Disability and the Global South, 2018
Vol.5, No. 2, 1365-1384

OPEN ACCESS
ISSN 2050-7364
www.dgsjournal.org

Audiology and Speech-Language Pathology: Practitioners' Reflections on Indigeneity, Disability and Neo-Colonial Marketing

Mershen Pillay[a*] and Harsha Kathard[b]

[a]*University of KwaZulu-Natal, South Africa;* [b]*University of Cape Town, South Africa. Corresponding Author- Email: pillaym1@ukzn.ac.za*

Indigenous peoples are part of those populations who are underserved by Audiology and Speech-Language Pathology. They include minority world populations like Aboriginal Australians/Canadians and majority world peoples in Asia, Africa and the Americas. How do Western-oriented rehabilitation/disability practitioners practice with Others? In this article, we reflect on our own experiences and use ideological critique to reveal the fault lines in Audiology and Speech-Language Pathology practices. Along with other examples, we analyse South African data, viz.: canonical articles as illuminators and our works (c1990-). We reveal predominant practices/ideologies that contribute to the production of disability. We focus on three interconnected issues (i) the construction of rehabilitation/disability practitioners as (il)legitimate providers for indigenous peoples; (ii) the engagement of epistemic violence across disability practice, educational and policy domains; and (iii) the authoritative (re)inscription of indigenous persons as disabled by transnational practitioners who, like their corporate counterparts, market practices. Professional marketeering is infused with bigotry, masked as benevolence and resourced/justified by global, neo-liberal policies (e.g., international conventions) and funding. We conclude that disability practices and indigeneity in the post-colonial moment capitalises on established settler-native relationships to continue dominance over Others' lives. Finally, we present a way forward, namely the relationship of Labouring Affinities which promotes deimperialisation and decolonisation practices to enable professional transformation.

Keywords: Audiology; Speech-language pathology; Indigeneity; Decolonisation; Marketeering

Introduction: audiology and speech-language pathology as colonial products

Audiology and Speech-Language Pathology (SLP) are interconnected rehabilitation professions, products of Empires (Pillay and Kathard, 2015). Our collective experiences as professional practitioners, educators and researchers serve as lived experiences for a critique

of our ontological history. As such, we explore how our professions have sensibly and faithfully conducted business in familiar ways within a colonial settler-native schema. Collectively armed as established professions, we proffer western scientific methods with our masks of benevolence (Lane, 1992). We map, territorialise and penetrate the lives of people with disabilities, albeit with good intention. In memetically similar ways to *Black Lives Matter*, we ask rehabilitation practitioners: when you practice *that* way, how do you think about Others? Especially relevant to indigenous people with disabilities, we consider Grech and Soldatic's (2014) question about which bodies-and-minds matter and which don't. Considering that disabled people remain underserved (Marmot, 2011; Wylie et al., 2013), do rehabilitation professionals relegate indigenous people with disabilities to, what Fanon (1952) called, a 'zone of non-being'?

Here, we offer Audiology and SLP practices as an exemplar of how the colonial project has infiltrated the world of rehabilitation care. Both these rehabilitation professions specialise in 'communication', emphasising a deficit perspective (Braun et al., 2017). Audiologists primarily deal with hearing and associated balance disorders, while SLPs manage speech, language, voice, fluency and associated swallowing and/or feeding disorders. Similar to Occupational and Physical Therapy, our markets consist of a subaltern (Spivak, 2014) external to political power structures and usually complicated by who they are and where they live. Often, this results in an exclusion from recognized organizations and a repudiation of their social citizenship and agency or voice (Murphy et al., 2018). Indeed, this loss of voice is often very literal and therefore central to the experiences of persons with communication disabilities. This experience Can be linked to what Ramón Grosfoguel (2011), a Puerto Rican decolonial scholar, rather fatefully refers to as a 'modern/colonial/capitalist/patriarchal world-system'. This is a system from which nobody escapes being members of class, sexual, gender, spiritual, linguistic, geographical and racial hierarchies. One can apply Grosfoguel's hierarchies to a person with communication disability in contrast to a person with physical disability like the 'Blade Runner' (Oscar Pistorius). People with communication and/or swallowing disabilities are relatively invisible. This is in comparison to persons with highly visible disabilities like wheelchair users whose iconicity is reflected in the international symbol for 'disability'. As the Others' Others (Pillay, 2013; Kathard and Pillay, 2013), people with invisible disabilities include a variety of mental and physical disabilities of varying severity. These may include temporary or permanent disabilities (Prince, 2017). Reasons for this may range from low occupational or environmental exposures resulting in multiple chemical sensitivities (Sepp, 2017) to hearing disability regarded as a 'major global health challenge' (Looi et al., 2015: 944). They remain poorly represented even in the much awaited World Report on Disability (WHO and World Bank, 2011) where persons with communication and/or swallowing disabilities were barely mentioned (Pillay, 2013).

We can look at persons with disabilities at the intersections of being white, Western, Anglo-

Saxon/Judeo-Christian, male and heterosexual. Indigenous peoples, especially those with invisible disabilities, are subaltern too (Spivak, 2014). However, their being 'subaltern is not just a classy word for 'oppressed', but refers to a space of difference where there is limited or no access to cultural imperialism' (de Kock, 1992: 29). In popular culture (books, films etc.), persons with communication disabilities are represented as experiencing threats to their political agency even when elite citizens. Consider how being male, white, heterosexual and middle/upper class, for example, produced Jean-Dominique Bauby (*The Diving Bell and the Butterfly*, 2007) or Stephen Hawkins (*The Theory of Everything*, 2014). Indeed, socio-political entanglements of race, class, gender, sexual orientation, geography and related political matters produce such icons. More critically, can we honestly claim that they share the same forms of marginality as politically and economically disenfranchised peoples like indigenous peoples?

South Africa, albeit for its classification as an upper middle-income country, has the dubious honour of being the world's most inequitable country (Barr, 2017). It is also our immediate context of practice and serves as a worthwhile post-colonial territory to interrogate professions and their response to indigenous persons with disabilities.

Indigeneity in South Africa

What would the world look like if we moved the locus of enunciation from the European man to an Indigenous woman in Africa? Within this adaptation of the epistemic question by Grosfoguel (2011), we consider indigeneity for South Africa as a case example.

