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The creation of debility and disability in South Africa: Colonial and apartheid encounters

The global legacy of colonialism has historically been studied in disciplines ranging from sociology and human geography to development economics, political sciences and international relations. However, over the years, the field of public health has also seen an emergence of research on the impacts of colonialism on the health outcomes of populations in the Global South. Operating at the nexus of the field of disability studies and decoloniality, I critically historicise South Africa's colonial and apartheid encounters, with specific reference to how they created debility and disability. I argue that, while disability existed in pre-colonial African societies, including in South Africa, it was not deemed as an impairment that eroded the humanity and value of persons with disabilities. The construction of disability as an impairment, and the consequences related to this construction, emerged out of colonial and apartheid encounters. Both epistemologically and through layered forms of violence, colonialism and apartheid created debility and disability. Situating discourse in the field of disability studies within the context of colonial and apartheid encounters in the Global South in general, and South Africa in particular, is crucial. It is especially necessary that such discourse be anchored in decolonial theorisation in order that the particularities of the experience of disability in post-colonial and post-apartheid societies can be understood within this context.

Significance:

Research and theoretical orientations of disability studies remain profoundly skewed towards accounts from the Global North. One approach to correcting this bias is that of engaging with debility and disability in the context of colonial experience. Operating at the nexus of the field of disability studies and decoloniality, I critically historicise South Africa's colonial and apartheid encounters, with specific reference to how they created debility and disability. The analysis lays the foundation for theorising the interconnected systems of post-colonial violence and oppression, as well as the interlocking systems of power that continue to marginalise persons with disabilities.

Introduction

The global legacy of colonialism has historically been studied in disciplines ranging from sociology and human geography to development economics, political sciences and international relations. However, over the years, the field of public health has also seen an emergence of research on the impacts of colonialism on the health outcomes of populations in the Global South. In works such as Alison Bashford's *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*[1], racial imaginings emerging from the empire that have shaped the subjects and spaces of public health are critically analysed, drawing the link between colonial encounters and public health systems in developed and developing countries. While research into this link is undoubtedly important given the centrality of health in determining the overall outcomes of a society, there is a paucity of research focusing specifically on this link in the subject of debility and disability.

Despite the complex experiences that persons in the Global South have with debility and disability, and the particularities that define these experiences, the field of disability studies has historically been dominated by Global North thinking.[2] The implications of this are twofold. Firstly, with 80% of persons with disabilities worldwide being situated in the Global South[3], the disproportionate scholarship reproduces layered forms of epistemic and ontological violence. This exclusion, of both disability scholars and persons with disabilities, enables the erasure of important concepts developed in the Global South.[4] This silencing and suppression of Global South disability research universalises approaches to policy and resource interventions, disregarding the specific needs confronting the developing world. Secondly, the negation of experiences of those in the Global South sets parameters for an ahistoric engagement with the subject of disability. Specifically, it erases the impact of the colonial experience on the creation of debility and disability.

One approach to centring the conceptualisation of disability in the Global South is to engage with the subject in the context of colonial experience. This approach is valid, despite debates about the differences in the cultural traditions, spatial constructions, economic trajectories, administrative structures and geo-histories of countries in the Global South, due to colonialism being a universalising encounter. According to Grovogu[5], this colonial experience gave birth to the anti-colonialism struggle and to the Global South as a symbolic designation that has significant political implications. In critically engaging with debility and disability in the context of the colonial experience, interlocking systems of power that extend to the public health sphere are explored, laying the foundation for a nuanced understanding of debility and disability as colonial creations in the Global South. Characteristic of the Global South, the impact of colonialism has left a lasting impact on South Africa and its people. Ngcukaitobi[6] contends that the colonial experience, at the centre of which is the violent and systematic dispossession of land from Indigenous people, has irrevocably shaped modern South Africa, and that the imperial ambitions that the British exercised on the eastern frontier set the blueprint for the country, spatially and otherwise. Established in the 19th century, these ambitions crystalised during the apartheid era and later shaped the democratic dispensation.

Defining disability in the context of South African society

The implications of the dominance of Global North research on disability scholarship extend to the very question of how disability is defined. Global South countries, including South Africa, have struggled to construct a country-specific definition of the term 'disability'. While there is an understanding that disability is best defined with the balancing of the approach between the medical model and the social model[7], there is limited discourse on how the particularities of the colonial experience in the Global South necessitate a more nuanced definition of the term. In South Africa, it was only in 2006 that Cabinet approved the currently accepted definition of disability as "the loss or elimination of opportunities to take part in the life of the community equitable with others that is encountered by persons having physical, sensory, psychological, developmental, learning, neurological, or other impairments, which may be permanent, temporary, or periodic in nature, thereby causing activity limitations and participation restriction with the mainstream society"[8(p.17)].

