

**THE IMPACT OF PHYSICAL MOVEMENT  
DISABILITY AMONGST HOMELESS ADULTS  
IN THE WYNBERG HAVEN NIGHT  
SHELTER**

**Research Project for MSc in Physiotherapy**

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## **ABSTRACT**

The purpose of this study was to explore the impact of physical movement disability amongst adult homeless persons in the Wynberg Haven Night Shelter and secondly to make recommendations with regard to their needs that have been identified by the study. A cross sectional exploratory descriptive study was done using both qualitative and quantitative methods of data collection elucidating triangulation to validate data. Three approaches were used to answer the research question:

- Observation and description of the shelter, including staff to gain understanding of the existing situation.
- Structured questionnaire based on the ICIDH-2 Beta-2 draft (1999) was used to document and describe physical movement disability.
- In-depth interviews including story-telling to describe perceptions, beliefs and needs of adult homeless people with physical movement disability.
- Record and analyse perceptions and beliefs of adult homeless persons with no physical movement disability living in the Wynberg Haven Night shelter towards disability.

The Wynberg Haven Night Shelter was conveniently chosen amongst 34 homes and shelters in the Western Cape. Results showed that out of 50 residents in the Wynberg Haven Night Shelter, 10 had physical movement disability. Reasons for disability were amputation, stroke, trauma, peripheral vascular disease and neuromuscular conditions. The setting at the Wynberg Haven Night Shelter had developed neither clear structural adjustments nor support system for the homeless people with physical movement disability. The managers' authoritarian managerial style inhibited the adult homeless people from expressing their needs.

The adult homeless people with physical movement disability experienced many problems in movement related activities. Both story telling and results from the ICIDH-2 exposed this. This study showed that the disabled homeless people from the Wynberg Haven Night Shelter experienced a double burden i.e. that of disablement and homelessness. Although they are surrounded by health facilities only a few were able to take advantage to access them – mainly due to ignorance and lack of encouragement. A large percentage are educationally, socially and economically marginalised. Being homeless has further prevented them from equal access to rehabilitation, health and community social support and services.

Recommendations were made to the manager of the Wynberg Haven Night Shelter, disability movements in the Western Province, health care professionals, homeless people from the Wynberg Haven Night Shelter, Adult Homeless people with physical movement disability from the Wynberg Haven Night Shelter and future studies.

## DEFINITION OF TERMS

1. The World Health Organisation (WHO) in 1980 defined impairment, disability and handicap in the following manner:

**IMPAIRMENT:** Any loss or abnormality of psychological, physiological or anatomical structure or function.

**DISABILITY:** Any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

**HANDICAP:** Is a disadvantage for a given individual, resulting from an impairment or a disability that prevents the fulfillment of a role that is considered normal (depending on age, sex, social and cultural factors) for that individual.

2. Whereas The Union of the Physically Impaired Against Segregation (UPIAS) in 1976 had already defined impairment and disability in this manner:

**IMPAIRMENT:** [is] the functional limitation within the individual caused by physical, mental or sensory impairment.

**DISABILITY:** [is] the loss or limitation of opportunity to take part in the normal life of the community due to physical and social barriers (Bickenbach et al., 1999).

*The term handicap will not be used to describe the participants of this study. Only people with physical movement disability will be part of the study. People with mental, cardiopulmonary, visual, hearing and other sensory impairments will not be included. Therefore to be more precise, the sample includes those with physical movement disability; anyone having problem with the following will be considered as a person with physical movement disability:*

- Movement related functions e.g. mobility of joints.
- Structures related to movement e.g. structure of upper extremity.
- Activities related to movement (including dexterity, fingering, gripping and holding) e.g. walking activities (WHO ICIDH-2, 1999).

3. **HOMELESS PEOPLE:** People who lack a stable home and the personal resources, such as work, family and friends to assist in acquiring a home (Abdul-hamid, 1996).

4. **SHELTER:** A place, which provides emergency housing and meals for women or men who have no other place to eat or sleep. The shelter provides three different types of accommodation: emergency shelter, transitional accommodation, and permanent or semi-permanent accommodation (Tryssenar et al., 1999).

5. **PARTICIPANTS AND HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY:** These terms will be used in the study interchangeable, which ever is the most appropriate in the context under discussion.

## **LIST OF ABBREVIATIONS**

|                 |   |
|-----------------|---|
| <b>AIDS</b>     | Acquired Immune Deficiency Syndrome                                       |
| <b>TB</b>       | Tuberculosis  |
| <b>CASP</b>     | Coordinated Action for Street People                                      |
| <b>CBR</b>      | Community Based Rehabilitation  |
| <b>DPI</b>      | Disabled People International   |
| <b>DPSA</b>     | Disabled People South Africa  |
| <b>HIV</b>      | Human Immune Deficiency Virus   |
| <b>NCCD</b>     | National Coordinating Committee on Disability                             |
| <b>NGOs</b>     | Non-governmental Organisations  |
| <b>OSDP</b>     | Office on the Status of Disabled People                                   |
| <b>RDP</b>      | Reconstruction and Development Programme                                  |
| <b>SAFCD</b>    | South African Federal Council on Disability                               |
| <b>ICIDH-1</b>  | International Classification of Disability and Handicap<br>(WHO, 1980)    |
| <b>ICIDH-2</b>  | International Classification of Functioning and Disability<br>(WHO, 1999) |
| <b>ICIDH- 2</b> | International Classification of Functioning and Health<br>(WHO, 2000)     |
| <b>UPIAS</b>    | Union of the Physically Impaired Against Segregation                      |
| <b>WHO</b>      | World Health Organisation   |

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## CHAPTER 1

### THE PROBLEM AND ITS SETTING.

#### 1.1 Evolution of the problem

*“Not until the creation and maintenance of decent conditions of life for all men are recognised, and accepted as common obligation of all men and all countries. Not until then shall we, with a certain degree of justification be able to speak of mankind as being civilised “(Hellander, 1992 covering unnumbered p.).*

There are many reasons that motivated me to do this study. Maybe the most significant one is where I come from, and how I was brought up. I was born in a rural environment and, though by the standard of today, one could describe our village people as predominantly poverty stricken, as young people we were not aware of this. There was always a spirit of sharing without questioning or comparing amongst us. I would also like to mention that there were no visible homeless people in the village streets. People with disability were integrated within their families and the less severely profound pupils were in mainstream schooling. Unfortunately even then there was a stigma attached to having a disability as people with disabilities were marginalised by some members of the community and names like *Umntwana karulumente* (a child that belongs to the government - as the government was expected to take care of the child with disability) were a common use.

In this village there was a strong work ethic and each household followed rituals which were goal orientated towards development. In my home I was close to my grandmother who one could describe as a human rights activist. She was a teacher by profession but was incapacitated because of asthma. Many people used to come to her for advice, she was an ardent reader and listening to news bulletin was her daily ritual. She never openly told us to feel passionate about issues on social justice and social development but she influenced our beliefs and attitudes.

I chose the physiotherapy profession as it was drummed into my ears, again by my grandmother that, for us to succeed in life we needed to get a profession of some kind. Why physiotherapy? I wanted to help people who had been injured to be back on their feet again, that was my understanding of physiotherapy then. I have worked in a variety of settings, with clients requiring a variety of rehabilitation skills. I have also been a physiotherapy educator for a number of years. I have always had a passion for rehabilitating clients until they reach their highest potential. I always strive to support physiotherapy students until they reach their goal. Certain specific milestones contributed towards seeing myself being able to make a contribution to this study. I believe in life that certain individuals and certain events can have a universal impact and can alter the way human beings think and see the world. In 1982 during my last year of training for physiotherapy at the Medical University of Southern Africa (MEDUNSA) the United Nations World Programme of Action outlined and summarised a modern disability policy

emphasising three main areas – *prevention, rehabilitation, and equalisation of opportunities*. This was a milestone for people with disabilities and was a thoroughly exciting time for them, as well as their families, disability advocates and rehabilitation specialists, as they saw this as an opportunity to bring the plight of people with disabilities right to the forefront.

After I qualified as a physiotherapist I continued to have an interest in disability issues especially community based ones. I was aware of the changes that were happening in terms of the rights of people with disability in the South African context. The Office on the Status of Disabled Persons (OSDP) was established as a directorate in the office of the Deputy president in June 1994 with responsibility for policy development for people with disability. This led to development of the White Paper on Integrated National Disability Strategy in 1997. There are parliamentarians with disabilities who advocate for the rights of people with disability. This has given people with disabilities a citizenship status they long deserve.

I live and work in Cape Town. I have observed the escalation of homelessness by the increase number of people who come asking for money when I stop at the robots. I have never thought deeply about homelessness and disability within the homeless population and I had not brought homelessness close to the heart. When the lecturer and co-ordinator for physiotherapy students' final year research projects asked me to comment on the feasibility of a mini- student research project that was looking at disability within the homelessness population in the Cape Peninsula (due to my CBR background), I felt an immediate interest to get involved. I had observed the insurmountable problems faced by people with disability that have homes; I couldn't imagine how a homeless person with a disability could make his/her voice be heard and his needs acknowledged.

It also concerned me that in the area of disability and rehabilitation, I had never thought about disability within the homeless population. I was already aware that both homeless people and people with physical disability are marginalised by society. Why have I not thought of being homeless and physically disabled, which would appear to be a double burden to those who experience such a situation?

## **1.2 The problem**

Murray (1996) maintains that researchers agree that all people, if left homeless for a sufficient period of time, will develop some type of mental disorder or disability. Plumb (1997) ascertains that chronic disease is seen more frequently in homeless persons; these chronic illnesses may be silent until late in their course, and because of limited medical attention, often go unrecognised and untreated. Even if the condition is detected and treated, lack of compliance and consistent follow-up often results in disease progression, disability, morbidity and premature death.

I have read that homeless people make up an increasing vulnerable population, which is at high risk for preventable diseases, progressive morbidity and premature death (Plumb, 1997). A mini study done by the fourth year physiotherapy students that was used as the

pilot study for this study focused on describing physical movement disability within ten conveniently selected shelters in the Cape Peninsula. Their study showed that 13.7% of the homeless people in these shelters had physical movement disability. Bhagwamjee (1999) states that recent estimates of disability prevalence in South Africa indicated an alarming population prevalence of 13% in 1995 with 5% of the population being severely disabled. The assistant manager of one of the shelters studied has worked in various shelters and estimated physical movement disability within shelters to be between 20-25%. In December 2000, the Wynberg Haven Night Shelter had 20% of the residents had physical movement disability. Very few studies – if any at all – have investigated the impact of physical disability amongst homeless people. There is therefore a dearth of reliable information relating to this topic.

### 1.3 Motivation for the study

Much of the medical literature has concerned itself in describing the pathology and treatment of a great variety of physically disabling problems of stroke, cerebral palsy, head and spinal chord injury. However, few studies have been conducted that focus on disability and its impact on a specific groups of people. I saw that the mini research study done by fourth year physiotherapy students could be taken further by doing an in-depth exploration of the impact of disability on this vulnerable group of people in their specific environment. I felt that this is a new line of enquiry that could raise the level of awareness about homeless people's disability issues to the disability sector and could also contribute to the rehabilitation field. I asked myself the question, "What was the impact of physical movement disability on homeless adult persons living in a specific environment – the shelters?"

The United Nations World Programme of Action of 1982 put *equalisation of opportunities for people with disabilities* as a major issue (Lindvist, 1995). By equalisation of opportunities the World Programme of Action (1992) meant the process through which the various systems of society and the environment, such as services, activities, information and documentation is made available to people with disabilities. The disability movement further describes this, as the future structure and social mores of a future society, which would indeed be free from oppressive structures and negative social attitudes held by the society at large, thereby enabling people with disability to attain the legitimate status of full citizenship – an almost Utopian situation (Lang, 2000).

In the Republic of South Africa, it is the constitutional right of disabled homeless people to access the same fundamental rights as all citizens of this country, e.g. equal rights to access health services, housing, water and sanitation, employment opportunities, and education. I further asked myself - are the homeless people with disabilities living in shelters able to gain access to these fundamental rights? Are they able to be included when resources are being distributed? Are they accessing some of the social rights such as disability grants that some of the disabled people in South Africa are eligible for? Social organisation and social networks are some of the basic needs which connect the person with the outer society and give the individual social power (Friedemann, 1992).

What are the social networks of adult homeless people with physical movement disabilities? Murray (1996, p18) asked this question then, *“Who speaks for homeless persons during health care reforms? What are the needs and resources of the homeless persons?”*

The White Paper (Integrated National Disability Strategy, 1997) also indicates that disabled people often have additional needs that add to cost, more space to move around the home, accessible entrances, and pathways for wheelchairs, rooms for caregivers and personal assistants, adapted security systems etc. It further highlights the importance of recognizing that there are sectors within the disabled community that experience greater discrimination than others have. These sectors still experience comparatively higher levels of exclusion from social, economic and the political environment.

Homeless people are still widely perceived as being dirty, dumb, wanting in skills, drugged, prone to violence and generally irresponsible. In Cape Town they are associated with stolen supermarket trolleys that are overloaded with their mouldy possessions. Society regards them with suspicion and sees them as needing to be controlled, institutionalised, and managed (Friedemann, 1992). Most homeless people are reluctant to stay in shelters and some say shelters are like jail, institutionalising and patronising (Cape Metropolitan Street Field Worker project, 2000). In the Street Field Worker Project conducted by the Cape Metropolitan Council in June 2000, 10% of street people had physical disabilities, this percentage is lower than the numbers mentioned for the people with physical disabilities living in shelters.

The external factors facing an individual can have a positive or negative influence on participation as a member of the society, on performance of activities or body structure or function (WHO, 1999). Furthermore I asked myself the following questions: How is the immediate environment of the homeless people with disabilities responding to their needs related to disability? What use do homeless people with disabilities make of this environment? Is it a hostile or supportive immediate environment? According to Lang (2000) altering the environment is an obvious way to start. So one needs to ask, have the shelters of the participants altered their environment to accommodate residents with physical movement disability?

In the Cape Metropolitan Street Field Worker Project (2000), the violent nature of street life and the vulnerability of street people was exposed. Since the research on both people with disability and homeless population is still in its infancy, more research is crucial to voice the needs of these marginalised communities. It is a fact that people with disabilities do become homeless, and that some homeless households (the shelters) do contain people with disabilities.

Finding the impact of physical movement disability among adult homeless persons in the Wynberg Haven Night Shelter may open a doorway whereby the managers of the shelters, the disability movements, the able-bodied professionals and the adult disabled homeless persons can understand each other and interact in a meaningful way. Murray (1996, p23) says, *“To listen to the homeless population is the first step in meeting what*

*we consider is their health needs, certainly then the homeless population can be considered more realistically in health care reform and we can move closer to the holistic care that had been envisaged - health care professionals can create that reality”.*

#### **1.4 Purpose of the study**

This research seeks firstly to gain an understanding of the impact of physical movement disability amongst adult homeless persons in the Wynberg Haven Night Shelter, and secondly to make recommendations with regards to their needs that have been identified by the study. These recommendations would be targeted at:

- Managers of the shelter
- Disability movements
- Health care professional
- Adult homeless people
- Adult homeless people with physical movement disability

#### **1.5 Limitations of the study**

The scope of the study was limited by:

- A convenient sample of shelters that was chosen initially due to accessibility of these shelters and later due to the aim of having information rich participants as the study was unfolding.
- Interviews sometimes were interrupted especially the manager’s interview due to her hectic work schedule.
- The instrument that was used for describing disability has just been developed (ICIDH-2 Beta – 2 draft, 1999). There was no literature on other studies that had been conducted using it. This instrument was also in the developmental stage, by the time I finished collecting data, some additions had been made. Its adoption was in May 2001.

#### **1.6 Significance of the study**

Schwartz et al. (1996) and Plumb (1997) stated that there are heterogeneous groups from all levels of society with a variety of acute and chronic health problems. Homeless men, women and children make up a small but growing vulnerable population that has an unacceptable high risk for preventable disease, progressive morbidity, and premature death. There has been a lack of initiatives by hospitals to take part in healthcare of this population. Institutions had shown reluctant attitudes in treating homeless persons and other clients who lack financial resources (Schwarz et al., 1996).

For those people with a stable home, disability can be a major obstacle to overcome both physically and psychologically. So the question has to be asked, how much more will disability affect someone without a home? What has been done about disability in the shelters? What can be done? What is the role of the managers of the shelter, the disability

movements and the professional able-bodied in this field? Can the voice of the homeless person with disability also be heard? Where is the entry point for the needs of homeless person with disability in the new dispensation? These are some of the questions I wanted to answer in this study. As Shakespeare (1996, p 210) says, “ *We must enable people with disabilities to speak for themselves, and must recognise that it is the expertise of having lived this experience which is needed, not the professional technical knowledge*”.

Answers to my questions may encourage further studies regarding the prevalence and impact of physical movement disability within the homeless people. This would further assist the managers of the shelters when advocating about homeless people with movement disabilities by having valid information to back up their arguments. I think this will raise awareness of the need for inclusion of the homeless people with physical movement disabilities by the disability movements in the broader framework of their policies and plans as well as broader social development initiatives.

As far as can be ascertained no such study of this nature has been conducted by a physiotherapist in South Africa. This is a new line of enquiry for the physiotherapy profession while professions like nursing and occupational therapy have long seen the need to work with homeless population. I hope the study will raise awareness among physiotherapists about homeless people with physical movement disability, and the specific role physiotherapists could play in this population. I also see that this could open an avenue for interdisciplinary work with students and health professionals. Trysenaar (1999, p189) says, “ *there is a need to promote social justice by health care professionals by promoting rehabilitation which enable people to participate as valued members of the society despite diverse or limited potential*”.

### **1.7 Objectives of the study**

The objectives of the study are to:

- Describe the functioning of the Wynberg Haven Night Shelter regarding their approach to homeless people with physical disability.
- Describe physical movement disabilities of adult homeless persons in the Wynberg Haven Night Shelter.
- Record and analyse perceptions, beliefs and needs of the adult homeless persons with physical movement disability in the Wynberg Haven Night Shelter.
- Record and analyse perceptions and beliefs of the adult homeless people with no physical disability living in the Wynberg Haven Night Shelter towards disability.
- Make recommendations with regard to the needs of the adult homeless people with physical movement disability in the Wynberg Haven Shelter.

### **1.8 Integration of objectives to answer the research question**

The aim of the study is to get an insight into the plight of homeless people with physical movement disability living in the Wynberg Haven Night Shelter. The first four objectives were selected with the aim of exposing this. Each objective was aimed at showing the impact of disability on the participants at three levels i.e. physical, personal and immediate environment. The findings from each objective were analysed in relation with findings from other objectives. These findings assisted me in making recommendations with regard to the needs of the participants.

### **1.9 Changes to the proposal**

Initially it was planned that the study would research the impact of physical movement disability amongst homeless adults in three shelters in Cape Town. Due to the developmental nature of the study, the study concentrated on only one shelter.

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## CHAPTER 2

### LITERATURE REVIEW

This study explores the impact of disability on a vulnerable group of people, the adult homeless people with physical movement disability residing in a shelter. It is my intention to highlight this through literature relating to both the plight of people with disability and that of homeless people in relation to their way of life and their immediate environment. Poverty is seen as a problem overarching in both people with disability and those who are homeless. I have also discussed the role of health care workers and rehabilitation professionals, with special consideration to physiotherapy, as external resources that could play a supporting role in homeless people with physical movement disability. Lastly I reviewed literature on research tools used for this study.

#### **2.1 Developing an understanding of the concept of disability**

People who are homeless and those with physical disability are marginalised by society. To be homeless and physically disabled would appear to be a double burden to those who experience such a situation. People with disabilities are excluded from the mainstream of society and experience difficulty in accessing fundamental rights. There is furthermore, a strong relationship between disability and poverty; poverty makes people more vulnerable to disability, and disability reinforces and deepens poverty (White Paper on the Integrated National Disability Strategy, 1997). Disability tends to be couched within a medical and welfare framework, identifying people with disabilities as ill, different from their non-disabled peers, and in need of care. Because the emphasis is on the medical needs of people with disabilities, there is a corresponding neglect of their wider social needs and this has resulted in severe isolation of people with disabilities and their families (Integrated National Disability Strategy, 1997).

Initially, the medical model dominated disability issues and rehabilitation services (Bauer, 1989 and Correll, 1981). The current medical system in South Africa is also strongly based on the medical model, which is biased towards curative and institution based care, where the doctor plays a dominant role in the health hierarchy (National Health Plan for South Africa, 1994). Within the medical model, all rehabilitation efforts are prescribed and closely supervised by the doctor. There are contradicting views on disability between the medical model and the social model.

Lang (2000) makes the following comments regarding the medical model:

- The medical model classifies 'disability' as essentially a 'problem' focusing on the individual. It is perceived as a deviation from the 'norm'. Therefore the role of the medical and paramedical professions is to cure, correct or ameliorate this problem, so that the disabled person can be as 'normal' as possible.

- Secondly, the medical model assumes that disabled people are biologically and psychologically inferior to those who are able-bodied. Therefore they are considered to be 'not fully human' and by implication, do not have the competence to make decisions for themselves.
- Thirdly, disability is seen as personal tragedy, which occurs in individuals on a random base and is regarded as a misfortune. However, the disability movement maintains that disability is a cultural construct. Impairments do not just happen by chance but are the results of structural factors within the society. In many countries disability is a result of poverty.
- Fourthly, the medical model assumes that there is an objective state of 'normality' that gives professionals, especially within the medical model, a dominant role. Furthermore, social and economic development and advances in medical technology will change the portfolio of impairments that occur.
- There is little scope for disabled people and their families to participate in decision-making. Within most institutions staff have vested interest in not questioning the quality of the patients environment too radically, as they themselves are part of the environment.

Over the past decade, disabled people's organisations all over the world have worked to reposition disability as a human rights and development issue (Integrated National Disability Strategy, 1997). They have approached this by looking at the way society disables people with disability. Hence the social model, in contrast, is the antithesis to the medical model. The focus here is placed upon the community and society rather than the individual. It is the social barriers, such as inaccessible buildings, unusable transport systems, social attitudes and prejudice, and institutionalised discrimination that are the real concerns of people with disability.

