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The original manuscript for review is appended below.

Reviewer 1: Round 1

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Reviewer 2: Round 1
Date completed: 01 November 2024
Recommendation: Accept / **Revisions required** / Resubmit for review / Resubmit elsewhere / Decline / See comments
Conflicts of interest: None

Does the review fall within the scope of SAJS?
Yes/No
Is the review written in a style suitable for a non-specialist and is it of wider than only specialist interest?
Yes/No
Do the Title and Abstract clearly and accurately reflect the content of the review?
Yes/**No**
Does the review provide a significantly novel perspective or significant recent advances in the field?
Yes/No
Is the objective of the review concisely stated?
Yes/No
Is appropriate and adequate reference made to other work in the field?
Yes/**No**
Do current debates and points of contention receive appropriate coverage?
Yes/**No**/Not applicable
Are gaps in the literature adequately identified?
Yes/No/Not applicable
Does the review provide direction for future research?*
Yes/**No**/Not applicable
Are the methodology and statistical treatment appropriate?
Not applicable/Yes/No/Partly/Not qualified to judge
Are the interpretations and recommendations aligned with the objective?
Yes/**Partly**/No
Please rate the manuscript on overall contribution to the field
Excellent/Good/**Average**/Below average/Poor
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Is the manuscript concise and free of repetition and redundancies?

Yes/**No**

Is the supplementary material relevant and separated appropriately from the main document?

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Yes/No

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Comments to the Author:

The paper addresses a highly relevant and intellectually stimulating research topic that has generated considerable interest across multiple disciplines within the social sciences, including critical disability studies, crip theory, disability anthropology, and the sociology of health. Furthermore, the authors aim to trace how violent historical, political, economic, and socio-cultural events have shaped contemporary ideas and discourses surrounding non-normative bodyminds in present-day South Africa. While the analysis offers a fresh perspective on genealogies of disability in South Africa during colonization and apartheid—drawing effectively on decolonial theories and approaches—several general and specific issues need to be addressed to further strengthen the article. Consequently, I consider the article suitable for publication, pending major revisions. Below, I provide broad suggestions and queries that I hope will help refine the manuscript.

The authors should clearly define terms such as "disability" and "debility," referencing relevant fields like critical disability studies, crip theory, disability anthropology, and the sociology of health. Scholars such as Julie Livingston (on Botswana) and Jasbir Puar (on disability in the context of the Israel-Gaza conflict) have provided nuanced definitions of debility and explored how colonial institutions produce and reinforce this state alongside broader social inequalities. Additionally, the article would benefit from a definition of disability that extends beyond the social model. I recommend consulting works by scholars such as Faye Ginsburg, Rayna Rapp, Herbert Muyinda, Susan Reynolds Whyte, and Benedict Ingstad, who clarify distinctions between ailments, diseases, impairments, and disabilities, particularly in the context of (colonial) biomedicalization in the Global South.

The authors should provide more information on chronic, acquired, and congenital disabilities. Throughout the article, phenomena such as land dispossession, labor exploitation, and food desertification are presented as causes of secondary, acquired disabilities. If the focus is limited to acquired disabilities, it would be useful to specify that congenital disabilities are excluded from the analysis. If congenital disabilities are indeed included, the authors should clarify how they fit into the argument.

The authors are advised to avoid generalizations regarding the social status of people with disabilities in pre-colonial Africa. Historical written sources are often biased, as they were primarily authored by white explorers, travelers, and missionaries from the Global North, who tended to project their socio-cultural preconceptions onto their observations, if they indeed observed such phenomena accurately. To balance these sources, the article could benefit from incorporating oral histories. Additionally, the authors should clarify the point that the concept of disability, as understood today, did not exist in pre-colonial Africa; instead, various terms described different forms of non-normative bodyminds. Scholars like Silla, Ingstad, and Whyte note that the concept of disability only became widespread in Africa with the influence of disability rights movements in the West, especially following the UN's declaration of the International Year of Disabled Persons in the 1980s as well as the imposition of ideas about medi-calized ways (see Iliffe on

this) to address non-normative bodyminds came from religious and bi-omedical institutions (e.g., camps for people with leprosy).

The article would benefit from a clearer temporal framework. For example, issues such as obesity are not solely a result of historical colonialism and apartheid but are also linked to modern neo-colonial and neoliberal systems that foster unemployment, food deserts, and other socio-economic challenges. By clarifying these distinctions, the authors can better contextualize how historical and contemporary forces shape disability in South Africa today.

