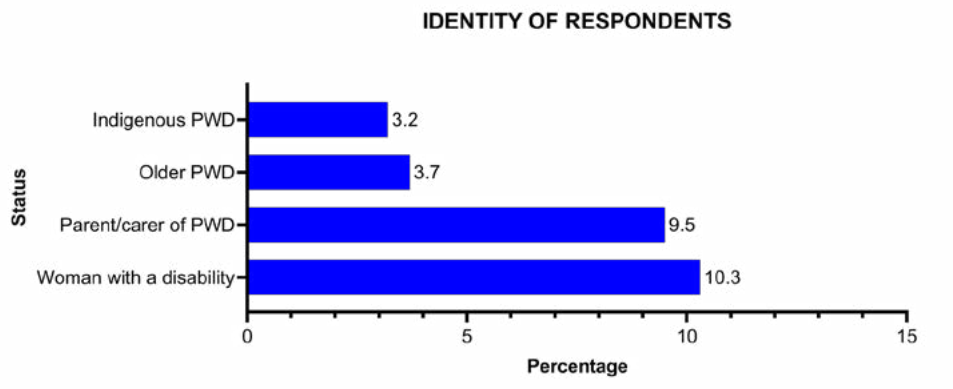
Persons with Albinism were well represented at 8,6 per cent of respondents, while persons with psycho-social disabilities were not well represented at 5,2 per cent of respondents. Representation of autistic persons and those with Down Syndrome was also low, at 2,3 per cent and 3,7 per cent respectively.

The survey options allowed respondents to choose disability type (or cross-disability), as well as other identifying demographic information such as being a woman, indigenous or older person with a disability. In some instances, respondents only identified as a woman with a disability without also identifying the specific disability type. Accordingly, the category of woman with disability is misleading as only 10,3 per cent of respondents identified this in the disability type question, while the demographic data of the survey indicates that the majority of respondents across all statuses (whether a person with disability or the government, for example), were female. Cross disability, which refers to multiple disabilities, was represented at 6,6 per cent of respondents.



Graph 1: Disability type of respondents disaggregated.

Surprisingly, only 3,7 per cent of the respondents with disabilities identified as elderly and similarly only 3,2 per cent indicated their indigenous status. Family members or carers of PWDs represented 9,5 per cent of respondents.



Graph 2: Status disaggregation of respondents.

The respondents indicated their residence either as living in the community, at 75,6 per cent or living in an institutional setting at 4,6 per cent. Twelve point four (12,4) per cent of respondents indicated that neither of these categories apply to them and some of those may have been OPDs. A relatively low participation rate of persons living in institutions poses challenges for information sought to garner the experience of this group of persons in relation to their experience of the health, safety and protection measures.

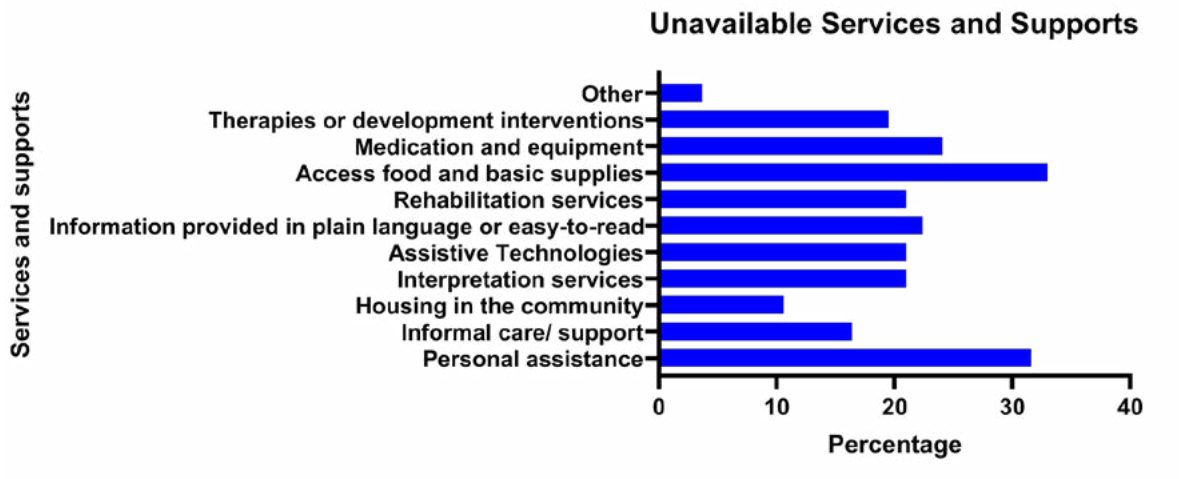
5. ANALYSIS

From the analysis of the survey responses several key themes arose and these are discussed in turn.

5.1 Unavailability of services and supports

The survey sought to understand which services and supports were unavailable or not accessible to PWDs during state-imposed lockdowns or because of the COVID-19 situation. The ten categories that respondents could identify included:

- Personal assistance;
- Informal care/support;
- Housing in the community;
- Interpretation services;
- Assistive technologies;
- Information being provided in Plain Language or Easy Read;
- Rehabilitation services;
- Access to food and basic supplies;
- Medication and equipment; and
- Therapies or development interventions.



Graph 3: Percentages of services and supports.

The survey did not allow for respondents to choose 'none of the above' and only provided respondents with the opportunity to indicate which specific services or supports were not accessible. Many respondents chose to articulate this gap in the formulation of the survey (that no services or supports were offered) with their written responses. Twenty point five (20,5) per cent of respondents did not select any of the ten options of services or supports and written responses indicated the devastating fact that services and supports were immediately stopped in many countries with harsh consequences for persons with disabilties. For example, repondents with disabilities from Namibia indicated that: 'There were no measures' or '[a]ll were not accessible' with other respondents, for example indicating 'none' or 'nothing' (respondents with disabilities from Lesotho). A respondent from Malawi indicated that family planning clinics were not available during this period. Monitoring of access to reproductive health services for PWDs during COVID-era restrictions is therefore an area that should be explored in future research.

5.1.1 Lack of access to food, personal assistance and medical treatment and interventions

The immense gap in service provision during this period was most acutely felt by respondents in relation to access to food and basic supplies. This may be as a direct result of lockdown regulations which restricted the operation of economies and mobility of persons and inevitably meant access to food and basic supplies was restricted for entire populations. However, the response rate of 33 per cent of respondents identifying this category of services and support as being absent indicates a disproportionate impact of barriers to access food and basic supplies on PWDs.

Since it can be presumed that many of the respondents with disabilities such as Deaf blindness, Blind and low vision, Deaf and physical disability may require personal assistance in their daily lives, it is not surprising that a high percentage of respondents indicated that PWDs could not access personal assistance during the COVID period (31,6 per cent). Similarly, 24 per cent of responses on this issue indicated that access to medication and equipment was restricted, with 19,5 per cent of responses identifying challenges in accessing therapies and development interventions, and 21 per cent each for access to rehabilitation and assistive devices.

Written responses indicated that lack of personal assistance impacted on their quality of life and right to life:

> 'Persons with disabilities were left at quarantine without guide assistance. This made the situation worse until we lost collegues with disability.' (Parent/carer of a person with a disability from Malawi).

> 'In my case I am a Covid-19 survivor. I lost my husband in the third wave. Mostly as a person with a disability we need close monitoring cause most of the times you need someone rather than health personnel to take care of you e.g. bathing, toilet, eating.' (DPO and woman with an undisclosed disability from Malawi).

5.1.2 Barriers to interpretation and sign language access for the Deaf and hard of hearing

A sub-theme that emerged in the quantitative responses was the lack of access to sign language and interpretation services for Deaf and hard of hearing persons. Therefore, again a 21 per cent indication of inaccessibilty of interpretation services is an indictment in this regard. The written responses explained the impact of these barriers, particularly felt in hospitals:

> '[D]eaf people, they do not get information on time also no communication because of lack of interpreting … in the hospitals' (respondent from Namibia).

> 'Persons living with hearing impairment find it very difficult to cope during the pandemic, because [they have] no one to talk to when they are admitted in the hospitals' (unofficial government respondent from Namibia).

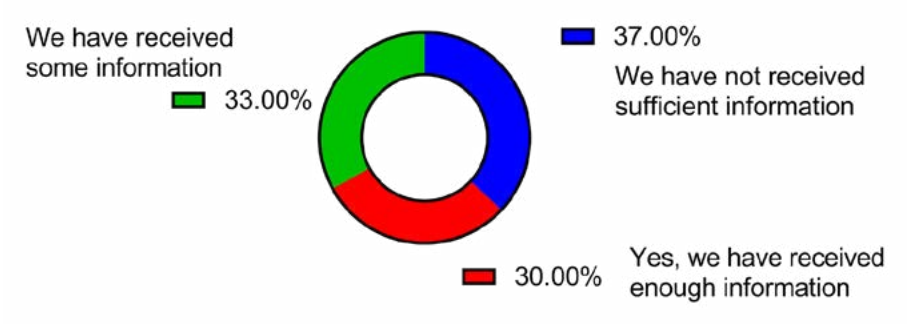
> 'No interpreting sign language during vaccination service in the community.' (Deaf respondent from Lesotho).

> 'I can't understand anything they are saying about COVID because they don't use sign language' (Deaf and hard of hearing respondent who also has a psycho-social disability from Lesotho).

Commenting on challenges experienced during government responses to COVID-19, a respondent who is hard of hearing from Malawi indicated challenges he experienced as a result of '[l]ack of information in sign language [and] stigmatisation'.

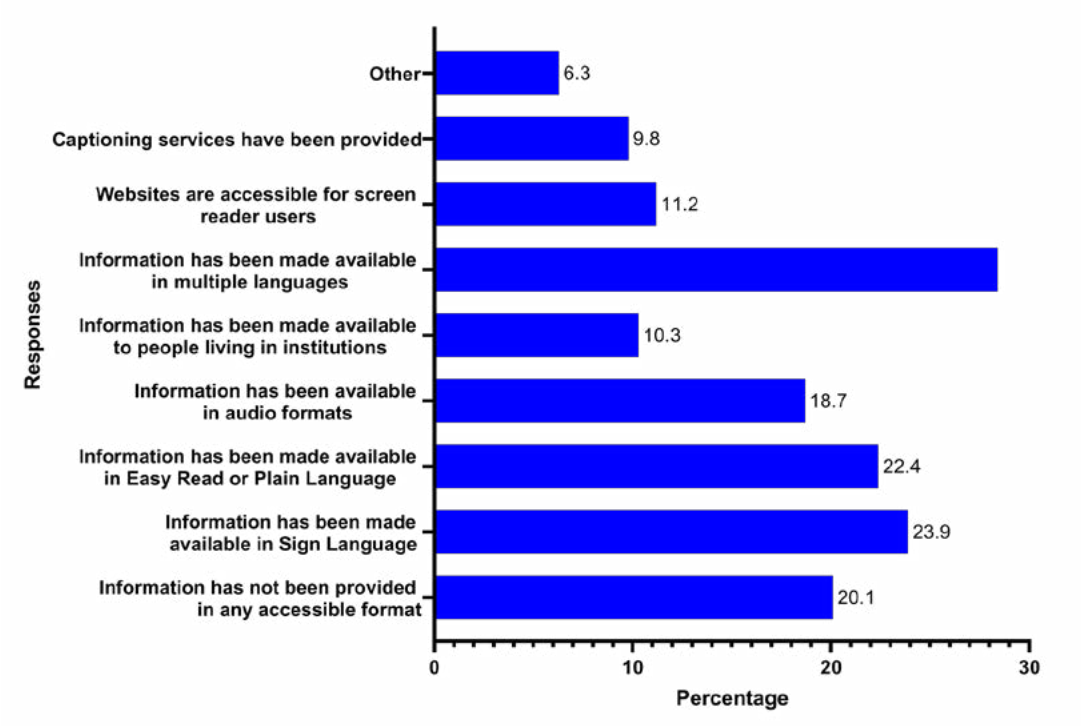
5.2 Barriers to access to information and the need for awareness-raising

A third of respondents (37 per cent) indicated that PWDs did not receive adequate information about the prevention of COVID-19 and the country response thereto. Thirty (30) per cent of respondents indicated that they received enough information while 33 per cent indicated that they received some information.



