CASE STUDY

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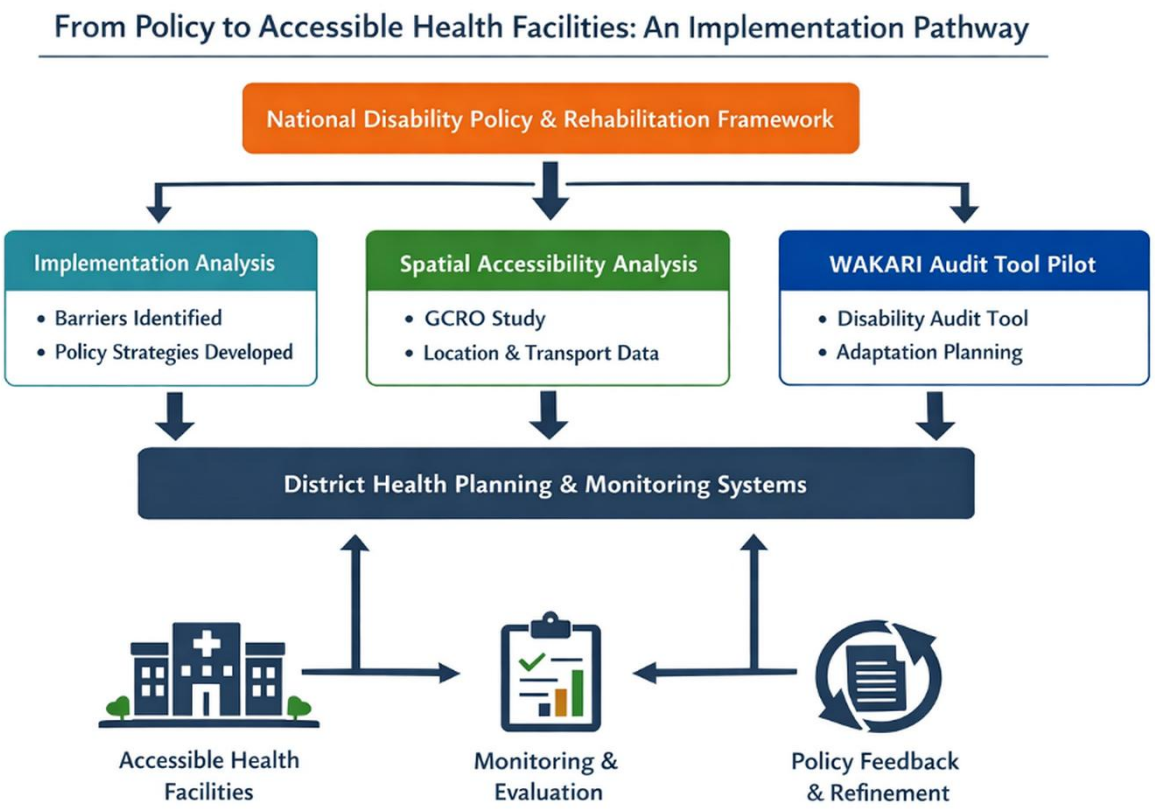
Strengthening Disability Inclusion in Health Facility Planning and Accessibility Governance in Johannesburg

Research in Johannesburg identifies barriers to disability-inclusive health access and proposes policy and monitoring tools to improve planning.



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1. Overview and Purpose

In rapidly urbanising contexts, health facilities are often assumed to be accessible public assets. Yet for many persons with disabilities, physical, transport and systemic barriers limit meaningful access to care. In Johannesburg, disability inclusion is supported by strong policy frameworks, but implementation gaps persist at facility and district level.

This case study reflects a university-led body of work at University of the Witwatersrand that has focused on identifying barriers to disability-inclusive health service delivery and proposing structured implementation strategies. The work combines policy implementation research on South Africa's disability and rehabilitation framework, a spatiotemporal accessibility analysis of public datasets from the Gauteng City-Region Observatory, and emerging plans to pilot the UK-based WAKARI disability audit tool in Johannesburg.

Rather than implementing physical infrastructure changes directly, the initiative has generated evidence on where and why accessibility gaps occur and have developed policy-relevant strategies to support more inclusive planning and monitoring. The case study contributes to the commitments of the Commonwealth Sustainable Cities Coalition (CSCC) and aligns with the Commonwealth Declaration on Sustainable Urbanisation adopted at CHOGM 2022 and reaffirmed at CHOGM 2024, particularly in relation to integrated planning and skills development.

The key lesson is that improving accessibility in urban health systems requires rigorous diagnosis of implementation failures and structured policy translation, not only design standards.

2. Context and Structural Challenge

Johannesburg sits at the centre of Gauteng Province, South Africa's economic hub. It is characterised by high levels of spatial inequality, long commuting distances, and uneven distribution of public services. Health facilities range from tertiary hospitals to community clinics; many located in historically marginalised areas.