Black South Africans are the majority population group who declare indigeneity (ILO and the African Commission on Human and Peoples' Rights, 2009). Purely by their numbers, indigenous South Africans are critically different from Australasian or North American contexts where indigenous peoples are minority groups. This positioning of indigeneity in South Africa is not without contestation. Significantly, Southern Africa was most possibly exclusively populated by the San hunter-gatherers and KhoeKhoe herders over 2000 years ago (Schlebusch et al., 2016). While there are no official statistics, it is believed that the San and KhoeKhoe constitute approximately 1% of our 55.91 million peoples (StasSA, 2016). Not only are the San and KhoeKhoe regarded as Southern Africa's first peoples, they are all our ancestors: scientists postulate that we have descended from their original gene type, migrating in waves over thousands of years to where you, as a human, find yourself today (Wells, 2002).

Approximately 1800 years ago, Bantu-speaking farmers came from the north, forming our current majority of 80.7% Black South Africans (StatsSA, 2016). Some 500 years ago the Europeans followed. The Portuguese, Dutch, British and others like the French Huguenots

settled, occupied and/or colonised SA. They intensified a locally flavoured version of colonialism called Apartheid. This brief review is necessary to explain two aspects of how 'indigenous' has been declared in Africa.

Firstly, we refer to the perversification of indigeneity as the creation of the settler identity simultaneously as outsider/settler but also as insider belonging to the colony. In SA, this resulted in a re-branding of the European along with British colonial/apartheid rule. The settler-European morphed into a colonially imagined indigenisation of the 'white African'. Along with this re-invention of European identity, was the convenient creation of the Afrikaner. This phenomenon was common across colonies as signified via the character of Abel Magwich in fictional works such as *Great Expectations* (Dickens, 1861). Magwich was a convict sent to Australia, became a wealthy settler and subsequently benefactor to a poor English boy (Pip). Said (1993) explained how the fictional enterprise of the novel assisted in establishing a colonial process that maintained Empire and their settlers' connection to their homelands by redirecting colonially-acquired riches. However, they were expected to 'go native' and fashion a local identity by re-birthing as Australians, Canadians, Americans and other similar perverse interpretations of belonging (autochthony). Locally, Afrikaners reified their autochthony to the point of twice petitioning that they be recognised as indigenous by the United Nations (UN). Both times, they were rejected on the basis that they were not discriminated or marginalised. Therefore, depending on who (coloniser or colonised) declares it, being indigenous is a contested notion.

Secondly, the African Commission on Human and Peoples' Rights (ACHRPR) declare that as all Africans are indigenous, they were 'here' before European colonialists. This current use of the term is to highlight discrimination relative to indigeneity or aboriginality. It is not used to either deny others like the majority isiZulu/Ndebele peoples their African identity, nor is it about ethnic or tribal protectionism. In South Africa, while the Griquas, Koranas and the revivalist Khoesan self-declare indigeneity, it is recognised that the San and KhoeKhoe are forgotten, marginalised peoples. In a post-colonial state, they continue to experience economic dispossession, live in isolated spaces with limited land rights and have lost/are losing their language and culture. While colonial languages (English and Afrikaans) are given official status in our Constitution, San or KhoeKhoe languages remain unlisted. As indigenous peoples, it is important to remember the uniqueness of the San and KhoeKhoe while not flouting discrimination experienced by Black South African persons with disabilities as part of their colonial encounter.

Our experience/expertise as evidence

We think it important to identify ourselves as coming from and being within the clinical, rehabilitation professions of Audiology and SLP. Why must we explain our experience as

evidence for the bases of this article? Researchers soaked in Empire's empiricism will (and have done in reviews of this and similar articles too) demand published evidence as proof to validate our knowing to meet their epistemological criteria of what constitutes good science. Therefore, we foreground that, via our personal experiences as members of our respective professions, we analyse what are really dominant values of our professions' core. While we account for contrapuntal ideological shifts (which represent marginal, emerging epistemologies), we have not completed a systematic review of the literature, and acknowledge that not being an exhaustive or comprehensive literature review, will invite contestation. Critically, reflecting on our collective experiences means that we write not as 'outsider' disability activists, but as 'implosionists' disrupting practices from within our professions. This positionality allows for our engagement with transformative dissonances generated from being 'out of place' (Said, 1999). We are both South Africans of colour and minorities in our (still) white dominated professions. Our biographies allowed us to, long ago, recognise the need to defy the importing and mainstreaming of Anglo-Saxon/Judeo-Christian practices for people living on the tip of Africa (Kathard and Pillay, 1993). It is this episteme that forms the basis for the following ideological critique of selected canonical articles and our works (c1990-). An important methodological note is that our expertise, our lived experience serves as evidence for rehabilitation practitioners/practice. We write as a case of being Other than white women from Europe, North America, Australia or New Zealand. While we have used refereed works to support our arguments, we want to ensure that readers know what we think about the evidence base in our professions and of who produces this evidence. Our professional literature is replete with a science imbued with White Western values of what can be said, as though it is the only way to legitimately tell a story (Pillay, 2003; Pillay and Kathard, 2018). Similar to the use of transformative dialogues to engage scoping literature reviews by Chambers et al. (2018), we emphasise that knowledge gained from our experience matters. This harks to the original sentiment of evidence based practice (Sackett et al., 1996) where clinical expertise also matters as a form of evidence. Of course, Sackett et al. (ibid) promoted an integration of evidence with published research. Here, we integrate current literature and perform an ideological critique of a body/genre of professional literature. This genre analysis reflects an indirect method of holding up a critical lens to our professional literature. We have also directly selected references to support arguments when/where deemed necessary.

We focus on three interconnected issues: (i) the construction of rehabilitation/disability practitioners as (il)legitimate providers for indigenous peoples; (ii) the engagement of epistemic violence across disability practice, educational and policy domains; and (iii) the authoritative (re)inscription of indigenous persons as disabled by transnational practitioners who, like their corporate counterparts, marketeer practices.