Graph 4: Responses on information received.

Specific responses on accessible formats are identified in the graph below.



Graph 5: Responses on accessible formats.

Five sub-themes arose from the responses on access to information and accessible formats.

5.2.1 Information was not shared in accessible formats but was shared in multiple languages

Worryingly, for PWDs, the accessibility of information in accessible formats shared by governments or other stakeholders on COVID-19 was disappointing. A significant number of respondents (20,2 per cent) did not select any of the following eight options:

- Information available in sign language;
- Information available in Easy Read or Plain Language;
- Information in audio formats;
- Information in multiple languages;
- Information to people living in institutions;
- Websites accessible to screen reader users;
- Captioning services; and
- Other.

Another 20,1 per cent of respondents indicated that information was not made available in any accessible formats. Therefore, approximately 40 per cent of respondents did not choose any of the accessibility formats. A person with disability in Malawi, in a written response, indicated that 'COVID-19 messages are not being transmitted in sign language and Braille'.

Linguistic equality was more readily available, according to respondents, when it came to accessibility of information across all countries. 28,4 per cent of responses identified that information was made available in multiple languages.

Information to people living in institutions, according to respondents, was provided in some measure (10,3 per cent of respondents). However, given the low participation rate of persons living in institutions in this survey, this response rate should be cautiously interpreted.

5.2.2 Information shared in sign language

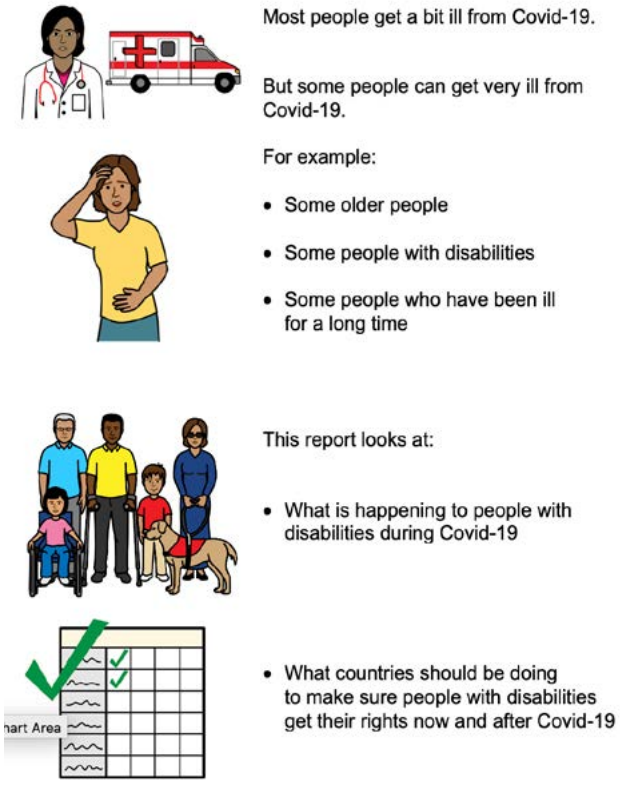
A relatively high number of respondents indicated that information was provided in sign language at 23,9 per cent. That notwithstanding, respondents in written responses articulated the lack of either sign language or interpretation being provided in relation to information about COVID-19 or the government responses thereto. This is a similar finding to the responses on access to support and services being restricted for sign language users due to lack of sign language or lack of interpretation services being provided discussed earlier.

> 'Lack of information in sign language, stigmatisation' (respondent who identified as hard of hearing from Malawi).
>
> 'The deaf do not have knowledge about COVID-19 because they do not have translators' (Blind respondent from Botswana).

5.2.3 Information shared in Plain Language/Easy Read

A relatively high response rate was also indicated for information made available in Plain Language and Easy Read at 22,4 per cent. However, the answers to the category of Information in Plain Language and Easy Read may be misleading because Plain Language and Easy Read are two different formats. Easy Read (or also known as Easy to Read) is a manner of presenting information to persons unfamiliar with a dominant language, with low literacy levels or with an intellectual disability. The layout and style of Easy Read, similar to a handout, uses images to complement the information usually only provided in text. It is rare for governments to disseminate information in Easy Read format. Provision of information on COVID-19 in Easy Read format was advocated for by the World Health Organisation (WHO).[68]

An example of Easy Read can be found in the United Nations' (UN) policy brief on disability inclusive approaches to COVID-19, with an extract from that document duplicated below:[69]



The use of Plain Language is more likely to have been understood by respondents and also more likely to have been utilised by governments in their COVID-19 informational measures.

68 WHO 'Disability considerations during the COVID-19 outbreak' (undated) https://www.who.int/docs/default-source/documents/disability/covid-19-disability-briefing.pdf (accessed 05 May 2022).

69 UN 'Policy brief: A disability inclusive response to COVID-19: Easy Read Version in Word' (undated) https://www.un.org/development/desa/disabilities/covid-19.html (accessed 05 May 2022).

Captioning of information was provided according to 9,8 per cent of respondents. A parent/carer of a person with disability from Lesotho indicated that: 'There was limited captioning services', similarly a respondent from Zambia who identified as hard of hearing, stated that there was: 'A lack of closed caption of most televised COVID-19 information clip'.

5.2.4 Information not provided in audio, Braille or websites inaccessible to screen reader users

Information was provided in audio formats, according to 18,7 per cent of respondents, with 11,2 per cent of respondents indicating that websites were accessible to screen reader users. However, written responses to the question in the survey either indicated that information was provided in Braille or indicated that information was *not* provided in Braille.

Written responses to other questions in the survey identified that for the majority, information was not provided in Braille. Twelve written responses articulated challenges in accessing information for persons who are Blind or with low vision. A respondent with a disability from Eswatini indicated that:

> Persons with visual impairment are usually left out during messaging because such is [not often translated into Braille]. This usually leaves us in the dark as regards to what needs to be done during disasters or emergencies.'

A governmental respondent from Zambia indicated in an unofficial capacity that:

> '{M]ost of the COVID-19 information is not translated in Braille for the blind'.

5.2.5 Use of the radio, social media and word of mouth to share information

Written responses articulated that social media and word of mouth, as well as the radio were three methods that were utilised to disseminate information and through which PWDs could access some information. For example:

> 'I remember the time when the Ministry of Health gave persons with visual impairment radios and flasks as well as Braille materials about COVID-19 information, during vaccination some visual impaired persons were offered special treatment, vaccine was brought to their learning institution' (DPO of persons with multiple disabilities from Lesotho).

The lack of accessible information was also described as attributing higher risk to infection with COVID-19 for PWDs:

> 'They might lose their lives because information about COVID-19 is not accessible to them. They sometimes fail to interpret the messages and hence adherence to the protocols becomes difficult' (respondent with an intellectual disability from Botswana).
>
> 'The lack of accessible info made them left behind with the most important information making them vulnerable' (Namibian DPO respondent identifying as servicing the Deaf).

'[I am] worried about lack of information which might put them [at] high risk' (respondent with a physical disability from Lesotho).

'They are not given enough information about the risk and impact of COVID in their lives' (respondent with albinism from Botswana).

Another respondent indicated how information is distributed through inaccessible formats:

'Because the government's campaigns for Covid-19 awareness raising, everyone is treated equally eg usage of spoken language which is exclusive to a Deaf person who would attend the gathering, distribution of typed materials which exclude the visually impaired' (respondent with multiple disabilities from Lesotho).

The educative aspect of access to information – not only having information in accessible formats, but also being educated about COVID-19 was stressed in written responses:

'Lack of counselling services. If a person with a disability is not well educated on something things get stuck. Covid-19 is real and if the government does not get involved then there is a great risk/ danger for people with disabilities' (NHRI respondent from Malawi)

'Government were supposed to send nurses and social worker to educate people/persons with disabilities on how to protect themselves from COVID' (respondent who is Blind from Namibia).

'Most of persons with disabilities are not well educated about the spread of COVID-19' (Blind respondent from Namibia).

'My concern is the fact that normal people are well sensitised on COVID-19, but why is it that people with disabilities are not? Let's try to think how our visually impaired colleagues can prevent it, how those with speech difficulties can prevent it, the elderly' (DPO respondent from Malawi).

'Right from the time we heard about the disease up to now no person with disability has been educated on how they can protect themselves from COVID-19 not even non-governmental organisation. People with disabilities have been excluded for fear that they will infect other with COVID-19. People with disabilities do not have access to information on how they can prevent the spread of the disease. Therefore, they are in the dark, they don't know anything' (Respondent with Deafblindness from Malawi).

Clearly, written responses showed that respondents supported the training and capacitation of healthcare workers to disseminate COVID-19 information in a disability friendly manner and for those in rural areas:

'People living with disabilities in rural areas need more information on COVID-19. The government should train more health workers to ensure the national dissemination of COVID-19 information' (Deaf respondent from Namibia).

'The government needs to train more health workers to assist in disseminating information about COVID-19 in all regions' (Deaf respondent from Namibia).

'For persons with disabilities at the village, the government shall send health workers to educate people' (Blind respondent from Namibia).

It is therefore unsurprising that written responses favoured government responses with awareness campaigns, for example:

'Educate people on how to protect themselves from COVID-19. Create awareness campaign on how to protect themselves. Include lesson about Covid19 in schools/education syllabus' (Deaf respondent from Namibia).

'Awareness, governments should provide awareness to persons with disabilities all over the country especially in rural areas. Educate them. This will help save more lives as disabilities lives matters too' (respondent with physical disability from Namibia).

'Create awareness campaign on how to protect yourself/persons with disability from COVID-19' (Blind respondent from Namibia).

The link between rurality and access to information and services was evident in a number of written responses and this theme is explored later. The issues of access to information and awareness were also linked to lack of participation of (consultation with) PWDs a major theme discussed later as well. Suffice to state at this juncture that respondents identified the following recommendations:

'There should be materials for people with disabilities. Need for money to fund smaller disability organisations to conduct COVID-19 awareness campaigns. By doing so, many people with disabilities will be able to prevent COVID-19 and supported in dealing with COVID-19' (respondent who identified as a woman with a disability from Malawi).

'Involvement of persons with disabilities in awareness raising campaigns so that their counterparts can find sense in adhering to precaution measures for emergencies' (Blind respondent from Eswatini).

While others indicated their concerns:

'My concern is the fact that people with disabilities are excluded in most committees aimed at preventing disease or put it differently the messages are not accessible to people with disabilities' (Respondent: DPO of persons who are Blind from Malawi).

Exclusion from accessible information was identified as constituting discrimination. For example, in a written response, a respondent DPO of persons with psycho-social disabilities from Malawi stated that:

'They do not get any support. They are discriminated against depending on their type of disability. Those with visual impairment are not told to wash their hands. Other have speech/hearing impairment and depend on interpreters to access information on how to protect themselves.'

Clearly then, a major theme that emerged from the survey's written responses is the need to raise awareness on COVID-19 protective measures and the need to promote the involvement of PWDs in such campaigns.