Lang (2000) maintains that the UPIAS (1976) is of the view that it is the society that disables physically disabled people. Disability is something imposed on top of their impairments by the way they are unnecessarily isolated, excluded from full participation in society, they conclude by saying that disabled people are therefore an oppressed group in society.

Protagonists of the social model assert that disabled people live in a 'disabling world'. In contrast with the medical model, the social model maintains that disablement has nothing to do with the body, as it is exclusively the consequence of social oppression. Furthermore, disability is seen as a human rights issue, in which progress is made through disabled people collaborating together to achieve common mutual objectives. Lang (2000) maintains that people with disabilities have started to come together to challenge the 'right' of charities and professional people to control their living conditions; in order to do this, people with disabilities have had to fight against the power which these groups have held on them.

Hellander (1992) also argues that it should be noted that not all people - not even those with visible disability - would be perceived as having disability. He further maintains that an adult who suffers an amputation of a limb, receives prosthesis and then continues his or her normal adult social role may not be seen as "disabled". He continues his argument by saying that when one discusses disablement, one should be aware of the cultural and developmental factors that influence the concept of disability especially in developing countries. In Northern Mali, the most "disabling condition" for a woman is to be seen as being ugly, while in Somalia a woman was classified as "disabled and labelled a fool" because she refused an arranged marriage by her father to an elderly person.

What then is meant by disability? The literature draws a crucial distinction between 'impairment', 'handicap', and 'disability' (WHO definition of 1980 in the definition of terms p1). According to Lang (2000), these terms are easily confused with each other. He continues to cite comments made by Disability Movements that are as follows: Impairment refers to physical or cognitive limitations that an individual may have, such as the ability to walk or speak. Whereas disability is a result of socially imposed restrictions, i.e. the socially imposed restrictions, that is, the system of social constraints that are imposed on those with impairments by the discriminatory practices of society. While Bickenbach et al. (1999) maintain that the UPIAS in 1976 defined impairment as the functional limitation within the individual caused by physical, mental or sensory impairment and disability as the loss or limitation of opportunity to take part in the normal life of the community due to physical and social barriers (Bickenbach et al., 1999).

Many people with disabilities are excluded from the mainstream of society and some experience difficulty in asserting fundamental rights. Under the new constitution of the Republic of South Africa of 1996, both people with disabilities and the homeless people should be able to access the same fundamental rights as any South African citizen. But on the contrary, Riddel (1996) describes how these rights and duties of citizenship that accrue automatically to the non-disabled population, maybe granted conditionally to people with disability.

## **2.2 Contribution of health care and rehabilitation workers**

Health care providers have a very important role to play in enhancing good health for all people, and rehabilitation workers also have a unique role to play in ensuring that people get rehabilitated to their highest level of function, and also try to integrate them back into their communities. Physiotherapists are bound by their code of ethics to provide health care for all people, irrespective of their race, creed, religion and social status. The kind of health care provided should be determined by particular needs of the individual. Hellander (1992) of the United Nations Development Programme maintains that people's needs are manifold and that each society sees its priority differently. Consequently, approaches to health care should take particular requirements of the person into consideration thereby providing holistic and appropriate services. Persons with disability need health care as any other person but might have additional needs, such as accessible rehabilitation services.

Physiotherapists are trained to rehabilitate physical parts of the body which are not

functioning properly (Blake, 1992). Thus, their role is to assist people to recover maximum movement where possible and use it to restore independent function in daily activities (Blake, 1992). Living independently can involve using resources and supports such as attendant care, walking aids, wheelchair and other adapted equipment. As a person with disability, Hershely (1993) maintains that she is living independently though she has to use attendants, an electric wheelchair and a voice activated computer.

Shakespeare (1996) stated that reliance on others is not necessary about dependence. Instead he argued that access to services delivered or social independence to employ one's own carers can ensure high levels of social independence, despite low levels of physical independence; and this should be delivered as a right. Some people, whether disabled or not, make use of technology or human resource in order to get certain tasks done. Healy (1993 p38) summed this up when she said "*money buys help all the time, help that is taken for granted by the rich and is a source of humiliation for the poor*".

### 2.3 Disability complexities

Notwithstanding the significant contribution that the disability movement has made during the past thirty years, there are still, a number of contentious issues, the most important issue revolves around disability complexities and the need for people with disability and able-body health care/rehabilitation workers to develop a working relationship. A number of suppositions, which highlight the above problem, are made by Lang (2000) and can be summarised as follows: The disabled people are indeed an oppressed group, some disability movements have advocated that conflict should not be used in trying to combat such oppression and discrimination. While appreciating the foundation of such sentiments, and without denying the validity the assertion that people with disability do indeed face discrimination and oppression, it is contended here that disability is a far more complex phenomenon that can be solely and adequately explained by social oppression.

However, anti-discrimination legislation is necessary, but in no manner sufficient in achieving a non-disabling society. Even with those countries where anti-discrimination legislation has been enacted, there had been much discussion regarding efficacy of such measures. Assuming the premise that disability is essentially concerned with attitudes, such legislation is a blunt instrument, since it is impossible to legislate a change in the manner in which individuals think or behave.

The disability movement has been successful in raising the profile of disability on the political agenda, by poignantly highlighting the social, economic and political structures, as well as the pejorative attitudes that have contributed in ascribing people with disability the status of second citizenship (Lang, 2000). The literature emanating from the disability movement is somewhat parsimonious in delineating and envisioning the future structure and social mores of a future society, which would indeed be free from oppressive structures and negative social attitudes held by society at large, thereby enabling disabled people to attain the legitimate status of full citizenship. According to Lang (2000), altering the physical environment is an obvious place to start, but there is far more

required. The disability movement campaigned for anti-discrimination legislation, analogous with that passed with reference to race and gender within the United Kingdom, to be enacted by all countries throughout the world, that would prohibit blatant manifestations of discrimination in the areas of employment, education, health and housing. Such legislation has already been enacted in countries like United States, Zimbabwe, India and South Africa.

A further question arises concerning the appropriateness and applicability of the western-base notion of empowerment, with decisions that are made in accordance with the preferences and wishes of an individual. Such an individualised notion of empowerment as espoused by the international disability movement runs contrary to accepted social customs and practices that are found in many developing countries, where collective action is valued (Hellander, 1992; Lang, 2000).

Many people, rather than actively oppressing people with disabilities, are in fact fearful and ignorant of disability, which leads them to relate to disabled people in inappropriate and often demeaning ways. The more appropriate and pertinent strategy for the creation of a non-disabling society might be through the medium of education.

Lang (2000) raises a related point that concerns the controversial issue of the role that should be played by able-bodied professionals in the realm of disability. Those aligned with the radical wing of the movement would maintain that unless one has had personal experience of disability, there is no mandate to speak on disability issues whatsoever. The genesis of such sentiments stem from the past experiences of disabled people being excluded from decision making process, both at policy level and within their own lives, where the medical model held the dominant hegemony. Others within the disability movement adopt a more conciliatory stance, maintaining that the role of an able-bodied professional is that of a 'facilitator', enabling disabled people to make effective choices for themselves in determining the kind of lifestyle they wish to lead. To coin the phrase of well-known disability activist, David Werner, the role of the able-bodied professional is to be "on tap, but not on top". The professionals feel threatened by the growth in the power and influence of the disability movement.

In addition Lang (2000) maintains disabled people have been quite rightly worried about the undue influence and the power professionals have had in barring disabled people from having an effective mandate in setting disability policy agenda. In the future, the strength and the influence of disability movement is inevitably going to increase, a trend that should be endorsed and encouraged. However the disability movement should be prudent and wise in the future development of the relationship it fosters with able-bodied professionals. Considerable care should be exercised to ensure that "the baby is not thrown with the bath water", so that those who were hitherto oppressed do not become the oppressors of contemporary society. The research carried out in this project intends to investigate some of these suppositions.

## 2.4 Disability movements in South Africa

In South Africa Disabled People South Africa (DPSA) is a national organisation of smaller community-based disabled people's organisations. Disabled People International (DPI) is recognised by the United Nations as the international assembly of disabled people. DPI recognises DPSA as the national assembly of disabled people in South Africa. The National Co-ordinating Committee on Disability (NCCD) in South Africa was established in 1993 and played a key role in the establishment of the Disability Programme in the Ministry without Portfolio in the Office of the State President which was responsible for the Reconstruction and Development Programme (RDP). On the closure of this Ministry, the office on the status of Disabled Persons was moved to the Office of the Deputy President and later in 1997, the Presidents' Office and here it now has a directorate status.

The South African Federal Council on Disability (SAFCD) is the national umbrella body for all national disability Non Governmental Organisations (NGOs). It is the national forum where all national welfare organisations as well as national organisations of people with disability, parents of children with disability, come together and negotiate and develop common visions for equalisation of opportunities for people with disabilities. The national welfare councils concentrate on service delivery and are partly subsidised by government.

## 2.5 Problems experienced by disabled people in accessing education and work

Despite the work which is being done by disability movements in advocating for the rights of people with disabilities, people with disabilities are still experiencing severe discrimination in both education and workforce. Furie and Coombs (1990) argued that people with disabilities who have grade 8 of schooling or less education had an employment ratio of less than 17 % (compared to 55 % for the able - bodied), while those with university degrees had an employment ratio of 50 % (compared to 87 % of able-bodied university graduates). Inequality of opportunity is particularly evident in the workforce, where people with disability are universally and substantially under-represented in the formal and labor force, and over-represented among the poor (Furie and Coombs, 1990).

## 2.6 Homeless people and their plight

Historically, people at the margins of society in high-income countries, including those with disabilities, are excluded from society. Plumb (1997) maintains that the working poor live on a precipice that can tumble them into homelessness any time. An illness or an unexpected layoff brings missed pay cheques which lead to skipped utility or rent payments, which snowballs into penalties and ends in shutoffs or eviction. That leaves a choice between no place at all or city- run homeless shelters, which often are dirty, noisy and unsafe.

Clarke *et. Al.* (1995) cited an interview with the homeless people who felt that reasons for homelessness were a combination of factors such as loss of job, family problems and

health problems. Globally three factors have contributed to homeless expansion and differentiation. Initially unemployment leads to economic hardship, decreased entitlement benefits, loss of housing and lack of medical insurance. Lack of community resources and family social support fosters the homeless plight for those unable to cope with societal demands. Personal factors such as substance abuse, physical and mental disability and family disruption prevent the individual from positively adapting to the stress of life and might contribute to some becoming homeless.

According to the draft summary paper of the Conference for Homeless Persons held in October 1995 (The Haven News, 1995), growing unemployment, lack of affordable housing, social disintegration, social, economic and political policies are contributing factors to the phenomenon of homelessness in South Africa. The Haven News (1996) mentions many other reasons that drive people into the streets namely, alcoholism, divorce, abuse and mental disturbances.

Homeless persons are socially, economically, and politically vulnerable (Jewzeski, 1995). Friedemann (1992) maintains that the territorial base of the household economy including the physical space in which household members cooked, ate, slept and secured their personal possessions, is the most highly prized social power of all, and households are prepared to make almost any kind of sacrifice to obtain it. Homeless persons had already lost this valuable social power.

However, the fact that homeless people do not have a home does not mean that they do not have a home environment. They mark out for themselves particular neighbourhoods, blocks, buildings and doorways whilst others find refuge in night shelters which they may frequent on a regular basis (The Haven News, 1991).

## **2.7 Health status of the homeless people that might result in disability**

Homeless persons struggle to adapt to their environment and difficulties that arise when adaptation fails. Life's stresses may cause or exacerbate physiological/psychological disorders and violence. As stress increases, more energy is needed to meet life necessities, coping with bizarre behavior of others and defending ones street territory. This then becomes a vicious circle.

These unprotected individuals with no social network and support, unemployed, powerless and with low self-esteem and inadequate self-care, experience health problems unique to their environment. Some of the environmental extremes such as temperature, noise, pollution, violence are common in their environment.

The White Paper on an Integrated National Disability Strategy (1997) maintains that poor people face a greater risk of impairment and disability. It also cited several factors as the main cause of disability. Among these factors, poverty, accidents, violence and unhealthy life style are mentioned. The above-mentioned factors were confirmed by Abdul-Hamid et al. (1996), where they maintained that the high prevalence of drinking problems among homeless people make them vulnerable to accidents. Most of the trauma is related to

violence among the homeless people, and this may later result in physical disability. Abdul-Hamid et al. (1996) also indicated that due to the constant mobility of the homeless, together with inadequate personal care and poor diet, the homeless people are more at risk to varied health problems, such as limb ulceration that ultimately lead to impairments.

Homeless persons are a population at risk and are increasingly suffering from many health-related problems. To date there has been a lack of initiatives by hospitals to take part in their health care. Sweeny (1993) says that homeless people are likely to receive poorer quality of health care than others do and are subject to greater risk of disease due to their life style. The negative attitude that people harbour towards homeless people makes it hard, if not impossible, for them to ask for help. In fact, many institutions have had reluctant attitude in treatment of homeless persons and other client who lack financial resources. Plumb (1997, p974) supports this view, *“As health-care policies continue to encourage the transfer of the medical care of the poor (including homeless people) into managed health care systems, gate-keeping mechanisms designed to ration care may lead homeless adults to further avoid seeking care in the early stages of illness if the care-seeking process becomes more arduous or time-consuming”*.

Under the new constitution of the Republic of South Africa (1996), the right to have access to health care services is under the Bill of Rights. This implies that both people with disability and the homeless people should be able to access the same fundamental rights as any other South African. Homeless people need emotional support, caring professionals and resources that work within their frame of reality. Each homeless community will have different demographics and health needs. The common denominators are the obstacles encountered when trying to access the health care: bureaucracy, transportation, accessibility, time orientation, limited resources. All these lead to frustration and anxiety and ultimately avoidance to access these commodities.

Plumb (1997) maintains that providing effective health care for homeless persons is a formidable task. This is largely because the homeless person experiences both internal and external barriers to health care. Internal barriers include those inflicted by the homeless people on themselves; denial of health problems by the person or pressure to fulfil competing financial needs, such as those for food, clothing and shelter. External barriers include unavailable, fragmented, costly health care services and misconceptions, prejudices, frustrations on the part of health care services for homeless persons.

Homeless people who have disabilities experience multi-faceted problems that require innovative rehabilitation skills. The WHO definition of rehabilitation (1995) offered by an expert group maintains that rehabilitation is the combined and co-ordinated use of medical, social, educational and vocational measures for training or re-training the individual to the highest possible level of functional activity. Professionals early on recognised *the role the environment plays in rehabilitation*. This was of particular importance for people with problems of mobility. These individuals encounter difficulties climbing stairs, passing through narrow doors or passages, using ordinary bathrooms and

kitchens or public means of transportation or moving outdoors on steep hills or in the terrain.

When rethinking the whole concept of rehabilitation for the homeless population with physical movement disabilities the issue of "*equalisation of opportunities*" that draws attention to the widespread discrimination experienced by all people with disability in all societies comes to mind (Lindqvist, 1995). Another important concept in rehabilitation which is identical to the preceding one - relates to "*equal access to all and distribution of resources*;" in that context, many mottoes were created, for instance, "*new economic order*", and "*health for all,*" "*education for all*". Hellander's (1992) operational definition includes broad issues about rehabilitation including measures aimed at reducing the impact of disability for an individual, enabling him or her to achieve independence, social integration, a better quality of life and self-actualisation. He continues to argue that rehabilitation includes not only the training of disabled people but also interventions in general systems of society, adaptations of the environment and protection of human rights.

## 2.8 Rehabilitation

Approaches to physical rehabilitation services can be delivered in several ways. It can be through institution based programmes; outreach programmes; or community based rehabilitation programmes.

### Institution-based rehabilitation programmes:

Institution-based rehabilitation of the physically disabled client often takes place in an outpatient rehabilitation department of a hospital. On the other hand, clients with complex needs and problems, may be admitted to an in - patient ward. Outpatient rehabilitation is in most cases done in separate physiotherapy, occupational therapy and speech therapy departments. A client with severe disabilities and complex problems frequently requires treatment in more than one of these departments. This may exert a lot of stress especially to clients with low stress intolerance like the homeless person. Communication between these departments may be limited or absent. The client's appointments with different therapists may also be on different days of the week, which can become very costly for the client and may foster a spirit of defaulting especially to clients who live in unorganised setting like the homeless environment (Goodwill & Chamberlain, 1990).

In South Africa institution-based rehabilitation programmes are provided mainly in large urban areas such as the metropolis of the Cape Peninsula. These institutions are inundated with clients on long waiting lists and they are inaccessible to the majority of disabled clients and their caregivers from rural communities. The Haven Newsletter (1995) states that hospital authorities harbour negative attitude about the homeless people and see them as being disorganised, disorientated and alcohol abusing. Some practitioners are even afraid to touch the 'bergies'. These negative attitudes can result in the late presentation of illness by the homeless person, thereby contributing to the significant increase in the number of preventable disabilities (The White Paper On Integrated National Disability Strategy, 1997).

### Outreach programmes:

The outreach programmes for rehabilitation as defined by the WHO professionals leave the institution, in teams, to deliver the service for people with disability closer to their communities. Some contact with and involvement of the family and community is possible. However, this kind of service is regarded as being costly (WHO Rehabilitation Unit, 1995).

The services of the specialist rehabilitation team are inaccessible to a large number of disabled as discussed earlier. Such teams are non-existent in some areas due to inadequate funds and lack of service provision. However, other health care workers in these communities could be utilised in providing relevant, be it limited, rehabilitation services under the guidance and with the help, training and support of such a specialist team.

### Community-based rehabilitation (CBR):

Community-based rehabilitation (CBR) is a strategy within the community development for the rehabilitation, equalisation and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health education, vocational and social services (WHO, 1995). Successful CBR programmes are based on the following principles, equality, social justice, solidarity, integration and dignity (Hellander, 1992).

WHO advocates that a special category of health worker needs to be trained for this kind of service delivery. The professionals at district level are responsible for the CBR workers and they act as referral resources. More people with disabilities can be reached with this approach, even though it renders only a fairly basic service. Although it is recommended by the WHO and is being discussed as part of the general health plan for South Africa and has already been implemented in places like Tintswalo hospital in the Northern Province, Kwazulu Natal and peri-urban areas of Cape Town, this type of service is not freely available in our rural communities, and neither are there professionals at district level.

Any of the three approaches could be applied to the needs of the homeless people with physical movement disability in South Africa. The challenge to the health professionals is being able to interface appropriately at a relevant level, be it institution or community level. Friedemann (1992) maintains that the very poorest, e.g. famine victims, landless rural labourers, women-headed households in squatter areas of big cities and homeless persons may simply lack the means to help themselves. They require help from religious organisations, labour unions, and even the State. But even for the less destitute, collective self-empowerment is rarely a spontaneous process of community action. External agents are needed.

Efforts to promote and protect the human rights of homeless people with disabilities are seen as one of the cornerstone of the strategy for their rehabilitation. Such rights are

described in the constitutions of most countries. The seriousness of disability and homelessness were indicated by the declaration 1986 as being the National Year of the Disabled (White Paper On Integrated National Disability Strategy, 1997) and 1987 as an International Year of the Homeless (Haven Night Shelter Newsletter, 1987).

A host of studies show that in more developed countries such as United States of America and Great Britain the issue of homelessness has been taken seriously (Cohen, 1997; Haven News, July 1995 and William et al, 1989). In these countries measures to include the homeless people in decision-making processes regarding their needs has been undertaken. For example, in London a study was done to assess the needs of the homeless people with regard to inclusion in primary health care plans (Williams et al., 1989).

In South Africa, the present government has taken positive steps in dealing with disability and homelessness. The White Paper on the Integrated National Disability Strategy (1997) had drafted policies and recommendations on issues concerning the rights of people with disabilities. These are used as guidelines at provincial level. In the Western Province, an Integrated Provincial Disability Strategy had been written for the Western Province October 2000.

The issue of homelessness in the Western Province has led the government, local authorities and NGO's to form a partnership, whereby workable and realisable policies are being formulated. It is hoped this would ensure a holistic and multi-disciplinary team approach to homelessness as indicated by street people mission statement and recommendations for local authorities in the Cape Metropolitan area (CMA) in 1998. The Social Department of the Economic and Social Directorate of the Cape Metropolitan Council have currently instituted research on street people. This has enabled Local Government in the CMA to engage in a constructive and comprehensive planning as well as to be able to draw up and implement effective programmes and strategies for the homeless population (Street Field Worker Project, 2000).

## **2.9 Research instruments used in this study**

In the light of my research questions and the study population, I needed an approach that would adequately capture complexities of disability and its nuances. I also needed a way that I could present the perception and the feelings of homeless people with disability in a specific environment (the shelter). Hence I decided to incorporate both quantitative and qualitative methods for methodology. Table 2.1 represent a summary of the research methods. This is followed by a more detailed account of the evolution of each method.

**TABLE 2.1: SUMMARY OF LITERATURE FOR RESEARCH METHODS**

| <b>INSTRUMENTS</b>  | <b>Method</b>                | <b>MEASUREMENT</b>   |
|---|------------------------------|--|
| International Classification of Functioning and disability (Beta – 2 Draft short version, July 1999).   | Quantitative                 | Description of area of impairment and severity including the impact of impairment on activity level and participation of that person and environmental impact.   |
| The realistic tale Miller et al. (1998).  | Qualitative                  | Observation and description of the Wynberg Haven Night Shelter.  |
| The confessional tale Miller (1998).  | Qualitative                  | Self-reflection during the process of this study.  |
| The critical tale Miller (1998).  | Qualitative                  | This approach I used during Discussion and Recommendations.  |
| Interviews for homeless people: Occupational performance needs of the homeless population, Joyce Tryssenaar et al. (1999). Perceived needs of homeless people, Murray (1996). | Qualitative and Quantitative | Interviews and story telling to obtain perceptions and beliefs about disability and homelessness from the managers of the shelter and the homeless people with disability. Analysis of the interviews and stories. |

### Quantitative research

Treece and Treece (1984) describe quantitative research as assisting in learning the frequency of events and evaluation scales that can capture day to day happenings. The quantitative aspect assisted in describing the numbers and severity of impairment of the adult homeless people with physical movement disability in the Wynberg Haven Night Shelter.