Faithful to empiricism, Audiology and SLP engage the glamour of medicalised frameworks and/or associated positivist, ideological values. These value systems were dispersed to the

colonies by organisations such as the International Monetary Fund, the World Bank and the World Trade Organisation (Peet, 2009). Indeed, with partners like the World Bank and associates such as the World Health Organisation (WHO), similar goals are continued, even when they claim to do otherwise, as may be assessed by their ideological perspectives in the 2011 World Report on Disability (Kathard and Pillay, 2013). Empire's empirically-oriented science, frames lives and provides an evidence base for our practice, enabling our justification to dominate Others' lives. This curious coincidence of 'Empire and Empiricism' meant that our clinical encounters are actually always colonial encounters (Pillay et al., 1997; Pillay, 2003). Continuing this thought here, we ask: are indigenous disabled peoples on the colonies, new(er) market opportunities for rehabilitation professionals?

The construction of rehabilitation/disability practitioners as (il)legitimate providers for indigenous peoples

In this section, we focus on the legitimacy of professionals (local/foreign) who work with indigenous persons. In Audiology and SLT, there are 'international', 'humanitarian' and/or 'global' practices delivered under various guises like 'Bush Audiology', operating either via Northern and/or westernised educational institutions, professional associations, hearing aid/commercial companies, or commonly associated with religious/missionary-type organisations. In just one of our professions, audiology, some examples include Mercy Air, (http://mercyair-sa.blogspot.co.za/2015/10/audiology.html), Sound Seekers (http://www.sound-seekers.org.uk/about/, (http://www.hearingforhumanity.org/), Ears inc. (http://www.earsinc.org/about-us/), Hearing for Humanity (http://www.hearingforhumanity.org/) and Hear the World Foundation (https://www.hear-the-world.com/en). They market their services in various countries including Brazil, India, China, the Philippines, Jordan and Vietnam (for example see http://www.wwhearing.org/our-projects). Global or humanitarian audiology has evolved into a variety of schemes that allow practitioners to provide hearing aids, education/training and related rehabilitation services to the underserved. Other foci include global education, research and various forms of networking within hearing health care communities (Ballachanda et al., 2011: 2). Groups headquartered in old and/or neo-colonial countries (USA, UK, France, Australia and so on) drive this good work. Such work includes what the American Speech-Language and Hearing Association (ASHA) refers to as 'non-profit groups'. ASHA list established, international humanitarian networks like the International Federation of Red Cross and Crescent Societies, the International Medical Corps, Rehabilitation International and the American Federation of Teachers. ASHA also includes country-based or regionally focused groups like Africare, Hearing International, Nigeria and profession-specific programmes like Harding University in Zambia Speech-Language Pathology and International Stuttering Association (ASHA, 2017).

Notably, hearing aid companies engage humanitarian work that is delivered either as part of

their corporate social responsibility efforts and/or in partnership with the private ear and hearing care sector. For example, hearing aid manufacturing companies listed with both the European Hearing Instrument Manufacturers Association and the USA based Hearing Industries Association are established partners with humanitarian hearing care projects, globally (McPherson, 2014; World Wide Hearing, 2014; Kingma Queen, 2015). Therefore, via a large network of local groups like individual hearing health care practitioners and agencies like universities, hearing aid manufacturers collude with international groups to engage humanitarian work locally and across borders.

What this phenomenon has done, is sharply remind us of the legitimacy of our practices even when delivered by local/in-country practitioners who offer services to indigenous populations. In Figure 1, reference is made to foreign and local markets that are exposed to both colonial (empirical) and neo-colonial (neo-empirical) rehabilitation. The neo-colonial is also coded as neo-empirical, and refers to our professions' adoption of things like human rights and social justice into its focus on communication. Importantly, this uncritical adoption of liberal ideologies has occurred while continuing epistemologically similar, colonially inspired work. Whether by foreign or local practitioners, this work is to/for underserved communities (see Wylie et al., 2013 for a review of such work internationally) and which include indigenous populations. The relocation of rehabilitation and/or disability services to non-mainstream (education, healthcare) settings is laudable and regarded as a positive practice shift. However, we argue that even when placed in community, disability services, rural or remote settings, rehabilitation practitioners continue to employ epistemologically familiar practices. Ramugondo and Kronenberg (2015) disrupted these entrenched epistemologies using the notion of collective human occupations to signal the importance of a genuine reconceptualization of the underpinnings of our professional practices. There is an uncritical shifting of the ways of the old colonial masters that affect interactions at the micro-level between native patient and expert/settler practitioner. What do we mean by this?

Firstly, the three-Cs undergird empirical rehabilitation, viz.: Christianity, civilisation and commerce (see figure 1 below), all of which go hand-in-hand. When we refer to colonialism, we refer to the three-Cs, since neither can be considered without the others. It is by no accident that South African Audiologists and SLPs are predominantly white and located mainly in urban centres serving private sector needs alongside underserving Black Africans (Kathard and Pillay, 2013). There is a replication of the same macro-level three-Cs at the micro-level clinical moment. Colonially-soaked practices like these, implicated with Audiology and SLT, are mere products of a bigger faith. Packed in Empire's epistemological suitcase next to its crosses, railways and roads is its treasured science, *Empir*icism or positivism. Focusing on the individual and on pathology, relocation to rural, remote, 'community' or other underserved spaces is critical to the seizure of these new disability markets. The empirical soldiers of settler professions - even if native – are not beyond engaging neo-liberal benevolence. Many will be hard-pressed to disagree with the fact that

Audiology and SLP was never imagined for Others. Essentially, these professions were designed by and for white, Western peoples. And what's wrong with that?