Examples of good practices were identified in the written responses:

'The institution of people living with disabilities in collaboration with other stakeholders has been conducting COVID-19 campaigns throughout the country to create public awareness on COVID-19 causes and prevention measures' (Deaf respondent from Namibia).

'They came together as OPDs to educate themselves on the spread of COVID-19' (DPO respondent from Namibia).

'When people with disabilities were included in the awareness practices' (Respondent with a physical disability and a DPO from Zimbabwe).

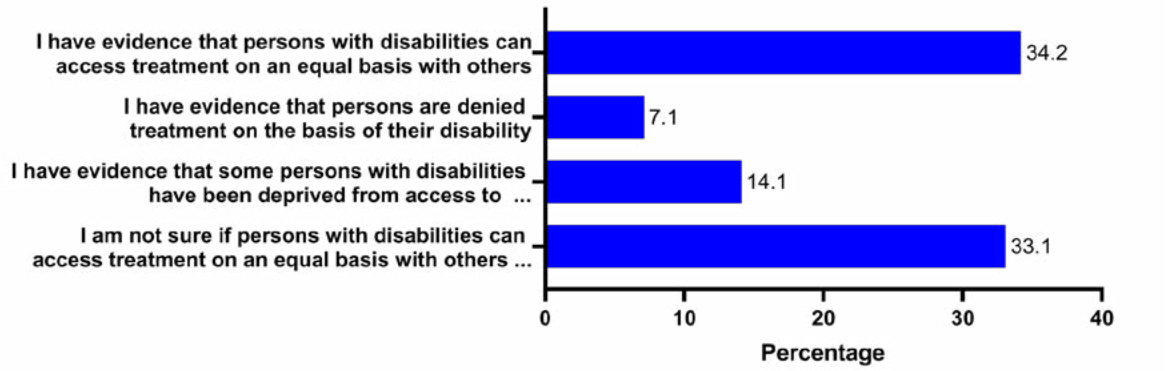
'Good example I can give you is the sensitisation that a non-governmental organisation is doing and what the Zambian [DPO] is doing educating persons with disabilities' (governmental body respondent from Zambia).

5.3 Barriers to access to medical care

5.3.1 Medical treatment for COVID-19

The survey provided respondents with the opportunity to indicate that they have evidence that PWDs can access medical treatment 'on an equal basis with others' in relation to medical treatment for COVID-19. About a third of respondents indicated that they had evidence that PWDs can access medical treatment for COVID-19 on an equal basis with others (34,2 per cent), and more than a third indicated they were not sure if PWDs can do so (35,1 per cent). Further nuances were expected from responses to the questions whether respondents have evidence that some PWDs were deprived of *access to* medical treatment because of their disability or *denied treatment* on the basis of their disability. For these two categories, the responses were 14,1 per cent and 7,2 per cent, respectively.

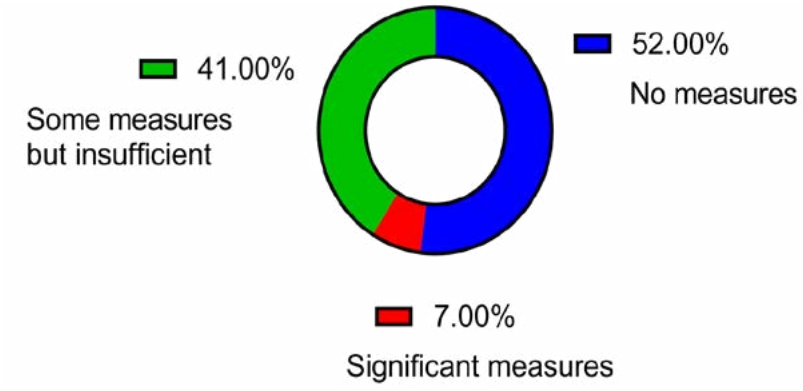
The relative lack of written responses on the issue of access to and denial of medical treatment could be explained by the survey not providing an option for respondents to elaborate on their answer to this particular question.



Graph 6: Percentage of responses to the question on what respondents know about access to medical treatment for COVID-19 for PWDs.

5.3.2 Denial of access to general and specialised medical healthcare, including transport barriers

The majority of respondents indicated that there were no governmental measures taken to ensure that PWDs can access general and specialised healthcare (52 per cent). The provision of some (insufficient) measures, was indicated by 41 per cent of responses. Only 7 per cent of responses indicated that significant measures were taken by the government to this end.



Graph 7: Percentage of responses to the question on government measures taken to ensure that PWDs can access general and specialised healthcare.

Written responses illuminated the specific challenges faced in relation to access to medical treatment, including a shortage of medication and inaccessible (and unaffordable) transport to hospitals.

> 'Because they could not go for medical check-ups and in some instances, there was shortage of medication. People could not take care of or check on their family members' (Blind respondent from Botswana, also a representative from a DPO).
>
> 'Persons with disabilities should be given extra care at hospitals. They must be provided with transportation to medical facilities' (parent/carer of a person with a disability from Botswana).
>
> 'During the COVID-19 lockdowns persons with disabilities [were unable to access] medical, rehabilitation services, hence the situation is very bad' (respondent with a physical disability from Zimbabwe).
>
> 'I have had the honour of working/interning at a rehabilitation centre for children living with disabilities and there is a huge strain on parents who are unemployed as they need to look after their child due to their condition. No efforts that I know of have been made to assist these families' (Blind respondent from Namibia).
>
> 'Less access to rehab' (respondent with disabilities from Zimbabwe).
>
> 'The persons with disabilities should be given enough equipment and open specific centres for them to access the medicine before the worst comes to the worst' (respondent from a DPO of the blind from Zimbabwe).

'A lack of medicine especially psychotropic drugs in non-specialist health facility' (DPO of psycho-social disabilities from Zimbabwe).

'Persons with disabilities still lack food, shelter and medicine' (Deaf respondent from Zambia).

In written responses, respondents identified that access to transport including as a result of long distances and inaccessibility of hospitals or clinics was a challenge in relation to transportation to medical facilities.

5.3.3 Barriers to access COVID-19 vaccines

Surprisingly very few respondents mentioned access to vaccination, but this may be explained by the experience of an initial delay of access to vaccination at the outset of the pandemic. Respondents' written responses identified the following challenges for PWDs to access vaccinations:

- Vaccine unavailability;
- Long distances to travel to obtain vaccines and long waiting periods at vaccination sites;
- Lack of priority for PWDs when queueing at vaccination sites;
- Lack of efforts to make vaccinations accessible to PWDs; and
- Lack of education on the need to take vaccines, including to address the fears of PWDs regarding the vaccination.

A written response indicated: 'No encouragement for taking vaccine' (DPO of persons with intellectual disabilities from Zimbabwe).

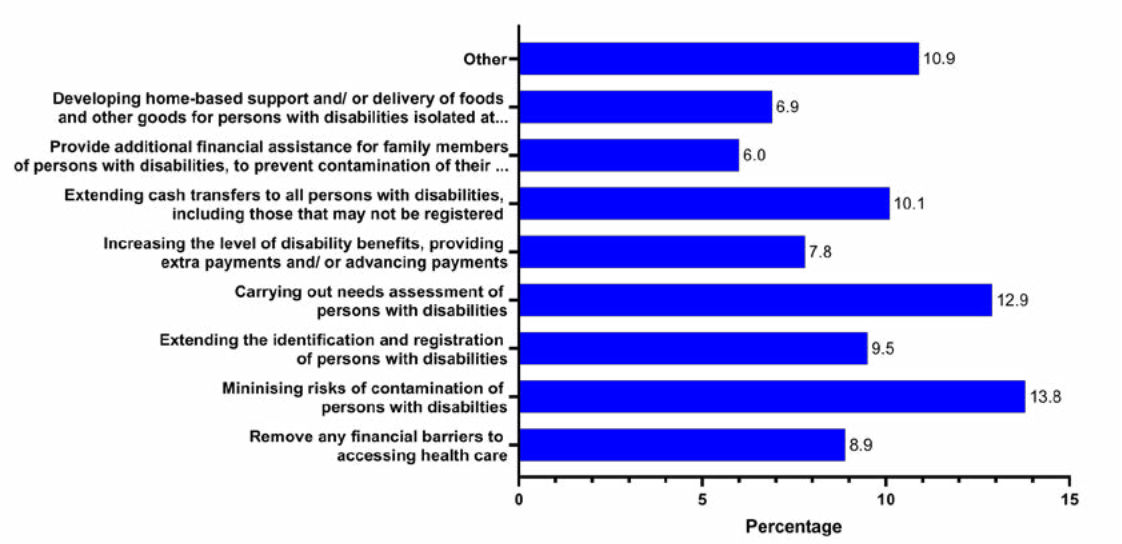
One respondent identified the need to provide mobile vaccination programmes to communities for the benefit of PWDs as '[t]his will ease the burden of caregivers of carrying/assisting the persons with disability to vaccination centres' (pastor/clergyman from Zimbabwe). Another respondent with a physical disability from Malawi advocated for vaccination of PWDs at home to address inaccessible vaccination sites.

5.4 Lack of and gaps in social protection measures

The findings of the survey suggest that generally speaking, social protection measures to support PWDs living in the community were not taken. This is evident from the fact that 54,4 per cent of respondents did not choose any of the options provided. Less than half of respondents therefore identified the following social protection measures being taken by their governments:

- Removing any financial barriers to accessing healthcare (such as co-payments to visit a medical professional or hospital fees) at 8,9 per cent;
- Minimising risks of contamination of PWDs, such as at payment points, expanding mobile or online registration at 13,8 per cent;
- Extending the identification and registration of PWDs (such as use of different data registries to facilitate the provision of support) at 9,5 per cent;

- Carrying out needs assessment of PWDs at 12,9 per cent;
- Increasing the level of disability benefits, providing extra payments and/or advancing payments at 7,8 per cent;
- Extending cash transfers to all PWDs officially registered, including those that may not be eligible under regular circumstances at 10,1 per cent;
- Provide additional financial assistance for family members of PWDs, to prevent contamination of their family members with disabilities at 6 per cent;
- Developing home-based support and/or delivery of foods and other goods for PWDs isolated at home at 6,9 per cent and;
- Other at 10,9 per cent.



Graph 8: Percentage of responses for categories of social protection measures taken by governments.

The response rate for the 'other' category is misleading because those written responses predominantly identified '[n]one of the above'. In other words, other social protection measures (aside from those in the list) were not identified as being offered and respondents indicated that such measures were not provided at all, alternatively, written responses indicated that they were not aware that social protection measures were put in place *specifically* for PWDs.

A written response identified a good practice in Zambia:

> 'Through the Zambia agency for persons with disabilities government has introduced a programme for persons with disabilities to register themselves so that they can be assisted if they are registered and this is going well country wide' (governmental body respondent from Zambia).

Two sub-themes emerged from the written responses.

5.4.1 Barriers to access cash transfers

Cash transfers were provided in some countries and not others; receipt of a disability grant excluded receipt of a COVID-grant; and perceptions were that where cash transfers were provided the amount was too low, especially as the needs of PWDs are not homogenous:

'A once-off grant of Ns750.00 was given' (respondent with a psycho-social disability from Namibia).

'Due to a lack of budget the state did not add on social protection measures such as the increase of grants during the state of emergency' (Blind respondent from Namibia).

'This is through cash transfer which a number of persons with disabilities are registered to be on the program' (governmental body respondent from Zambia).

'Parents for children with disabilities were excluded due to that they are receiving 250 for their kids' (respondent with albinism from Namibia).

'During the state of emergency, the government introduced a basic income grant of N750 for some citizens and those already on existing social grants did not benefit' (Blind respondent and DPO from Namibia).