Charles et al.[9] contend that, while this definition of disability outlines some key characteristics of disability, it has limitations in failing to consider that barriers to accessibility are key to the inability of many persons with disabilities to participate in community life. There are also universalist inclinations in the definition, and a failure to be cognisant of regional and cultural differences in the experience of disability. Another definitional limitation is the absence of the geohistory of South Africa, which informs some important particularities of its disability context. While the White Paper on the Rights of Persons with Disabilities addresses the interrelated barriers experienced by persons with disabilities, namely, psychological barriers such as fear for personal safety; social barriers such as communication difficulties and lack of disability awareness; and structural barriers such as limited infrastructure and information[8(p.17)], there is no sense that the colonial and apartheid context of disability in South Africa is considered. This specific context is important as it illustrates the intersectionality of disability, race, gender, class and geography, demonstrating the complex ways in which disability is experienced on the basis of South Africa's colonial and apartheid history. Such intersectional realities faced by persons with disabilities in the Global South, where colonial legacies continue to shape access to health care, education and employment, cannot be ignored. Thus, this article considers the roots of the structural limitations arising from colonial and apartheid encounters as well as the spiritual, relational, and community-based understandings in defining disability. Indigenous epistemologies, which are frequently based on relational and communal values, offer alternative frameworks for making meaning of disability. For example, the African philosophical notion of *ubuntu* considers disability as a shared obligation rather than an individual deficiency.[2] This definitional approach is relevant not only for South Africa, but for all societies that have experienced colonial and apartheid encounters. In the field of disability studies, there is a need for a decolonial sociological imagination, or what Bhambra[10(p.21)] aptly articulates as "a more thoroughgoing analysis of the underlying assumptions upon which discourses and practices come to be premised".

Following the social model of disability, queer perspectives, feminist theories, and post- and decolonial approaches have further offered valuable theoretical and empirical analyses of disability as a political and social phenomenon, as well as the complex relations between non-normative bodies, racial, gender, class issues and histories of domination and colonialism. Alongside Crip Theory, which emerged with an analysis of disability, sexuality and queerness, new viewpoints of disability studies emerged: Disability Critical Race Studies, Black Disability Studies, and Indigenous Post-Colonial Theories. The first assertion described by these perspectives is the intersectional issues related to living with a disability in exclusionary, racist and ableist societies. The second assertion relates to the indigenous, moral-spiritual ideas, practices and discourses about disability. Furthermore, theoretical entanglements between critical disability studies and post- and decolonial theories which explore matters of coloniality, decoloniality and neocolonialism beyond the Global North epistemics emerged.

Methodology and theoretical framing

The prevailing public health system in South Africa, with its structural limitations, particularly for persons with disabilities, is reflective of the dehumanisation and exclusion that persons with disabilities faced during the colonial and apartheid eras. The aim of this article is to critically historicise South Africa's colonial and apartheid encounters, with specific reference to how the disruption and dispossession of Indigenous people from their lands has created debility and disability. I employed a qualitative approach and used secondary data (official and unofficial) to provide deeper insights into the link between colonialism, debility and disability.

Debility, a concept introduced by Julia Livingston[11], is a case example here. Livingston shows how Batswana's notions of kindship and personhood underscore the interconnectedness of individual bodies. Therefore, debility refers to how forms of bodily non-normativity result not solely from past colonial genealogies of exploitation as well as individual accidents, but can also be linked to moral misdeeds and behaviours of individuals within the network of relationships surrounding the person with the condition. In other words, marginalisation and social issues are not directed toward the individual but redistributed within the community. Puar[12] has also developed work on debility to describe individuals deemed unable to fully participate in society, as seen as a product of social and structural barriers, rather than an inherent characteristic of the individual. A critical perspective on disability and debility in the Global South challenges dominant narratives, drawing attention to the intersection of disability with issues like colonialism, racism and classism. Critical disability scholars posit that neoliberal frameworks often view individuals through the lens of productivity and market participation, leading to the marginalisation of those deemed "debilitated" or unable to fully engage. While debility scholars critique disability studies and rights movements for their tendency to focus only on the most "assimilable" individuals – an aspect which leads to a neglect of the experiences and needs of those who are further marginalised due to intersecting oppressions or those who are debilitated – Global North disability scholars criticise debility studies for possibly flattening and ignoring the hierarchy that exists between disabled and non-disabled people.[13] They attribute this to critical disability studies where disability is used as an inferential object to advance another argument – one which does not develop disability politics. Global South scholars, however, are of the view that debility encompasses disability and also goes beyond it.[14] As Livingston[11] observes:

> *Debility – the impairment, lack or loss of certain bodily abilities – is, on one level, a profound challenge to personhood. But debility also has a history, in the sense that impairment and disfigurement often arise out of a particular historical juncture – for example, the rise of mining and mining accidents, wars, or violence in societies that may not even be at war, in the military sense. This understanding of debility gives us insight into people's sense of historical experience and changing assumptions about personhood and self.*[11(p.2)]

This article operates at the nexus of the field of disability studies and epistemological decoloniality. Such an approach is significant because, as traditionally constituted, disability studies often perpetuate a colonial epistemology by universalising Western conceptions of disability and neglecting other cultural, historical and geopolitical contexts. The implication of this is in the erasure of many interpretations which are rooted in the Global South and in universalising Western conceptions, as shaped by colonial legacies. Therefore, a decolonial approach to disability studies is both theoretically and practically necessary as it entails redefining disability as a lived experience influenced by overlapping identities, such as race, gender, class, and geography, rather than only portraying it as a deficiency or medical disease. A decoloniality lens is particularly important to serve not only as the guiding theoretical framework, but as a prism through which critique of the limitations of disability studies in the Global South is constructed. Precisely because the field of disability studies is dominated by Eurocentric knowledge forms, despite the experiences of disability being most pronounced in

the Global South[2], there is a need to challenge the very histories that inform these knowledge forms and this macro-history. The decolonial approach enables us to reconsider how language, representation and power relations shape the continuation of ableist and colonial narratives.