The tool that was chosen for the quantitative aspect of this research was the International Classification of Impairment disability and Handicap (ICIDH)-2 (Beta –2 draft July 1999). The ICIDH belongs to the "family" of classifications developed by the World Health Organisation (WHO) for application in various aspects of health. The WHO family of International Classifications provide the language to code a wide range of information about health (e.g. diagnosis, functioning, and disability) and uses a standardised common language permitting communication about health and health care across the World in various disciplines and sciences. The classification covers any disturbance in terms of "functional state" associated with health conditions at body, individual and society levels. "Functioning " and "disability" are umbrella terms covering three dimensions (1) body function and structure (2) activities at the individual level; and (3) participation in society.

In 1980 the World Health Organisation produced a manual of classification relating to the consequences of disease for trial purposes (this was used in the pilot phase of this study).

Thuriaux (1995) mentioned that a report of the United Nations Commission on Human Rights encouraged the WHO to revise the ICIDH-1, and to consider more specifically the role played by the environment in disability. The suggestions for improvement include a greater emphasis on presenting handicap as a description of the interrelation between impairments or disabilities and their physical and social environment.

Many studies (Thuriaux, 1995; Brandsma et al., 1995; Bickenbach et al., 1999 and Halbertsma, 1995) had given an over view of the concepts of the ICIDH-1 and the need for a revised version that focused attention to the impact of the social environment on the person with disability. Ten years following the publication of the ICIDH-1, the WHO initiated a revision process with the full version of the ICIDH - 2 published in July 1999 (this revised version will be used for this study). Some parts of the latter version are still on development phase.

### **Properties and scope of the ICIDH-2**

ICIDH -2 organises information according to three dimensions: (1) body level; (2) individual level; and (3) society level. These dimensions are named: Body functions and structure (b); Activities (a); and Participation (p). These dimensions contain various domains of body functions and structure, performances of activities, and involvement in life situations. ICIDH-2 classifies functioning and disability from the perspective of an individual's life circumstances. The term "dimension" refers to level of functioning, whereas "domain" denotes categories in each dimension. The ICIDH - 2 dimensions are conceived as having two poles: At one end they can be used to indicate problems (e.g. impairment, activity limitation or participation restriction); at the other end they can indicate non-problematic (i.e. neutral and positive) aspects of functional states." Functioning " is used as an umbrella term for positive or neutral aspects of dimensions at body, individual and society level.

The unit of classification is therefore the "domain" of functioning (the area where functioning or disability occurs. It is important to note, therefore, that ICIDH-2 persons are not the units of classification; that is ICIDH-2 does not classify people. "Disability" is used as an umbrella term for problems in these dimensions.

Briefly these dimensions cover the following areas:

#### ***(a) Body function and structure and impairments:***

*Definition: Body Functions are physiological or psychological functions of body systems. Body Structure is anatomical parts of the body such as organs, limbs and their components. Impairments are problems in body function or structure as a significant deviation or loss. Once impairment is present, it may be scaled in terms of its severity using the uniform qualifier.*

**(b) Activity/Activity Limitations:**

*Definitions:* Activity is the performance of a task or action by an individual. Activity Limitations are difficulties an individual may have in the performance of activities.

**(c) Participation/Participation Restrictions:**

*Definitions:* Participation is an individual's involvement in life situations in relation to health conditions, body functions and structures, activities and contextual factors. Participation Restrictions are problems an individual may have in the manner or extent of involvement in life situations.

A value is attached to participation (i.e. a participation restriction is a disadvantage). This value is dependent on cultural norms, so that an individual can be disadvantaged in one group or location and not in another place. As used in ICIDH - 2, the notation of participation incorporates as overarching, international standard that of the "equalisation of opportunities" for persons with disabilities as formally adopted by the United Nations in its standard rule on the Equalisation of Opportunities for Persons with Disabilities.

**(d) Contextual Factors:**

Contextual factors represent the complete background of an individual's life and living. They include environmental factors and personal factors that may have an impact on the individual with a health condition and that individual's functional state. A list of environmental factors that form part of this classification will be included (appendix 2). Environmental factors have an impact on all three dimensions and are organised from the individuals most immediate environment to the general environment

**(e) Environmental Factors:**

*Definition:* Environmental factors make up the physical, social and attitudinal environment, in which people live and conduct their lives. The factors are external to individuals and can have a positive or negative influence on the individual's participation as a member of society, on performance of activities of the individual or on the individual's body function or structure.

Environmental factors interact with all dimensions of functioning and disability, namely body functions and structure, activity and participation. Environmental factors are organised in the classification to focus on three different levels:

- (a) **Individual** - in immediate personal environment of the individual, including but not limited to settings such as home, workplace and school. Includes the physical and material features of the environment that an individual comes face to face with as well as direct personal contact with others such as family, acquaintances, peers, and strangers.

- (b) **Services** - formal and informal social structures and services in the community or local setting, that have an impact on individuals in their specific setting. Includes organisations and services related to the work environment, community activities, government agencies, communication and transportation services, and informal social networks.
- (c) **Systems** - the overarching approaches and systems established in a culture or subculture that set the pattern for the concrete individual and services levels. Includes laws, regulations and formal rules as well as informal rules, attitudes and ideologies.

### Qualitative research instruments

The need to describe and capture the demography of the Wynberg Haven Night Shelter and to give a voice to the adult homeless people with physical movement influenced me to choose the qualitative approach as my second method of data collection.

Kirk (1986) sees qualitative research as a particular tradition in social science that fundamentally depends on watching people in their own terms. Its diverse expression includes analytic induction, content analysis, semiotics, hermeneutics, elite interviewing and other related subjects. Kirk (1986) continues to say that qualitative research is socially concerned, cosmopolitan and above all objective. To comprehend the depths of social life and lived experience, the researcher must understand the total man/woman in his/her total environment significantly. This extends the researcher's interest to emotionality, calling for "deep probes into human soul".

Douglas (1997) further argues that access to the truth of experience is not gained by mere proximity. It requires open sharing and intimacy, affective sensitivity, "even surrender of the soul" that is necessary to developing true empathy and understanding. The goal is to capture, even re-enact the subject's experience in full emotional colour. Douglas (1977 p5) concludes by saying, "*We do not stand outside experience, we do not put society on a rack and try to torture the truth out of it. We seek the truth in the ways we find necessary in the natural social world. To answer questions; one must focus on people and meaning that people exist in and emerge from and are consequential for those methods of life that course and result in research*".

I based the qualitative component of this research on three articles I reviewed, which described methodologies that are important for the research I carried out. The first one was by Miller et. al. (1998) on writing and retelling multiple ethnographic tales. The article is based on the narrative of three tales about a soup kitchen for the homeless and near homeless. Miller et al. (1998) maintain that there are numerous ways of telling ethnographic data. They quoted Wolcott (1994) who suggests that using some combination of description, analysis and interpretation. They referred to Van Maneen (1998) who maintains that there are tales that incorporate different researchers' perspective such as *realistic, confessional, and critical tales*.

Miller et al. (1998) explained that the *realistic* tale employs an impersonal point of view, conveying a concrete, scientific, and objective perspective. The author is absent, the

native's point of view is represented, and a documentary style focussed on minute, sometime precious, but not thoroughly mundane details. Miller et al. (1998) wrote the realistic tale of the soup kitchen to provide an objective account that had not been written, and one that present a descriptive analysis and interpretation of the culture of one of the soup kitchens.

For these writers, the soup kitchen became a microcosm for them to study the homeless population, and they could learn much from an ethnographic study that explores alternative narratives about the culture of a soup kitchen. Three research questions emerged during Miller and colleague's study: (a) how might the soup kitchen, as a cultural setting, be described? (b) what are the cultural themes of the soup kitchen? (c) how can we become advocates for the soup kitchen, day shelter and homeless population.

These questions relate very closely to my study and to the position I find myself in as the researcher and the *realistic tale* of Millers' paper guided me during observation and description of the Wynberg Haven Night Shelter.

Miller et al (1998) further quote Van Maanen (1988) who suggests that *confessional tales* reveal "how field work odyssey was accomplished by the researcher". The primary audience for confessional tales are students of fieldwork – those who are in search of guidance and reassurance regarding the field work experience. They maintain confessional tales to some extent reveal the researcher's vulnerability because they demonstrate "the human qualities of the researcher" Confessional tales explore how researchers viewed things at the beginning of the study, and saw things different at the end of the study. They provide the researchers with an avenue for confessing their personal biases, revealing their shock or surprise, blunders, character flaws, and bad habits. Confessional tales are also increasingly used as "vehicles ... to launch into self-reflective encounters with hermeneutic and representational issues".

I used this approach in Chapter 6 on self-reflection on the journey I travelled during the process of visiting the various dimensions of this study.

Lastly Miller et al. (1998) maintain that with the *Critical tale*, "concern for representing social structure as seen through the eyes of a disadvantaged group", and there is something of a crusading spirit behind many critical tales. These critical tales are written with the intent of shedding some light on larger social, political, symbolic, and economic issues. There are three criteria for assessing the quality of an interpretative or qualitative study that includes a commitment to emergent relationship with participants, a set of stance about positionality and subjectivity and a vision of research that promotes social justice. Miller continue to argue that, to be more specific, the researcher advocates for giving voice to the participants, sharing rewards, and privileges, and a heightened writers subjectivity.

This approach I used through my interaction with the various settings and persons who participated in this study and also during discussion and recommendations. The aim was to give a voice to the homeless people with physical movement disability living in the Wynberg Haven Night Shelter.

I further reviewed an article by Murray (1996) who did an exploratory, descriptive study to describe the perceived needs and resources of, or services for, homeless men who were either in situational crisis, severely and mentally ill, or alcohol or drug dependent.

Murray (1996) designed a questionnaire based on literature and his experience with homeless individuals. The tool he used obtained self-reported demographic data, open-ended questions obtained information about the subject's perceptions of the experiences of being homeless, health status and care, meeting basic needs, and available needed services. Results of the interviews were grouped into categories with common themes.

I used this methodology during data collection by using story telling to obtain perceptions and beliefs about disability and homelessness from the managers of the shelter and the homeless persons with disability.

Lastly I reviewed an article by Tryssenaar et al. (1999). Tryssenaar interviewed 25 persons at a shelter using the Canadian Occupational Performance Measures (COPM). Tryssenaar quoting Takashi and Wolch (1994) indicate that researchers need to explore homelessness from the perspective of the people who are homeless and obtain their views on the potential success of various strategies to alleviate deprivation in the homeless population. Not only do assessments need to be modified for the unique needs of this population they also need to be client centred.

Tryssenaar (1999) study was analysed using both quantitative and qualitative methods of data collection. The data was analysed using codes and themes from the data rather than structured before hand. The authors of this article independently identified main qualitative concepts using the detailed line by line approach they maintained was described by Van Manen 1980. In this approach Van Manen suggests that we look at every single or sentence cluster and ask what it reveals about the experience being described.

I used this approach in the analysis of data on the interviews I had with the managers and the assistant manager and the stories told by the homeless disabled persons, on their perceptions on how it is for them to have disability and be homeless.

Why is it important to link the two methods of data collection for this research? I hope to expose common themes captured during interviews in the qualitative method by comparing what has been said by disabled homeless people in relation to their impairment and activity level, participation restriction and environmental aspects (exposed by ICIDH-2, 1999 in the quantitative method).

Treece and Treece (1984) describe triangulation as using the two (qualitative and quantitative) methods to uncover a unique variance that might not have appeared in a single method of investigation. I intend to use these two methods to complement each other in exposing the impact of physical movement disability of the adult homeless people in the Wynberg Haven Night shelter.

Miles and Huberman (1994) quoting Rossman and Wilson (1984,1991) further suggest

three broad reasons for using the two methods. (a) to enable confirmation or collaboration of each other via triangulation; (b) to elaborate or develop analysis, providing richer detail; and (c) to initiate new lines of thinking through attention and surprises or paradoxes, turning ideas around, providing fresh insight.

Giele (1998) maintains that merging quantitative and qualitative data analysis provides important clues for explaining the process of continuity and change in human behaviour over life course. Merging quantitative and qualitative analysis would provide a more complete portrait of disability over life course. This approach will enable me to explore the interaction of the homeless people with physical movement disability in their environment, and illuminate the complex underlying process. The homeless people with physical movement disability's turning points throughout life including changes in social bonds can be explored, and such questions as to what would be the turning point that would change the present situation in their lives could emerge.

Reasons for the

University of Cape Town

## CHAPTER 3

### METHODOLOGY.

This research gradually unfolded and developed and in that sense it could be considered to be action research. The process of this unfolding directed me to divide the methodology into three parts:

- Methodology Part 1- Pilot study
- Methodology Part 2 - Adjustment of methodology Part 1
- Methodology Part 3 - Data validation

Each part will be presented in a more or less a similar sequence. The rationale for this approach is presented below.

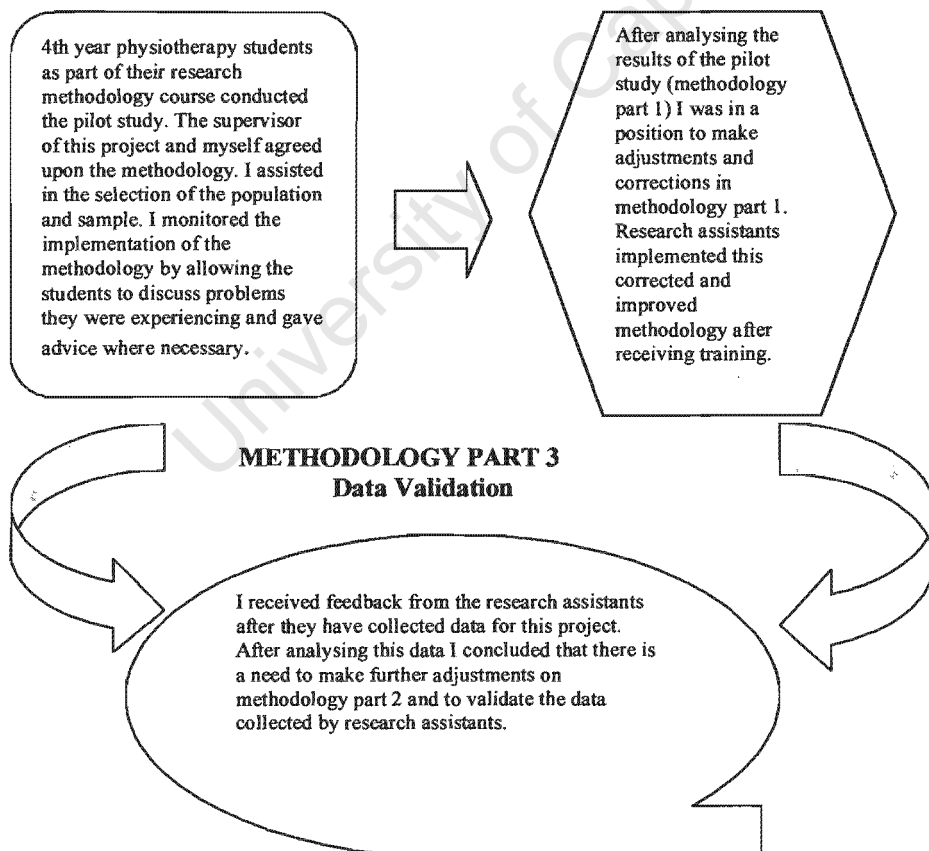
**FIGURE 3.1: BRIEF DESCRIPTION OF THE METHODOLOGY.**

#### METHODOLOGY PART 1

#### METHODOLOGY PART 2

##### **Pilot study**

##### **Adjustment of methodology Part 1**



### 3.1 Methodology Part 1 – Pilot study

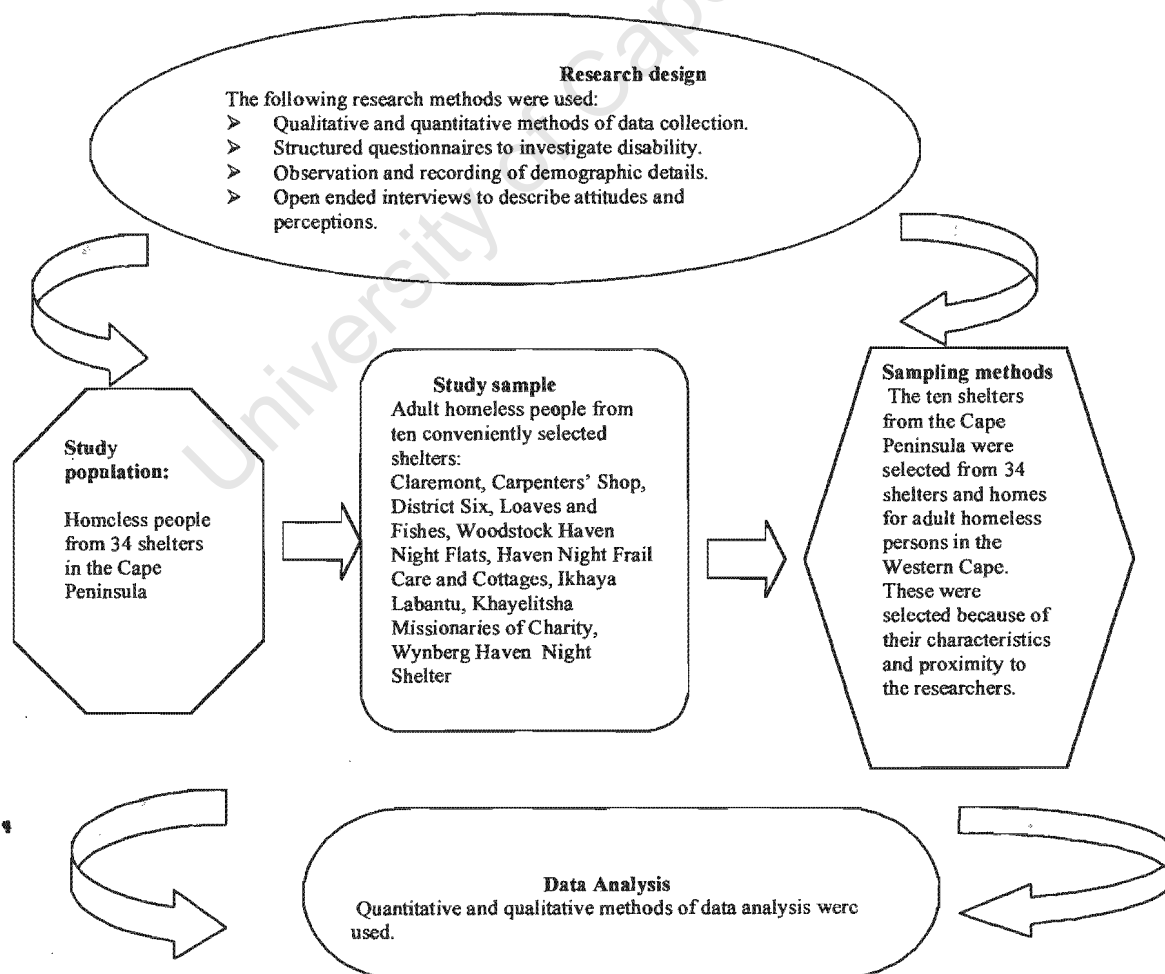
The purpose of the pilot study was to support my claims for wanting to conduct the study and establish a format for the study. I also wanted to test my ability to be able to manage both qualitative and quantitative research methods, and finally to modify some aspects of the research design.

The objectives were to:

- Describe the functioning of the shelters
- Investigate the number of adult homeless people with physical movement disabilities in ten (10) shelters in the Cape peninsula
- Evaluate the level of physical movement disability of these adult homeless people with disability
- Describe the attitudes and perceptions of adult homeless people to their physical disability and to their health
- Support students who were conducting the pilot study

Figure 3.2 is a summary of the methodology used in the pilot study.

**FIGURE 3.2: THE METHODOLOGY OF THE PILOT STUDY**



### 3.1.1 Ethical considerations

In 1999 the final year physiotherapy students requested permission to do the research from the relevant authorities i.e. non-governmental organisations, dealing with homeless people. All participants signed informed consent forms fulfilling the ethical requirements of the University of Cape Town. Participants were informed that there would not be any intervention from the researchers and information gathered during this research will be handled in a confidential manner and will only be used in this study.

### 3.1.2 Procedure

Appointments with the managers of the shelters or the social workers working in the shelters were made via the phone for initial contact. The managers and social workers were reminded the day before the conduction of the research. Aims and objectives of the research were clearly outlined to the person in-charge. The first visit was used for observation of the shelter and for a general interview with the person in-charge to gain knowledge about the shelter and the residents since the environment and the way the person lives also has an impact on the life of that person. A second appointment was made to come and interview the residents. This was also confirmed by a telephone call a day before the interviews to remind the person in-charge to make arrangements for the interviews. The participants were the homeless people who were willing to participate in the study.