'We were given money in the sum of P300. This is a small amount on which one cannot live' (respondent with physical disability and parent/carer from Botswana).

'Government does not adequately support or provide financial grants for emergency for the disabled' (respondent with a physical disability from Zimbabwe).

'Some families managed to get COVID relief funds. Even though it wasn't a lot it managed to cover a few things. Due to the differences in the type of disability in some families the funds might not have an impact' (respondent with albinism from Zimbabwe).

'Persons with disabilities were not included in social cash transfer' (Autistic respondent from Malawi).

'Many of the people living with disabilities were left out from the many beneficial areas such as [being] allocated cash to them' (DPO for persons with intellectual disabilities from Zimbabwe).

'Few people living with disabilities had access to COVID-19 risk allowances, including myself, which was just a drop in the ocean which could not buy a 5kg mealie meal' (respondent with a physical disability from Zimbabwe).

5.4.2 Exacerbation of socio-economic deprivation

The poverty that some PWDs experience was exacerbated during the COVID-19 era, particularly in relation to access to food and due to the impact on income opportunities (including for PWDs who engage in begging):

'Unemployed, no disability grant, they could not even manage to pay [for] basic needs at home, even school for [the] children's sakes' (Deaf respondent from Lesotho).

'During lockdown we were not able to work, we were starving and government did not provide

masks and sanitizers for people with disabilities' (Respondent with a disability from Lesotho who identified as a woman with a disability).

'There is no money. There is no food. There are many diseases. People are dying. There is no vaccine' (Autistic respondent from Botswana).

'Some lost jobs, lost shelters, less access to rehab. Shortage of food to those who are self-employed, beggars, blind people, wheelchair bound beggars' (Respondent with a physical disability from Zimbabwe).

'Persons with disabilities are at risk because some of their caretakers lost their jobs and this makes it difficult for them to be provided with adequate care' (DPO of persons with Down Syndrome from Botswana).

'State of emergency exacerbated poverty rate amongst ourselves' (family member/carer of a person with a physical disability from Lesotho).

'Some people living with disability [were] left aside when it comes to getting financial benefit. In fact, 60 per cent of people living with disabilities are vendors and beggars so during lockdown they were left empty handed. No one was giv[ing] them food for their families' (indigenous respondent with a disability from Zimbabwe).

'Government didn't do anything. People suffered. They needed food during the lockdown' (DPO respondent from Malawi).

'There wasn't any support given to people with disabilities. Many children were ill (malnutrition) due to hunger' (NHRI respondent from Malawi).

'I did not get food or clean bucket or soap to wash hands.' (Hard of hearing elderly person from Zimbabwe).

5.5 Barriers to protective measures

The provision of measures to protect the life, health and safety of specific persons is considered next. The survey findings show that protective measures were not provided to PWDs living in the community. Protective measures such as masks and sanitisers were generally not available to PWDs, particularly due to their cost and the lack of PPEs affected employment prospects, ability to travel and the health of personal assistants. There was insufficient data on protective measures for persons living in institutions or the elderly.

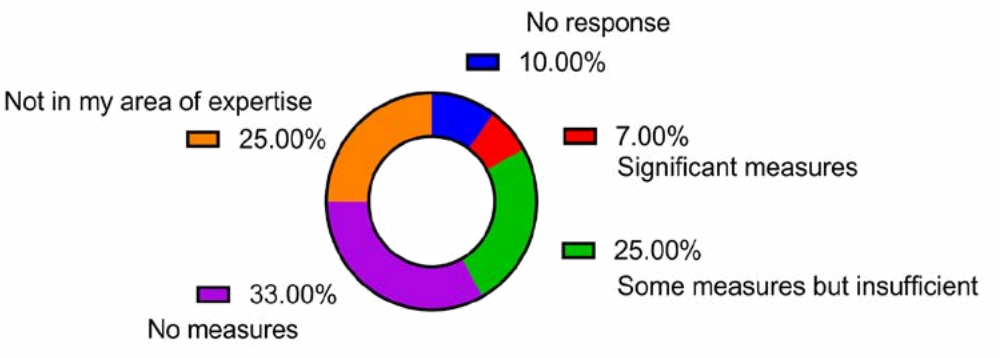
Protective measures for these groups is discussed next.

5.5.1 Measures to protect the life, health and safety of persons living in institutions and the elderly (whether living in the community or in institutions)

Since only 4,6 per cent of respondents to the survey identified that they reside in institutions for PWDs, and very few elderly PWDs or persons with psycho-social or intellectual disability participated in the survey (since those are usually persons that

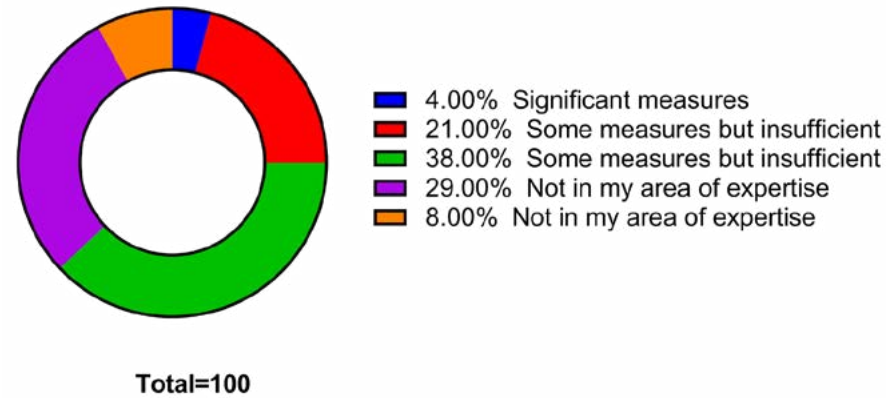
may be resident in such facilities), the results should be cautiously interpreted.

A third of respondents identified that government measures to protect the life, health and safety of PWDs living in institutions were not taken (33 per cent of responses), while 25 per cent of respondents indicated that some measures were taken but that these were insufficient. Only 7 per cent of respondents identified that significant measures were taken. As 10 per cent of respondents did not answer this question and 25 per cent indicated it was not in their area of expertise, it means that what can be gleaned from about another third of the data is restricted.



Graph 9: Response rate on government measures to protect the life, health and safety of PWDs living in institutions

Survey responses indicated that measures were generally not taken to protect the life, health and safety of the elderly, whether they reside in the community or in institutions (38 per cent). 21 per cent of responses indicated that some measures were taken but that these were insufficient. A paltry 4 per cent of responses identified that significant measures were taken. Again, a high rate of either non-responses or the information not being to the knowledge of the respondents affect the interpretive value of this data (at 29 per cent and 8 per cent, respectively, amounting to almost 40 per cent of responses).



Graph 10: Measures taken to protect the life, health and safety of elderly PWDs.

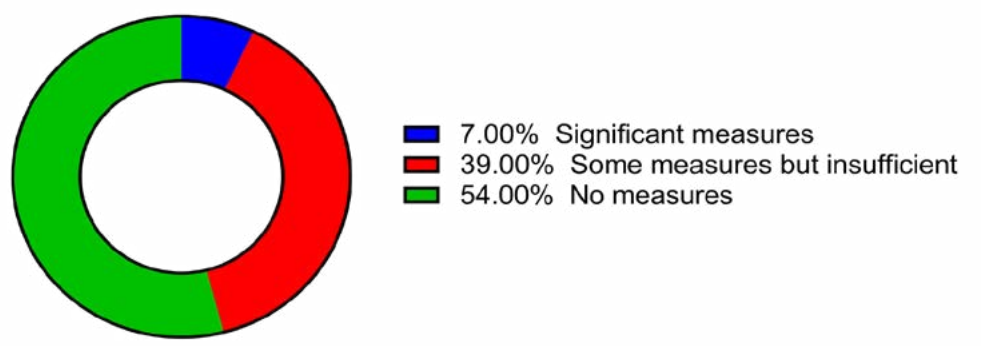
There were no written responses on measures for the elderly and very few regarding persons living in institutions. The latter comments were alarming, however, such as this response:

'The government did not put in place protective measures for people with disabilities [residing in institutions]. People with disabilities are discriminated and many of them died because of lack of care' (DPO of persons with psycho-social disabilities from Malawi).

5.5.2 Gaps in provision of measures to protect the health, life and safety of PWDs living in the community

The survey findings show that there are gaps in the provision of protective measures for PWDs living in the community. By and large, measures to protect the health, life and safety of PWDs were said to be not provided at all, inadequate where they are provided, or not disability friendly/inclusive.

A high proportion of respondents indicated that no measures were taken to protect the life, health and safety of PWDs living in the community (54 per cent), compared to 7 per cent who indicated significant measures were taken and 39 per cent indicated some measures were taken but these were insufficient. The non-responses for this question is excluded from the report.



Graph 11: Measures taken to protect the life, health and safety of PWDs living in the community.

The written responses identified that access to water was extended for residents in some countries, which included access to water for PWDs, but not in others.

'In the informal settlement water that was sold on prepaid basis became free for all including people with disabilities' (DPO that identified cross disability from Namibia).

'The government gave access to clean water but not food' (respondent from Namibia).

'At some point government provided water tanks in communities to enhance clean water prioritisation' (respondent with physical disability from Zambia).

'Persons with disabilities were not getting protection to health no masks no food, clean water and internet to communicate, nothing' (respondent with a physical disability, Zimbabwe).

This protective measure was identified as a good practice by several respondents from Namibia such as this one: 'They provide free water like any other person' (DPO of persons with albinism from Namibia).

A high volume of written responses was received on the availability of PPEs. The survey findings show that access to PPEs such as masks and sanitisers was restricted because of their unaffordability to PWDs. Furthermore, this lack of PPEs impacted on the ability to look for employment, travel, and the health of personal assistants.

> 'I have not seen any measures or changes … We don't have money to buy medication and sanitisers, masks' (respondent with albinism from Zimbabwe).
>
> 'These protective clothes (face masks and gloves) were expensive for us people with disabilities to afford' (family member/carer of a person with physical disability from Zimbabwe).
>
> 'No protective materials as we buy most materials on our own' (respondent with an undisclosed disability from Malawi).
>
> 'No, there is no protective measures in our community because if we have to travel we buy our own protective materials like face masks' (respondent with a physical disability from Malawi).
>
> 'For the visually impaired people all PPEs were obtained through proposals to NGOs' (NHRI Respondent from Lesotho).
>
> 'The persons with disabilities need support with funding to mitigate many rife challenges faced by people with disabilities. These include funds to buy/procure sufficient PPE, fund to roll out information to members in accessible manner' (DPO of the Deaf from Namibia).
>
> 'No measures taken by government because we were not provided with assistive devices including diapers and PPE' (family member/carer of a person with intellectual and physical disabilities from Lesotho).
>
> 'We use wheelchairs so we touch and push rims so we need protection like hand sanitizers. Hand washing soap and some face masks to be provided. Those who are lifted, sometimes their caregivers do not have protection' (respondent with Down syndrome from Zambia).
>
> 'I do have worries because people with disabilities are not being given protective materials. I cannot afford a mask and because of this I am not able to go out and hunt for a job or enter some premises without a mask' (woman with a disability from Malawi).
>
> 'It was very sad that in Namibia person with disabilities where not included in any measure special for us but we were discriminated based on the disability grant. We were failed to be assisted whether with the support of food or masks neither sanitisers' (DPO of persons with Albinism from Namibia).
>
> 'Emergency response – I think the government should provide emergency for person with disabilities, providing enough masks just to ensure that persons with disabilities are safe as they are at high risk. Persons with disabilities should feel secure and safe' (respondent with a physical disability from Namibia).