Creating debility and disability through disruption and dispossession

This section explores the complex ways in which debility and disability were created through dispossession. In this context, dispossession refers not only to the systematic and violent theft of the lands of Indigenous people, which forms part of the geographical or spatial dispossession of the colonised, but also to intellectual dispossession, giving rise to epistemic erasure. In this regard, Harris[15(p.165)] contends that "the legitimation of and moral justification for dispossession lay in a cultural discourse that located civilisation and savagery and identified the land uses associated with each". Although dispossession has always been central to the function of colonialism, and in particular, settler colonialism[16], it is important to state that African history does not begin with colonialism. Ndlovu-Gatsheni[17(p.2)] posits that:

> *As a people, Africans were always there in human history. They were never creatures of 'discovery'. Africans were always present. Africans were never absent. Africa was never a* tabula rasa *(Dark Continent). Africans always had their own valid, legitimate and useful knowledge systems.*

African history does not begin with colonialism, thus the Africa before the colonial encounter did not resemble the one that emerged out of that experience. In that respect, it would not go amiss to state that, rather than birthing African history, colonialism interrupted it. This is especially true in the pre-colonial African conceptions of disability. This is not to say that the disability experience is homogeneous across African contexts.

Pre-colonial African societies conceptualised disability differently from the dominant Eurocentric conception of disability as bodily impairments. Similarly, the concept of disability, as understood today, did not exist in precolonial Africa. Rather, various terms described different forms of non-normative bodyminds.[2] According to Ojok and Masenze[18], in pre-colonial Africa, disability was not always perceived as a handicap, and persons with disabilities were accepted and well-integrated into their communities, where their human value was not negated by their disabilities. According to Gallagher[19], the people of Dahomey in West Africa believed that infants born with disabilities possessed supernatural powers and symbolised good luck. As they grew into adults, they were appointed to important roles, such as state constables. Obermann[20] contends that the Chagga people in East Africa believed that children with disabilities were protectors of their communities. Thus, African spiritualism consecrated persons with disabilities in profound ways.[2] Similarly, many Indigenous societies in Asia and Latin America view disability through symbolic and spiritual lenses, frequently linking it to special skills or divine intentions.

In South Africa, pre-colonial KhoiSan communities co-existed with persons with disabilities and utilised their own psychosocial health practices, the therapeutic merits of which are under-researched. In their study on psychosocial health management practices of the KhoiSan in the Northern Cape Province of South Africa, Mahlatsi et al.[21] demonstrate that the said community has, since long before the dawn of colonialism, conceptualised ill-health as a manifestation of the interruption of the connectedness of life, rather than as individual pathology. This theorisation of ill-health, and of disability, was systematically delegitimised by colonial and apartheid governments, primarily legislatively, with the promulgation of Section 1 of the *Witchcraft Suppression Act (Act no.3 of 1957)*[22], which suppressed and criminalised Indigenous African health systems. The impact of this has been devastating to the health outcomes of black people.[23] Ndlovu-Gatsheni[24] characterises this as the direct result of Euro-North American centric modernity, and colonialism, as it were, creating modern problems for which there is no modern solution, and argues that the imposition of Euro-North American centric knowledges and theories have impeded on the understanding of contemporary challenges of the Global South.

Beyond the dispossession of African Indigenous knowledges and theories of disability, colonial and apartheid encounters created debility and disability through physical and violent dispossession of land and the economy in South Africa. According to Ohenjo et al.[25], people dispossessed of land, and without security of tenure, have poorer health outcomes in comparison to those who own and control the land. Several factors were at play. Firstly, land dispossession initiated food insecurity in urban and rural South Africa. Achieved through systematic violence and the creation of institutions that legitimised draconian laws facilitating the annexing of land and forced removals, land dispossession meant that Indigenous black people could no longer produce their own food.[26] This assault on subsistence farming forced them into the segmented labour market where wages were too low to afford even the most basic nutrition. This may be linked to issues of poor nutrition in many communities.

Linked to this, many labour workers in the Western Cape Province of South Africa lived on the farms which grow grapes and produce wine. Under the system of apartheid, for over at least two centuries, these workers were provided with wine as a form of partial payment for their labour. This practice was referred to as the 'dop' system. Believed to present a major public health problem, this dop system has elevated drinking rates in South Africa and rates of impairments such as foetal alcohol spectrum disorders (FASD) to this day. The same apartheid system played a limited role in assisting families to care for the needs of their children with disabilities. Affirming this, Swartz[27] acknowledged these South African realities, pointing out that black South Africans with disabilities have historically been shamefully excluded from a range of services and opportunities – exclusion which was often on the basis of racial oppression as part of the colonial and apartheid project to provide only to white people, including white people with disabilities, in order to ensure a better standard of living to that of their black counterparts. It is here that we clearly see how the intersecting systems of power operate to disempower others (e.g. black disabled) while empowering others (white disabled). We also see the clearly complex interplay between congenital/biological and the socio-political context within which disabilities are formed.

Secondly, and interrelated with the inability to produce their own food and to afford nutritional food, black people were compelled to consume adulterated food as substitutes.[26] This gave rise to a myriad of health-related problems, including the rise in obesity levels. Obesity has been linked to debility and disability[28], with black people having the highest prevalence of obesity of all racial groups in South Africa, particularly in urban areas[29]. The same study noted the prevalence of overweight in rural women being significantly higher than that of women in urban areas. While poor diets contribute to the obesity and overweight challenges in black communities, another important factor, linked to landlessness, is imposed sedentary lifestyles.