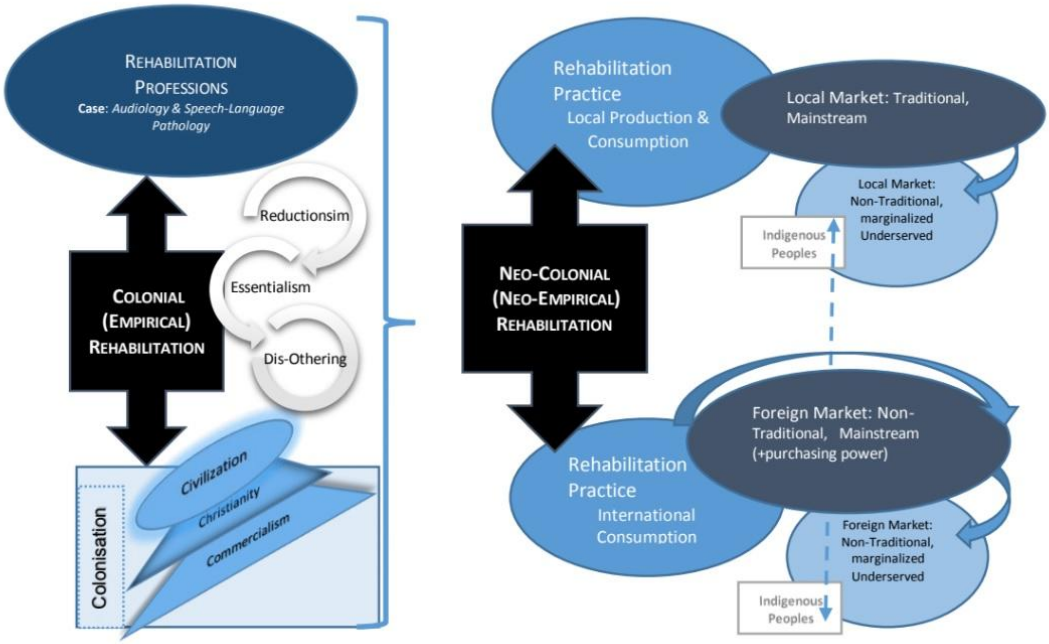

Figure 1: Empirical rehabilitation

Epistemologically, Audiology and SLP embed and re-present white, Western colonial values – such as reductionism, essentialism and dis-othering (see figure 1). Professionals often believe that merely relocating to community, schools or occupational settings, means that these interrelated processes miraculously lose their medical rehabilitation origins and epistemologies. However, consider that such processes include the assigning of disability labels, assessment/diagnoses of disorder, and the treatment/management thereof. Hiding behind neo-liberal strategies like parent/caregiver consultation and participation, including analyses of 'strengths' or immersion in communities, does not mitigate the use of strategies that really come from positivist, empirical and/or medicalised thoughts and values. One such value is reductionism, which is when we use scientific knowledge to produce diagnostic and therapeutic practices. This scientific knowledge reduces a whole person to speech, swallowing, hearing, balance and other molecules. We have developed a largely technicist knowledge base of tests, methods, treatment regimes among other things. This has been done by relying on Empire's cherished dominant notion of science perpetuated within colonial universities. What we question here, is the utility value of reductionistic approaches. Lives, experiences and similar aspects, defy an unnatural science premised on the colonial myth of heteronormative, monolingual, monocultural lives. The unique and shared experiences of indigenous people are never really (re)imagined outside of narrow professional lenses. For

colonised, indigenous peoples, such knowledge is not merely essential but provides legitimacy to professionals' incursions into lives.

Reductionism is related to essentialism which is a well-established process used by rehabilitation professionals to create disability. In broader colonial cultures, essentialism has operated to produce coolies, coons, cunts and queers. Similarly, disability typologies, functional classification systems and elegant labels to foreground 'disability' have been used to shrink wrap complex people into 'persons with communication disabilities'. Indeed, our libraries overflow with texts produced around essentialist notions of, for example, the deaf, aphasic or dysphagic. These labels enable access to social grants, education or health care by writing powerful assessment reports. While useful, these labels are often applied in unidimensional medical terms as we portray ourselves as objective purveyors of a certain, generalizable truth to deliver the adult with aphasia or the child with a language learning disability. This truth is bolstered by our linear logic of causal patterns that neatly explain communication, feeding/swallowing disabilities. For South Africa's indigenous peoples, how could a mainly white, Eurocentric knowledge base, be used to grasp the essence of any person? Consider that for indigenous populations, we over-rely on informal/unstandardised tests, translated/adapted tools or culturally competent frameworks. All this to convert *them* into being more like *us*. Essentialism is a Cartesian inspired duality between the normal, expert practitioner and the abnormal patient/disabled person. This duality exists only because we prop them with the tools of our benevolence, well affirmed in the last intersected process of 'dis-Othering'.

Dis-Othering is a term we coined (Pillay, 2001) from Spivak's (1988: 272) notion of the Other and the slang 'dis' meaning to disrespect. Dis-Other cross references a word/slang used in popular culture and an abbreviation of 'disrespect'. So, as rehabilitation professions, we are part of the social machinery that produces our Others, viz.: people with communication disabilities relative to social, economic, political and cultural capitals. This form of control is inscribed into our professional scopes of practices and/or professional associations' policies. Without dis-Othering we will have no legitimate Other. Without seizure and control of our Others, we cease to have significance as professionals.

In concluding, we foreground that colonially invented rehabilitation professions, cannot be cast as innocent or immune from processes like commercialism, self-interested capitalism and cultural imperialism. As such, we ask: surely this work is 'better than nothing'? What is wrong with wanting to be a Good Samaritan? Surely, all they want is to do good? We agree with Meekosha (2011) who reminded us that such work goes unquestioned while being celebrated for its legitimacy to provide services to the Majority World and Other underserved populations, including indigenous peoples. We argue that this work is illegitimate. Furthermore, it is understandably offensive to position us caring professionals, as disability marketers, let alone illegitimate. However, what is more than merely offensive is our

professions' use of reductionism, essentialism and Dis-Othering. It is an act of violence.

The engagement of epistemic violence across disability practice, educational and policy domains

Our professional discourse conveys its bias to an empirical/positivist framework by covertly presenting knowledge (and the production thereof) about disabled peoples' agency, of what (dis)ability means and of the nature of human action, citizenship and so on (Pillay, 1998). Similar to other rehabilitation professions, Audiology and SLP is replete with a host of conventions especially about what is objective and/or subjective evidence. Indeed, the focus on evidence-based practice is hard to reconcile if we asked first: whose evidence matters? Subjective realities, lived experiences do not count if we have insufficient, objective data to substantiate claims. Of course, backed by a science that insists on observed, empirical data immediately relegates subjectivity to the realm of inaccessibility if not tritely admitted as anecdotal or at best as the lesser form of inquiry: qualitative research. If it cannot be seen, quantified and graphed then it does not exist. In this way, empirical science, founded in rationalism, extended with positivist ideals is what defines civilisation and the mark of Western, white thought.