Some respondents called for either free materials or subsidisation of these materials.

> 'Disabled communities need masks and hand sanitisers or soaps to be distributed to them' (respondent with albinism from Zimbabwe).
>
> 'We did not put in place any measure. We are failing to buy protective materials like masks, sanitisers and gloves. It would be better if the government distributed them for free to all people with disabilities or if it subsidised their prices' (respondent with physical disability from Malawi).

Others articulated the need for disability/user friendly materials such as masks:

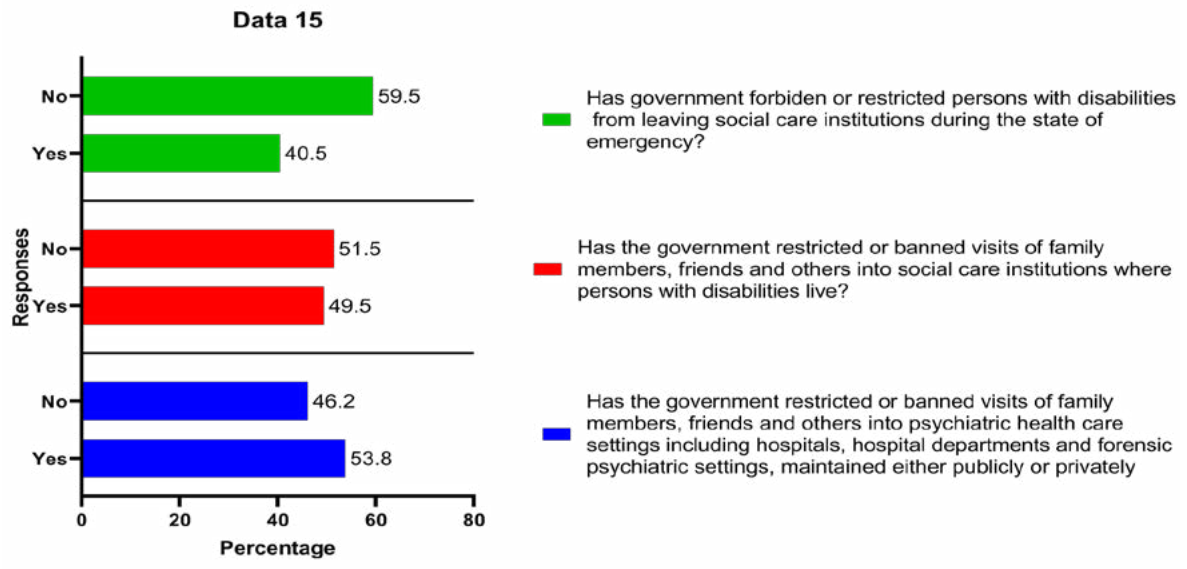
> 'The government is to ensure persons with disabilities have necessary preventative measures to COVID-19. User friendly masks to person with disabilities before they suffocate in tight ones, distribution of hand sanitisers to be also considered' (family member/carer of a Deaf person from Zimbabwe).
>
> 'They did not make masks which are tailored to the needs of persons with disabilities' (parent/ carer of a person with a disability who is also a person with a physical disability from Botswana).
>
> 'The use of transparent masks by people with speech and hearing impairment so that can at least read the lips' (respondent who is hard of hearing from Malawi).

A written response explained why protective measures were not provided for PWDs living in the community:

> 'Because the government does not do enough research to understand the lives of people with disabilities in communities. The government has done nothing to protect them or just to sensitize them about their rights' (Blind respondent from Malawi).

5.6 Government restrictions (visitation and freedom of movement) on PWDs living in facilities

Where the non-responses or 'not in my expertise' responses are excluded from the responses received (of total responses that amounted to 46, 42 and 40 per cent respectively) on the questions regarding governmental restrictions, the response rate appears to indicate that in some instances governmental restrictions were in place (graph 19 below).



Graph 12: Responses on government restrictions to facilities of PWDs or PWDs residing at such facilities.

A few written comments shed light on this issue, particularly regarding the relative isolation of this sub-group and accordingly this is a minor theme emanating from the survey:

'Persons with disabilities living in the institutions were no longer allowed to meet people outside the institutions' (Blind respondent from Lesotho).

'Government restricted visits for institutions for persons with disabilities to prevent the spread of COVID-19. They also provided sanitisers for them. They did not include them in changes of law during COVID-19 like wearing of mask etc' (respondent with a disability from Botswana).

'Because they could not go for medical check-ups and in some instances there was shortage of medication. People could not take care of or check on their family members' (DPO and Blind respondent from Botswana).

Isolation was also identified for persons living in the community where restrictions impact on their freedom of movement and that of their family members/friends: 'People with disabilities appreciate being visited by family and friends as this makes them happy and lightens their stress/burdens' (respondent with Albinism from Malawi).

A concern regarding unmanaged deinstitutionalisation or lack of support to persons with psycho-social disability was raised in some written responses:

'Because they always told us that they could not manage and they don't know what could be done. Those with psychological challenges were just roaming around' (Blind respondent and DPO from Botswana).

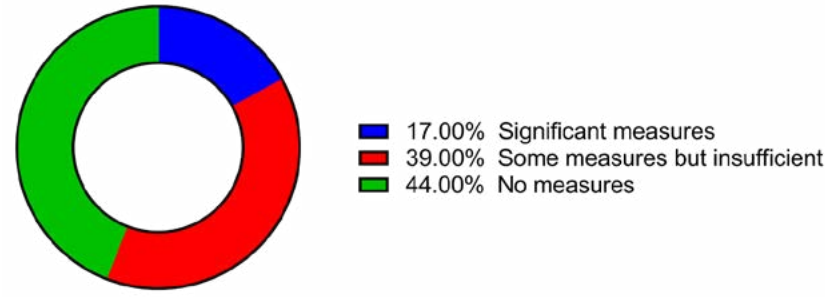
'They were not included. This is because persons with disabilities who stay in institutions were moved from such institutions back to their homes. This then placed them at risk' (Blind respondent from Botswana).

On the other hand, one response indicated a lack of protective measures being provided in institutions: 'I live nearby [an] Institution for the Disabled and I have seen persons still living ordinary life without adequate protection' (family member/carer of a person with an intellectual disability from Lesotho).

The response rate on the issue of governmental measures to inform PWDs living in institutions about the state of emergency (and restrictions/banning of external visitors) in an accessible and appropriate manner was restricted as 37 per cent of respondents did not record a response, alternatively indicated it was not in their area of expertise to comment. Of the responses obtained, 17 per cent of respondents indicated that significant measures were taken, while 39 per cent indicated some measures were taken but these were insufficient and 44 per cent indicated no measures were taken.

A written response identifies the impact of ableism in some governmental responses:

'The government has tried to educate persons with disabilities about the dangers posed by Corona. However, some are not able to comprehend due to the nature of their disability, eg mental health patients' (governmental body respondent and person who is hard of hearing from Botswana).



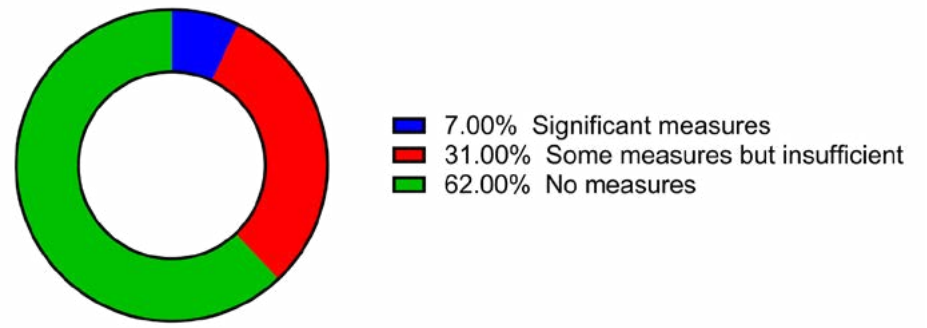
Graph 13: Responses on the question: Has the government taken measures in order for PWDs staying at/living in institutions to be informed about the state of emergency, including restrictions/ bans on visits of external people, in a manner that is accessible and appropriate?

5.7 Lack of measures to protect the health, life and safety of children in particular settings

The survey findings suggest that few measures were taken by governments to protect the life, health and safety of children with disabilities residing in institutions or in the community, including those living with family, foster family or in kinship care).

5.7.1 Lack of measures to support children living in the community

No measures being taken was identified by 62 per cent of responses, while 31 per cent of responses indicated that some measures had been taken but that these were insufficient. Only 7 per cent of responses were in favour of significant measures having been taken. This graph excludes the non-responses.



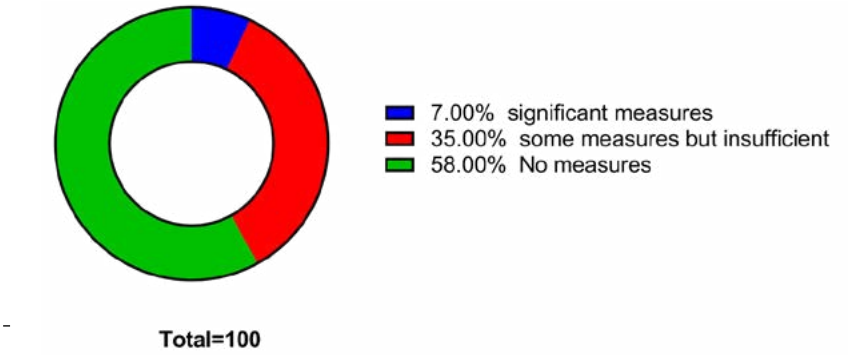
Graph 14: Responses on the issue of measures to protect the health, life and safety of children with disabilities.

5.7.2 Lack of measures to support children in residential schools

The response rate on whether or not governmental measures were taken in relation to children with disabilities attending residential schools shows that:

- 7 per cent of respondents indicated significant measures were taken;
- 35 per cent of respondents indicated that some measures were taken but these were insufficient; and
- 58 per cent of respondents indicated that no measures were taken.

Non-responses were excluded from this graph.

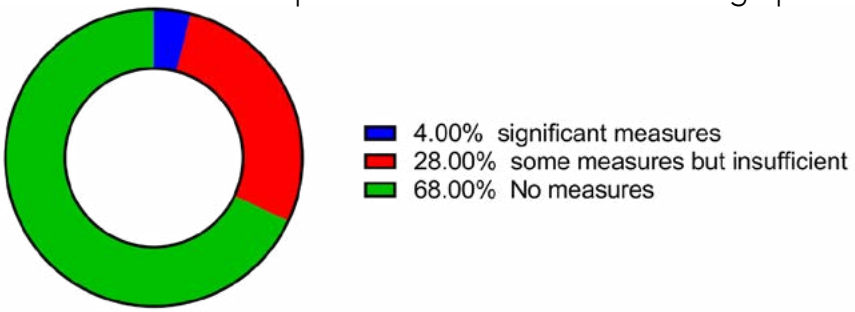


Graph 15: Responses on the question: Has government taken measures in relation to children with disabilities attending residential schools?

The survey findings show that measures generally were not taken to support children with disabilities in residential schools.

5.7.3 Lack of measures to support families

The response rate on whether governmental measures were taken to support families of children with disabilities shows that 68 per cent of respondents identified that no measures were taken, with 28 per cent indicating that some measures were taken but these were insufficient and 4 per cent indicated that significant measures were taken by their governments. The non-responses are excluded from this graph.



Graph 16: Responses on the question: Has the government taken measures in order to support families of children with disabilities during the state of emergency?