### 3.1.3 Data collection

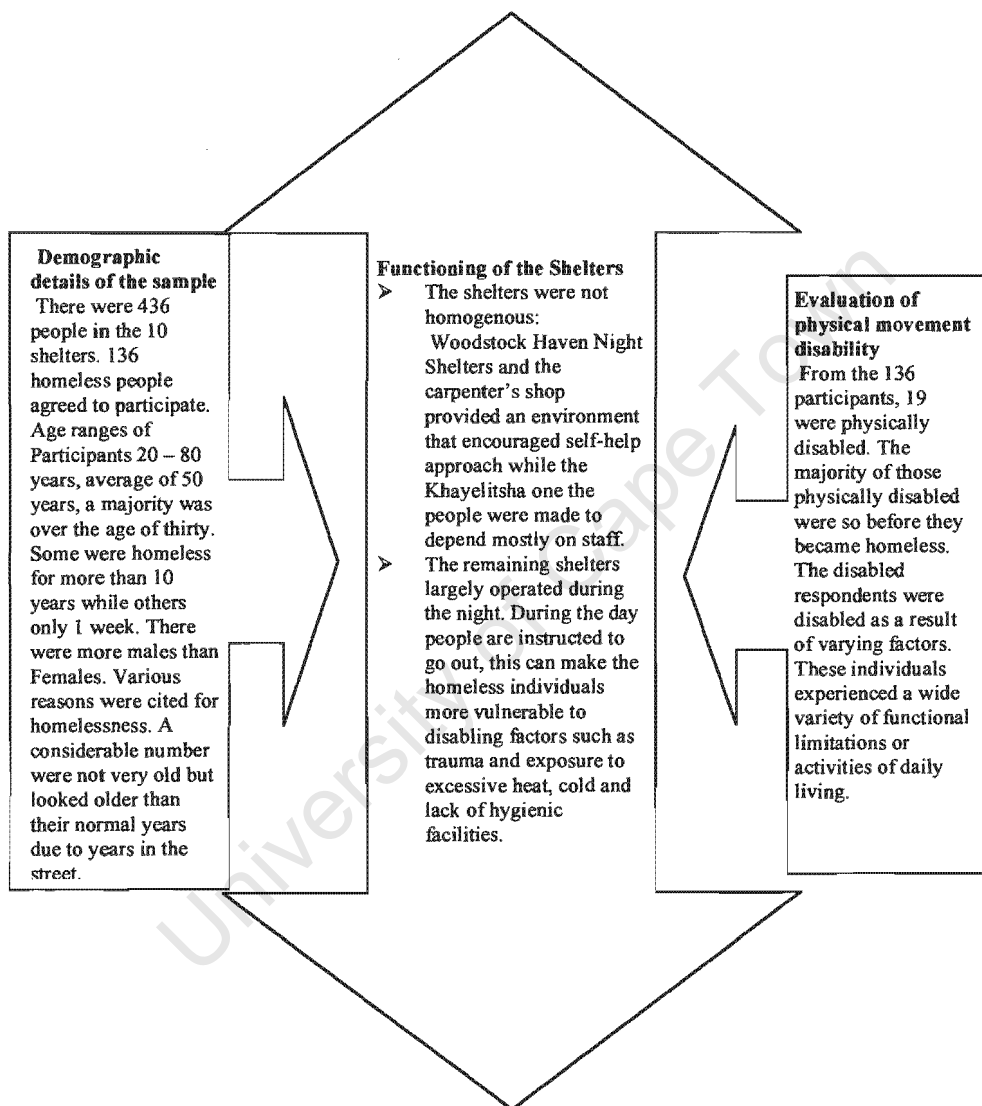
Three physiotherapy final year students conducted the study. Data collection took the form of in-depth structured interviews involving open-ended broad and non-directive questions. The interviews were held in a private environment within the 10 shelters as explained in the methodology. Interviews using the questionnaires were conducted in the evenings, as that was the convenient time that all residents were in the shelter. To promote maximum personal input from the interviewee, interviews were conducted in an informal manner using the questionnaire as a guide to ensure that all aspects were covered.

The students also probed for details or clarification of issues. The interviews were conducted in the language of the homeless people i.e. English, Afrikaans, Xhosa and Sesotho. A brief summary of the interview was done for the interviewee as a method of clarification and validating what was heard (particularly for Afrikaans as it was the students' third language). All the interviews were transcribed and the transcripts formed the main "data" for the study. One student would take notes of answers, another observed, while the other conducted the interview. Immediately after conducting an interview the students would then discuss the interview process and ensure that the questionnaire was completed.

The following section includes the results of the pilot study conducted by the student. It is included here as it offers insight into the way that part 2 had to be conducted. These results are presented in Figure 3.3, table 3.1. and 3.2

### 3.1.4 Summary of results

**FIGURE 3.3: A BRIEF DISCRPTION OF DEMOGRAPHIC DETAILS, FUNCTIONING OF THE SHELTERS AND DETAILS OF PHYSICAL MOVEMENT DISABILITY**



**TABLE 3.1: PERCEPTIONS AND BELIEFS OF ADULT HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY AND ADULT HOMELESS PEOPLE WITH NO PHYSICAL MOVEMENT DISABILITY**

| <b>Perceptions and beliefs of Adult homeless people with physical movement disability</b>  | <b>Perceptions and beliefs of adult homeless people with no disability towards adult homeless people with disability</b>   |
|--|--|
| <u>Spirituality:</u> A significant number expressed religious belief, as some of the interviewees commented, <i>"If you walk with the Lord nothing can touch you"</i> .  | <u>Spirituality:</u> Some of them emphasised that, <i>"We are all human beings but just that they are not physically fit, God made us for a purpose, people must learn to love one another."</i>   |
| <u>Feeling vulnerable:</u> Others said that they rarely walked too far from the shelter, and consider their shelter to be safer than being outside.  | <u>Feelings of empathy and sadness.:</u> They felt sorry for them as they saw them as being functional limited in some of the things they wanted to do.  |
| <u>Awareness of individual strength:</u> <i>"Being disabled makes you think thoroughly which makes you see things before they actually happen to you."</i>   | <u>Admire their strength and resilience:</u> Another person commented, <i>"They are very remarkable people, they have a capacity to endure; they are disabled in one sense but of double capacity in the other"</i> .  |
| <u>Absence of meaning and resentment:</u> A few expressed feelings of anger, sadness, loneliness, and rejection.   | <u>Helped and supported them:</u> Most could recall instances from the past where they helped disabled people from the shelter.  |
| <u>Homelessness and disability a double burden:</u> Most of them said being homeless made their disability worse and homelessness added to hardships that they already experienced as people with disability.  | <u>Identifying with their problems:</u> A majority identified with problems experienced by Adult homeless people with physical movement disability. One of the interviewees said that, <i>"We are all the same and because we are homeless this brings us together, the fact that we are homeless makes us relate more to disabled people because we are in the same boat"</i> . |
| <u>Acceptance of present situation:</u> When talking about hardships of having physical movement disability, they mostly quickly pointed out that the shelters are contributing positively in alleviating the hardships they had to endure in the street, and for some even at home. | <u>Lack of understanding and avoidance:</u> Comments such as <i>" disabled people sometimes are very rude and this makes me feel reluctant to help them. If a disabled person is nice I will help... disabled people think you are feeling sorry for them"</i> .   |

Table 3.1 shows that the adult homeless people with physical movement disability and adult homeless people with no disability shared a common belief of spirituality. The participants felt vulnerable outside the shelter and consider their shelters to be safer while adult homeless people with no disability empathised with their functional limitation. The participants were aware of individual strength while the adult homeless people with no disability admired the strength of the people with disability. Some of the participants expressed feelings of loneliness, resentment and anger, they saw disability and homelessness as a double burden while others demonstrated feelings of acceptance of the present situation. Other homeless people with no disability showed understanding of the plight of people with disability and were prepared to assist them while others showed lack of understanding and tend to avoid them.

**TABLE 3.2: NEEDS IDENTIFIED BY ADULT HOMELESS PEOPLE WITH MOVEMENT DISABILITY AND ADULT HOMELESS PEOPLE WITH NO PHYSICAL MOVEMENT DISABILITY INCLUDING WHAT IS SEEN AS NEEDS OF ADULT HOMELESS PEOPLE WITH MOVEMENT DISABILITY BY BOTH GROUPS**

| Needs identified by adult homeless people with disability  | Needs identified by adult homeless people with no disability for adult homeless people with disability  |
|--|---|
| <u>Independent Living:</u> Most of them cited that They want houses so that they can leave the shelter and stay on their own. Others mentioned frail care houses and centres for people with disabilities. | <u>Independent living:</u> Most of them mentioned more homes and frail-care centres for better environment.   |
| <u>Need for Family:</u> Examples stated were that they want to go back home to their families.   | <u>Rehabilitation within the shelter:</u> Some of them said, <i>“these people need to be looked after by trained people and thereby helping them to be rehabilitated to the highest level of function-integrating them back into society”</i> . |
| <u>Health needs:</u> They expressed a need for the government to prepare an infra-structure for their consultation and health needs.   | <u>Environmental changes:</u> Others mentioned need to alter public facilities e.g. Pavements, public transport, in order to accommodate people with disability.  |
| <u>Respect and acceptance by society in general:</u> Some Mentioned that they require respect and society in general.  |   |
| <u>Basic Needs:</u> Most of them also cited basic needs like more therapy, clothing, jobs, transport   |   |

Table 3.2 shows that participants and homeless people with no disability both cited independent living as a need for the participants. The homeless people with no disability further saw rehabilitation and structural changes as major needs for the participants while the participants saw family, health, basic needs including respect and acceptance by society in general as important needs for them.

### 3.1.5 Contact with health care services

All the homeless people with physical movement disability responded that they do use the hospital, clinics and private doctors. A substantial number of respondents mentioned Groote Schuur hospital as one of the hospitals they have consulted and are still consulting. The respondents used more than one hospital or health care facility. Most of them indicated that it was a long time since they went to any health care centre or facility. Some could not even remember the specific times that they went to a hospital, though they could still remember the occasion and reasons that they sought help. About 90% of the interviewees with physical movement disability said the health care providers treated them with respect. Only two stated improper handling from the health care staff. One respondent said *“I feel like I am being ignored by people who work in the hospital because I have got more needs and require assistance”*. The other one said the fact that he is homeless drew less attention to his needs and that he was treated differently because as he said, *“I am disabled or homeless or the two I cannot tell”*.

22% of the homeless people with physical movement disability did not get physical rehabilitation as part of their treatment. They were also issued with some assistive

devices. The types of assistive devices were walking frames, crutches, callipers and wheelchairs. From 63% who received assistive devices 92% of them were shown how to use them. A majority of them didn't know who had shown them how to use the assistive devices.

### **3.1.6 Summary of results of the pilot study and discussion**

In the study sample there were more males (n10) than females (n8). There was a large variation of participants' ages from shelter to shelter, but a majority was over the age of thirty. A considerable number were not very old but looked older than their years due to years in the street.

The way the shelters were structured and the manner they operated were not homogenous. Some encouraged self-help approach while others encouraged dependency. There were some shelters the researchers felt the environment lacked both physical and visual stimulation. People with disability were found tucked in their beds. There were no activities or skills as in some other shelters.

Other shelters operated largely during the night. During the day people are instructed to get out. It seemed most supervisors are saddened by this fact. Some shelters are aiming at operating day and night. Releasing people out of the shelter made them vulnerable to trauma. Exposure to excessive heat or cold and lack of hygienic facilities can lead to some illness and, in some instance, disability (Abdul-Hamid, 1996).

The ten shelters were structurally inaccessible for the homeless people with physical movement disability. They had narrow doors, narrow stairs, others with no rails, and no inclines. They were built with no thought for people with disability. This lead to people with disabilities experiencing problems in using them. They expressed frustration as they were confined to their rooms or on ground floors and were prevented by the structural barrier from moving about.

Those homeless people who had received therapy during hospitalisation felt that it helped them particularly in coping with disability in their every day functioning. Concerns were raised regarding lack of continuity post hospitalisation. The homeless people with physical movement disability asserted that they were using health services but it was apparent that most were not frequent users of these kind of services. The researchers noted that for those who were using the health services this was due to the presence of a social worker or supervisors who were concerned with the individuals health, and also due to the proximity of the Groote Schuur Hospital to those shelters.

One of the findings of the pilot study is that the homeless people with disability reported that they were treated well by health professionals, despite their disability and their being homeless. This contrasted with the literature (Barton, 1993; Willmot, 1993 and Homelessness Whose Responsibility, 1995) who maintained that disparaging views which are held by both the people with disabilities and the homeless people towards health professionals. Only two participants agreed with literature by asserting that they

felt angry and 'ignored' by health professionals, and they attributed this lack of proper attention mostly to their homelessness and disability.

The homeless people with physical movement disability said they did not readily accept help, they preferred to do as much as possible by themselves. They said asking for help was embarrassing and begging was dehumanising, but it was also noted that participants were not shy to ask for help from other homeless people. Homeless people from the same shelter helped one another and took care of one another.

The majority of the participants did not consider themselves as being different from their able-bodied peers. They asserted that lacking one limb or body part does not make them different from other people. They said that by concentrating on what they can do gives them a positive outlook towards life.

In the pilot health services was not considered as a priority when it come to perceived needs. This is supported by a study by Murray (1996), that health needs were not at the top of the list of the homeless man. The most expressed needs were: more shelter which are friendlier and more human (Ubuntu), speeding up disability grants processing, food and clothing and discounts for homeless people with disability.

#### **Recommendations from the pilot study:**

- Physical rehabilitation was identified as a need; students and qualified rehabilitation therapist can be involved in studying these particular shelters and plan how intervention can be instituted.
- A comparable study, between a group that uses shelters and a control group of homeless people who literally stay in the street, is suggested in order to establish similarities or differences in perceptions and use of health care facilities.
- Further research on disability and homelessness to increase public awareness with the hope that attitudes of society might be influenced.

#### **3.1.7 Brief comments on the problems experienced by the students during the pilot study**

- The students were not sure whether the interviewee might have given answers that they think the interviewer wanted.
- The students tried to explain disability and its operational definition as indicated in the definition of terms but they were still unsure if the homeless people understood this term and what it embodies.
- It has been pointed out that not all people – even those with visible disability – will be perceived as disabled, as noted by Hellander 1992. This presented the students with a conflict that they might be labeling people as being disabled. There might also be people with physical movement disability who might not have been interviewed as

participants volunteered to be interviewed. This might have made them give a lower figure of the number of homeless people with physical movement disability.

- During interviews the students were concerned about whether they were showing appropriate professional behavior. Smith (1998) sees perceived professional behavior as the ability to distance oneself and display the 'correct' emotions. The dilemma with the students was the when, where and how should they draw the line during the interview as some of the experiences of the homeless people with physical movement disability were very painful and it was difficult for them to keep a 'non judgmental façade'.
- They also felt glad that what they had conducted was a pilot project and felt that there was a need for further research to be done into understanding disability within the homeless population. There were also feelings of reciprocity and they saw me as the avenue through which the plight of these individuals could be taken further by encouraging further research into this area and involving more students and other professions.

### **3.1.8 Comments on the pilot study**

The Pilot study gave an insight to the proposed research. From the pilot study it became clear that homeless people with physical movement disability had special needs that might require professional assistance but have also social needs as a result of being homeless. It was also clear that there was no clear rehabilitation strategy. I again experienced feelings of social injustice. I wanted to gain an understanding of how disability was impacting on their daily lives and how environmental factors and the attitudinal world was affecting them. It was obvious that I needed to adjust and improve the research instruments.

#### **Sample size:**

The pilot study was conducted in 10 shelters in the Cape Peninsula. The students had to work within a specific time frame to finish their project. As they had never conducted a research that includes qualitative components they miscalculated the time that is required for this sample. They felt rushed during the interviews as the sample was too large; hence it was difficult to gain an in-depth understanding on the qualitative component of the study. The interviews were conducted at night so sometimes they felt the concentration of the participants straying as they were tired or wanted to be with other homeless people to reflect on the happenings of the day.

#### **Tools and method of application:**

##### Observation and description of the shelters:

The time given for describing the environment of the 10 shelters was not enough. It was not clear how this environment was impacting on the participants. The position of the

managers with regard to the homeless people with physical movement disability was not evaluated. I see this as a major omission of the pilot study as the managers of the shelters play a major role in influencing the ethos of the shelters and seeing that objectives and goals are reached. Depending on their attitude, they could play a major role in improving the conditions of homeless people with disability.

Describe and number homeless people with physical movement disability:

The World Health Organisation (WHO) International Classification of impairments, disabilities and handicaps (ICIDH1), a manual of classification relating to the consequences of disease used for the pilot study was the 1980 version. By the time the pilot study was completed a new version the ICIDH-2 Beta-draft, July 1999 had already been released for trial purposes. Because of this (using the old version of the ICIDH1 in the pilot study):

- There was no distinction of which type of disability that was being evaluated (impairments, disability).
- No grading system was used to show the severity of disability.
- The level of activity and participation of the participants was not evaluated.
- The impact of the environment and the attitudinal world on the participants was not well evaluated and clearly graded.

In-depth open-ended interviews:

During in-depth interviews, focus was not put on the participant who is having a disability but was more on the handicap (ICIDH-1) and the role of the health professionals. This took away the aspect of how the participants see themselves in relation to their disability and their environment.

In the interviews focus for the managers of the shelters, it was not on how they related with the participants but was more on what they were doing and not on how they were doing it and what feelings were evoked as they were doing it and how they managed those feelings.

Based on the above comments the researcher had to adjust some of the tools as well as identify new tools.

### **3.2 Methodology Part 2 – Adjustment of methodology Part 1**

The following aspects were adjusted to improve the methodology from the pilot study:

- (a) Research design: story telling was included to gain an in-depth understanding of the impact of disability on the participants.
- (b) Study sample: homeless people with physical movement disability were chosen from only 3 shelters instead of 10 as in the pilot study with the aim of having a smaller confinable sample.

- (c) The ICIDH-2 (Beta Draft-1999) was used instead of the ICIDH-1 of 1980, this is a more recent instrument and from this instrument environmental impact on the person with disability can be evaluated.
- (d) A day was spent in the shelters instead of just a visit for few hours as in the pilot study to gain a deeper understanding of the demography and functioning of the shelters.

### 3.2.1 Objectives

The objectives of methodology Part 2 of this study were to:

- Refine the methodology used by physiotherapy students in the pilot study
- Train research assistants
- Monitor the progress of the research assistants in the implementation of methodology Part 2
- Analyse and comment on the data collected by research assistants
- Repeat with modifications, the research carried out in the pilot study

### 3.2.2 Research design

A cross-sectional exploratory descriptive study was done using both qualitative and quantitative methods of data collection using triangulation to validate data with the following research methods and tools:

#### 1. Quantitative methods:

Structured questionnaires based on the WHO ICIDH-2 Beta –2 draft (1999) were used to document and describe physical movement disability. Below is a description of the classification of the ICIDH-2.

#### Classification using the ICIDH-2

- (a) ICIDH - 2 uses an alphanumeric system whereby the letters b, s, a, p, and e denote the components body Functions, Body Structures, Activities, Participation and Environmental Factors. These letters are followed by a numeric code that starts with the chapter number (1 digit), followed by the second level (2 digits), and the third and fourth levels (1 digit).
  - (b) The short (concise) version that will be used for this study has two levels. The full (detailed) version cover four levels. Both version codes are in correspondence i.e. the short version can be aggregated from the full version. Any individual may have a range of codes in each dimension. These may be independent or interrelated.
- © The coding also allows for addition of one or two numbers after a decimal point,

that provides additional information. These additional places are called "qualifiers".

Use of any code should be accompanied by at least one qualifier. Without qualifiers codes have no meaning when used for individuals or cases.

- (d) A uniform qualifier has been developed to describe the extent or magnitude of the problem in that dimension. This is to be used as the first qualifier. It can be used for the three dimensions and environmental factors.
- (e) According to the uniform qualifier, all dimensions (b, a, p) and e component are coded in the same manner. Having a problem may mean an impairment, limitation, restriction or barrier depending on the dimension. Appropriate qualifying words as shown in brackets below should be chosen according to the relevant classification domain.

#### Uniform Qualifiers

|      |   |                  |                            |       |
|------|---|------------------|----------------------------|-------|
| xxx. | 0 | NO problem       | (none, absent, negligible) | 0-4%  |
| xxx. | 1 | MILD problem     | (slight, low)              | 5-24% |
| xxx. | 2 | MODERATE problem | (medium, fair...)          | 25-9% |
| xxx. | 3 | SEVERE problem   | (high, extreme)            | 50-5% |
| xxx. | 4 | COMPLETE problem | (total)                    | 96-0% |

- (f) In case of Environmental Factors, this qualifier can also be used to denote the extent of positive aspects of the environment, namely facilitators. To denote facilitators, the same 0-4 scale can be used, but the decimal point is replaced with a plus sign: e110 +2.
- (g) Second qualifiers: For different users, it might be appropriate and helpful to add other kinds of information to the coding of each item. There are a variety of potential second qualifiers for each dimension and environmental factors as well as suggested second qualifiers to be developed.
- (h) It is important to collect data independently on these dimensions and thereafter explore associations and casual links between them. Some of the details regarding the ICIDH-2 are in appendix.

#### 2. Qualitative methods:

- Observation and description of the demographic details, the functioning of the shelter, including personnel staff were recorded to gain understanding of the existing situation
- In-depth interview to evaluate perceptions and beliefs of the adult homeless people with physical movement disability
- Showing of slides to the homeless people with no disability to evaluate perceptions and beliefs of adult homeless people with no disability towards disability as it was assumed that their perceptions and attitudes would influence how they interact with

the participants.

### 3.2.3 Study population

Homeless people, aged 18 and above, in the 34 adult shelters in the Cape Peninsula.

### 3.2.4 Study sample

The study sample was narrowed from adult homeless people from ten shelters to adult homeless people from three shelters, and these were the Wynberg Haven Night Shelter, Loaves and Fishes and Ikhaya Labantu Haven Night Shelter. The study sample were candidates who participated in the pilot study and the members of the three shelters who did not participate in the pilot study but were willing to participate in this follow up study.

### 3.2.5 Sampling methods

From the 10 shelters used in the pilot study, 3 were chosen for this study, viz Wynberg Haven Night Shelter, Loaves and Fishes and Ikhaya Labantu Haven Night Shelter.

The results of the pilot study influenced the researcher to select Wynberg Haven Night shelter, Loaves and Fishes and Ikhaya Labantu Haven Night Shelter . This study did not attempt to estimate prevalence of disability nor did it necessarily intend to project the findings to other shelters.

The three shelters were specifically chosen because:

- The results of the pilot study showed that they had more adult homeless people with physical movement disability more than the other shelters. Information-rich cases were a guarantee and this sample was in a position to assist the study to meet the objectives
- The researcher wanted to carry out a more focused in-depth investigation to gain an understanding of the beliefs, norms and needs including the everyday activities of the adult homeless people with physical movement disability. This is more difficult to achieve with a larger sample and is not necessarily appropriate
- The managers of these shelters showed interest in the study during the pilot phase and wanted to continue with the study
- These shelters were within a reasonable distance and convenience from the researchers, in terms of cost and time they were convenient

### **3.2.6 Research plan**

#### **Procedure and instrumentation**

##### Step 1

#### **Negotiating entry to the shelters**

Arrangements were made by telephone to the managers of the shelters for the research assistants to spend a day in the shelters. A full description of the study was given and ethical considerations were explained. During this visit the research assistants tried to build trust with participants, being sensitive to ethical considerations and tried to be as minimally intrusive as possible.