In the South African context, sedentary lifestyles are not a question of moral failure or a lack of desire for healthier living. Rather, they are a function of the consequences of colonial and apartheid spatial planning. Beyond this, issues such as obesity are also linked to modern neo-colonial and neoliberal systems that foster unemployment, food deserts, and other socio-economic challenges. This link also demonstrates how historical and contemporary forces shape disability in South Africa today, especially the link between disability, poverty and ill-health. According to the African Centre for Obesity Prevention, environments that lack neighbourhood sidewalks and recreational spaces do not support active, healthy lifestyles, and are usually the cause of obesity.[30] Shackleton and Gwedla[31], in their study on the effects of colonialism and apartheid on urban greening and sustainability, contend that the contemporary urban form – with green spaces that do not reflect African identities, needs and perspectives on the natural and built environments – is reminiscent of colonial and apartheid spatiality. Furthermore, in a South Africa where contact and violent crime occurs mainly in townships[32], where African races reside, the implication is that sedentary lifestyles have been imposed on Africans, as the fear of

crime leads to confinement. Additionally, this highlights the difficulties regarding mobility and productive existence for persons with disabilities.

Frantz Fanon has commented on the contribution of colonialism to the continuation of systemic injustices, especially those that impact people with disabilities. In *The Wretched of the Earth*, Fanon[33] discusses mental health pathologies in colonised people. He draws comparisons between the experiences of persons with disabilities who have encountered both systematic and symbolic violence and the psychological and physical effects of colonial oppression. He contends that colonialism as a system gave rise to mental health pathologies in black people, who have had to negotiate their existence in violent societies, with violence being both structural and institutionalised. According to Fanon, colonialism, in alienating colonised people from themselves, created a world in which they were in a permanent state of discombobulation from their very humanity and their ways of being. The impact of colonialism and apartheid continues to find expression in post-apartheid South Africa, and to impose upon the colonised mental health pathologies. Wa Azania[34] traces these mental pathologies to Black students in institutions of higher learning, contending that they battle with debilitating mental illnesses that are both structural and generational. In this regard, she connects the mental health problems among black students to the apartheid encounter of their parents and the systemic violence in post-apartheid South Africa. This encounter is punctuated by the persistent legacy of coloniality, which Ndlovu-Gatsheni[35(p.181)] describes as "an invisible power matrix that is shaping and sustaining asymmetrical power relations between the Global North and the Global South". This power matrix continues to shape and define post-apartheid South African society. It is on this basis that Ned[36(para.10)] insists that: "The rates of suicide, mental distress and violence mean we need to look at how mental health is influenced by effects of landlessness and the continuing stressors of colonisation, imposed sedentary lifestyles and inferior self-image, all of which leave landless people with very little autonomy over their lives."

Finally, an equally salient cause of debility and disability arising from disruption and dispossession is the uneven and separate development that made it possible for rural areas and townships to be neglected, while historically white-only areas were prioritised for development and investment. Magubane[37] contends that the deliberate institution of policies of separate development led to limited or non-existent infrastructure for black people, including health infrastructure. According to Coodavia et al.[38(p.817)], the root of South Africa's dysfunctional health system, and the collision of the epidemics of communicable and non-communicable diseases, is the direct result of policies beginning from colonial conquest to apartheid dispossession, and, ultimately, the post-apartheid dispensation in which a two-tier and unequal health system is in place. Significantly, under apartheid, spending on health care in former white provinces was ZAR172 average per capita, in contrast to only ZAR55 in the homelands and townships.[39] This uneven spending has continued in the post-apartheid dispensation in which we continue to see large racial differentials existing in social determinants of health, particularly housing and sanitation for the poor, who are predominantly black.[40] And while there are no data on the current government expenditure on average per capita for persons with disabilities, we can infer from statistics on the under-funding of the public healthcare system, on which the majority of poor black South Africans rely, that the challenges of poor access persist.

Disability, debility and the migrant labour system

The migrant labour system formed the backbone of the political economy of the colonial and apartheid states. Magubane[41] posits that the incorporation of black South Africans into the evolving settler society through proletarianisation, initially into agriculture and then into mining, is one of the key events that have an explanatory value for the development of South Africa's socio-economic order. This incorporation was not geared towards equalising the colonisers with their colonised subjects, nor to equalise the metropole with the colony. Rather, it sought to facilitate the creation of a black reserve army of labour. According to Vosloo[42(para.1)], the migrant labour system is

> *an historical system, manipulated by capitalist, colonial and apartheid powers as a means of reconciling the conflicting needs for cheap labour in the mines and cities of 'White' South Africa, with the desire to restrict Black people to rural areas far away from the 'White' cities.*

The creation of Bantustans, or homelands, which Evans[43] characterises as an extension of the patterns of colonial segregation that were already in existence, was facilitated through the devolution of political structures that would be replaced by putative independence in the native homelands. Thus, Bantustans were not only intended to segregate black South Africans by confining them in ethnic, poverty-stricken enclaves, but were also an effective means of 'influx control'. This system impacted not only the nature of work in South Africa, but also the profile of the worker – mainly black, male and able-bodied.