The written responses underscored the closing down of schools during the lockdowns imposed in the countries, and the impact on access to education and the collateral damage of access to school nutrition that ensued:

> 'The government introduced online schooling as an alternative for school closing but the government did not intensively focus on the special needs of children with disability' (NHRI respondent from Namibia).

> 'In Botswana Disabled students are home their schools are closed, which means they are left behind in their education' (family/carer Respondent of a Deaf person from Botswana).

> 'Children with disabilities have since stopped going to school during the national lockdown and travelling restriction even to this date they are not attending school' (Blind respondent from Botswana).

'There is nothing. When schools were open, they could get food at school, but when schools closed they were not giving food and it became the responsibility of their parents to provide them with food despite that they do not have money' (DPO respondent from Botswana).

'The government did not provide any support for children. The schooling of children with disabilities got disturbed' (NHRI from Malawi).

'The government did not put in place anything to do with people with disabilities. Many children were failing to go to school because they were lacking support' (NHRI from Malawi).

Generally, therefore, the findings from the survey show that families of children with disabilities did not receive sufficient support measures from their governments. This finding is further supported by general statements in written responses, including in relation to lack of financial support to families such as the following:

'Parents of the disabled kids do not get enough assistance' (respondent who is hard of hearing from Namibia).

'Some children are very vulnerable they need a serious attention either from their parents or government' (Blind respondent from Namibia).

'Government is broke and cannot provide services to facilities of children with disabilities during states of emergency' (respondent with a physical disability from Eswatini).

'Nothing has been done. I am certain of this because I live with a child with disability' (respondent with an intellectual disability from Botswana).

'Families of children with disabilities are struggling to make ends meet especially those with multiple or wheelchair bound. They have made peace with life of blisters since they use their hands to move' (respondent with Albinism from Zimbabwe).

There were, however, a few positive written responses from respondents on this issue of family support measures in relation to receipt of food hampers, but this was often indicated as a once-off gesture or not enough.

5.8 Lack of protective measures for sub-groups

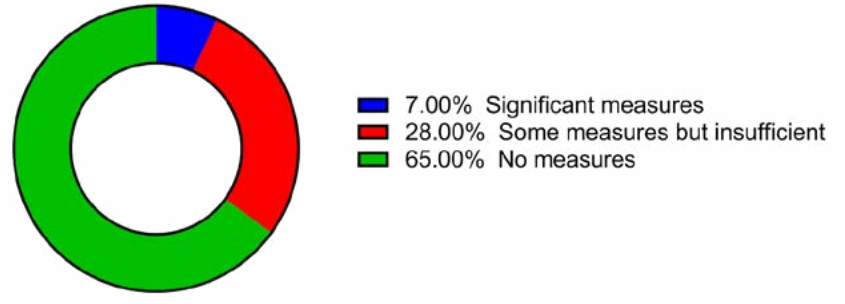
The findings in relation to lack of protective measures provided for 'homeless' persons (street and shelter living persons), PWDs residing in remote or rural areas and the extent of these measures for PWDs, including groups of disabilities, is discussed next.

5.8.1 Supporting street and shelter living persons

The survey findings indicate that protective measures were generally not offered to PWDs living on the streets or in shelters. The response rate shows that 65 per cent of respondents indicated that such measures were not offered; 28 per cent indicated some measures were offered but these were insufficient and 7 per cent identified that significant measures were offered. Non-responses were excluded from the graph. However, this did not appear as a major theme in the written responses.

Only two written responses elaborated on this issue:

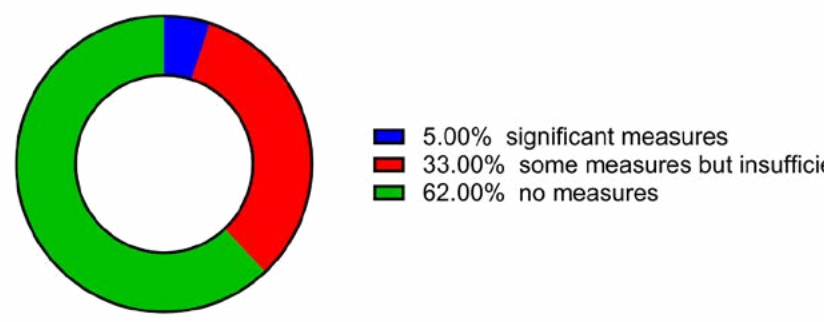
> 'Some lost jobs, lost shelters, less access to rehab. Shortage of food to those who are self-employed, beggars, blind people wheelchair bound beggars' (respondent with a physical disability from Zimbabwe).
>
> 'Their access of basic healthcare and social amenities especially those living in the streets is my main concern and worry' (governmental body respondent from Zambia).



Graph 17: Response on the question: Has the government taken measures in order to protect the life, health and safety of PWDs living on the streets or in shelters for homeless persons?

5.8.2 Gaps in protective measures for PWDs residing in rural areas

The survey findings show that rurality is a major barrier to access protective or social protection measures for PWDs. The responses on the question whether governmental measures were taken with regard to PWDs in rural and remote areas, identified 62 per cent of respondents indicated no measures were taken for this sub-group, while 33 per cent of respondents indicated some measures were taken but were insufficient and only 5 per cent indicated significant measures had been taken. Non-responses were excluded for this graph.



Graph 18 above: Responses on the question: Has the government taken measures with regard to PWDs in rural and remote areas?

Twenty-two (22) written responses identified rurality as a barrier in relation to access to information, supportive measures and access to PPEs.

> 'Most persons with disabilities have no sources of income thus can't afford soap for the washing of hands, buying of face masks and for transport in cases where they have to visit health centres for treatment. A majority to those in remote areas who mostly consists of those with severe

disabilities have not been reached and risk being victims of the deadly pandemic' (respondent with a physical disability from Eswatini).

'People living with disabilities in remote rural areas still need information on preventative measures against the virus' (Deaf respondent from Namibia).

'I have not seen any measures or changes, people with disabilities continue to suffer in rural areas. We don't have money to buy medication and sanitizers, masks' (respondent with Albinism from Zimbabwe).

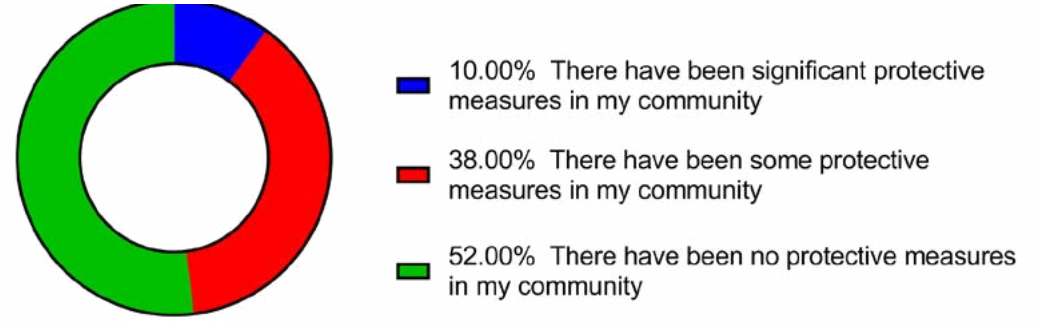
'Resources and materials to support the vulnerable communities are there but most persons with disabilities' needs and wants have not been prioritised by government. Most persons with disabilities, especially in rural areas don't receive specific attention' (respondent who identified as a cross-disability social movement from Zambia).

'Only in some areas, some places like rural areas have been left out (forgotten)' (respondent with a physical disability from Namibia).

'Masks and gloves barely reached the villages' (parent/caregiver of a Deaf person from Namibia).

5.8.3 Extent of protective measures for PWDs including groups of disabilities

The survey findings show that protective measures were not taken for PWDs or for some groups of PWDs. The graph below shows that 52 per cent of the respondents indicated that no protective measures were available; 38 per cent indicated that some protective measures were available; while 10 per cent indicated that significant measures were available. Non-responses were excluded.



Graph 19: Responses on protective measures for PWDs including for some groups of disabilities.

One hundred and seventy-four (174) written responses were received on this question. By and large, respondents indicated in their written responses that measures specifically for PWDs: were not provided; where they were provided, they were insufficient or provided by individuals, donor aid or NGOs; or that they were not inclusive.

'There is none that I heard of to have been specially designed for persons with disabilities' (parent/carer of a person with a disability from Eswatini).

'It has not been easy for government to provide protective services for persons with disabilities as a result of many factors ranging to none availability of funds to lack of transport (including fuel)' (person with a physical disability from Eswatini).

'There are not enough masks for disabled people in my community' (respondent who is Hard of hearing from Namibia).

'This was not from the government but from organisation and yet was not enough' (parent/carer of a person with a disability from Namibia).

'There were few from individuals but not part of the government support' (DPO and wheelchair user from Namibia).

'There have been some protective measures in my community but not disability inclusive' (governmental body respondent and a woman with a disability from Namibia).

'Only at some areas but not in the old settlements. Persons with disabilities in my community received no benefits during the pandemic periods. We have to provide for ourselves with everything' (respondent with a physical disability from Namibia).

'The government did not put in place measures for people with disabilities. They did not distribute masks, gloves and not even spraying doors' (respondent with a physical disability from Malawi).

'No disability specific interventions' (DPO respondent from Lesotho).

'There wasn't any measure. The government does not care about people with disabilities. They lacked food' (respondent with deaf blindness and a physical disability from Malawi).

The written responses, bar a few, did not elaborate on protective measures for groups of disabilities:

'Protective measures for some persons with disabilities were provided to some persons depending with their level of disability, but to those with complex situations nothing was done' (clergyman from Zimbabwe).

Good practices were identified, but whether government or third parties were responsible is not clear from the written responses:

'COVID-19 supplies have in the recent past been donated to schools where children with disabilities could benefit' (DPO respondent from Zambia).

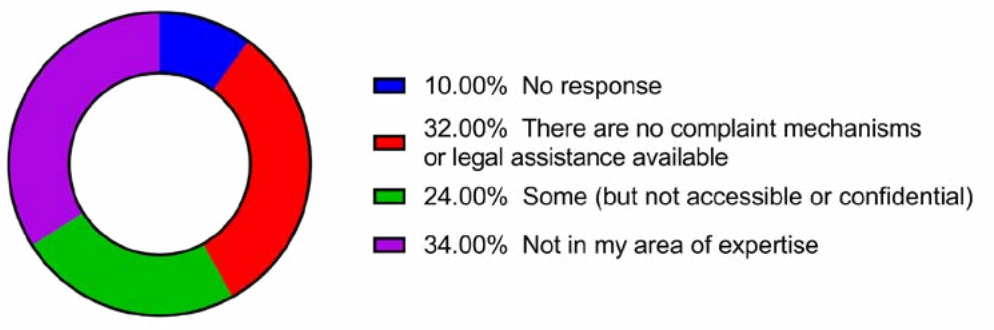
'The measures that have taken place for persons with disabilities have been significant in the sense that washbasins, hand sanitisers and face masks and disinfectants have been given to leaders of the community and leaders have distributed to most of the households, if not some have been shared' (DPO respondent from Zambia).

5.9 Lack of measures to access justice

Access to independent complaints mechanisms (ICMs), lawyers and legal assistance is one of the main themes that emanated from the responses. In the survey, the responses on availability of these measures to promote equal access to justice, also required respondents to reflect on its accessibility and confidentiality.

The survey findings suggest that there are generally no complaints mechanisms or legal assistance available to PWDs (32 per cent of responses), or that where they are available, they are not accessible or confidential (24 per cent of responses). A

significant number of respondents either did not have knowledge of this issue (34 per cent) or chose not to respond to this question (10 per cent).