Audiology and SLP are by no means exempt from upholding these values locally and globally via their professional regulations, practice policies, research vetting processes, professional education and clinical/practice methods and tools. However, African epistemologies may admit other ways of knowing even if this is not verifiable through empirical means (Brown, 2004), and seek to understand the nature of (dis)order and (dis)ability within their own paradigms. Indeed, while South African traditional healing and indigenous knowledge systems (IKS) has now been brought into official dialogue with Western health care (e.g. via SA's National Research Foundation funding and supporting of IKS), its impact on mainstream rehabilitation professions remains to be felt. This is important, as we have evidence that what Audiology and SLP values and believes to be 'disability', does not neatly fit e.g. isiZulu epistemology (Pillay, 1992). So, given that African epistemology and ontology are different from Western rationality, it is fair to assume that there will be paradigmatic collisions especially that reality can be influenced by more than what is empirically verifiable, such as spiritual/ancestral factors, as identified by Pillay (1992). Epistemologically, African ideology is based on ideological positions like uBuntu (a person is a person through other persons) and Seriti which regard African society to be '...based both on the community and on the person and in which, because it was founded on dialogue and reciprocity, the group had priority over the individual without crushing him, but allowing him to blossom as a person' (Senghor, 1966:5). As such, 'disability as impairment' relies heavily on personal, individualised rehabilitation. This implies the negation of fundamental ontological and epistemological orientations uniquely foregrounded by South

African indigenous peoples. Worse still, to not only negate, but also to supplant these worldviews with the superiority of European paradigms, is to perpetuate oppression. For example, in mainstream Audiology and SLP, objective evidence is critical in for example describing and justifying social limitations and participation barriers. So, assessing objective evidence is useful if asked to describe the experience of living with a disability. However, it is quite another thing to ask indigenous, disabled peoples to confirm their experiences of, for example feeling marginalised or experiencing oppression. Hard evidence of these kinds of prejudices, are seldom obtainable. Yet, it is exactly because it is hard to 'evidence' objectively, that indigenous peoples occupying Black and broken bodies/minds branded as Other, may rely on ontologies that are not only independent of rational positivism (Empire's science), but are most likely replaced with faith in the lived experience. For us, this faith in the lived experience is not only about resistance, but also about surviving a science, a culture, a profession and a world where objectivity is casually used by researchers, educators, policy makers and clinical practitioners alike as a weapon of personal (and mass) destruction.

Our professions abrogate embodied experiences that are neither meta-cognitively accessible nor reliant on language/communication– which is an immense paradoxical challenge when working with people who live with communication disabilities. In this way, the invalidation of Others' indigenously sound ways of seeing and knowing their world, becomes uncaring, harmful and repudiating. It also constitutes a violent act which negates the essence of indigenous knowing. As such, their lives are re-imagined within epistemologies that maintain white superiority and continue Empire's project. This is what we refer to as epistemic violence, a term used by Spivak (1988) to describe when non-Western means of knowledge and worldviews are blocked.

Epistemic violence is not physical harm, nor is it necessarily directly inflicted (often it is subtle), but the violence has a subject (the Audiologist/SLP) and an object (indigenous individuals/communities). These violent acts may take the form of making both the subject and, more specifically, the object's life epistemologically invisible, denying indigenous persons' voices, choice/consent and even the 'non-act' to challenge Eurocentric practices and thoughts as the only (or superior) way of engaging knowing (Teo, 2010). Within the therapeutic clinical encounter, there can be many more ways in which epistemic violence is enacted such as that illuminated by Pillay (2003) and discussed regarding how reductionism, essentialism and dis-Othering are used.

Speaking on persons with disability, Spivak (2014) asserted that their being Othered meant occupying the subaltern. This hierarchical space at the bottom of society is part of the grander colonial project. Quoting the Italian Marxist theorist, Antonio Gramsci, she highlighted how we, as intellectuals, should instrumentalise ourselves in a master-disciple relationship where the master is the environment of the subaltern. She emphasised this, relative to the ability to access the space from which the Other is learning. Furthermore, Spivak cautioned about

bringing subalternity into crisis with the subaltern declaring that they are indeed subaltern. Extending this caution into education, she argued for those who recognise their subalternity to use this opportunity to become the 'menders' not the 'mended' (Spivak, 2014) possibly to incorporate their awakening into a pedagogy.

What is appealing about Spivak's suggestion is that, not only was it made directly for practitioners working with persons living with disabilities, it also foregrounds that we must actively work against an erasing of indigenous consciousness by (un)deliberately overwriting it with Western epistemologies. This fundamental shift in conversation with our clients must occur so that a contrapuntal stance is created, one that challenges the positioning of African and Others' epistemologies as infantile and inferior. Colonialism was based on a rationality that we, as people of colour, lacked even the authority and/or sense to manage our own lives. In Africa, Black Africans were considered sub-human. As our professions are born out of this ideological network, our core practices become impossible to consider for local consumption. When we value 'international' [Western] standards of care, what we do is then correct indigenous South Africans for the way they speak, listen, or even eat. When practiced as though colonial histories and thought did not affect them, Audiology and SLP are complicit in the cynicism, even denialism, of indigenous peoples' lived experiences of disability. Is this, perhaps, something that all of us, as scholars, have been blind to?

In conclusion, epistemic violence is not only about blocking how people know their world, and their worldviews, but also about denying the legitimacy of such knowing. Audiology and SLP practices besides being colonial and epistemologically Eurocentric, are also about enabling participation through speaking, listening, and being a communicator in the world. Regardless of the practices used, Audiology and SLP can be experienced as a violent, destructive and negative experience. However, this may not be for all individual indigenous peoples. Some may experience Audiology/SLP as useful, as providing solutions to problems in especially acute medical or other settings where fixing the impairment is focused. Effective technicist methods provide great, immediate practical solutions like modified food textures to swallow safely, alternative communication systems, hearing aid/cochlear implant use and others. However, the very science that grew our technicist solutions, breeds clinical interactions that are prejudicial, derogatory and inferiorizes Black indigenous knowledges. Consider how, for example, offering 'them' what 'we' consider Audiology or SLP practice, maintains the superiority of White colonial knowledges. As will be argued below, these technicist roles remain central to our professional activities. Why do they persist?