The authors should consider dedicating a section to the analytical framework, where the intersections of Critical Disability Studies, Crip Theory, and decolonial approaches are more explicitly articulated. While there may be epistemological tensions, incorporating references to works on necropolitics and the postcolony by Achille Mbembe would enhance the decolonial perspective. Additionally, including insights from African scholars such as Elvis Imafidon could provide further depth and regional specificity to the analysis.

I hope these comments help sharpen the article's argument and enhance its overall approach. Thank you for your work on this important and timely topic.

Author response to Reviewer 2: Round 1

The authors should clearly define terms such as “disability” and “debility,” referencing relevant fields like critical disability studies, crip theory, disability anthropology, and the sociology of health. Scholars such as Julie Livingston (on Botswana) and Jasbir Puar (on disability in the context of the Israel-Gaza conflict) have provided nuanced definitions of debility and explored how colonial institutions produce and reinforce this state alongside broader social inequalities.

AUTHOR: I have expanded the section on “theoretical framing” on pages 4 and 5 to clearly define debility and I have referenced the above mentioned fields.

Additionally, the article would benefit from a definition of disability that extends beyond the social model. I recommend consulting works by scholars such as Faye Ginsburg, Rayna Rapp, Herbert Muyinda, Susan Reynolds Whyte, and Benedict Ingstad, who clarify distinctions between ailments, diseases, impairments, and disabilities, particularly in the context of (colonial) biomedicalization in the Global South.

AUTHOR: I have expanded the definition of disability on page 3 and 4.

The authors should provide more information on chronic, acquired, and congenital disabilities. Throughout the article, phenomena such as land dispossession, labor exploitation, and food desertification are presented as causes of secondary, acquired disabilities. If the focus is limited to acquired disabilities, it would be useful to specify that congenital disabilities are excluded from the analysis. If congenital disabilities are indeed included, the authors should clarify how they fit into the argument.

AUTHOR: I have added an example of congenital disabilities such as FASD on page 6 to reflect that the argument remains the same across congenital or acquired disabilities.

The authors are advised to avoid generalizations regarding the social status of people with disabilities in pre-colonial Africa. Historical written sources are often biased, as they were primarily authored by white explorers, travelers, and missionaries from the Global North, who tended to project their socio-cultural preconceptions onto their observations, if they indeed observed such phenomena accurately. To balance these sources, the article could benefit from incorporating oral histories.

AUTHOR: I note this important point. Due to the limited time of responding, I could not source oral histories for this paper. I will certainly incorporate this in following papers.

Additionally, the authors should clarify the point that the concept of disability, as understood today, did not exist in pre-colonial Africa; instead, various terms described different forms of non-normative bodyminds. Scholars like Silla, Ingstad, and Whyte note that the concept of disability only became widespread in Africa with the influence of disability rights movements in the West, especially following the UN’s declaration of the International Year of Disabled Persons in the 1980s as well as the imposition of ideas about medicalized ways (see Iliffe on this) to address non-normative bodyminds came from religious and bio-medical

institutions (e.g., camps for people with leprosy).

AUTHOR: This is an important point. While a different source is used, I have expanded paragraph 2 of page 5 to make this more clearer.

The article would benefit from a clearer temporal framework. For example, issues such as obesity are not solely a result of historical colonialism and apartheid but are also linked to modern neo-colonial and neoliberal systems that foster unemployment, food deserts, and other socio-economic challenges. By clarifying these distinctions, the authors can better contextualize how historical and contemporary forces shape disability in South Africa today.

AUTHOR: Thank you for pointing this out. I have added two sentences on page 6 to make this distinction clearer.

The authors should consider dedicating a section to the analytical framework, where the intersections of Critical Disability Studies, Crip Theory, and decolonial approaches are more explicitly articulated. While there may be epistemological tensions, incorporating references to works on necropolitics and the postcolony by Achille Mbembe would enhance the decolonial perspective. Additionally, including insights from African scholars such as Elvis Imafidon could provide further depth and regional specificity to the analysis.

AUTHOR: The new paragraph on page 4 has considered this request.
Please note that, due to word limits, I could not elaborate comprehensively. I also could not add further references. However, I will consider developing a follow-up paper which further unpacks these nuances.

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

Abstract

The global legacy of colonialism has historically been studied in disciplines ranging from sociology, development economics, human geography, 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 impairment that erodes 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, development economics, human geography, 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 two-fold. 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” (p.17).[8]

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 is key to the inability of many persons with disabilities to participate in community life. 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 (p.17)[8], 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. Thus, this article considers the official definition of disability in conjunction with the roots of the structural limitations arising from colonial and apartheid encounters. 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 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”.