##### Step 2

#### **Observation and description of the social activities of the shelters**

Observing and describing the activities that were taking place within the shelters did this. This included the area and surrounding complex, community and type of population, size of population, demographic details of the sample and the management staff.

##### Step 3

#### **Interviews with the managers of the shelter**

In-depth interviews were also conducted for the managers of the participating shelter to gain an understanding of the functioning of the shelters, and their role in the management/prevention of disability. These were done in a private environment and with only the research assistants present. A standardised open-ended question interview schedule was used, the researcher explored a few general topics related to the shelter and disability, allowing and respecting the way in which managers framed and structured their response.

##### Step 4

#### **Description of the demographic details of the participants**

Gathering demographic data: In a one to one private interview the following information was asked and documented from participants: Age, nationality, gender, marital status, children/childless, level of education, skills, years the participants have been homeless and disabled, cause of disability, last job, receive/not receive disability grant/pension.

### Step 5

#### **Description of area of impairment and severity including the impact of impairment using the ICIDH-2**

From each of the 10 participants with physical movement disability, in a private area, muscle testing and range of movement were graded results from this evaluation were converted to aspects of the ICIDH-2 relating to the categories under the domain of body function (b) and body structure (s) e.g. *mobility of joints/region shoulder*. Later in one to one interview questions were asked relating to categories under the dimensions of:

- activity level (a) e.g. *washing and drying oneself*
- participation in various aspects of life (p) e.g. *participation in family relationship*
- environmental factors (e) *societal attitudes*

These aspects were coded using uniform qualifiers that have been developed to describe the extent or magnitude of the problem in a category under that dimension. According to the uniform qualifier, all dimensions (b), (a), (p) and (e) component are coded in the same manner. Having a problem may mean an impairment, limitation, restriction or barrier depending on the dimension. Appropriate qualifying number was chosen to show the extent or magnitude of the problem.

These qualifiers from each category under a specific dimension were added up according to the uniform qualifiers.

### Step 6

#### **Description of perceptions and beliefs of the adult homeless people with no physically movement disability towards disability**

Slides were shown to the homeless people with no disability of people, which depicted people with various forms of disability. Immediately after the showing they were asked to talk about the feelings they have experienced when watching the slide show.

### Step 7

#### **Training of research assistants**

I was fortunate that one of the students who did the pilot study on the research was still present in my department and willing to be one of the research assistants. The second research assistant, was doing her last year in Social Sciences. The research assistants received training from me in the following areas:

#### Preparation for negotiating for second entry

- To begin negotiations for the second entry the research assistants were warned about the need to give adequate explanation of the pilot study that was conducted and the need for this second entry.

- Discussions also covered issues of practising caution and being sensitive to the rhythms and norms of the shelters. A stress was put on ethical considerations that might include awareness about the politics of the shelters and how to respond appropriately to them
- The need to be efficient in organising their time and how they will deploy the resources including themselves for the study to ensure full response to the research questions was also discussed
- The research assistants were cautioned about the qualitative nature of the research and the possibility of merging new questions during data collection and the need to stay within the framework of the research question
- Aspects the researcher assistants were supposed to observe were discussed. They were also warned about the need of being an unobstructive observer. The need to discuss and reflect on observed issues was emphasised as sometimes events move very fast making it difficult for the researcher to fully comprehend what was going on.

#### Use of ICIDH-2 (Beta 2- Draft, July 1999)

This instrument was used to describe the area of impairment and severity including the impact of disability on the adult homeless people in the three shelters.

- Firstly they had to learn and understand the background of the ICIDH-2
- Secondly they had to understand the use of the structured questionnaire that was based on the ICIDH-2. This was done by one of them acting as the participant and the other as the researcher and with me observing, correcting and encouraging where necessary. This was done until the research assistants felt confident about the instrument

#### Conducting of in-depth interviews:

Aspects of the format for an in-depth interview were explored and based on Marshall and Rossman (1995) style who maintain that an in-depth interview should emphasise the following points:

- During the interview, the interviewer should start by exploring general topics to help the participant to relax and develop a general understanding of the participant
- Respect how the participant frames the responses
- Convey an attitude of acceptance that the participants' information is valuable

➤ Use gentle probing for elaboration

#### Length of training of research assistants:

The initial training of the research assistants took a week, but whenever they had a problem they would come back for clarification.

### **3.2.6 Ethical considerations**

The research assistants' visits to the shelters chosen for this study was to be the second visit, the managers of the shelters were given a clear explanation on the reasons for coming for the second time. Feedback of the pilot study was also given. Participants who were not part of the pilot study signed informed consent forms fulfilling the ethical requirements of the University of Cape Town (appendix1). Participants were informed that there would not be any intervention from the researchers, information gathered from this research will be handled in a confidential manner and will only be used in this study. Permission was asked from the participants to allow recording of the interviews

### **3.2.7 Procedure**

Appointments with the managers of the shelters were arranged through the phone. The managers were reminded the day before the conduction of the research. The second visit was used for observation of the shelter and for a general interview with the person in-charge to gain knowledge about the shelter and the residents since the environment and the way the person lives also has an impact on the life of that person. A third appointment was made to interview the residents. This was also confirmed by a telephone call a day before the interviews to remind the person in-charge to make arrangements for the interviews.

### **3.2.8 Data collection**

Two research assistants collected the data for this study. Data collection took the form of in-depth structured interviews involving open-ended broad and non-directive questions. The interviews were held in a private environment within the shelter. Interviews using the questionnaires were conducted on a Saturday afternoon as that was the convenient time when all residents were in the shelter. Interviews for homeless people with physical movement disability lasted longer as the questionnaire for them was longer. The interviews were recorded using an audiotape and permission to record the interview was asked from the participant prior the interview. To promote maximum personal input from the interviewee, interviews were conducted in an informal manner using the questionnaire as a guide to ensure that all aspects were covered.

The research assistants also probed for details or clarification of issues. The interviews were conducted in the language of the homeless people i.e. English, Afrikaans, Xhosa and Sesotho. A brief summary of the interview was done for the interviewee as a method of clarification and validating what was heard (particularly for Afrikaans as it was the students' third language). All the interviews were transcribed and the transcripts formed

the main “data” for the study. Immediately after conducting an interview the research assistants would then discuss the interview process and ensure that the questionnaire was completed. The research assistants formatted this data for the researcher.

### 3.2.9 Validity

The sensitivity of the instruments was evaluated during the pilot study and necessary changes made. A week was spent training the research assistants on the use of the instruments. To enhance reliability the research assistant’s role-played the use of the instruments. Questions were repeated to gain clarity where necessary. To minimise bias the research assistants asked questions in the same manner so that at the end there was no wrong or right answers. During formatting of data the research assistants critically analysed each other’s interpretation and checked and re-checked the data.

### 3.2.10 Comments made by research assistants about their process of data collection

When the research assistants finished writing a report on the data they collected, I arranged a day that they could give their feedback. Below are brief comments about their data collection process:

#### 1. Immediate environment and social activities of the shelters:

The three shelters according to classification in the definition of terms should have more or less similar approaches. However the following differences were noted on the second visit (first visit was that of implementation of the pilot study a year ago, the setting in the Loaves and Fishes and Ikhaya Labantu haven Night Shelter had changed and those changes are explained below):

- Loaves and Fishes showed characteristics of sheltered employment and Ikhaya Labantu Haven Night shelter, accommodated mostly refugees and destitute elderly people. In these two shelters there was a strong reluctance to participate in the study from the shelter dwellers and there was minimal support from the managers regarding the study
- The shelter that fitted most closely the description of shelters was the Wynberg Haven Night Shelter i.e. it provided emergency housing and meals to men and women who had no other place to sleep or eat. The type of accommodation offered fitted with Trysenaaars’ description of accommodation offered in shelters (emergency shelter, transitional accommodation, and permanent or semi-permanent residence for people who are homeless). It had an open door policy unless a person displayed a violent behavior. In the Wynberg Haven Night Shelter, the manager was interested in the research assistants doing the study. They felt they were able to build a trusting relationship, and it was possible to find information-rich cases

## 2. Use of instruments:

The research assistants found using the ICIDH-2 difficult in evaluating attitudes, values and beliefs because this is qualitative not quantitative, as sometimes they were unsure if they were accurate in their description.

## 3. Reciprocity issues:

The research assistants felt that they needed a platform where they could speak about their experiences as they found listening to the interview responses of the homeless people very painful. They were also concerned about what support can they give after having made homeless people talk about their painful experiences. The research assistants found themselves lacking in skills for comforting and supporting the participants. Having interviewed them, they appeared to raise their hopes, while on the other hand they had nothing to offer but a listening ear.

### 3.2.11 Comments on the feedback made by research assistants

The information gathered by research assistants formed part of raw data for this study. The above comments from the research assistants made the researcher draw the following conclusions:

- I felt that to gain a clear understanding of the impact of disability on homeless people and its nuances I needed to concentrate on one shelter, and that is the Wynberg Haven Night Shelter. Hence the title of the study is: **The impact of physical movement disability on adult homeless people in the Wynberg Haven Night Shelter**
- It appeared too that I only had a superficial understanding of the data that the research assistants gathered. This would be problematic to analyse since the data is qualitative in nature
- I felt I needed to visit and spend time in the Wynberg Haven Night Shelter to validate data that was collected by the research assistants

## 3.3 Methodology Part 3 – Validation of data

### 3.3.1 Objectives

The objectives of methodology part 3 were to:

- Observe and describe the social activities of the Wynberg Haven Night shelter
- Record the demographic details of the homeless people with physical movement disability
- Validate data gathered by research assistants on the ICIDH-2

- Elicit stories from the homeless people with physical movement disability about their experiences as disabled homeless people
- Interview the managers of the Wynberg Haven Night shelter about their perceptions and attitudes towards homeless people with physical movement disability
- Visit agencies involved in homelessness and those that are involved in disability.
- Receive objective critique from colleagues

### 3.3.2 Research design

A cross-sectional exploratory description study was done using both qualitative and quantitative methods of data collection elucidating triangulation to validate data with the following research methods and tools:

#### 1. Quantitative methods:

To validate data gathered by research assistants on the ICIDH-2. The completed structured questionnaires based on the WHO ICIDH-2 Beta –2draft (1999) used by research assistants to document and describe physical movement disability was validated (appendix 2.2).

#### 2. Qualitative methods:

- Observation and description of the demographic details of the homeless people with physical movement disability
- Observation and description of the functioning of the Wynberg Haven Night shelter was observed and recorded to gain understanding of the existing situation
- In-depth interviews were conducted for the following groups of people:
  - Manager and assistant manager of the Wynberg Haven Night shelter
  - Managers of agencies involved with homeless people and those that are involved in disability
- Recording and interpreting of stories from the homeless people with physical movement disability about their experiences as disabled homeless people
- Analyse critique from colleagues regarding the methodology of this research

### 3.3.3 Study population

- Homeless people, aged 18 and above, in the 34 adult shelters in the Cape Peninsula
- Agencies dealing with homelessness within the Cape Peninsula
- Agencies that deal with disability within the Cape Peninsula (South African Federal Council for Disability (SAFCD) and Provincial Disability Desk)
- OSDP National, Health professionals within the Cape Peninsula and WHO delegate

### **3.3.4 Study sample and sampling methods**

#### Study sample 1: Homeless people

The study sample was further narrowed from adult homeless people from three shelters (Wynberg Haven Night Shelter, Loaves and Fishes and Ikhaya Labantu Haven Night Shelter) to Wynberg Haven Night Shelter. The rationale for choosing this shelter had been explained in methodology part 3.2.11.

#### Study sample 2: Agencies dealing with homelessness

These were Co-ordinated Action for Street People (CASP), Napier Street shelter, the Big Issue and were conveniently chosen with the aim of gaining a deeper understanding of what has been done about disability within the homeless population.

#### Study sample 3: Agencies dealing with disability

The Provincial Disability Desk and SAFCD were conveniently chosen as they were seen as the two organisations within the Cape Peninsula that could interface with homeless people with disability. The aim of choosing them was to see whether they have included homeless people with physical movement disability in their policies.

#### Study sample 4: Receive objective critique from colleagues

OSDP delegates for the May ICIDH-2 conference in Durban on the 11th-12th May 2000, Physiotherapy educators from the physiotherapy department at the University of Cape Town, Masters students from the Occupational Department of the University of Cape Town and WHO delegate, Ms Schneider. Since this was action research – developing and redefining as it went along, I was keen to enlist objective criticism from colleagues and experts.

### **3.3.5 Instrumentation**

- Observation of the setting and activities of the Wynberg Haven Night Shelter
- For adult homeless people with physical movement disability the ICIDH-2
- questionnaires filled up by research assistants were checked for validity
- Story telling by each person with physical movement disability was done. In-depth one to one private interviews were conducted with the manager and assistant manager of the Wynberg Haven Night Shelter
- In-depth private one to one interviews were conducted for the managers of Napier Street shelter, the Big Issue, the Provincial Disability Desk and The South African Federal Council For Disability

- A meeting for Co-ordinated Action for Street People (CASP) was attended in January 2001
- I attended workshops, seminars and meetings with colleagues who served as my critical audience

### 3.3.6 Procedure and data collection

#### Visit to the Wynberg Haven Night Shelter to Validate Data

I spent a week in December 2000 in the Wynberg Haven Night Shelter. I started working at 8h00 and finished at 12h00. In this shelter I was well received. I explained my need to validate the data collected by the research assistants. Here I played the role of an observer, interviewer and assisted in areas where there was a need e.g. unloading a truck full of food donations from Woolworth Wynberg. A suitable private environment was created where I was in a position to listen to the stories of the disabled homeless people and to classify their functioning and disability using the ICIDH-2. I was also given an opportunity to speak to the manager and the assistant managers in private, and allowed to observe the functioning of the shelter.

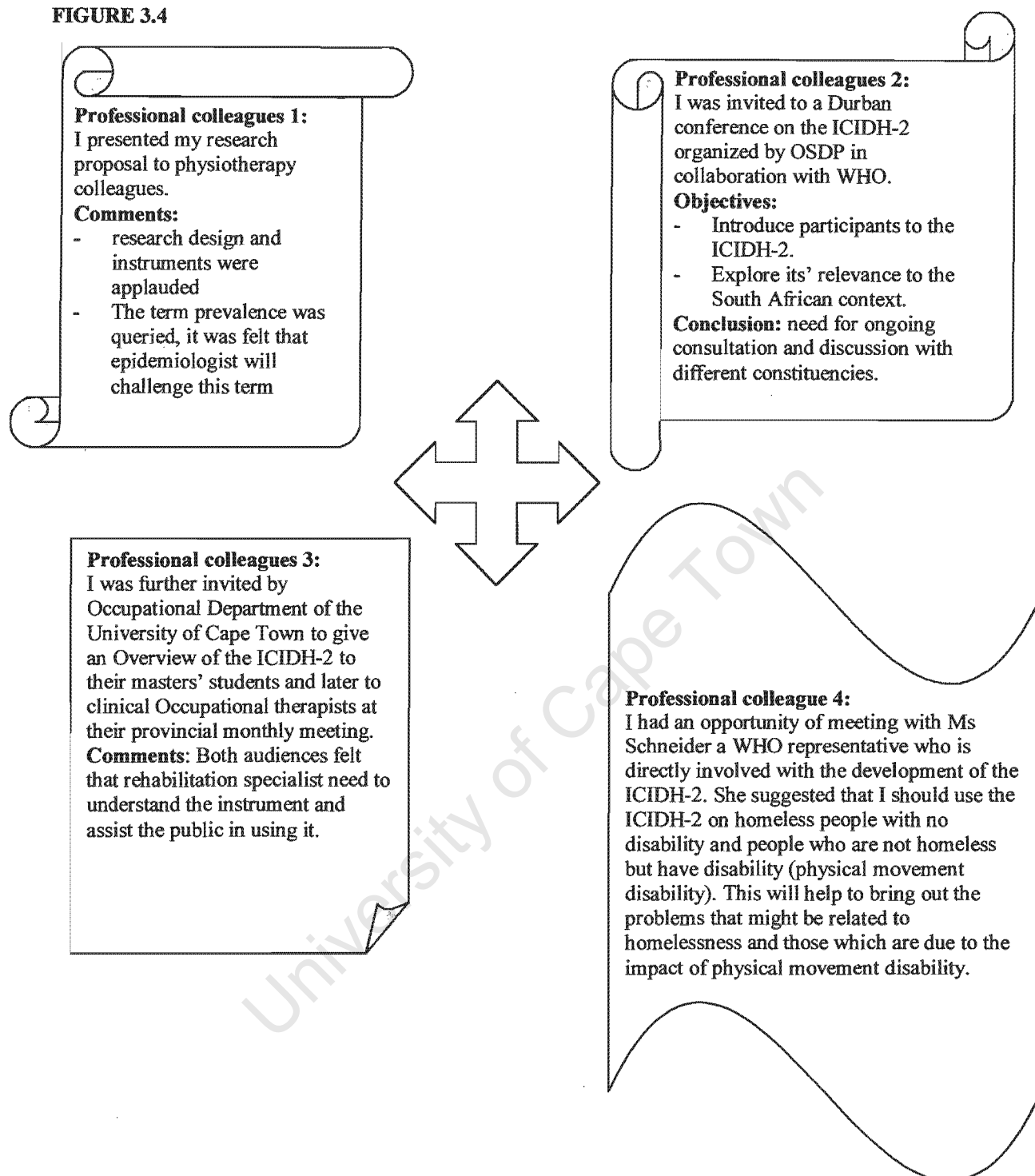
During data collection it became clear that there was a need to explore some other agencies that deals with both disability and homelessness. This would help me in gaining an understanding of the Wynberg Haven Night Shelters' position on disability and homeless issues and to investigate the link between these agencies and the Wynberg Haven Night Shelter.

*“I would like to comment that, by the end of the week I spent at the Wynberg Haven Night Shelter I felt I was not the same person. My feelings towards social injustice were evoked, my levels of subjectivity towards what was happening to the participants were heightened, I also had this strong feeling that I needed to come up with a plan to help some of the participants (reciprocity). That journey is still unfolding and will be put in detail in chapter 6 on the Researcher’s reflection”.*

### 3.3.7 Professional colleagues as critical audience

During the process of this research I also presented the proposal to various professional audiences with the objective of sharing knowledge and obtaining advice. Below is a brief summary of those encounters. Below in figure 3.3.2 is a brief summary of those encounters.

FIGURE 3.4



I gained a lot of experience from the above discussions. I changed prevalence of disability to impact of disability. This assisted me in looking more on qualitative aspect of the research. I took Ms Scheineders' suggestion of using the ICIDH-2 on homeless people who are not disabled and disabled people with a home. I re-visited Wynberg Haven Night Shelter to look at activity level, participation restriction and environmental

factors using the ICDH-2 on homeless people with no disability. I consulted a statistician for how many homeless people I should interview, he suggested that they shouldn't be less than 50% of my sample. I also interviewed six persons with physical movement disability but who were not homeless using the ICDH-2 for activity level, participation restriction and environmental factors.

University of Cape Town

## CHAPTER 4

### PRESENTATION OF FINDINGS

#### 4.1 Description of the Wynberg Haven Night Shelter - *THE REALISTIC TALE*

##### **Background and shelter setting**

The Wynberg Haven Night Shelter is under The Haven Night Shelter Organisation. Father Roger Hickly, and a leading city attorney Mr Sam Gross started the Haven Night Shelter Organisation in 1977 (Haven Night Shelter Organisation, 1998).

Their main objectives were:

- To help homeless people re-enter society and become employed through gaining dignity and pride, learning useful, basic skills and becoming involved in running and maintenance of the shelter
- As a night shelter, people on the downward spiral can get help, draw a breath, sort out their options and get re-organised (Haven Night Shelter Organisation, 1998)

The Wynberg Haven Night Shelter is situated in Wynberg suburb, which is one of the twelve suburbs under the South Peninsula administration area. The residents of the Wynburg Suburb are predominantly white. This suburb has the highest number of street people in the twelve suburbs of the Cape Peninsula (Cape Metropolitan Street Field Worker Project, 2000).

The Wynberg Haven Night Shelter is situated close to the central business area in Wynberg. There is Shoprite- shopping complex, 3 Liquor stores, a parking area, and a residential area at the back of the shelter. The Wynberg police station is a five-minute walk from the shelter. There are three hospitals (Victoria, Military and Claremont day hospital); the three are within a fifteen-minute walking distance from the shelter. Victoria and Military hospitals both have physiotherapy departments.

Very close to the shelter are the Wynberg State library and a State park. In front of the shelter is a parking area and there are a number of homeless people living in the streets who refuse to live in shelter because they do not want to abide by the rules of this shelter.

There are surrounding houses whose residents sell drugs to the people in the shelter. The surrounding liquor stores have a negative impact in the shelter. According to the manager of the Wynberg Have Night Shelter, on payday the residents of the shelter tend to drink all their money and come back to the shelter with “nothing but bad behavior”. Being close to Main Road makes it easier for the residents to find jobs and find places to spend the day outside the shelter.

### **The residential area**

There is high fence surrounding the shelter. At the entrance of the shelter is a gate that is electrically operated from the reception area. There is a small veranda at the entrance of the main building and no stairs at the entrance. The main building is painted in an orange gold with Wynberg Haven Night Shelter written boldly on the face of the entrance. The main building consists of a reception room at the front where the manager is in good view of the gate and controls access to the shelter. This area is also used as an office.

- Behind the office is a big dormitory with 15 beds, lockers, a TV, toilets and showers. This is where the female residents sleep
- Next to the female dormitory is a combined dining area and lounge, adjacent to this are a kitchen and a pantry
- Behind the kitchen is a laundry room with a washing machine and this lead to the washing lines outside
- Next to the female dormitory is a small kitchen that does not seem to be in use, and a toilet. Adjacent to these is a flat-let that is used for emergency services. This has four bedrooms, a kitchen and a toilet, and presently houses four ladies and three men who are homeless
- There is a flight of approximately fifteen stairs which lead to the man's dormitory, which is bigger than the female's one and has 26 beds and lockers. Adjacent to the dormitory are toilets and showers. All male residents sleep in this dormitory including those with physical movement disability
- Next to this dormitory is a bigger office where most of the administration of the shelter takes place. This office is also used as the social worker's consultation area.