Linking the migrant labour system to debility and disability is important, as "inequality of revenue and wealth is not only an economic fact; it implies inequality of life chances"[41(p.2)]. Furthermore, the development of the capitalist mode of production necessitated the deprivation of the immediate producers of the means of production, this being especially pronounced in people with disabilities. While black people experienced collective deprivation, marginalised groups within the black community, particularly persons with disabilities, suffered far more. With colonialism and apartheid functioning spatially, black settlements were established in under-developed rural areas and in townships on the outskirts of towns and cities. For persons with disabilities living in these segregated spaces, access to the already limited healthcare and social services was very difficult, resulting in black persons with disabilities not receiving the necessary and appropriate medical attention.[44]

That exploited black labour built the South African economy has been established.[41,45,46] The colonial and apartheid states were built on cheap labour, largely in the agricultural and mining industries that served as the backbone for their economies. Black men, in particular, forced into wage labour by centuries of dispossession and landlessness, provided a reserve army of labour in the metropole. On the diamond fields of Kimberley, in the gold mines of Johannesburg, and in the platinum mines of the North West, they toiled for low wages and were concentrated in hostels on the outskirts of central business districts, and isolated from the urban fabric, where they lived in conditions that were unfit for humans.[42] It was in these hostels, under these conditions, that disease spread. Specifically, workers' compounds in the gold mines of Johannesburg became the epicentre of tuberculosis outbreaks, caused by poor working and living conditions.[47] But tuberculosis was only one of several devastating diseases that plagued black workers, families and communities in the 20th century, and these created a backlog of diseases that were worsened by the lack of development of effective public health measures for treatment.[47] The outcome of this was a heavy disease burden in black communities[38], which contributed significantly to debility and disability.

The intersection of the migrant labour system and the spread of HIV/AIDS is observable in South Africa. According to the International Organization for Migration's *Position Paper on HIV/AIDS and Migration*, in Africa, migration has emerged as the strongest single predictor of the prevalence and risk of HIV.[48] The study contends that men who work far from home and live in men-only camps are more vulnerable to HIV infection. This is significant because, under the apartheid regime, hostels were constructed as men-only dwellings[42] as a means of controlling the movement of black labourers. But migrant workers were not the only group at risk of infection. The International Organization for Migration[48] contends that the partners of migrant workers are also shown to be at a particularly high risk of infection when their partners return from countries or cities with a high prevalence of HIV. This is aptly summarised by Lurie (cited in Nicholas et al.[49(para.19)] who states:

> *It is not hard to see how migrant labour plays a major role in the spread of the HIV/STI epidemic in Southern Africa: take millions of young men, remove them from their rural homes, house them*

> *in single-sex hostels, give them easy access to sex workers and alcohol and little or no access to condoms, and pretty soon, you will have a major HIV/STI epidemic.*

With the spread of sexually transmitted diseases in hostels built for male migrant workers, the parameters for debility and disability were set, and they persist in the post-apartheid dispensation.

Debility, disability and violence in post-apartheid South Africa

Structural inequalities that persist in modern South Africa, rooted in colonial and apartheid histories, continue to shape economic and social practices and outcomes, impacting on the lives of persons with disabilities. These inequalities created and reproduced a toxic paradigm of difference whereby the 'other', in this case persons with disabilities, were deemed not only unfit for work, but were also seen as non-human. In their study on enhancing the public sector's capacity for inclusive economic participation of disabled youth in rural communities, Ned and Lorenzo[50] contend that, in post-apartheid South Africa, young persons with disabilities face bleak prospects for skills development and securing employment. While South Africa's official unemployment and youth unemployment rates are very high, at 32.1% and 44.3%, respectively, in the fourth quarter of 2023[51], the rate is significantly higher for persons with disabilities. According to Morwane[52], unemployment rates for persons with disabilities are as high as 80% to 90%.

The implications of the low participation rates of persons with disabilities in the South Africa labour market are far-reaching. According to Braithwaite and Mont[53], these low participation rates are a key pathway from disability to poverty. This is evidenced by findings which indicate that households headed by persons with disabilities experienced higher rates of poverty, with more than half not having access to a flush toilet, as well as a significant number lacking basic sanitation and electricity, thereby relying on wood for cooking and candles for light.[54] Disability thus becomes both a cause and a consequence of poverty[55], as persons with disabilities, encountering tougher barriers to the labour market, as well as education and skills development, have limited income owing to unemployment, and reduced earnings owing to the disability pay gap, which is used to measure pay gaps between disabled and non-disabled people and for different groups of disabled persons.[56(p.x)] These inequalities cause poverty for persons with disabilities. In terms of consequences, poverty limits access to health care, preventative health care and social services.[55] In the context of South Africa, these limitations are often a result of uneven development – spatially and economically – linked to our colonial and apartheid encounters.

In post-apartheid South African society, debility and disability are often the direct consequence of violence and violent crimes. This is especially true of disability in young black men, who experience the highest levels of violent crime, including homicide, attempted murder and assault with intent to cause grievous bodily harm. According to Langa et al.[57], black South Africans in general are more likely to be victims of violent crime than their white counterparts. While white South Africans make up just over 8% of the population, they account for less than 2% of murder victims, with black people accounting for a significantly higher and disproportionate number.[58] There is clear statistical evidence that black men in particular are victims of this violent crime. Yet, according to van Niekerk et al.[59], black men receive less prioritisation as victims of violent crimes. The invisibilisation of black men in post-apartheid South Africa is a continuation of the colonial and apartheid practice of locating them in what Fanon[60] describes as a "zone of non-being", which he describes as "an extraordinarily sterile and arid region, an utterly naked declivity"[60(p.2)] where black people are simultaneously problematic and inhuman. This colonial process of dehumanisation – made possible precisely because the very construction of being, in the eyes of whiteness, depends on non-being[61] – is at the heart of why, under colonialism, black people in general were rendered invisible in law and beyond. Cock[44] asserts that the invisibilisation was especially pronounced for black persons with disabilities – a practice that continues today.