Graph 20: Percentages of responses indicating whether or not PWDs in both public and private institutions or in the community have access to independent complaints mechanisms and to lawyers

If the non-responses are excluded, the response rate looks even more alarming. Of those respondents who chose one of the two options, 56 per cent indicated that independent complaints mechanisms and legal assistance were not available, while 44 per cent indicated that only some complaint mechanisms or legal assistance were made available (but this was not accessible or confidential).

Graph 21: Percentages of responses on complaint mechanisms or legal assistance without non-responses.

This picture is further strengthened by the sheer number of written responses about lack of access to independent complaint mechanisms and legal assistance (58 written responses) and others delineating barriers to the affordability of lawyers (16 written responses).

> 'I have never heard of such let alone a lawyer for disability' (Blind respondent from Eswatini).
>
> 'Legal aid, supported by government does not adequately cater for the many persons with disabilities needing legal assistance' (DPO respondent from Zambia).
>
> 'Majority of the time folks living with disabilities have nowhere to file complaints. We often feel like second class citizens in our own country' (Blind respondent from Namibia).
>
> '[There are] no structures or institutions where people with disabilities can go for advice and assistance' (elderly respondent with a physical disability from Botswana).
>
> 'We are not able to access lawyers. The police promise to take our cases to courts for prosecution,

but they never do so. We need people who can assist us when our rights are violated. I need help with my cases' (respondent with disability (blind, and physical disability) from Botswana).

Lack of information or inaccessibility of information about rights and recourse for violations is a sub-theme that emanated from the surveys. For example,

Even if these are accessible, persons with disabilities are not aware of such communication and advocacy on that is low' (NHRI respondent from Namibia).

'They are able to lodge complaints with the Chief, the police and the Magistrate. However, persons with disabilities are timid. They are afraid to lodge complaints when they are supposed to do so' (DPO Respondent and person with disability from Botswana).

'They do not have information about where to go' (respondent who is hard of hearing from Botswana).

'With deaf and dumb, people who are blind to access to get adequate assistance since government institutions don't have sign language interpreters and Braille' (respondent with multiple disabilities from Zimbabwe).

'Many people are not aware of their rights and it is therefore difficult for them to approach lawyers' (respondent with a physical disability from Malawi).

Transportation was identified as a barrier to access complaint mechanisms or legal assistance:

'Even though there is the legal aid, transportation money is still a thorn and in most cases the location in which the legal aid offices are not easily reachable' (respondent with physical disability from Zambia).

Alternatives to government provided legal assistance were mentioned by one respondent:

'The mechanisms are there but they are not from the government. In [our area] there is a disability forum, which helps to deal with issues concerning people with disabilities' (respondent with a physical disability from Malawi).

Challenges with affordability of lawyers and perceptions of free civil legal aid not being provided abounded in the written responses, for example:

'No complaint as the law in our country does not provide for lawyers for free. Persons with disabilities has less access to this mechanism' (Blind respondent from Zambia).

'You can only approach a lawyer if you have money' (Blind respondent from Malawi).

'There is no support because lawyers are very expensive and the people cannot afford the cost. And in most cases people/lawyers are not interested in us' (respondent with a physical disability from Malawi).

'Lack of information to people with disabilities approaching lawyers might be a hassle because people believe money is needed' (respondent with physical disability from Zimbabwe).

Alarmingly, one problem identified was a perception of corruption on the part of lawyers:

> 'Most of them lawyers demand bribery measures from either the complainant or the accused' (respondent with a physical disability from Zimbabwe).

A COVID-specific barrier was identified by one respondent – that hard lockdowns/ quarantines meant that mechanisms that may have been available previously were not accessible at all:

> 'No time for complaints everyone was home' (respondent with a physical disability from Zimbabwe).

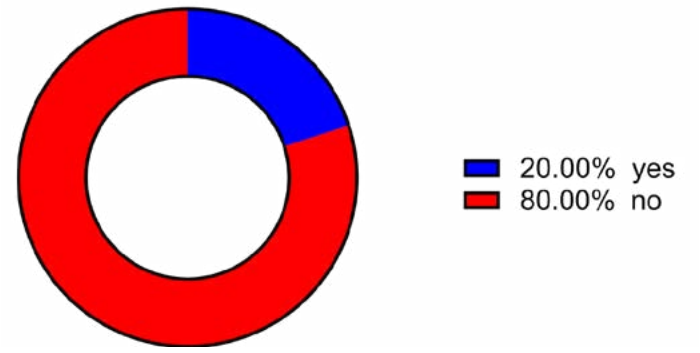
The perception that PWDs are too 'shy' to obtain legal assistance was articulated by one respondent:

> 'I think PWDs are too shy to get help when they need it unless you ask them but mechanisms are in place to assist them. Social workers are there' (governmental body from Botswana).

Persons with disabilities' (or their carers or assistants') access to justice may have been violated by governmental measures to enforce COVID-regulations such as curfews and a question was posed in the survey to elicit this information. However, the question was not a model of clarity and respondents were therefore likely unable to properly reflect on this. The question posed was:

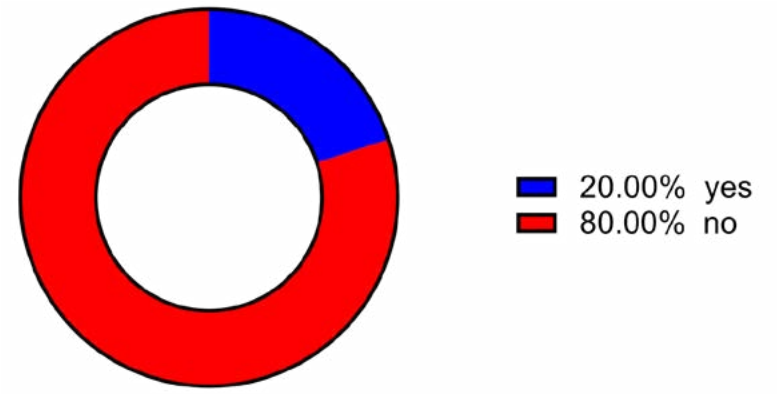
> 'Do you have any information on whether penalties resulting from breaking state of emergency rules (fines, sanctions, arrest) are imposed on persons with disabilities or their personal assistants and carers, because of support and care provided for persons with disabilities?'

The response rate below indicates that the results are not easily interpreted.



Graph 22: Responses on penalties from breaking of rules.

Where the non-responses are excluded, the picture emerges more clear-cut – that 80 per cent of respondents indicated they have no such information while 20 per cent indicated they do have such information.



Graph 23: Responses on penalties from breaking of rules (non-responses excluded).

There were only six written responses on this issue that elaborated on the arrest of PWDs or their carers. Of those, two respondents from Eswatini indicated that there were reports that persons with 'mental challenges', which presumably refers to persons with intellectual or development/cognitive disability and Deaf members of the community, were arrested for transgression of governmental regulations.

5.10 The need for representation and consultation with PWDs

A major theme that arose from the survey is the need for representation of PWDs on COVID-responses, whether as members of committees, task forces or other bodies, and the need for consultation with PWDs regarding how emergency situations impact on them. Respondents identified this need for representation and consultation in over sixty written responses.

> 'Persons with disabilities are often left out during emergencies. There needs to be a way [to ensure] that they are always part of intervention like housing their representatives forming part of committees that strategise for national emergencies' (parent/carer of a person with a disability from Eswatini).

> 'Having representation in the national and cluster covid-19 committees. Having inclusive policies and implement them' (Autistic respondent from Malawi).

> 'Including the representatives of people with disabilities in the decision-making process such as state of emergency laws' (DPO from Namibia).

> 'In order for government to fight Covid-19 effectively it must consider concerns and experiences of persons with disabilities, associations of persons with disabilities and [a local DPO] and incorporate them in their planning' (parent/carer of a persons with a disability from Lesotho).

> 'To fight Covid-19 effectively government must engage with all stakeholders including persons with disabilities, so as to learn from our experiences' (respondent with a physical disability from Lesotho).

> 'Persons with disabilities do not participate in response because they were not included. Decisions were made without them because they don't have representatives in the parliament' (Woman with a disability from Botswana).

> 'Data on persons with disabilities is insufficient with regard to COVID-19. Makes it difficult to monitor the situation' (governmental body respondent and a family member/carer of a person with a disability from Zimbabwe).

'They have not been included anywhere. Laws and regulations relating to the prevention of COVID-19 are just promulgated without taking into account persons with disabilities' (person with multiple disabilities from Botswana).

'Allowing PWDs to participate in decision making on issues affecting them. Giving them an opportunity for self-representation' (DPO respondent from Zambia).

'Involve persons with disabilities in information share forums eg [the] slogan: Nothing for us without us. Equal sharing and involving us is the better answer' (respondent with Down syndrome and a DPO from Zambia).

'Inclusion of persons with disabilities in the COVID task force' (respondent who is hard of hearing from Zambia).

'The committee on COVID-19 should also include representatives of people with disabilities' (Blind respondent from Malawi).

'Include persons with disabilities in the making process affecting their lives because they are experts of their lives (decision-making)' (respondent with a physical disability from Lesotho).

5.11 PWDs' experiences of and perceptions of discrimination and stigma

A staggering volume of written responses identified that measures for social protection and protective measures for life, health and safety were provided 'equally' amongst all residents. In other words, the responses articulated that there was a lack of a disability inclusive approach, prioritisation of PWDs or those PWDs at higher risk. One written response identified the perceptions of discrimination:

'I have not seen sufficient measures being taken. I believe the reason behind that is because our government believes that if its able-bodied citizens are affected then all is well (this is my personal opinion)' (Blind respondent from Namibia).

Some respondents described PWDs in stigmatising terms: 'timid', 'inferiority complex', and '[not] confident'.

Lack of a disability inclusive approach was articulated in some written responses:

'They have not been included anywhere. Laws and regulations relating to the prevention of COVID-19 are just promulgated without taking into account persons with disabilities' (DPO for persons with physical disabilities from Botswana).

5.12 Governments' fiscal challenges and perceptions of corruption

A minor theme that emerged is the portrayal of fiscal challenges on the part of government and respondents' perceptions of corruption and its impact on provision of protective measures.

Some written responses identified that governments used fiscal challenges as an excuse not to provide protective measures, while others indicated that respondents

perceived that corruption was to blame for lack of provision of protective measures.

Written responses on fiscal challenges included the following:

> 'Government announced that she did not have money to carry out some programmes and the health department was not spared' (respondent with a physical disability from Eswatini).
>
> 'Government has continuously complained of insufficient funds and has put many projects and programmes on halt as the COVID-pandemic started' (respondent with a physical disability from Eswatini).
>
> 'The government say there is no money' (family member/carer of a person with a disability from Zimbabwe).
>
> 'Due to budget restrictions the government could not provide people with all the necessary protective items, like masks and hand sanitizers' (governmental body from Botswana).

Written responses on corruption included the following:

> 'Monopoly of funds' (respondent with a physical disability from Zimbabwe).
>
> 'Most people with disabilities lacks information on what is on the ground. Major reasons are caused by the grand corruption' (respondent with a physical disability from Zimbabwe)
>
> 'Funds to do all these expected acts are sabotaged. Funds just disappear without an explanation, knowing or believing that people with disabilities won't notice' (respondent with a physical disability from Zimbabwe).
>
> 'Measures and protection support: not all persons with disabilities are getting or receiving support. Only few benefits. This has been due to corruption and tribal causes. Lack of transparency and accountability' (social movement from Zambia).
>
> 'Not at all, politics was at play during relief food distribution' (Deaf respondent from Zambia).
>
> 'The government did not buy masks for people with disabilities but it got a lot of money for COVID-19' (Blind respondent from Malawi).