South Africa has progressive disability and rehabilitation policies, including a national framework for disability and rehabilitation services. However, evidence from Gauteng shows that policy intent does not consistently translate into accessible facilities, integrated referral systems, or coordinated rehabilitation pathways. Barriers include inaccessible built environments, weak interdepartmental coordination, limited monitoring tools, and insufficient integration of disability considerations into district health planning.

These challenges are relevant across Commonwealth countries, where health facility expansion often prioritises service coverage targets over inclusive design and access monitoring. As highlighted in coalition discussions following the Wilton Park Dialogue that informed the establishment of the CSCC, sustainable urbanisation must move beyond commitments to measurable inclusion. Health facilities are critical nodes in this agenda.

This case advances national disability policy mandates, universal health coverage goals, and integrated development planning processes by focusing on implementation and governance rather than infrastructure expansion alone.

3. Project Approach and Delivery Model

The core of this work has been the systematic identification of implementation gaps and the development of practical policy strategies to address them.

First, mixed-methods implementation research examined how South Africa's disability and rehabilitation framework was being operationalised in Gauteng. Through document review, stakeholder interviews and structured implementation science approaches, the research identified barriers such as fragmented accountability, limited district-level guidance, and lack of measurable accessibility indicators. The findings informed the development of tailored implementation strategies designed to support health managers and policy actors in translating framework commitments into operational practice.

Second, utilising a public dataset from the Gauteng City-Region Observatory, a spatiotemporal analysis of accessibility in Johannesburg is currently exploring how geographic location, transport networks and service distribution influence access to health facilities over time. This work highlights the uneven spatial distribution of services and the compounded disadvantage experienced by persons with disabilities living in peripheral or under-serviced areas. By integrating spatial analysis with policy review, the study demonstrates that accessibility is not only a facility-level issue but also a planning and transport governance issue.

Third, a collaboration with a South African-led project based in the United Kingdom, WAKARI, is focusing on adapting a structured disability audit tool for potential piloting in Johannesburg. WAKARI is designed to assess accessibility across multiple dimensions, including physical access, communication, and service processes. The intention is not to conduct isolated audits, but to test how such a tool could be embedded within district health monitoring systems. This reflects a shift from compliance-oriented checklists to governance-oriented monitoring frameworks.

Across all components, the work has prioritised policy engagement. As a research consultant to the National Department of Health and a technical expert to the Council of Medical Schemes, the researcher has translated findings into policy briefs through D20 and other streams, technical reports and advisory inputs. The emphasis has been on aligning disability inclusion with existing health system reforms, rather than proposing parallel systems.

In practice, this approach functions as an evidence-to-policy bridge. It identifies where breakdowns occur, proposes structured implementation strategies, and supports integration into existing planning and regulatory frameworks.

4. Transferable Insights

Accessibility failures are often systemic rather than architectural. Even where physical ramps exist, transport barriers, referral gaps and information asymmetries may prevent effective access. Integrated planning must therefore link health facility design with transport and spatial governance.

Additionally, spatial data is a powerful tool for urban inclusion. The spatiotemporal analysis demonstrates that disability-inclusive planning requires attention to geographic distribution and travel burden, reinforcing the importance of integrated planning approaches within the CSCC framework.

Audit tools such as WAKARI are most effective when embedded within institutional monitoring systems. Stand-alone audits may produce reports, but institutionalised monitoring can drive accountability and incremental reform. Challenges remain, including data limitations, capacity constraints at district level, and competing policy priorities. However, the experience shows that universities can play a critical role in diagnosing implementation bottlenecks and designing context-sensitive strategies.

For the CSSC Housing, Urban Finance and Integrated Planning Action Groups, this case highlights that accessible health facilities are core urban infrastructure. Financing models, performance indicators and planning guidelines must incorporate measurable accessibility standards if sustainable urbanisation is to be genuinely inclusive.

5. Key Lessons

Key transferable lessons include:

- Disability inclusion in health facilities requires governance reform, not only infrastructure upgrades.
- Spatiotemporal analysis can reveal hidden geographic inequities in urban health access.
- Implementation science provides practical tools for translating disability policy into operational strategies.
- Audit tools like WAKARI should be embedded within district monitoring systems for sustained impact.
- Aligning accessibility reforms with national health and urban planning mandates enables scale-up and institutional embedding.

This Case Study was prepared by Dr Naeema Ahmad Ramadan Reis, Department of Physiotherapy, School of Therapeutic Sciences, Faculty of Health Sciences, The University of the Witwatersrand, Johannesburg, South Africa, by way of contribution to the work of the CSCC Sustainable Urbanisation Expert Group, 05 March 2026.

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