Ratele[62] posits that the highest rates of interpersonal violence-related fatalities in South Africa occur within African race groups in poor and low-income neighbourhoods. Specifically, these occur largely in metropolitan areas, mainly Cape Town. This is a significant finding given that the city served as the bedrock of colonial and apartheid administrations.[63] Black men are particularly rendered vulnerable to homicidal victimisation and violence due to interlinked dynamics located at individual and societal levels.[64] These interconnected dynamics are in great part the direct result of "a past marked by apartheid racism and segregation, state repression, arbitrary detentions, political unrest and violence, and a struggle for national liberation"[64(p.249-250)]. Significantly, this violence contributes significantly to the debility and disability that is experienced in black communities.

Conclusion

While disability existed in pre-colonial African societies, including in South Africa, it was not deemed an impairment that eroded the humanity and value of persons with disabilities. The construction of disability as an impairment, and the consequences related to this construction, emerged out of colonial and apartheid encounters. Both epistemologically and through layered forms of violence, colonialism and apartheid created debility and disability. The migrant labour system in particular, which emerged out of the colonial and apartheid encounters as a means to dispossess, disenfranchise, dehumanise and de-civilise black people, played an important role in the legislation and practice of the exclusion of persons with disabilities. This exclusion continues in post-apartheid South Africa, evidenced through the social, economic, cultural and structural impediments that have been imposed on persons with disabilities.

Situating discourse in the field of disability studies within the context of colonial and apartheid encounters in the Global South in general, and South Africa in particular, is crucial. It is especially necessary that such discourse be anchored in decolonial theorisation in order that the particularities of the experience of disability in post-colonial and post-apartheid societies can be understood within this context. And while decoloniality may not be the panacea to erasing the experiences and prevailing perceptions, as well as consequences of coloniality towards persons with disabilities, it provides us with the opportunity to seek epistemological and ontological justice. It also lays the foundation for theorising the interconnected systems of post-colonial violence and oppression, as well as the interlocking systems of power that continue to push persons with disabilities to the margins.

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There are no data pertaining to this article.

Declarations

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References

1. Bashford A. Imperial hygiene: A critical history of colonialism, nationalism and public health. New York: Palgrave Macmillan; 2004.
2. Ned LY. African Renaissance as a premise for reimagined disability studies in Africa. J Black Stud. 2022;53(5):485–504. https://doi.org/10.1177/00219347221074391
3. United Nations Office for Disaster Risk Reduction. Global survey report on persons with disabilities and disasters [webpage on the Internet]. c2023 [cited 2024 Jun 06]. Available from: https://www.unwater.org/news/undrr-2023-global-survey-persons-disabilities-and-disasters
4. Ned LY, Dube K, Swartz L. Challenges and opportunities of centring the African voice in disability research. Afr J Disabil. 2022;11, Art. #1089. https://doi.org/10.4102/ajod.v11i0.1089
5. Grovogu S. A revolution nonetheless: The Global South in international relations. The Global South (TGS). 2011;5(1):175–190. https://doi.org/10.2979/globalsouth.5.1.175
6. Ngcukaitobi T. The land is ours: South Africa's first Black lawyers and the birth of constitutionalism. Cape Town: Penguin Books; 2018.

7. World Health Organization. World report on disability 2011 [webpage on the Internet]. c2011 [cited 2024 Jun 06]. Available from: https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/world-report-on-disability

8. South African Department of Social Development. White paper on rights of persons with disabilities. Gazette no: 39792. Pretoria: Government Communications; 2016. Available from: https://www.gov.za/sites/default/files/gcis_document/201603/39792gon230.pdf

9. Charles P, Gie L, Musakuro RN. Barriers to the employability of people with disabilities in the South African public service. Afr J Disabil. 2023;12, Art. #1178. https://doi.org/10.4102/ajod.v12i0.1178

10. Bhambra GK. Rethinking modernity: Postcolonialism and the sociological imagination. New York: Palgrave Macmillan; 2007.

11. Livingston J. Debility and the moral imagination in Botswana. Bloomington, IN: Indiana University Press; 2005.

12. Puar JK. The right to maim: Debility, capacity, disability. Durham, NC: Duke University Press; 2017. https://doi.org/10.1215/9780822372530

13. Goodley D, Lawthom R, Liddiard K, Runswick-Cole K. Provocations for critical disability studies. Disabil Soc. 2019;34(6):972–997. https://doi.org/10.1080/09687599.2019.1566889

14. Ramugondo E. Healing work: Intersections for decoloniality. World Fed Occup Ther Bull. 2018;74(2):83–91. https://doi.org/10.1080/14473828.2018.1523981

15. Harris G. How did colonialism dispossess? Comments from an edge of empire. Ann Assoc Am Geogr. 2004;94(1):165–182. https://doi.org/10.1111/j.1467-8306.2004.09401009.x

16. Englert S. Settler colonialism: An introduction. London: Pluto Press; 2022. https://doi.org/10.2307/j.ctv2x6f052

17. Ndlovu-Gatsheni SJ. Epistemic freedom in Africa: Deprovincialization and decolonization. New York: Routledge; 2018. https://doi.org/10.4324/9780429492204

18. Ojok P, Musenze JB. A defence of identity for persons with disability: Reflections from religion and philosophy versus ancient African culture. Afr J Disabil. 2019;8, Art. #490. https://doi.org/10.4102/ajod.v8i0.490

19. Gallagher HG. By trust betrayed: Patients, physicians, and the license to kill in the Third Reich. rev ed. Arlington, TX: Vandamere; 1995.