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. The article employs a qualitative approach and uses secondary data (official and unofficial) to provide deeper insights into the link between colonialism, debility and disability.

This article operates at the nexus of the field of disability studies and epistemological decoloniality. 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 need for challenging the very histories that inform these knowledge forms and this macro-history.

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[11] (p.165) contends that "the legitimation of and moral justification for dispossession lay in a cultural discourse that located civilization and savagery and identified the land uses associated with each". Though dispossession has always been central to the function of colonialism, and in particular, settler colonialism[12], it is important to state that African history does not begin with colonialism. Ndlovu-Gatsheni[13] (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.

Pre-colonial African societies conceptualised disability differently to the dominant Eurocentric conception of disability as bodily impairments. According to Ojok and Masenze[14], 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[15], 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[16] 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]

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.[17] 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, were 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)[18], which suppressed and criminalised indigenous African health systems. The impact of this has been devastating to the health outcomes of Black people.[19] Ndlovu-Gatsheni[20] characterises this as the direct result of Euro-North American centric modernity, and colonialism, as it were, creating modern problems for which it has 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.[21], 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.[22] This assault on subsistence farming forced

them into the segmented labour market where wages were too low to afford even the most basic nutrition.

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.[22] This gave rise to a myriad of health-related problems, including the rise in obesity levels. Obesity has been linked to debility and disability[23], with Black people having the highest prevalence of obesity than other racial groups in South Africa, particularly in urban areas.[24] 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 lack of desire for healthier living. Rather, they are a function of the consequences of colonial and apartheid spatial planning. 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.[25] Shackelton and Gwedla[26], 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[27], 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.

In *The Wretched of the Earth*, Fanon[28] discusses mental health pathologies in colonised people. 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[29] 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

situates the mental health problem 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[30] (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 [Author][31] (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[32] 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.[33] (p.817), the roots 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 where a two-tier and unequal health system is in place. Significantly, under apartheid spending on healthcare in former White provinces was R172 average per capita, in contrast to only R55 in the homelands and townships.[34] This uneven spending has continued in the post-apartheid dispensation where we continue to see large racial differentials existing in social determinants of health, particularly housing and sanitation for the poor, who are predominantly Black.[35] And while there is no data on current government expenditure on average per capita on persons with disabilities, we can infer from statistics on the under-funding of the public healthcare system, which the majority of poor Black South Africans rely on, 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[36] 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[37] (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[38] 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"[36] (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.[39]

That exploited Black labour built the South African economy has been established.[36,40,41] 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.[37] 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.[42] But tuberculosis was 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.[42] The outcome of this was a heavy disease burden in Black communities[33], 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 *Position Paper on HIV/AIDS and Migration*, in Africa, migration has emerged as the strongest single predictor of the prevalence and risk of HIV.[43] 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[37] as a means of controlling the movement of Black labourers. But migrant workers were not the only group that was at risk of infection. The International Organization for Migration[43] 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 high prevalence of HIV. This is aptly summarised by Lurie (cited in Nicholas et al.[44], 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, [Author and Author][45] 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[46], the rate is significantly higher for persons with disabilities. According to Morwane[47], unemployment rates for persons with disabilities are as high as 80% to 90%.

The implications for the low participation rates of persons with disabilities in the South Africa labour market are far-reaching. According to Braithwaite and Mont[48], 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.[49] Disability thus becomes both a cause and a consequence of poverty[50], 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 (p.x).[51] These inequalities cause poverty for persons with disabilities. In terms of consequence, poverty limits access to healthcare, preventative healthcare and social services.[50] 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 assaults with intent to cause grievous bodily harm. According to Langa et al.[52], 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.[53] There is clear statistical evidence that Black men in particular are victims of this violent crime. Yet, according to van Niekerk et al.[54], 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[55] describes as a “zone of non-being”, which he describes as “an extraordinarily sterile and arid region, an utterly naked declivity”[55] (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[56], is at the heart of why, under colonialism, Black people in general were rendered invisible in law and beyond. Cock[39] asserts that the invisibilisation was especially pronounced for Black persons with disabilities – a practice that continues today.

Ratele[57] 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.[58] Black men are particularly rendered vulnerable to homicidal victimisation and violence due to interlinked dynamics located at individual and societal levels.[59] 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"[57] (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 as impairment that erodes 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 encounter 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 in 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 hurl persons with disabilities to the margins.

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