Outside there is:

- A conference room, which is also used as an art studio and adjacent to this is a linen room
- There are also three containers, one stores second hand clothes that are sold to bring income to the shelter and also provides for the clothing needs of the residents

The buildings are surrounded by flower gardens that are well kept and at the front of the main building there are beautiful flowerpots.

## **Residents**

There are 51 residents who are staying in the Wynberg Haven Night Shelter (31 male and 20 female). 20% of residents do not contribute a cent, either because of having no job or disability grant.

## **Criteria for admission**

The shelter admits any adult person who is destitute and homeless. Abused or battered women and children are also accommodated temporarily.

The Wynberg Haven Night Shelter depends on the following agencies for its funding:

- The government
- Food donations are from churches and Woolworths
- Public donations - people from the community also give donations especially during Christmas time
- ABSA bank (Job creation project – R15 000)
- Car wash by the people – certain percentage goes to the shelter
- Hair dressing saloon within the shelter
- Antique furniture repair within the shelter

## **General rules and regulations of the shelter**

- Gates are opened at 5 am, 7 am, 8 am, and 10 am, due to a variety of needs of the homeless persons to start their day
- Residents are expected to be back at 16:30 if they are not working and 19:00 if they are working
- Residents have a choice to stay during the day, for security reasons the gate is kept closed during the day to protect the people inside
- If a resident is found drunk for over 4 occasions, s/he is chased out or locked in at the back room, (residents can be violent at times which need very strong people to deal with them, i.e. police)
- Each resident (destitute, homeless and sober) pays R3 per day for three meals and a snack at 10:00 in the morning and 16:00 in the afternoon
- Residents have to wash their sheets every fortnight and sterilise them
- If a resident is drunk she\he then pays R8 for three meals and R5 penalty
- Residents who receive disability grants and pension pay R300 per month; this amount is more than half their grant

- However the actual amount for care of each person is R38 per day
- Every resident helps with house chores, i.e. cooking, cleaning and laundry

During the day the people from the shelter participate in the following activities:

(a) *Rehabilitative activities*

- Group therapy session every morning about AIDS, HIV, and TB – these are conducted by the project manager, trained by ATICC and sponsored by SAB (it started on March 1999)
- Games, e.g. cards, TV

(b) *Life skill activities*

The residents are involved in lot of activities geared towards life skills some of these are: sewing, making pavements, training to become security guards, pottery, handcrafts and embroidery, making container covering for soup kitchen and new shelters, build gas stoves, do own lockers and for other shelters, memorial garden stones for those who died. It was noted that the homeless people with disability were mainly engaged in gardening activity. They regarded this activity as difficult for them due to their physical movement disability.

(c) *Health services*

There used to be a doctor visiting the shelter, he stopped six months ago. Nurses from the Victoria hospital, day hospital and clinic come from time to time. Residents who are sick are encouraged to visit the neighboring hospitals.

**Staff**

When we first visited the Wynberg Haven Night Shelter there was one staff member who is the project manager. She said that she does have somebody who assists her with night duties. Committee members especially female ones come and assist with cooking. There is a driver who assists with picking up of food donations. In December 2000 when I visited the shelter there was also an assistant manager who was employed temporarily since September 2000 and was leaving at the end of December 2000. He was busy with the activities the other homeless people were doing like cleaning vegetables in preparation for lunch. I had an opportunity to interview him. He had worked for 15 years with the homeless population. I did find him to have a lot of insight towards the needs of the homeless people with physical movement disability. In January 2001a social worker had joined the staff and there was a promise of a couple who were going to reside in shelter. The duties and responsibilities of the manager are outlined below.

## ***THE MANAGERS' TALE***

### **Personal Information and responsibilities of the project manager**

When I got the opportunity to interview the manager of the Wynberg Haven Night Shelter I found her willing, open and enthusiastic to talk about various aspects regarding the shelter. She sounded as if she had made her own conclusions on the handling and management of these aspects. The project manager maintained that she has social work background and administration skills. She organises fundraising and liaises with the public and business sector for the shelter.

She does not stay in the premises unless working a night shift. Before coming to the Haven Night Shelter she was earning a good salary but after achieving certain personal goals she felt like giving something back to civil society. So she took over the job and she felt she was thrown into the deep end. Before she was unhappy about her payment. She then demanded a new contract because of the nature of the job.

She proposed a fund raising project that was accepted by the committee. She feels that she is earning a good salary now. She grew into the job and feels good about it particularly when things are changing. She wishes she had three drivers, a social worker and three more people to help.

### **The manager's workload**

The manager finds the workload big and stressful. There are racial tensions within the shelter, the Wynberg community and with other organisations for street people: *"All I can tell you is that it's is very politicay, it's whites against blacks, because I am not white and my committee is not white, it's terrible, they call us an old age home. The white people think they have the know how and they have experience and they think they know more than you know, we don't buy that, we don't buy that, so we are sitting on a political time bomb"*.

### **Manager's perception of the atmosphere of the shelter**

To an outsider the atmosphere of the shelter seems to be pleasant, and home-like. But according to the manager of the shelter there is some hostility and segregation among the residents of the shelter. She maintains that white people sit alone in their group, and some want special treatment (jam or butter on bread). A number of them used to be educated working people, so they refuse to do shelter chores i.e. gardening and cleaning. There is one person who refuses to eat with other people. The manager said that there is a stigma connected to black people in the shelter – young black residents are docile to coloured and white people. When given jobs, whites choose the comfortable jobs. White people do not eat when a black person has cooked. Blacks are verbally discriminatory, whites show racism by acts – whites call blacks "swart varkes" and blacks call whites "wit varkes".

### **Manager's relationship with Wynberg community, the police and other organisations for the homeless people and other shelters**

The Manager's relationship with the Wynberg community and the police seemed to be under strain. Though they are strategically situated with regard to opportunities for employment for the homeless people, she feels that the neighbours are not interested in the shelter, the community rejects the shelter, 90% of the community is white, whilst most homeless people are coloured. She concludes by saying that this is a nationalist government. She says she doesn't have a good relationship with the police, as they go around saying the homeless people don't benefit from the shelter, her family does benefit. There are also tensions between other organisations dealing with street people. She mentions that they say she should relocate, and the shelter area will be built as a skills centre for the homeless persons in the Wynberg area, she feels angry that they should suggest that she should move and they take her area.

She finds relationship with other shelters supportive: “ *Oh yes we have a relationship with other shelters, a very close relationship with other shelters; should we have a problem with a client we phone the other shelters to ask if we could take the person to them. We have a network*”.

### **Manager and assistant manager's perception regarding the sample of homeless people with physical movement disability**

In a one to one private interview, I had an opportunity to listen to both the manager and assistant manager about their perceptions regarding disability, health status and prospects for physical rehabilitation for each adult person with physical movement disability. Below is table 4.1 representing a summary of their perceptions.

**TABLE 4.1: MANAGERS' AND ASSISTANT MANAGERS' PERCEPTION OF HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY**

| ASPECTS RELATED TO THE HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY   | MANAGERS' PERCEPTION  | ASSISTANT MANAGERS' PERCEPTION   |
|--|---|--|
| What the Managers see as their goal and objective towards the homeless people with physical movement disability. | <u>Disempowering</u> : She sees herself as working with injured people who are absolutely disadvantaged and having nothing to give in return, her goal is to just make their miserable life a bit easier.   | <u>Supportive</u> : Sees his goal as somebody who must adopt a trustful, motivating approach.  |
| Approach.  | <u>Authoritarian school-master</u> : Sees herself as somebody strict and who must look after the interest of the residents, she says they call her a dragon.  | <u>Caring</u> : He says, "If you can adopt a certain schedule approach towards these people, not snubbing them what so ever, talk gently, talk nicely, that helps them".   |
| Insight to their background.   | <u>Hopeless</u> : "They all come from employees who had exploited them in paying them with drink and they all come out being alcoholics, they will die and be buried here".   | <u>Concerned</u> : "Also I have said this over and over, you see in the wine farms some people don't pay their workers with money, but just give them alcohol, and this still exists in some farms, up to five times a day they get a mug full of wine.  |
| What the managers see as attributes of the homeless people with physical movement disability.                    | <u>Insight</u> : She says about Eagle, "Eagle is very intelligent man, he is an educated man, and the day he wants he can be a true gentleman in both manners and dress". Others she describes them as her dearest old people who don't give her problem, who wash and are clean men, while she describes others as being rude, ugly, shrewd, big liars, aggressive and lazy. | <u>Insight</u> : "You see street people are a funny lot, there is a sort of mutual bond between them and there is always somebody who will help, that is why I say with a bit of mentality which is left, of course a lot of it is killed by alcohol, they can be trained to help." While he describes others as loners with twisted self-image who will never fit in society.   |
| Needs of the homeless people with physical movement disability.  | <u>Medical</u> : The manager was concerned about their health needs: Dawn was having asthma and epilepsy, while Eagle was having cancer of the oesophagus and TB; while she was suspicious that Sunshine was HIV positive,  | <u>Rehabilitative</u> : "he needs professional quality time, I am positive about his rehabilitation prospects. He also saw them in need of equipment, "In terms of his walking he walks very slowly, I wonder if he wouldn't be better with crutches, I saw him one day using one crutch".   |
| Rehabilitative needs.  | <u>Evasive/not clear</u> : "I don't have rehabilitation facilities for physical disabilities, because we don't cater for disabled people".  | <u>Understanding</u> : "Equipment is a big problem, you see the guy with an amputation (Mr. Moon) he must get a wheelchair, you see socializing is a big problem for him, even if we take him to the hospital, there is no carry over her, he sleeps upstairs and had to shift himself upstairs".  |
| Educational/rehabilitative prospects.  | <u>Pessimistic</u> : She sees them, as beyond rehabilitation in alcohol rehabilitation and sees that physical rehabilitation can be possible if they stop drinking: "You can educate and educate there is nothing you can do, they have lost interest in life."   | <u>Optimistic</u> : The assistant manager saw them, as having potential but the important issue is the approach of the manager to them. He feels with a good approach you can get more from them. He spoke about Jewel, "The other day he came and he said he wants to scrub the dining room, he scrubbed the whole dining room, yes he did it slower and longer than other people did, but he did it well. He felt very proud, he was doing something". |
| Support group for homeless people with physical disability.  | <u>Unsupportive</u> : "You see amongst the physically disabled, there needs to be strong one that can carry it through, somebody with leadership skills need to come out of this group, but among them there is not one with leadership skills, not one. I think you must talk to them about leadership skills".  | <u>Supportive</u> : "If you can get them organised so that will give them a feeling of worth, as they will be caring for each other, that is what life is all about one caring for the other". He saw some of them being well motivated with good self-image and independent.  |

According to table 4.1 the perceptions and attitudes of the manager of the shelter towards the homeless people demonstrated a one way disempowering approach with limited understanding of their physical disability including their needs and was negative towards their education potential. The assistant manager showed a caring, supportive approach that seems to see possibilities regarding their education and rehabilitation. The managers showed awareness regarding their positive and negative attributes.

## **4.2 Description of physical movement disability**

### **4.2.1 Demographic Information of the Sample (n=10)**

In a one to one private interview demographic details were gathered from the sample, a summary of such details in table 4. 2.

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**TABLE 4.2: DEMOGRAPHIC DETAILS OF THE ADULT HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY**

| Name           | Age | Nationality | Married/unmarried | Child/Children | Years Homeless | Years With Disability | Level Of Education | Last Job                 | Disability grant/pension |
|----------------|-----|-------------|-------------------|----------------|----------------|-----------------------|--------------------|--------------------------|--------------------------|
| Mr Jewel       | 47  | Coloured    | Unmarried         | 3              | 3 & 6/12       | 4                     | 5                  | Truck-driver/<br>Painter | Grant                    |
| Mr Dawn        | 72  | Coloured    | Unmarried         | 0              | 5              | 7                     | 5                  | Farm-worker              | Pension                  |
| Mr Star        | 69  | Coloured    | Unmarried         | 0              | 7              | 5                     | 8                  | Garden-worker            | Pension                  |
| Mr Eagle       | 64  | Coloured    | Unmarried         | 1              | 1 & 8/12       | 3                     | 10                 | Switch-board Operator    | Neither                  |
| Mr Moon        | 59  | White       | Married           | 2              | 6              | 2                     | 6                  | Post-man                 | Grant                    |
| Ms Sun         | 27  | Coloured    | Unmarried         | 1              | 2              | 3                     | 6                  | Domestic                 | Grant                    |
| Ms Energy      | 51  | Coloured    | Unmarried         | 2              | 2              | 3                     | 5                  | Domestic                 | Grant                    |
| Ms Wisdom      | 56  | Coloured    | Married           | 3              | 1/12           | 1                     | 7                  | Domestic                 | Grant                    |
| Mr Morning-Dew | 71  | Xhosa       | Widower           | 2              | 3              | 2                     | 5                  | Labourer                 | Pension                  |
| Ms Hope        | 50  | Coloured    | Unmarried         | 2              | 2              | 3                     | 5                  | Domestic                 | Grant                    |

Information on table 4.2 was compiled from the information gathered from the ten homeless people with physical movement disability that participated in the study. The mean age of the participants was 56.6 years with a range from 27 to 72 years. Sixty percent (n=6) were males, forty percent (n=4) were female. Of those interviewed eight (n=8) were coloured, one (n=1) was white and one (n=1) was black. Ninety percent were from outside Cape Town (rural areas of the western Cape, farm areas and Eastern Cape). Their mean level of education was standard 6 with a range from standard five to standard ten. Seven of them were unmarried, two were married and one is a widower. Two have never had children. Two have three children, four have two children each and two having one child. The type of work they did before being homeless were along traditional gender lines: females were domestic workers and males did a variety of jobs ranging from being a labourer to switchboard operator. Fifty percent (n=5) had been homeless for more than three years and seventy percent were disabled before they were homeless, 60% had motor vehicle accidents while 30% had neurological problems and 10% had arthritic problems.

Two of them had hearing problems and one had speech problems.

#### **4.2.2 Results of aspects from the ICIDH-2 assessed from the ten participants**

Ten participants were interviewed on one-to-one bases privately. Aspects from the ICIDH-2 relating to impairment namely body function (b) and body structure (s) were evaluated and coded using uniform qualifiers. Further on questions relating to activity level (a), participation in various aspects of life (p), and environmental barriers (e) were asked from the participants and these were also coded using uniform qualifiers. The scores from categories of each domain were added up according to the uniform qualifiers. Table (4.3, 4.4, 4.5, 4.6, 4.7, 4.8 and 4.9) and figure (4.1, 4.2, 4.3, 4.4, 4.5, 4.6 and 4.7) demonstrating the extent or magnitude of the problem in body function (b) and body structure (s) including combined scores of categories from the dimensions of activity (a), participation (p), and environmental barriers (e).

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**TABLE 4.3: IMPAIRMENT IN SPECIFIC MOVEMENT RELATED FUNCTIONS  
(COMBINED NUMBER OF RESPONSES ACCORDING TO UNIFORM QUALIFIERS)**

| Movement related functions                               | xxx.0<br>no problem | Xxx.1<br>Mild problem | xxx.2<br>moderate problem | xxx.3<br>Severe Problem | xxx.4<br>complete problem |
|--|---------------------|-----------------------|---------------------------|-------------------------|---------------------------|
| <u>Joint functions</u>                                   | 1                   | 1                     | 23                        | 7                       | 2                         |
| <u>Muscle power</u>                                      | 9                   | 5                     | 12                        | 7                       | 0                         |
| <u>Movement function (n=67)</u>                          | 40                  | 10                    | 13                        | 2                       | 2                         |
| <u>% combined responses for movement function (n=67)</u> | 60%                 | 15%                   | 19%                       | 3%                      | 3%                        |

Table 4.3 is represented in Figure 4.1.

**Figure 4.1**

Key: X-Axis = Uniform qualifiers.

Y-Axis = Combined responses of categories according to uniform qualifiers relating to movement of joints, muscle power, and movement functions evaluated from the ten participants.

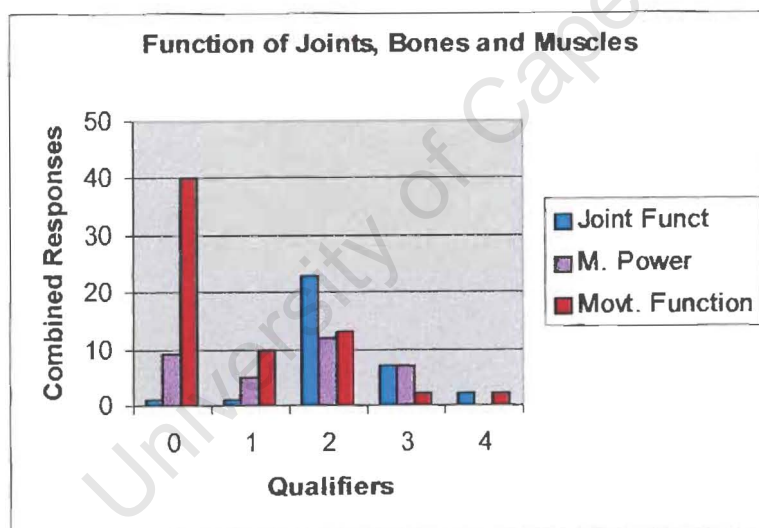


Table 4.3 and figure 4.1 demonstrates that under combined responses of movement related functions (n=67), 60% of the participants had no problem, 15% had mild problem and 19% had moderate problem, only 6% of responses had severe and complete problems.

**TABLE 4.4: IMPAIRMENTS IN SPECIFIC STRUCTURES RELATED TO MOVEMENT (UPPER LIMB)**

| Uniform qualifiers  | xxx.0<br>no problem | xxx.1<br>mild problem | xxx.2<br>moderate problem         | xxx.3<br>severe Problem | xxx.4<br>complete problem |
|---------------------|---------------------|-----------------------|-----------------------------------|-------------------------|---------------------------|
| Impaired upper Limb | 0                   | 1<br>(Right)          | 2<br>(1 both and<br>1 right limb) | 2 (1 right and 1left)   | 0                         |
| % of the sample     | 0%                  | 10%                   | 20%                               | 20%                     | 0%                        |

Table 4.4 is represented graphically in figure 4.2

**Figure 4.2**

Key: X-Axis = Uniform qualifiers

Y-Axis = Number of participants with impaired upper limb

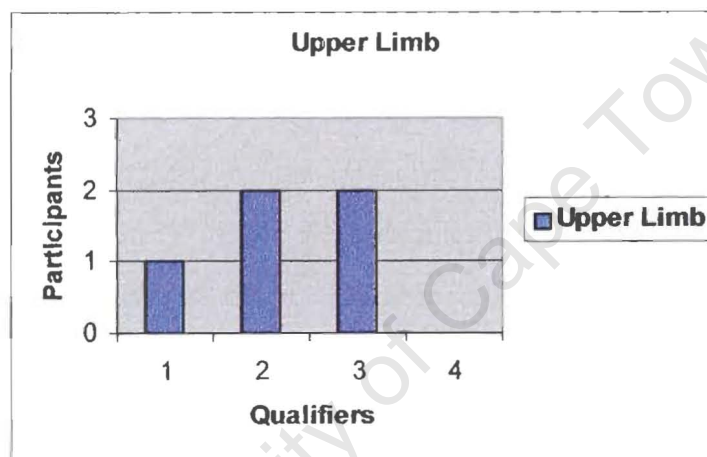


Table 4.4 and figure 4.2 demonstrated that 50% (n=5) of the participants had impaired structure of the upper limb. One had a mild impairment, two were moderately affected and two were severely affected.

**TABLE 4.5: PARTICIPANTS WITH IMPAIRMENTS IN SPECIFIC STRUCTURES RELATED TO MOVEMENT (LOWER LIMB)**

| Uniform qualifiers         | xxx.0 no problem | xxx.1 mild problem | xxx.2 moderate problem       | xxx.3 severe Problem | xxx.4 complete problem      |
|----------------------------|------------------|--------------------|------------------------------|----------------------|-----------------------------|
| <b>Impaired lower limb</b> | 0                | 4<br>Both limbs    | 2 both limbs<br>2 right limb | 1 both limbs         | 1 left limb<br>Lt limb Amp. |
| <b>% of the sample</b>     | 0%               | 40%                | 40%                          | 10%                  | 10%                         |

Table 4.5 is represented in figure 4.3.

**Figure 4.3**

Key: X-Axis = Qualifiers  
Y-Axis = Number Responses

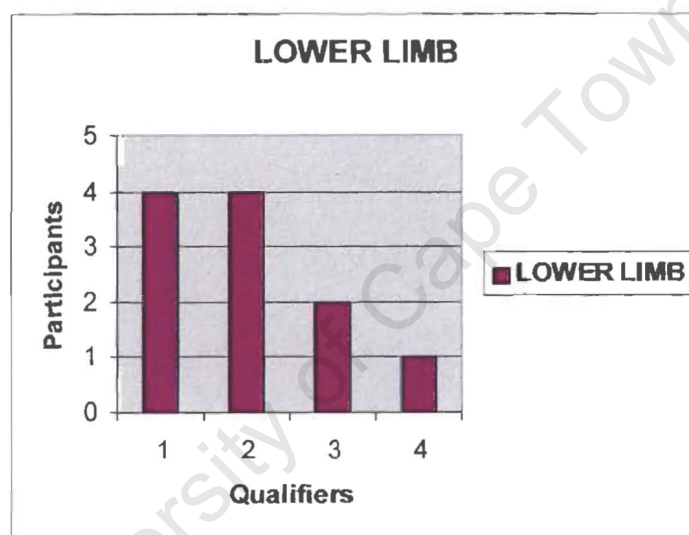


Table 4.5 and figure 4.3 demonstrate that 40% of the participants had mild impairment of the lower limb (n=4), 40% moderate impairment of the lower limbs (n=4), 10% severe impairment of the lower limb (n=2) and 10% complete impairment of the lower limb (AKA) (n=1). 70% had both legs affected (n=7).