The authoritative (re)inscription of indigenous persons as disabled by transnational practitioners

The term 'transnational practitioner' [TNP] was coined by Pillay (2003) to highlight the

production of health care professionals who were being produced to cross countries' borders. This process was intended to harmonise, especially when rehabilitation practices the nature of transnational practices. However, harmonisation across the South did not occur, and these processes were really designed to benefit Northern practitioners with little to no impact in regions like Africa. In reviewing its history, one may note that from the late 1990s onwards, several (Northern) countries embarked on the development of competency projects for Audiologists and/or SLPs. For example, in England, there was the Royal Colleges' Competencies Project and Europe's CPLOL (the French acronym for the Standing Liaison Committee of Speech and Language Therapists) which developed minimum standards (Brauneis and Leterne, 2000). The American Speech-Language-Hearing Association [ASHA] not only focused on the development of its national standards, but also entered into agreement with the Canadian Audiology Speech-Language Pathology Association [CASLPA] in 1998, and then extended to Australia, New Zealand, the UK and Ireland. This Mutual Recognition Agreement (MRA) is worthy of further exploration.

Pillay (2003) reviewed a panel discussion entitled *Gatekeeping Professional Standards: Boundaries, Borders, Bridges and Bonds* at the national conference of the Royal College of Speech & Language Therapists in 1998. Sharon Fotheringham [from CASPLA, Canada], Sharon Goldsmith (from ASHA, USA), and Stephanie Martin (UK/Europe representative) presented the notion of harmonising international standards across borders which were specific to countries of the North. As members of their audience, we challenged their reference to 'international' and to indicate how they wished to address the Majority world. They were unable to clarify how an international agreement would account for a range of contextually defined practices and thereby harmonise standards.

Approximately three years later, during a presentation entitled *Recognition Agreements: Bonds and Bridges*, Fotheringham and Goldsmith (2001) clarified the concern of global contextual relevance. They crystallised their theoretical framework with reference to the World Trade Organisation's (WTO) international trade agreements. In accordance with the WTO's multilateral trading system everything, from services to goods, are decided vis-à-vis WTO Agreements. These agreements are negotiated and signed by a large majority of the world's trading nations and ratified in their parliaments. One of the principles of the WTO system is for countries to lower their trade barriers and to allow trade to flow more freely. It is in this context that the MRA must be viewed; and within which it has been (overtly) formulated. But what of this?

Not only were Audiology and SLP making use of a trade metaphor, they literally incorporated globalisations' econometric discourse to create transnational practitioners (TNPs). In epistemologically similar ways to transnational corporations, TNPs and/or their local professional collaborators possess a problematic form of power. They use their competencies, rather authoritatively, to (re)inscribe their underserved, including indigenous persons, as

disabled. Coupled with the force of this movement is the advent of the humanitarian global practitioner, putting indigenous lives not only at risk of mis/over-diagnoses- of being pathologised- but which will almost certainly fall foul of epistemic violence. For example, let's consider how many minority world countries remain fixed in a Northern gaze. TNPs may be framed within competencies that inadequately address *how* practitioners engage specific social systems, de-emphasising the human cost of health care. An analysis of professional competencies focused in the various statements of MRA countries, revealed that there is centring on practitioners' abilities to display performance, to perform a specific task (e.g. screening task) for a specific communication/hearing and/or swallowing disability. This is precisely what one would expect when technically oriented competencies serve the purpose of international trade agreements because they can be measured as a commodity. More importantly, competencies can then be marketed for consumption across the globe. Therein lies the power of commodifying practices that enable easier border crossings. While the World Health Organisation (and related organisations) make statements about practitioners being highly accountable to local contexts (Sitthi-amorn et al., 2001), advents like TNPs are really not focused in accounting for epistemological reforms such as shifting images of 'community' and 'work' that depend on definitions that may not exist anymore (Pescosolido and Kronenfeld, 1995).

In recognising globalised notions of competencies that root trade as their point of reference, we place at risk the transformation of health care. Epistemologically, these TNPs, even when locally-bound, remain fixed on the creation of disability markets. For, as long as mainly Southern (mostly post-colonial) majority world countries remain seduced by Northern, minority world definitions of what constitutes competent practitioners, their professions' powers are extended in ways that allow them to 'sell out', especially their constituencies' interests (Storey, 2001). They do this by engaging neo-liberal ways of production and consumption maintaining established settler-native relationships with indigenous populations. Critically, our professions' reliance on Empire's positivistic science implies a tendency to provide narrow technical, yet seductively practical solutions. Consider for example, the use of diagnostic or therapeutic instrumentation like hearing aids, augmentative and other assistive devices and even telepractice that are usually rationalised by the business of health economics and/or wealth creation. How then do rehabilitation professions mediate being locally relevant, socially accountable and just, relative to globalisation's econometric rationalities?

Conclusion

Disability practices and indigeneity, when positioned in the post-colonial moment, capitalise on established settler-native relationships to enable the uncritical continuation of dominance over Others' lives. However, we do believe that this project of domination is an epistemology

that we can resist. We present the Relationship of Labouring Affinities (RoLA) (Pillay, 2003) to re-imagine a more democratic relationship between rehabilitation practitioners and their indigenous Others. This framework promotes deimperialisation and decolonisation practices to enable professional transformation. *Ndlovu-Gatsheni (2013) argued that deimperialisation and decolonisation must operate dialogically in similar ways to Linda Tuhiwai Smith (2012) who argued for a 'constant reworking of our understandings of the impact of imperialism and colonialism' (Tuhiwai Smith, 2012: 25). D*ecolonisation is mainly active work carried by the colonised, while deimperialisation must be performed by the coloniser first, and then on the imperialising population to examine its own subjectivity. Guided by the objective of transformation toward a more democratic practice with indigenous peoples, the nature of labouring affinities is really a mediational construct. As such, the mediation is between dominating ideological positions like reductionism, essentialism, dis-othering and more critical oriented positions existing in the dyads of (i) conflict and stability, (ii) certainty and uncertainty and (iii) moralism and unconscionability (cf. epistemic violence).