One response articulated the utilisation of PWDs when it is politically expedient to do so:

> 'Most communities are considered for funding needs for persons with disability in intervals when there are activities such as upcoming or past elections taking place. This is a past and present action. When some officials need to the community to vote leaders, the community and persons with disabilities are considered to have measures to protect them'. (DPO from Zambia).

6. CONCLUSION

The perspectives of the respondents to this survey reflect the continuous struggle of PWDs for self-representation and the need for better consultation with PWDs to formulate inclusive policy and legal solutions, including for emergency situations such as the COVID-19 pandemic.

The results from the study are generally in line with the literature reviewed. However, pertinent aspects were highlighted that are not evident in the literature such as the impact of rurality, corruption and lack of consultation with and participation of PWDs in various COVID-19 response structures.

Key themes arose from the survey findings:

- Access to services and supports were severely impacted, particularly in relation to access to food and basic supplies, personal assistance, medical treatment and interventions such as rehabilitation and therapies. The gaps in provision of these supports and services impacted on their quality of life and right to life.
- A general lack of access to sign language and interpretation services impacted on the ability of the Deaf and hard of hearing to access services and supports, including in hospitals.
- Governments generally did not make information available in accessible formats, with an emphasis on gaps in provision of Braille and sign language. The lack of accessible information attributed higher risk to infection for PWDs. Respondents called for the training and capacitation of healthcare workers to disseminate information about COVID-19 in accessible formats and to reach remote and rural areas.

- Measures were generally not taken to ensure PWDs can access general and specialised healthcare. Respondents identified shortages of medication and inaccessibility and unaffordability of transport to hospitals or clinics.
- Barriers to access vaccines was experienced, including due to its relative unavailability, long distances needed to travel and long waiting periods at sites; inaccessibility of vaccinations to PWDs and lack of education on the need to vaccinate.
- Social protection measures to support PWDs in the community were not taken. Respondents experienced barriers to access cash transfers including in some instances where receipt of a disability grant precluded receipt of further social assistance and the complaint that the cash transfer amount was too low. Respondents explained how poverty was exacerbated during the pandemic, particularly in relation to access to food and due to the impact on income generating opportunities.
- Protective measures (life health and safety) of PWDs living in the community were generally not available, inadequate or not inclusive. Respondents indicated that provision of free water was a positive measure in some countries. However, availability of PPEs to PWDs, particularly those in rural and remote areas was limited and these were unaffordable, impacting on the ability of PWDs to find employment and travel.
- PWDs residing in institutions experienced isolation, a lack of support and protective measures.
- Measures to protect the health, life and safety of children living in the community and in residential setting were generally not taken.
- Measures to support families were generally not taken. Respondents indicated how children's access to nutrition and education was affected and the ability of socio-economically depressed parents to narrow this gap was severely constrained during the lockdown. Distribution of food hampers was said to be once-off gestures or did not amount to enough to feed families.
- Protective measures were generally not offered to street or shelter living persons (homeless). PWDs who beg were severely affected by the lockdowns.
- Rurality is a major barrier to access protective or social protection measures for PWDs as well as access to information.
- Protective measures were not taken for PWDs or groups of PWDs. Respondents articulated the fact that protective measures were not designed for or specifically for PWDs but rather formulated as 'once-size-fits-all' which is not inclusive of the needs of PWDs. Some of the protective measures offered came from non-governmental organisations, private individuals or donors.
- No complaint mechanisms and legal assistance were made available to PWDs.

Respondents indicated that the affordability of lawyers, lack of legal aid, or lack of information about rights and recourse for violations were barriers to access justice.

- Respondents identified a general lack of self-representation and consultation with PWDs on the relevant COVID-19 fora.
- Respondents identified experiences of discrimination and stigma and a lack of prioritisation of PWDs.
- Respondents identified that governments' budgetary challenges were often used as an excuse not to provide protective measures; and that rampant corruption was to blame for gaps in distribution of food relief and PPEs.

7. RECOMMENDATIONS

The project sought to contribute towards ensuring that the emergency and other measures taken by governments in Southern Africa during the Coronavirus pandemic are mindful of PWDs and do not violate their human rights as set out in international and regional law such as the CRPD. The hope is that government will use this data in addition to data from other sources to address gaps in the protection of the rights of PWDs. DPOs will also be able to use the data in their advocacy work and NHRI's in monitoring the situation of PWDs thus assisting in holding governments accountable. As was identified in the literature review, a myriad of international and regional law obligations draws a clear map for states to ensure disability specific responses that are inclusive, accessible and promote reasonable accommodation of PWDs in the measures they introduce to mitigate the impact of the pandemic on this diverse population.

The lessons drawn from the perspectives of the participants, point to a number of key recommendations for how Southern African countries can better protect the rights of PWDs during times of pandemics and other risks.

7.1 Measures to promote the rights of access to health, including therapies, assistive devices and rehabilitation and habilitation

It is recommended that states identify ways in which disruptions to access to healthcare and attendant services such as rehabilitation and therapies is minimised.

It is recommended that states identify measures to ensure PWDs can access general and

specialised healthcare, including adequate medication supplies. The inaccessibility of and high transport costs to hospitals and clinics need to be prioritised as a major barrier to access health care and mitigating measures should be implemented, including provision of free or subsidised public transport to such facilities for PWDs.

It is recommended that barriers to access vaccines are addressed without delay and that access to information and education on vaccination is implemented for PWDs in accessible formats.

It is recommended that measures are developed to promote continued access to assistive devices and technology, as well as the ability to repair and replace these where necessary.

7.2 Measures that respect for the linguistic rights of the Deaf and sign language users

It is recommended that states provide sign language interpreters in vital areas such as hospitals and clinics and provide captioning to television broadcasts to promote the rights of access to information and language rights of the Deaf and hard of hearing. Capacitating healthcare workers to identify appropriate referral networks for obtaining sign language interpretation services is needed. More sign language interpreters need to be trained and accredited across the states.

7.3 Provision of information in accessible formats

Accessibility of information is a public health necessity aside from being an immediate obligation under the CRPD. The following recommendations are made:

- States should make information available in accessible formats and disseminate these widely in rural areas, not only urban areas.
- States should implement an accessibility audit of existing informational sources, including on social media, websites, print media, television and the radio and address any areas that are found wanting.
- States should implement strict monitoring protocols for ensuring that information is disseminated in accessible formats and evaluate whether their reach impacts on all relevant groups of PWDs, including Blind and visually impaired and Deaf and hearing impaired, as well as those utilising AAC (autism and low or limited functioning speech), and Easy Read and plain language (intellectual disability, low literacy). Recalcitrant government departments should be brought to book for failures in this regard. Here the monitoring by DPOs and NHRIs can assist in uncovering these instances and complaint mechanisms should be widely publicised to encourage greater uptake thereof.
- The radio and word of mouth were identified as good sources of information about COVID-19. Community leaders and structures should be provided with

accessible information to ensure that this is disseminated within community structures, particularly in rural areas where access to data, networks and televisions may be limited.

- Television news broadcasts and other informational segments should be in accessible formats. Particularly sign language interpretation and captioning should be implemented for all relevant broadcasts.
- Community workers, including social workers, health workers, child and youth care workers and auxiliary aides should be trained in communicating and sharing information with persons with diverse disabilities and capacitated with knowledge of relevant referral networks where needed.

7.4 Measures to access social assistance

It is recommended that states address barriers to access social assistance (cash transfers) such as arbitrary exclusions and inadequacy of some amounts to provide for the needs of PWDs, particularly those with high support needs.

Furthermore, it is recommended that social assistance should be extended to PWDs towards ameliorating the challenges in generating income for PWDs during the pandemic. Gender and child specific measures must be prioritised and measures for the informal economy should be included.

7.5 Disability inclusive protective measures

As indicated earlier, the findings of the survey identify that protective measures (life health and safety) of PWDs living in the community were generally not available, inadequate or not inclusive. The following recommendations are made:

- Best practices such as the provision of water for free should be scaled up.
- PPEs should either be available for free or subsidised for PWDs and that states develop measures to aid distribution of PPEs to reach rural and remote areas.
- Protective measures should be made available for free to street or shelter living persons.

Furthermore, it is recommended that states, in formulating their responses, do not consider provision of protective measures as a charitable gesture towards PWDs, but a human rights obligation and accordingly, a state obligation. This would mean that better collaboration with civil society, NGOs and donors should occur and in particular that the governments also meet their own obligations towards PWDs. Accordingly, it is recommended that states allocate appropriate budgets towards providing protective measures.

It is recommended that states consult with PWDs on the appropriateness, accessibility and inclusiveness of protective measures and to ensure that they are designed with their needs in mind.

7.6 Access to justice for PWDs

Four specific recommendations are made: First, it is recommended that accessible information is shared of existing complaint mechanisms, state legal assistance providers, pro bono assistance networks, law clinics and legal NGOs in each state.

Second, Departments of Justice and NHRIs should monitor access to justice and develop indicators to check the accessibility, reasonable accommodations, quality and quantity of complaint mechanisms, legal assistance provision and access to justice in the court systems for PWDs during humanitarian disasters and its aftermath.

Third, it is recommended that states should take measures to dismantle barriers to obtaining legal advice and redress such as financial barriers, transport barriers and informational barriers.

Fourth, it is recommended that departments of justice and NHRIs should draft and disseminate information in accessible formats about rights and recourse for violations.

7.7 Measures to ensure adequate participation by PWDs

The following recommendations are made to promote representation and consultation that meets the participation requirement:

- PWDs should be represented in all relevant structures and fora such as task teams on addressing humanitarian disasters in the different spheres (local, provincial, national as well as state/federal) and different sectors such as health, social welfare/development; education; justice; transport; and other relevant sectors.
- PWDs should be represented in monitoring groups and particularly in law enforcement. It is recommended that states, in consultation with PWDs and OPDs, identify these structures and fora and ensure adequate representation of PWDs in these bodies.
- Humanitarian disasters affect PWDs as a group and persons with diverse disabilities in different ways. A homogenous approach is unhelpful, misinformed and disrespects the dignity and equality of persons with diverse disabilities. Consultation with persons with diverse disabilities should be prioritised. This should be done to ensure measures that are developed and implemented to mitigate the effects of the pandemic, including protective measures and social or other assistance, and health measures, speak to the particular needs of persons with diverse disabilities.

- Disability forums should be established by communities, where they do not already exist and they should be linked with local, provincial and other spheres (as well as rural and traditional leadership structures) to ensure that pandemic responses are inclusive, accessible and meet the needs of persons with diverse disabilities, particularly those in rural areas.

7.8 Measures to promote equality and non-discrimination

It is recommended that states develop and implement awareness protocols in their state departments and service providers and at community level of the rights to equality and prohibition of discrimination on the basis of disability, including in the health sector.

7.9 Measures to safeguard against corruption

It is recommended that states should allocate appropriate budgets to meet the needs of PWDs during humanitarian disasters, including in the provision of protective measures and food relief. PWDs and their representatives should be consulted in the drafting of these budgets and the monitoring thereof. These budgets should be well publicised in accessible formats.

States should designate relevant departments, anti-corruption commissions and an ombudsman to implement and monitor anti-corruption measures. NHRIs should monitor these measures. Where corruption is identified, measures should be taken to bring the perpetrators to book. Furthermore, where gaps in provision of protective of food relief are identified (as a result of corrupt practices), those gaps should be filled immediately by ensuring that the relief reaches those who need it most, including PWDs.

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