20. Obermann CE. A history of vocational rehabilitation in America. Minneapolis, MN: T.S. Denison; 1965.

21. Mahlatsi KS, Pienaar AJ, Nare NE, Mulaudzi TM. A conceptual framework for psychosocial health management grounded in the therapeutic merits of indigenous KhoiSan health dialogues. Health SA. 2021;26, Art. #1626. https://doi.org/10.4102/hsag.v26i0.1626

22. South African Government. Witchcraft Suppression Act 3 of 1957. Available from: https://www.justice.gov.za/legislation/acts/1957-003.pdf

23. Burger R, Christian C. Access to health care in post-apartheid South Africa: Availability, affordability, acceptability. Health Econ Policy Law. 2020;15(1):43–55. https://doi.org/10.1017/s1744133118000300

24. Ndlovu-Gatsheni SJ. Decoloniality as the future of Africa. Hist Compass. 2015;13(10):485–496. https://doi.org/10.1111/hic3.12264

25. Ohenjo N, Willis R, Jackson D, Nettleton C. Health of indigenous people in Africa. Lancet. 2006;367(9526):1937–1946.

26. Mahlatsi MLS. The impact of the COVID-19 pandemic on urban food security in South Africa: A case study of the City of Ekurhuleni Metropolitan Municipality Central Food Bank [master's dissertation]. Pretoria: Tshwane University of Technology; 2021.

27. Swartz L. Oscar Pistorius and the melancholy of intersectionality. Disabil Soc. 2013;28(8):1157–1161. https://doi.org/10.1080/09687599.2013.808085

28. Piechota G, Malkiewicz J, Karwat ID. Obesity as a cause and result of disability. Przegl Epidemiol. 2005;59(1):155–161. https://doi.org/10.1080/09286580590932752

29. Benadé AJS, Oelofse A, Faber M. Body composition of different ethnic groups in South Africa. Asia Pacific J Clin Nutr. 1996;5(4):226–228. https://apjcn.nhri.org.tw/server/apjcn/5/4/226.htm

30. Action Obesity Africa. Causes of obesity in adults [webpage on the Internet]. c2024 [cited 2024 Aug 15]. Available from: https://www.action-obesityafrica.org/south-africa-article-causes-of-obesity-in-adults-south-africa

31. Shackleton CS, Gwedla N. The legacy effects of colonial and apartheid imprints on urban greening in South Africa: Spaces, species, and suitability. Front Ecol Evol. 2021;8, Art. #579813. https://doi.org/10.3389/fevo.2020.579813

32. Breetzke GD, Edelstein IS. The spatial concentration and stability of crime in a South African township. Secur J. 2019;32:63–78. https://doi.org/10.1057/s41284-018-0145-2

33. Fanon F. The wretched of the earth. New York: Grove Press; 1968.

34. Wa Azania M. Corridors of death: The struggle to exist in historically white institutions. Johannesburg: BlackBird Books; 2020.

35. Ndlovu-Gatsheni SJ. Global coloniality and the challenges of creating African futures. Strateg Rev South Afr. 2014;36(2):181–202. https://doi.org/10.35293/srsa.v36i2.189

36. Ned LY. The land question is linked to the burden of disease and disability. Daily Maverick. 2018 July 31 [cited 2024 Apr 15]. https://www.dailymaverick.co.za/article/2018-07-31-the-land-question-is-linked-to-the-burden-of-disease-and-disability/

37. Magubane BM. "Native reserves" (Bantustans) and the role of the migrant labor system in the political economy of South Africa. In: Safa H, DuToit B, editors. Migration and development: Implications for ethnic identity and political conflict. Berlin/New York: De Gruyter Mouton; 1975. p. 225–268. https://doi.org/10.1515/9783110808889.225

38. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: Historical roots of current public health challenges. Lancet. 2009;374(9692):817–834. https://doi.org/10.1016/s0140-6736(09)60951-x

39. Rensburg R. Healthcare in South Africa: How inequity is contributing to inefficiency. The Conversation. 2021 July 06. Available from: https://theconversation.com/healthcare-in-south-africa-how-inequity-is-contributing-to-inefficiency-163753

40. Mayosi BM, Lawn JE, Van Niekerk A, Bradshaw D, Abdool Karim SS, Coovadia HM. Health in South Africa: Changes and challenges since 2009. Lancet. 2012;380(9858):2029–2043. https://doi.org/10.1016/s0140-6736(12)61814-5

41. Magubane BM. The political economy of race and class in South Africa. London: Monthly Review Press; 1979.

42. Vosloo C. Extreme apartheid: The South African system of migrant labour and its hostels. Image Text. 2020;34:1021–1497. https://doi.org/10.17159/2617-3255/2020/n34a1