RoLA consists of three, inter-related elements: communication; thinking; and labour. The subject and object of the relationship between practitioners and indigenous Others are centered on communication as a fundamental social unit of their relationship. The second element, that is thinking, is promoted as a social, cultural, and political act, and imagined with reference to how uuncertainty and certainty are mediated. Thinking becomes, simultaneously, the source, resource, and medium to develop the ways we think about each other, and within the RoLA. Specifically, it suggested that thinking engages epistemological plurality or 'thinkings' relative to the dominance of empirical certainties which must be laboured through toward the *usefulness* of uncertainties, as exemplified for use within cases of extreme illness/disease. In reviewing theories of uncertainty management, thinking was highlighted as interacting with emotions. Furthermore, re-positioning thinking, may allow for the possibility of practitioners and indigenous peoples to collaborate around uncertain thinkings to (re)construct meaningful interactions, a strategic form of managing uncertainty and aspects like indigenous knowledges. The third element, that of labour, has been understood as a systemic, community based act. Situating labour as a joint, collective activity harks to *activity theory* (Engestrom and Miettinen, 1999) which theorises an activity (within a system) as undertaken by a human agent (subject) who is motivated towards the solution of a problem or purpose (object), and mediated by tools (artefacts) in collaboration with others (community). Thus, labour is constrained by cultural factors including conventions (rules) and social strata (division of labour) within the context. Importantly, labour produces conceptual/practical tools commensurate with the object of transformation, e.g. engaging human and disability rights to appropriate communication/media within an advocacy framework.

Notably, the RoLA, while contextually harmonious with the South African post-colonial state, is an attempt to code our conversation between ourselves, between peoples with

analogous hopes in analogous socio-political states. Our new relationships must be enacted within an era of globalization where hegemonic political, social, cultural and economic values threaten indigeneity. This enactment necessarily involves decolonising our minds as per Fanon (1952), Biko (1968) and Thiong'o (1986). It also involves deimperialisation processes on the part of neo-colonizer disability marketers so that we may develop a closer, more intense humanity.

References

American Speech-Language and Hearing Association (2017). Non-profit Groups with an International Focus. Available at: http://www.asha.org/Members/international/IntNonProfRes/

Ballachanda, B., Banerjee, S. et al. (2011). Report of the global and humanitarian efforts: Presidential task force. American Academy of Audiology. Available at: https://audiology-web.s3.amazonaws.com/migrated/20130122_ReportTaskforceHumanitarianAndGlobal.pdf_539970fb37e224.16981729.pdf

Barr, C. (2017). Inequality index: where are the world's most unequal countries? *The Guardian*. Available at: https://www.theguardian.com/inequality/datablog/2017/apr/26/inequality-index-where-are-the-worlds-most-unequal-countries

Biko, S. (1968, reprinted 2004) Black consciousness and the quest for a true humanity. In A. Stubbs (ed). *Steve Biko. I write what I like* (pp.106-108). Johannesburg: Picador Africa.

Braun, M.J., Dunn, W. et al. (2017). A pilot study on professional documentation: do we write from a strengths perspective? *American Journal of Speech-Language Pathology*, 26(3), 972-981.

Brauneis, F. and Leterne, M. (2000). The Commission on Education and Professional Practice. Paper presented at the Fourth European Scientific Congress of Speech and Language Therapists-Logopedists. Available at: http//www.cplol.org/en/cplol2000/leterme.html

Brown, L.M. (2004). Understanding and Ontology in Traditional African Thought. In L.M. Brown (ed.) *African Philosophy: New and Traditional Perspectives* (pp.158-178). Oxford: Oxford University Press.

Chambers, L.A., Jackson, R. et al. (2018). Decolonizing scoping review methodologies for literature with, for and by indigenous peoples and the African diaspora: dialoguing with tensions. *Qualitative Health Research*, 28(2), 175-188.

De Kock, L. (1992). Interview with Gayatri Chakravorty Spivak: New Nation writers conference in South Africa. *Ariel: A Review of International English Literatures*, 23(3), 29-47.

Donaldson A.L., Chabon, S. et al. (2017). Mirror, mirror on the wall: reflections on speech-language pathologists' image as advocates, activists, and aides. *Psychology in the Schools*, 54(10), 1285-1293.

Dickens, C. (1861). *Great Expectations*. London: Chapman & Hall.

Engestrom, Y. and Miettinen, R. (1999). Introduction. In Y. Engestrom, R. Miettinen and R. Punamaki (1999). *Perspectives on Activity Theory* (pp. 1-16). Cambridge: Cambridge University Press.

Englebrecht, C. and Kasiram, M.I. (2012). The role of Ubuntu in families living with mental illness in the community. *South African Family Practice*, 54(5), 441-446

Fanon, F. (1952) Black Skin White Masks. Markmann, C.L. (2008). London: Pluto Press.

Fotheringham, S. & Goldsmith, S. (2001). Recognition agreements: Bonds & bridges. Paper presentation. *25th World Congress of the International Association of Logopedics and Phoniatrics*, Montreal, Canada, 8th August 2001.

Grech, S. and Soldatic, K. (2014). Transnationalising Disability Studies: Rights, Justice and Impairment. *Disability Studies Quarterly*, 34(2).

Grosfoguel, R. (2011). Decolonizing Post-Colonial Studies and Paradigms of Political-Economy: Transmodernity, Decolonial Thinking, and Global Coloniality. *TRANSMODERNITY: Journal of Peripheral Cultural Production of the Luso-Hispanic World*, 1(1). Available at: http://escholarship.org/uc/item/21k6t3fq

ICED (2016). Do hearing aids improve lives? An impact study among low-income population in Guatemala. Research summary report. Available at: http://www.wwhearing.org/uploads/pages/Impact_Study_Final_Report.pdf

ILO and ACHPR (2009). Country Report of the Research Project by the International Labour Organization and the African Commission on Human and Peoples' Rights on the Constitutional and Legislative Protection of the Rights of Indigenous Peoples. Geneva: ILO.

Kathard, H. and Pillay, M. (1993). Educational development and professional transformation: a case study. In C. Boughey and B.Leibowitz (eds.). *South African Association for Academic Development. 1993 Conference Proceedings. Finding Our Voices* (pp. 142-155). South African Association for Academic Development. University of the Western Cape.

Kathard, H. and Pillay, M. (2013). Promoting change through political consciousness: A South African speech-language pathology response to the world report on disability. *International Journal of Speech-Language Pathology,* 15(1), 84-89.