### MOVEMENT RELATED ACTIVITY DIMENSION

| Uniform Qualifiers              | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>moderate restriction | xxx.3<br>Severe restriction | xxx.4<br>complete restriction |
|---------------------------------|-------------------------|---------------------------|-------------------------------|-----------------------------|-------------------------------|
| Combined responses              | 76                      | 48                        | 56                            | 26                          | 31                            |
| % of combined responses (n=237) | 32%                     | 20%                       | 24%                           | 11%                         | 13%                           |

Table 4.6 is represented below by figure 4.4

**Figure 4.4**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the ten participants from categories relating to activity dimension.

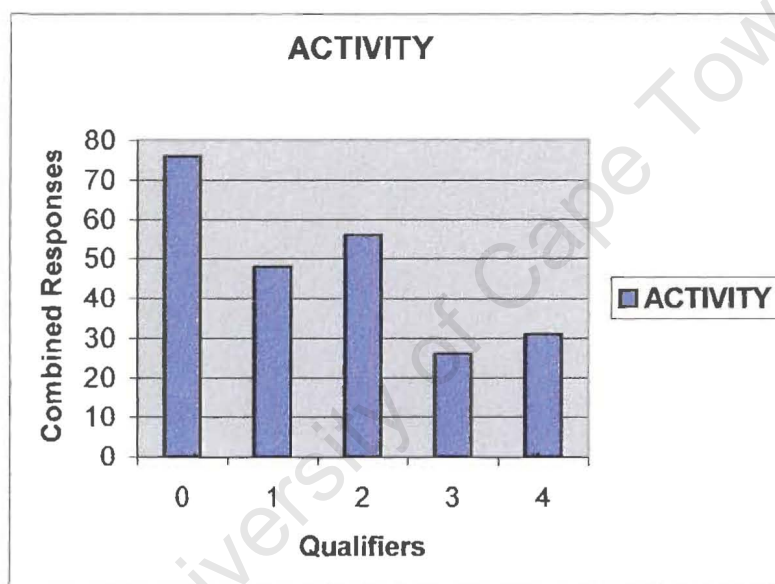


Table 4.6 and figure 4.4 demonstrates that out of 237 combined responses, 32% (n=76) of the participants had no problems, 20% (n=48) had mild problems, 24% (n=56) had moderate problems, 11% (n=26) had severe problems and 13% (n=31) had complete problems in categories relating to the dimension of activity. Changing body position, carrying and moving objects, and moving around either walking or with transportation was graded as moderate to severe problem in most of the participants. 70% of the clients had impairment of both lower limbs. The areas which the clients had minimal problems were self-care activities.

## PARTICIPATION RESTRICTION OF THE PARTICIPANTS

**TABLE 4.7: COMBINED CODED RESPONSES FROM THE CATEGORIES UNDER THE PARTICIPATION DIMENSION**

| Uniform qualifiers                     | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>Moderate restriction | xxx.3<br>severe restriction | xxx.4<br>complete restriction |
|--|-------------------------|---------------------------|-------------------------------|-----------------------------|-------------------------------|
| <b>Combined responses</b>              | 33                      | 41                        | 54                            | 90                          | 139                           |
| <b>% of combined responses (n=357)</b> | 9%                      | 12%                       | 15%                           | 25%                         | 39%                           |

Table 7 is represented by figure 4.5

**Figure 4.5**

Key: X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the ten participants from categories relating to participation restriction dimension.

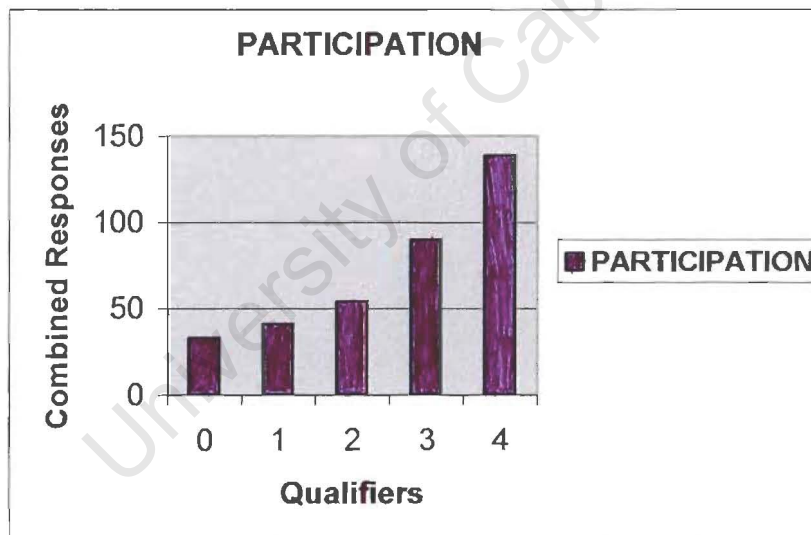


Table 4.7 and figure 4.5 demonstrate that out of 357 combined responses, 39% (n=139) of the combined responses showed severe restriction, 25% (n=90) showed severe restriction, 15% (n=54) moderate, 12% (n=41) mild and 9% (n=33) no problem. The areas, which the participants had, major problems in participation were the shelter, the community and economy. They had the least participation restriction in self-care.

## ENVIRONMENTAL BARRIERS FOR THE PARTICIPANTS

**TABLE 4.8: COMBINED CODED RESPONSES OF THE PARTICIPANTS FROM THE CATEGORIES UNDER ENVIRONMENTAL BARRIERS**

| Uniform qualifiers              | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>Moderate estriction | xxx.3<br>severe restriction | xxx.4<br>complete restriction |
|---------------------------------|-------------------------|---------------------------|------------------------------|-----------------------------|-------------------------------|
| Combined responses              | 41                      | 28                        | 73                           | 123                         | 277                           |
| % of combined responses (n=542) | 8%                      | 5%                        | 14%                          | 23%                         | 51%                           |

Table 4.8 is represented by figure 4.6

**Figure 4.6**

Key: X-Axis = Qualifiers

Y-Axis = Combined Responses

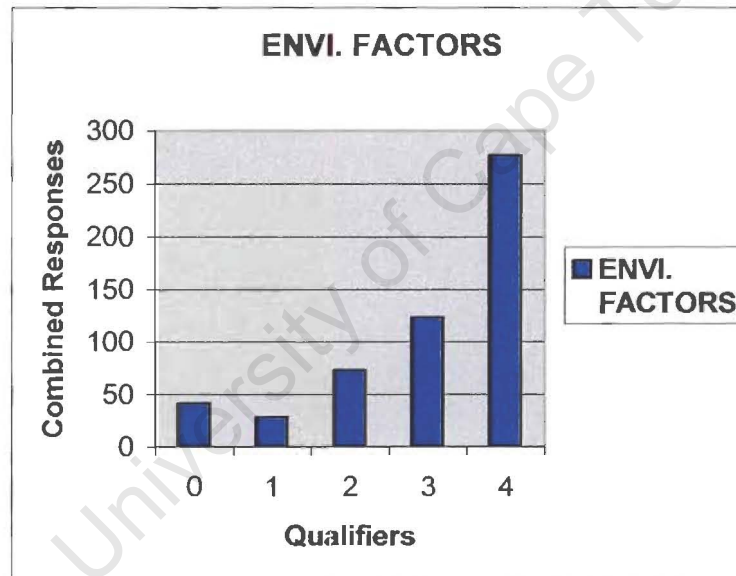


Table 4.8 and figure 4.6 demonstrates that out of 542 responses, 51% (n=277) of the combined responses from the categories of environmental barriers had a uniform qualifier that was severe to complete barriers, 23% (n=123) severe barriers, 14% (n=73) moderate barriers, 5% (n=28) mild barriers and 8% (n=41) no barriers.

The areas of the combined responses of the categories that were coded as complete and severe barriers were mostly those in services, systems and policies. The area which they had minimal problems were their own attitudes.

**TABLE 4.9: COMBINED RESPONSES OF THE PARTICIPANTS FOR ACTIVITY LIMITATION, PARTICIPATION RESTRICTION AND ENVIRONMENTAL FACTORS**

| Uniform qualifiers        | xxx.0<br>no problem | xxx.1<br>mild problem | xxx.2<br>moderate restriction | xxx.3<br>severe restriction | xxx.4<br>complete restriction |
|---------------------------|---------------------|-----------------------|-------------------------------|-----------------------------|-------------------------------|
| Activity                  | 76                  | 48                    | 56                            | 24                          | 31                            |
| Participation restriction | 33                  | 41                    | 54                            | 90                          | 139                           |
| Environmental barriers    | 41                  | 28                    | 73                            | 123                         | 277                           |

Figure 4.7 below represents Table 4. 9.

**Figure 4.7**

Key: X-Axis = Uniform qualifiers

Y- Axis = Combined responses by participants from the categories under Activity level participation restriction and environmental barriers

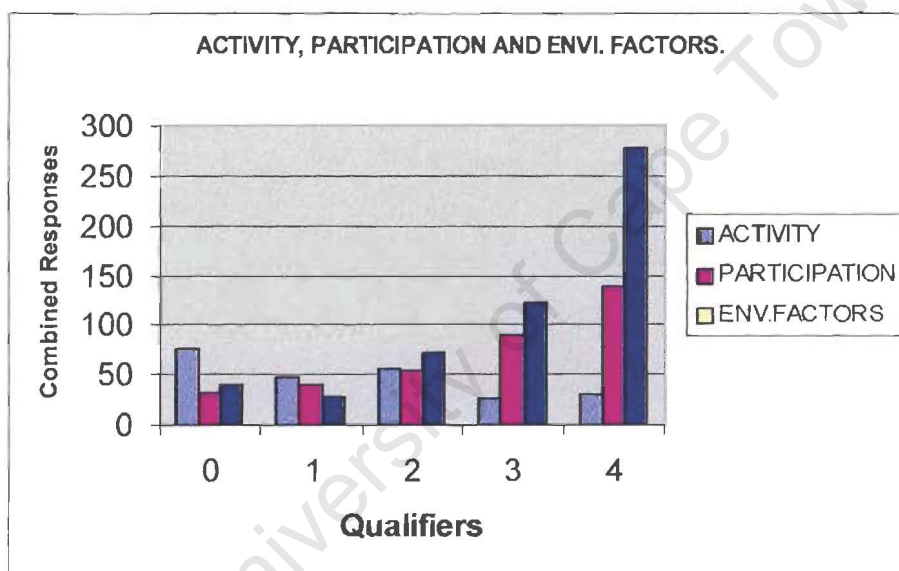


Table 9 and figure 7 shows that though the participants had minimal to moderate activity limitation, their responses in participation restriction and environmental barriers depicted severe and complete problems. The areas where they had severe to complete problem in participation and environmental factors were family relationship, community, education, services, policies and systems. The areas the client experienced mild to no problems were self-care and their own attitudes.

### 4.3 Perceptions and beliefs of adult homeless persons with physical movement disability

#### 4.3.1 Story-telling by homeless people with physical movement disability

In a private area, I listened to stories of the ten homeless people with physical disabilities on individual basis. These stories were transcribed and the data was analysed inductively, that is themes and categories were developed from the data (appendix). I identified main qualitative concepts using the detailed line-by-line approach as recommended by Tryssenaar et al (1999). I looked at each single sentence or cluster of sentences and asked myself what it reveals about the experience being described. Each sentence cluster was coded. Qualitative categories from the identified themes were classified as major if they were identified by 50% (n=5) of the homeless people with physical movement disability and minimal if they were identified by 20% (n=2). Below is a representation of those themes and categories.

**TABLE 4.10: THEMES AND CATEGORIES IDENTIFIED FROM THE STORIES OF ADULT HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY**

| Identified themes                                  | Categories under identified themes  |
|--|---|
| Problems experienced.                              | Activity limitation, participation restriction, restriction, health, difficulty in assessing health services lack of knowledge about physical rehabilitation, vulnerable in the street, unstable shelter life, strict institutional rules, lack of support and family abuse, poverty alcohol abuse, absence of meaning. |
| Needs identified.                                  | family/ relationships, accessibility in the shelter, respect and dignity, disability group and housing.   |
| Positive attributes they identified in themselves. | spirituality (belief in God), acceptance of present situation, awareness about individual strength, good relationship with society, gratitude, knowledge of physical rehabilitation services, good relationship with the government.  |
| Negative attributes they identified in themselves. | Substance and alcohol abuse, fighting among each other, not supporting each other and being short tempered.   |

Table 4.10 shows that four themes were identified from the stories of the homeless people with physical movement disability from categories developed. Below are table 4.11 and 4.12 showing the number of homeless people with physical movement disability

that identified each category.

**TABLE 4.11: PROBLEMS IDENTIFIED BY HOMLESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY**

| <b>Problem category</b>                         | <b>Number</b> | <b>% of Sample</b> |
|---|---------------|--------------------|
| Activity Limitation                             | 9             | 90%                |
| Participation Restriction                       | 9             | 90%                |
| Alcohol Abuse                                   | 7             | 70%                |
| Lack of Support and Family Abuse                | 6             | 60%                |
| Strict Institutional Rules                      | 6             | 60%                |
| Poverty (Not Enough Money for Basic Needs)      | 6             | 60%                |
| Unstable Shelter Life                           | 6             | 60%                |
| Absence of Meaning                              | 5             | 50%                |
| Health  | 5             | 50%                |
| Environmental Restriction                       | 4             | 40%                |
| Vulnerable in the Street                        | 4             | 40%                |
| Lack of Knowledge about physical rehabilitation | 3             | 30%                |
| Difficulty in Assessing Health Services         | 1             | 10%                |

**TABLE 4.12: TEN MAJOR PROBLEMS IDENTIFIED BY HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY (N=10)**

| Problems   | Number of People Identifying | % of Sample |
|--|------------------------------|-------------|
| Activity Limitation                              | 9                            | 90%         |
| Participation Restriction                        | 9                            | 90%         |
| Vulnerability in the Streets                     | 9                            | 90%         |
| Alcohol abuse                                    | 7                            | 70%         |
| Poverty ( Not enough money for basic self-care ) | 6                            | 60%         |
| Strict institutional Regulations                 | 6                            | 60%         |
| Unstable Shelter Conditions                      | 6                            | 60%         |
| Lack of Support and Family abuse                 | 6                            | 60%         |
| Absence of Meaning                               | 5                            | 50%         |
| Health   | 5                            | 50%         |

The participant's stories often focused on the barriers that impeded what they see as their progress or the coping strategies that facilitated their participation in the shelter community and the world beyond. This is demonstrated by the categories identified under table 4.11 and 4.12. There were eight major problems identified in table 12. They saw the impact of physical movement disability on their day to day activity as major problems.

One of them mentions that outside the leg is very bad in moving and going through the stairs, *"sometimes I had to be transported by the van to get to the hospital, when you are outside its not like being here, here you are sheltered"*. While another said that, *"I had been a worker all my life, now I cannot work except doing odd household chores"*. The participants were very much aware about their alcohol and substance abuse/ dependency and were concerned about it as they see this altering the way they behave, *"It's only when I have drunk that I am a different person, and tomorrow when the drink is up I am again a different person"*. While others see drinking as a way of hiding from the harsh reality of their lives, *" I am trying to stop drinking, if I think about my problems, just to forget about it, and I have money in my pocket, then I drink, the next day it's alright again, I have got a drinking habit "*.

Not having money for basic self-care needs was seen as a big problem. The unstable shelter conditions was seen as destabilising and made the disabled persons shy away from asking for help as one of them says, *" If you ask people why they insult other people, this makes me not like to ask people for something"*. They also hated the strict institutional regulations, *" I don't want this woman to hear this, as you are kept here and you are given work, the dormitories, this leg is very painful, I don't say anything because of fear"*

*of being chased out. I feel very unhappy here, I am still here, I am not given good treatment, I have to stay in like a child, and I must stay here like a convict. This woman, Mrs X I could be her father, why should she treat me like that she wants to control you. I want dignity, care and respect”.*

Neglect or abuse by family members was a sore area to the participants, “ *My family doesn’t treat me nicely; they don’t treat me like a brother, and they treat me like a stranger”*. This was echoed by others: *I used to stay with my daughter, and she married a man who doesn’t work, when he is in the house and I am out he steals my money I couldn’t take it anymore ”*. Some seemed to be depressed and lacked direction and were hovering on the brink of suicide, “ *My heart is sore, when I tell people about my life story it makes me very upset, that is why I like to keep it behind me. Not all people are good for me here, homeless people are not good and I am very lonely, sometimes I think to kill myself, and it is the only time then I won’t have any problems”*.

Four of them were aware and concerned about their health status and saw themselves as not normal and that their lives have changed since the onset of disability. Having to sleep upstairs and negotiate the stairs was seen as a problem while having to sleep in the lower bed was seen as a disadvantage. A few of the participants especially women felt vulnerable in the streets and felt that they would rather stay inside the shelter. There was a vague idea about physical rehabilitation and professionals who render rehabilitation, though only one mentioned difficulty in assessing health services.

#### 4.3.2 Needs identified by homeless people with physical movement disability

**TABLE 4.13: NEEDS OF HOMELESS PERSONS WITH MOVEMENT PHYSICAL DISABILITY**

| Need                         | Number Identifying | % of Sample |
|------------------------------|--------------------|-------------|
| A Disability Group           | 7                  | 70%         |
| Family/ Relationships        | 6                  | 60%         |
| Respect and Dignity          | 6                  | 60%         |
| Accessibility in the Shelter | 3                  | 30%         |
| Housing                      | 1                  | 10%         |

From table 4.13, shows that adult homeless people with physical movement disability who have so little in terms of material and social comforts expressed very basic personal relationships needs, namely shelter needs and belonging. Tryssenaar et al (1999) refer to this theme, “*the needs of the homeless people are the same as everybody”*. The need for forming a disability group within the shelter was expressed strongly. Simultaneously they said, “ *When we come together we must converse with each other, we all have an ailment and being one suffering as a team we will overcome this. (This was said with such*

vigour)”.

This sentiment is carried further by Lang (1998) who states that "Disabled people have started to come together to challenge their 'rights'. This group of individuals also wanted respect and dignity; *“ I mix well with other people because they like me, they respect me, and I like that. Another said, I want little respect, if you are drunk, and I am not don't talk to me, if I am drunk and want to be happy, and then I go to my room”*.

Family life was seen as a stabilising aspect and some of them expressed wishes of having a family while others wanted to be re-united with their families; *“I wish I could have my parents back, I could stay under their roof”*. Another said, *“ I see that people, who are married, I think I should have got married, my life could be better”*.

#### 4.3.3 Positive attributes identified by homeless people with physical movement disability

Some of the categories showed that homeless people have developed some form of coping skills with their situation, as shown by categories in table 4.14.

**TABLE 4.14: POSITIVE ATTRIBUTES OF HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY**

| Positive Aspect                      | Number Identifying | % of Sample |
|--------------------------------------|--------------------|-------------|
| Spirituality (Belief in God)         | 9                  | 90%         |
| Acceptance of Present Situation      | 9                  | 90%         |
| Attitude to Government               | 6                  | 60%         |
| Awareness About individual Strength  | 6                  | 60%         |
| Gratitude                            | 2                  | 20%         |
| Knowledge of Physical Rehabilitation | 1                  | 10%         |
| Relationship with Society            | 1                  | 10%         |

From table 14.14, other major categories that emerged from the data included a focus on spirituality, *“ Oh yes! I believe in God thus all. I ask Jesus to help me, guide me, and give me strength, and keep me safe in the hands of man”*. While another said, *“ But then I think again that I must thank God that he is still looking after me in spite of all the problems I have”*. Finally another said, *“I cannot say I respect richness. If I want to be rich, I must believe in God and God will help us all”*.

In the absence of having their needs met, some participants chose to be satisfied with the shelter, “ *The good thing about this place is that you have your bed and food, I am prepared to stick out in the shelter whatever conditions are*”. While another said, “ *You see there is nothing we are complaining about here, but it’s not a home*”.

They felt that the present government was far better to people with disabilities than the past government; “ *the government we have now is better than National Government, the National Government didn’t treat us nice, like we coloured people and the Bantu people were treated the same way, hey you Hottentot, hey you kaffir but now its no longer like that. Look at the pension we have, in the National Government we had very little then, but now they give us money, R540-00*”.

They were very aware about individual strengths and weaknesses and were grateful for their strengths; “ *I see myself as a good person, I believe in one using his common sense and working hard then you will live better. Another thing I am grateful about is my mentality; I am still alright, as we are talking. I am in a position to question you, as you are in a position to question me and we can conduct a dialogue, if my mentality was affected that was not going to be possible*”.

#### 4.3.4 Negative aspects identified by homeless people in themselves

**TABLE 4.15: NEGATIVE ATTRIBUTES OF HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY.**

| Problem category            | Number | % of the sample |
|-----------------------------|--------|-----------------|
| Substance and alcohol abuse | 7      | 70%             |
| Being short tempered        | 2      | 20%             |
| Fighting among each other   | 4      | 40%             |
| Not supporting each other   | 1      | 10%             |

Table 4.15 show that some of the adult homeless people with physical movement disability were aware and concerned about negative aspects in themselves. Seven of the participants identified alcohol abuse: “*I am trying to stop drinking, if I think about my problems, just to forget about it and I have money in my pocket, then I drink, the next day it’s all right again. I have got a drinking habit*”. They saw alcohol contributing towards having a bad mood that sometime result in fighting amongst themselves, “*especially me I am a drinker if somebody comes and fools with me I get aggressive and thus not nice.*” While the another said, “*You see I am very short tempered, if somebody tells me this and that I tell that person straight.*”

Finally the disabled homeless people from the Wynberg haven Night Shelter appreciated that I sat down and listened to their stories; “*I don’t want to ask questions, but want to respond and say, as far as I am concerned having you talking to us we feel very proud, and having this problem discussed we feel that there are people who are interested in us, who feel we need help and time, coming together as a group we could get this straightened out*”.