43. Evans L. South Africa's Bantustans and the dynamics of 'decolonisation': Reflections on writing histories of the homelands. S Afr Hist J. 2012;64(1):117–137. https://doi.org/10.1080/02582473.2012.655941

44. Cock J. Life 'Inside the Shell': A needs survey of spinal cord-injured wheelchair users in a Black South African township. Disabil Handicap Soc. 1989;4(1):3–20. https://doi.org/10.1080/02674648966780011

45. Magubane Z. The revolution betrayed? Globalization, neoliberalism, and the post-apartheid state. South Atl Q. 2004;103(4):657–671. https://doi.org/10.1215/00382876-103-4-657

46. Maseko R. Being a mineworker in post-apartheid South Africa: A decolonial perspective. In: Steyn M, Mpofu W, editors. Decolonising the human: Reflections from Africa on difference and oppression. Johannesburg: Wits University Press; 2021. p. 109–129. https://doi.org/10.18772/22021036512.9

47. Packard RM. White plague, Black labour: Tuberculosis and the political economy of health and disease in South Africa. Los Angeles, CA: University of California Press; 1989.

48. International Organization for Migration. IOM position paper on HIV/AIDS and migration [document on the Internet]. c2002 [cited 2024 Jun 30]. Available from: https://www.iom.int/sites/g/files/tmzbdl486/files/jahia/webdav/shared/shared/mainsite/about_iom/en/council/84/Mcinf252.pdf

49. Nicholas PK, Mfono N, Corless IB, Davis SB, O'Brien E, Padua J, et al. HIV vulnerability in migrant populations in southern Africa: Sociological, cultural, health-related, and human-rights perspectives. Int J Afr Nurs Sci. 2016;5:1–8. https://doi.org/10.1016/j.ijans.2016.09.003

50. Ned L, Lorenzo T. Enhancing the public sector's capacity for inclusive economic participation of disabled youth in rural communities. Afr J Disabil. 2016;5(1), Art. #189. https://doi.org/10.4102/ajod.v5i1.189

51. Statistics South Africa. Quarterly Labour Force Survey (QLFS) – Q4: 2023 [document on the Internet]. c2024 [cited 2024 Jun 30]. Available from: https://www.statssa.gov.za/publications/P0211/Media%20release%20QLFS%20Q4%202023.pdf

52. Morwane R. Employment of persons with severe communication disabilities. Pretoria: Centre for Augmentative & Alternative Information; 2021. Available from: https://www.up.ac.za/centre-for-augmentative-alternative-communication/news/post_3029434-employment-of-persons-with-severe-communication-disabilities

53. Braithwaite J, Mont D. Disability and poverty: A survey of the World Bank Poverty Assessments and implications. Alter. 2009;3(3):219–232.

54. Statistics South Africa. Census 2011 profile of persons with disabilities in South Africa. Report no. 03-01-59 [document on the Internet]. c2014 [cited 2024 Apr 11]. Available from: https://www.statssa.gov.za/publications/Report-03-01-59/Report-03-01-592011.pdf

55. Vallas R, Fremstad S. Disability is a cause and consequence of poverty. Talk Poverty. 2014 September 19 [cited 2024 Apr 11]. Available from: https://talkpoverty.org/2014/09/19/disability-cause-consequence-poverty/index.html

56. Equality and Human Rights Commission. The disability pay gap [document on the Internet]. c2017 [cited 2024 Mar 30]. Available from: https://www.equalityhumanrights.com/sites/default/files/research-report-107-the-disability-pay-gap.pdf

57. Langa M, Kirsten A, Bowman B, Eagle G, Kiguwa P. Black masculinities on trial in absentia: The case of Oscar Pistorius in South Africa. Men Masc. 2018;23(3–4):1–17. https://doi.org/10.1177/1097184x18762523

58. Hill G. Rising crime in South Africa. Washington Times. 2023 December 07 [cited 2024 Jun 11]. Available from: https://www.genocidewatch.com/single-post/rising-crime-in-south-africa

59. Van Niekerk A, Tonsing S, Seedat M, Jacobs R, Ratele K, McClure R. The invisibility of men in South African violence prevention policy: National prioritization, male vulnerability, and framing prevention. Glob Health Action. 2015;8, Art. #27649. https://doi.org/10.3402/gha.v8.27649

60. Fanon F. Black skin, white masks. London: Pluto Press; 2015.

61. Maldonado-Torres N. On the coloniality of being. Cult Stud. 2007;21(2–3): 240–270. https://doi.org/10.1080/09502380601162548

62. Ratele K. Subordinate Black South African men without fear. Cah Etud Afr. 2013;2(09–210):247–268. https://doi.org/10.4000/etudesafricaines.17320

63. Beyer S. Johannesburg: Where apartheid never ended [webpage on the Internet]. c2023 [cited 2024 Jun 30]. https://catalyst.independent.org/2023/05/29/johannesburg-apartheid-never-ended/

64. Rosenberg ML, Butchart A, Mercy J, Narasimhan V, Waters H, Marshall MS. Interpersonal violence. In: Jamison DT, Breman GJ, Measham AR, Alleyne G, Claeson M, Evans DB, et al., editors. Disease control priorities in developing countries. New York: Oxford University Press; 2006. p. 755–770.