Kingma Queen, R.M. (2015). Current perspectives on humanitarian hearing healthcare: A survey of U.S. audiologists. Independent Studies and Capstones. Paper 710. Program in Audiology and Communication Sciences. Washington University School of Medicine. Available at: http://digitalcommons.wustl.edu/pacs_capstones/710

Lane, H. (1992). *The Mask of Benevolence*. New York: Knopf.

Looi, L.M., Ganten, D. et al. (2015). Correspondence. Hearing loss: a global health issue. *The Lancet*, 385(9972), 943-944.

Marmot, M. (2011). Social determinants and the health of Indigenous people. *Med J Aust*, 194(10), 512-513.

McPherson, B. (2014). Hearing assistive technologies in developing countries: background achievements and challenges. *Disability and Rehabilitation: Assistive Technology*. 9(5), 360-364.

Meekosha, M. (2011). Decolonising Disability: Thinking and Acting Globally. *Disability & Society*, 26(6), 667-682.

Mercy Air (2015) Bush Audiology. Available at: http://mercyair-sa.blogspot.co.za/2015/10/audiology.html

Murphy, D., Lyons, R. et al. (2018). Communication as a human right: Citizenship, politics and the role of the speech-language pathologist. *International Journal of Speech-Language Pathology*, 20(1), 16-20.

Ndlovu-Gatsheni, S. (2013) The entrapment of Africa within global colonial matrices of power: Eurocentrism, coloniality and deimperialisation in the 21st century. *Journal of Developing Societies, 29(4), 331-353.*

Peet, R. (2009). *Unholy Trinity: The IMF, World Bank and WTO* (2nd Ed). London: Zed Books.

Pescosolido, B.A. and Kronenfeld, J.J. (1995). Health, Illness, and Healing in an Uncertain Era: Challenges From and For Medical Sociology. *Journal of Health and Social Behaviour*, 35, 5-33.

Pillay, M. (1992). Communication Disorders: Beliefs and Practices in a Zulu Community. Unpublished dissertation. Durban: University of Durban-Westville (now University of KwaZulu-Natal).

Pillay, M., Kathard, H. et al. (1997). The Curriculum of Practice: A Conceptual Framework for Practice with a Black African First Language Clientele. *South African Journal of Communication Disorders*, 44(1), 109-117.

Pillay, M. (1998) Developing Critical Practice: A South African's Perspective. *International Journal of Language & Communication Disorders*, 33(S1), 84-89.

Pillay, M. (2001). 'Do you speak practice-ese?' A discourse of practice for sharing communication. *International Journal of Language & Communication Disorders*, 36(S1), 351-356.

Pillay, M. (2003). *(Re)Positioning the powerful expert and the sick person: The case of communication pathology.* Unpublished D.Ed Thesis. Faculty of Education, University of Durban-Westville (now University of KwaZulu-Natal), Durban, South Africa.

Pillay, M. (2013). Can the subaltern speak? Visibility of international migrants with communication and swallowing disabilities in the World Report on Disability. *International Journal of Speech-Language Pathology*, 15(1), 79-83.

Pillay, M. and Kathard, H. (2018). Renewing Our Cultural Borderlands: Equitable Population Innovations for Communication (EPIC). *Topics in Language Disorders*, 38(2), 143-160.

Prince, M.J. (2017). Persons with invisible disabilities and workplace accommodation: Findings from a scoping literature review. *Journal of Vocational Rehabilitation,* 46(1), 75-86.

Ramugondo, E.L. and Kronenberg, F. (2015). Explaining collective occupations from a human relations perspective: bridging the individual-collective dichotomy. *Journal of Occupational Science,* 22(1), 3-16.

Sackett, D. L., Rosenberg, W.M.C. et al. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71-72.

Said, E. (1993). *Culture and Imperialism*. UK: Chatto and Windus.

Said, E. (2000) Out of Place: A Memoir. New York: Vintage.

Schlebusch, C.M., Prins, F. et al. (2016). The disappearing San of south eastern African and their genetic affinities. *Human Genetics,* 135(12), 1365-1373.

Senghor, L. (1966). Negritude. *Optima*, 16(8).

Sepp, L. (2017). Invisible barriers, invisible disabilities, invisible people. *Ecopsychology*. 9(2), 65-71.

Spivak, G. (2014). *Panel Discussion with Prof Gayatri Spivak*. [video] Teaching and Learning TV. University of KwaZulu-Natal. Recorded 29 September 2014. Available at: https://www.youtube.com/watch?v=7RBNHUeoyDQ

Storey, A. (2000). The World Bank, neo-liberalism, and power: discourse analysis and implications for campaigners. *Development in Practice,* 10(3-4), 361-370.

Student Academy of Audiology (2014, July 4). So you want to be a humanitarian audiologist? Available at: https://saa.audiology.org/news/so-you-want-be-humanitarian-audiologist

Sitthi-amorn, C., Somrongthong, R. et al. (2001). Some Health Implications of Globalization in Thailand. *Bulletin of the WHO*, 79(9), 880-893.

Teo, T. (2010). What is epistemological violence in the empirical social sciences? *Social and Personality Psychology Compass,* 4(5), 295–303.

The Theory of Everything (2014). [video] United Kingdom: James Marsh.

The Diving Bell and the Butterfly. (2007). [video] France: Julian Schnabel.

Thiong'o, N. (1986). *Decolonising the Mind: the Politics of Language in African Literature*. Portsmouth N.H: Heinemann Educational.

Tuhiwai Smith, L. (2012). *Decolonizing Methodologies. Research and Indigenous Peoples* (2nd Ed). Dunedin: Otago University Press.

Wells, S. (2002). *The Journey of Man: A Genetic Odyssey.* US: Princeton University Press.

Wylie, K., McAllister, L. et al. (2013). Changing practice: Implications of the world report on disability for responding to communication disability in underserved populations. *International Journal of Speech-Language Pathology*, 15(1), 1-13.

World Health Organization and the World Bank (2011). *World Report on Disability*. Geneva: WHO.

World Wide Hearing (2017, September 7). Our projects. Past and present. Available at: http://www.wwhearing.org/our-projects

World Wide Hearing (2014). Member association. Available at: http://www.wwhearing.org/member-association