#### 4.4 Response of homeless people with no disability to a slide presentation of people with disability

To elicit the perceptions and attitudes of the adult non-disabled homeless people towards disability, 12 adult homeless people were asked voluntarily to come and watch a slide presentation of people with disability. Immediately after that they were asked to talk about their feelings towards what they have seen. Though a majority of them were reluctant to comment, some of them shared their perceptions about what they saw. four themes emerged and these are reflected in table 14.16

**TABLE 4.16: THEMES IDENTIFIED BY ADULT NON-DISABLED HOMELESS PEOPLE FROM THE SLIDE PRESENTATION OF PEOPLE WITH DISABILITY**

| CONCERNED ABOUT THEIR WELL BEING  | BLAMING THE VICTIM   | SHIFTING RESPONSIBILITY TO SOMEBODY ELSE  |
|---|--|---|
| <u>Need for physiotherapy:</u> <i>“These people have physio care, is there any care centre for the homeless to receive physiotherapy Rehabilitation?”</i>             | Disability in some of the people with disability makes them angry. Their anger is due to being Around abled people and not being able to do some of the things.                          | Disabled people need attention i.e. professional counselling to prevent taking their frustration out on abled people. They need people who can identify with their situation. |
| <u>Helping disabled people:</u> A few of them have helped/ still help disabled people. They interact with them and they do not have any problems with them.           | Disabled people need to take out their fear and anger, express themselves in words to people who understand, and not bottle their feelings inside.                                       |   |
| <u>Concern regarding employment opportunities:</u> One of them said that there needs to be a difference between disablement and Unemployment.                         | Disabled people may loose self-respect and respect from other people, if they take out their frustration on other people disrespectfully. They disrespect others- they get disrespected. |   |
| <u>Equity with disability grants:</u> A need for a representative to deal especially with disability grants was expressed. They felt that this needs to be addressed. |  |   |

Table 4.16 shows that the non-disabled participants showed concern about the plight of people with physical disability in their own shelter. They compared their facilities with the facilities available to more advantaged disabled people while the people from the shelter did not have such facilities. Others were able to connect with negative feelings they felt towards people with disability while others shifted the responsibility of supporting them to somebody else.

#### 4.5 Comments on findings

This chapter has attempted to map out the findings that were produced during the research process. The impact of physical movement disability on adult homeless people was investigated from different angles i.e. (a) Description of the shelter setting (b) Interviews for manager and assistant managers' perceptions and attitudes towards adult homeless people with physical movement disability (c) Description of physical movement disability using the ICIDH-2. (d) story- telling to gain an understanding of perceptions and attitudes of the adult homeless people with physical movement disability (e) and slide presentation of homeless people with no disability to describe perceptions and beliefs of the homeless people with no disability towards disability. External agents who might advocate for the participants were also investigated. Qualitative and quantitative methods were used at both the level of data collection and analysis of findings.

#### 4.6 Bias

During interviews the participants might have given answers that they thought that the physiotherapy fourth year students and research assistants wanted to hear. To minimise this bias they asked questions in a neutral manner and assured the participants that there were no wrong or right answers. I introduced story-telling by the adult homeless people with physical movement disability to also reduce this bias.

#### 4.7 Validity

(a) The choices and investigation methods have combined four different approaches to the problem:

- Description of the shelter and interviews with the managers
- Quantitative description of physical movement disability using ICIDH-2
- Story-telling by the ten participants
- Slide presentation as an attempt to elicit perceptions from homeless people with no disability about disability

This range of methodologies was chosen to enable validation of data by triangulation.

(b) In-depth literature search was done on the following topics:

- Disability and disability movements
- Homelessness and shelters
- Rehabilitation
- Quantitative and qualitative instruments for this research

This assisted me to gain an in-depth understanding of the research topic that I am passionate about and to be in a position to develop a structure and validity on issues that were an assumption to me before.

(c) The methodology was divided into three parts:

- Pilot study
- Adjustment of tools used in the pilot study
- Data validation

Each part had its own methodology that was separate but flowing to the next part. After implementation of each part the data collected was analysed and corrected for the next part. This approach improved validity but also allowed flexibility.

- (d) I presented the research proposal and results from the ICIDH-2 to critical audiences, which assisted me to improve on the sample and research instruments as mentioned before.
- (e) To improve the data on the Wynberg Haven Night Shelter setting including the demographic details of the participants, I went back three times to do member checking.
- (f) Lastly I also used the ICIDH-2 on 6 homeless people with no disability from the Wynberg Haven Night Shelter and 6 people with disability staying at home as it became evident that to be more crystal clear about the double burden that is experienced by having a disability and not having a home (appendix).

## CHAPTER 5

### DISCUSSION

*“There are three criteria for assessing the quality of an interpretative or qualitative study that includes (i) a commitment to emergent relationship with participants, (ii) a set of stance about positionality (iii) subjectivity and a vision of research that promotes social justice. To be more specific, the researcher advocates for giving voice to the participants, sharing rewards, and privileges, and a heightened writers subjectivity” (Miller et al., 1998 p485).*

This research set out to bring about an understanding of the adult homeless people with physical movement disability and Wynberg Haven Night Shelter was used to gather participants for the study.

In order to achieve the purpose of the study the following objectives were identified:

- Describe the functioning of the Wynberg Haven night shelter regarding approach to homeless people with physical disability
- Describe physical movement disabilities of adult homeless persons in the Wynberg Haven shelter
- Record and analyse perceptions, beliefs and needs of the homeless adult homeless persons with physical movement disability in the Wynberg Haven Night Shelter
- Record and analyse perceptions and beliefs of adult homeless persons with no physical movement disability towards disability in the Wynberg Haven Night Shelter.
- Make recommendations with regard to the needs of the disabled adult homeless people in the Wynberg Haven Shelter (this will be discussed in chapter 7)

To achieve these objectives I used five different methodologies:

- Observation and description of the functioning of Wynberg haven Night Shelter
- Interviews with the managers of the Wynberg Haven Night Shelter
- Describe and analyse the area of impairment including level of activity, participation restriction and environmental barriers using the ICDH-2
- Story-telling by adult homeless people with physical movement disability
- Slide presentation to homeless people in the Wynberg haven Night Shelter with no disability to describe their perceptions and beliefs towards disability

Below is the discussion of the findings that were presented in Chapter 4.

## 5.1 Objective 1

### To describe the functioning of the Wynberg Haven Night Shelter

#### The setting

The environment plays an essential role in the individual's health status. It can provide stimulation and motivation for the individual; some environmental conditions can promote apathy and lack of insight with regard to a healthy life style.

Though the Wynberg Haven Night Shelter is strategically situated in a relatively secure area, 40% of the homeless people with physical movement disabilities felt vulnerable outside the shelter. Some of them mentioned that other street people grab at their things because they cannot run after them. Others mentioned that they prefer to stay in the shelter during the day. This has an impact on economic opportunities, as the homeless person needs to be in the street for begging and job opportunities.

The manager sees the Wynberg community as well as the police rejecting the shelter and the homeless residents. This again makes the homeless people from this shelter including the people with physical disability, vulnerable outside the shelter. The surrounding liquor stores and houses that sell drugs to the homeless persons pose a challenge to the physically disabled persons who are struggling to do away with their substance abuse problems.

The demography of the shelter does not pose a major problem for the physically disabled persons except for male persons who sleep upstairs, and some of the male physically disabled persons see this as a major problem. The homeless people with disability have adjusted themselves to the environment of the shelter.

#### Cultural setting

The environment within the shelter seemed to be pleasant but the strict shelter regulations and the manager's style of management (authoritarian) seem to cause tensions between the manager and the people with physical disability. Some of the physically disabled persons seem to be concerned about the control imposed over their finances. Some of them do extra jobs and manage to acquire more money than the others, but are still given the same pocket money as those with less money. This does not motivate those without skills to try and seek skills so that they can get work, as there seem to be little reward for this. The people with disability are required to do type of jobs in the shelter e.g. gardening and cleaning that are regarded by some to be too strenuous.

In spite of fairly serious physical movement disabilities amongst the adult homeless people in the Wynberg Haven Shelter and the fact that 60% are receiving disability grant there is very limited understanding and much misconception about the impact of physical movement disability in the homeless people. The manager sees them as having a problem

with their disability only when they are drunk. The disabled homeless people see their lives as never the same since the onset of disability, some are depressed with one of them feeling suicidal. Rehabilitation prospects are not clear from the manager, and she sees her work too demanding for her to be involved in physical rehabilitation of the homeless apart from organising a venue and time while the assistant manager feel that rehabilitation should be within the shelter.

There is awareness about their health conditions and attempts are being made to rectify this although this seems to pose a challenge due to the lack of compliance to go to the health centres. There seem to be contrasting views about their rehabilitation and educational prospects from the manager and the assistant manager. Although the environment in the Wynberg Haven Night Shelter seem to be pleasant, application of Friedemann (1992) (Dis)empowerment theory to the participants, results indicate that they have lost their social power in which to improve their conditions as members of the civil society and there are no clear strategies from their immediate setting to assist them find the power in themselves. Their dependency on substance abuse exacerbate the situation and undermines their physical rehabilitation prospects as they are seen as just drunkards with no future and will die in the shelter.

## **5.2 Objective 2**

**To describe physical movement disability of adult homeless people in the Wynberg Haven Shelter**

### **Demographic impact**

The demographic information of the participants show that except for three all the homeless people with physical movement disability were above fifty years of age, with a mean education level of standard six, and no clear skills training before and during the period of being homeless except for gardening. Two of them are married and 90% of them are from outside Cape Town so the chances of family support and improved family relationships are minimal. 70% of the sample were disabled before being homeless, and they see disability as a major contributor to their homelessness. 60 % are on disability grant while 30% are on old age pension. 90% of the physically disabled persons are in a position to cover the costs required by the shelter. The above information shows that 40% of the participants are above the wage earning age and even those who younger have disabilities that would limit them from doing labour jobs.

### **Physical movement disability**

According to uniform qualifiers, specific functions related to movement, the majority of responses from the participants ranged between having no problem to moderate problem. 50 % of the sample had both upper and lower limbs affected while 70% had both lower limbs affected, this has contributed to the sample experiencing more problems in movement related functions, though the overall activity limitation ranged between mild and moderate.

The added categories from the participation restriction and environmental barriers dimensions from the ICIDH-2 answered the question regarding the lived experiences and individuals' involvement given his or her health condition in societal context. The homeless people with physical movement disability had the majority of responses at activity level ranging between mild to moderate but their added coded responses for participation restriction and environmental barriers, the majority demonstrated severe to complete restriction.

At this point I would like to refer to the data for participation restriction and environmental barriers for homeless people and disabled persons with homes. The homeless persons (non-disabled) in the shelter for participation restriction showed an equal spread of responses (appendix 6, table 6.2 and fig.6.2). They gave the highest responses under severe environmental barriers (appendix 6, table 6.3 and fig.6.3). The people with disability who live at home in terms of impairments are more severely impaired than the sample (appendix 7). The home dwellers though they had severe impairments their responses for environmental barriers and participation restriction were low. Most of them responded under no problem in environmental barriers and participation restriction (appendix 7, Table 7.1 –7.4 and figure 7.1 - 7.4).

The responses of severe to total restriction in participation and environmental barriers of the participants further highlights the importance of recognising that there are sectors within the disabled community, which experience greater discrimination than others. These sectors still experience comparatively higher levels of exclusion from social, economic and the political environment.

In my professional opinion the homeless people with physical movement disability had the type of physical movement disabilities that have a potential for rehabilitation but the setting and the immediate environment had not been developed for this. Their physical disabilities were confounded by so many other factors. A majority of them were very concerned about their physical disability and saw their lives as having become bad since the onset of disability.

### 5.3 Objective 3

#### **To record and analyse perceptions, beliefs and needs of homeless adult persons with physical movement disability in the Wynberg Haven Shelter**

The physical disabled homeless people were aware of their physical movement disabilities and were concerned about their activity limitation, participation restriction and environmental barriers both in the shelter and outside the shelter. They believed that if they could form a support group and a professional could come and assist them they could overcome this problem: *“having this problem discussed we feel there are people who are interested who feel we need help and time, coming together as a group we could get this straightened out.”*

The participants did not have clear knowledge about rehabilitation and what physiotherapy could contribute to their rehabilitation but have an impression that health professionals were “good” to them when they go to the hospital. The participants were concerned about their abuse of alcohol but seem not to have an idea of how to stop, as alcohol was serving a comforting need. The participants were deeply disturbed by lack of family support.

The participants indicated a need for respect and dignity including to be re-united with their families or to have families. In the absence or lack of their needs being met the participants used coping strategies like spirituality and acceptance of the present situation.

Though homeless people are regarded as shrewd, ungrateful, dirty, rude and lacking respect, throughout the interviews I conducted with the adult homeless people with physical movement disability they showed respect and thanked me for coming and listening to their stories.

#### **5.4 Record and analyse perceptions and beliefs of adult homeless people with no physical movement disability in Wynberg Haven Night Shelter towards disability**

The adult homeless people with no disability from the Wynberg Haven Night shelter demonstrated mixed perceptions towards disability. Some of them were concerned about the lack of rehabilitation resources for the people with physical movement disability in their shelter while others were able to share the negative feelings they have towards people with disability. It can be assumed that some of them might be supportive towards the homeless people with physical movement disability in the Wynberg Haven Night Shelter while others might distance themselves from them as they fear the brunt of anger that they assume is carried by people with disability. Some of the participants felt unsupported by the people from the shelter and felt very lonely.

#### **5.5 Conclusion**

Both homeless and physical disabled people are marginalised by society so to be homeless and physically disabled would appear to be a double burden to those who experience such a situation. The methodology had attempted to expose the plight of the participants by trying to answer the research question at three levels i.e. physical (ICIDH-2), personal (story-telling) and environmental (narrative description of the shelter). These approaches are not separate as they have a direct impact on each other. The integration of these findings assisted me in answering the research question.

It is obvious from this study that the disabled homeless participants experience a double burden of disablement and homelessness and they are indeed a marginalised group. Most of the participants suffer from chronic disabilities although they are surrounded by health facilities. A large portion of them are educationally, socially and economically marginalised. Being homeless has further prevented them from equal access to rehabilitation, health and community social support and services.

As demonstrated by this study, there is a need to practise caution in generalising the homeless people with physical disability from the Wynberg Haven Night Shelter as lacking in assertiveness and leadership skills. In this study they demonstrated a strong need to take charge of their problems but just lacked skills and direction to do this. When addressing the issue of rehabilitation for this group of people, one must take cognisance of the complexity of their rehabilitation needs and try to develop a rehabilitation strategy, that is inter-disciplinary.

The managers of the Wynberg Haven Night Shelter need to keep reflecting on the goals subscribed for Haven Night Shelters' Organisations and see if they are still working within that framework.

For the disabled person with a home environment challenges are a formidable task, what about the one without a home? Disability movements need to develop an infrastructure, which will enable Homeless people with disabilities' voice to be heard. As Friedemann (1992, p71) says, "*external agents are critically important in advocating for needs of groups who are marginalised*".

## CHAPTER 6

### REFLECTION ON THE STUDY PROCESS – THE CONFESSIONAL TALE

I have mixed feelings about mapping out the emotional journey that I experienced during the twists and turns of this study. At certain stages of this study I have been promising to write about these feelings but on the other hand shifting this away. So here I am, feeling a bit nervous as if I am an animal in cage as this is the last chapter before the chapter on recommendations and there is no running away. My profession seem to keep pushing forward, and I need a plan to be able to write this. What I intend to do is to just walk through the chapters of this study and try and get in touch with the feelings that will emerge.

#### **6.1 My background and motives for doing the study**

In chapter 1, I had mentioned my background and motivation for doing the study but I feel where I am now, I need to re-visit this. Much as I always thought that professions shape individuals but I have gained a new understanding that there is interplay between professions and individuals. I think I chose the physiotherapy profession because I knew that it would satisfy my feelings of social justice that were already planted deeply in me by my grandmother. Hence I also feel that I was just waiting and ready for a topic of this nature to emerge as I was also emerging in my own context and could further not hide from who I was. But what I didn't realise was how the topic was going to affect me.

#### **6.2 Drawing lines between biases, facts and hearsay**

When the 4th year physiotherapy students needed support on this topic, I was very excited. I saw this topic as a new line of enquiry for physiotherapists. In some way I was still very much caught up in my medical model of rehabilitation and research mode. During that time I had not yet been exposed to Douglas (1977, p5) saying, "*We do not stand outside experience, we do not put society on a rack and try to torture the truth out of it. We seek the truth in the ways we find necessary in the natural social world. To answer questions; one must focus on people and meaning that people exist in and emerge from and are consequential for those methods of life that course and result in research*". There were also some assumptions about homeless people. Most of the homeless people I have been exposed to used to irritate me by disturbing my afternoon naps, by wringing the bell and asking for something. These individuals I used to handle with tolerance and divorce my feelings from them. I think when I accepted this study there was a lot of that clinical approach. I had reflective sessions with both the physiotherapy students who did the pilot study and the research assistants. The physiotherapy students wanted reassurance that I would take the pilot study further, so that the needs of homeless people with physical movement disability can be addressed. I picked up a level of sadness from the research assistants. I do feel that I was not able to connect with the depth of that sadness. I think if it was now I could have supported both groups differently by giving them more time to reflect on their feelings.

### **6.3 Where and what was the turning point?**

After I have decided to do the study I started doing literature search, this also opened another door for me. To know about disability and homeless issues and to read about them are two different things. I found myself when discussing issues around disability enlightening people about the accepted stance on how people with disability wanted to be addressed. I started speaking about the triad that cannot be ignored (poverty, disability and homelessness). This was an exciting time of discovery for me. It was at this stage that my supervisor felt that she needed to put her foot down. She told me in clear terms that, Gubela you are not focusing here on poverty but on the impact of disability on homeless people. I had to let go of my triad, but who knows? Maybe along the journey I might reconnect with it.

After scrutinizing the data gathered by research assistants, I decided that I wanted to validate this data. I also wanted to concentrate on one shelter – the Wynberg Haven Night Shelter. Here this is the first time I was able to sit, talk and listen to the homeless people. One must not forget the deep-seated stereotypes of that homeless people are drunkards, rude and violent. When I started the one to one interviews in a private area, there was a slight element of fear. When I started listening to their stories, I felt that I was touching something the research had not managed to elicit. These stories gave life to the study and profoundly influenced me. These stories did not fit stereotypes, they spanned through continuum of real life. They presented life issues, fantasies and struggles. I see myself as a quiet person who can contain her emotions. Here I was in trouble, because the feelings that were coming out were not quiet at all (anger at what I saw as exploitation, sad at what I saw as lost opportunities, discomfort at what I saw as my own exploitation of the homeless people, agitated because I could not find a quick solution to both the social and rehabilitation problems the homeless people were experiencing).

I interviewed the manager of the shelter regarding her perception and attitude of the homeless people with physical movement disability after I had interviewed the homeless people with physical movement disability. I was shocked at what I regarded as her lack of understanding of the plight of the homeless people with physical movement disability. After being in the Wynberg haven Night Shelter for one week in December 2000, I felt I needed to see other shelters and other people who work with homeless people. I also wanted to talk to disability movements regarding the triad (Disability, homelessness and poverty). I wanted to know what have been done about disability within the homeless population.

### **6.4 Journey outside the Wynberg Haven Night Shelter**

I have documented the twists and turns of this journey in methodology Part 3. What I would like to share is the lessons that were learnt. I got the confirmation from outside the Wynberg Haven Night Shelter that it is not only the manager of the Wynberg Haven Night Shelter who has not taken any steps to support the homeless people with physical movement disability. Disability movements though they are very concerned about poverty within the disability sector and are trying to create opportunities for people with disability to interface the job market, they have not thought about the triad that I felt

strongly that it cannot be ignored (disability, poverty and homelessness). I also started having feelings of discomfort that maybe I am judging the manager of the shelter harshly in thinking that she does not support her residents with physical movement disability. I felt that in the study her name should not be mentioned, I even did not want to say I was writing about the Wynberg Haven Night Shelter. I gave the participants other names that were related to the positive feelings I had about them when they were telling their stories.

### 6.5 Reciprocity feelings

In my professional judgement I felt I could assist the adult homeless people with physical movement disability with some of their rehabilitation needs. I wanted to build parallel bars for Mr Moon (Homeless person with one of his leg amputated above knee), and I thought the homeless people could assist me. There was again another lesson to be learnt from this. I again visited the Wynberg haven Night Shelter to further validate the data in March 2001. I was surprised to find positive changes; (1) A social worker was employed to assist homeless people with social needs and disability was mentioned as part of her priorities (2) I was shown paintings that some of the adult homeless people with physical disability had made, already rehabilitation was taking place within the shelter (3) Moonshine had a wheelchair (though again in my professional judgement, I doubted if this was what he requires) but it was a step in the positive direction-needs being addressed.

### 6.6 Journey to try and find *THE CRITICAL TALE*

In this heightened state of subjectivity, I needed something solid ground under my feet so that I could develop some objectivity when I try to negotiate *the critical tale*. Miller et.al. describe *the critical tale* as having concern for representing social structure as seen through the eyes of a disadvantaged group, shedding light on larger social, symbolic and economic issues. To be able to approach the critical tale of the homeless people with physical movement disability, my instrument was the data I had collected. I had to analyse that data. That process I did find very exciting as confirmation on assumptions was happening and new material that require further research was being exposed. So here I am after what I regard as a long journey poised to making the following opening remarks for chapter 7 -

## CHAPTER 7

### RECOMMENDATIONS

I have gone full circle through the journey of this study. I have asked myself questions regarding the sample and their environment. I have questioned myself regarding my own biases and my position in this study. I have doubted and challenged myself and I have already raised some of these issues in chapter 6. In all of this, there is one thing I am sure of, the homeless people from the Wynberg Haven Night Shelter saw me as one of the people who could carry some of their problems and needs forward (especially those problems and needs with regard to physical movement disability). They saw me as an advocate for their problems and needs. Hence I see myself being positioned to make the first recommendation to myself that I should be their advocate to the following groups and aspects:

- Manager of the shelter
- Disability movements
- Health care professionals
- Adult homeless people adult people in the Wynberg Haven Night Shelter.
- Adult homeless people with physical movement disability in the Wynberg Haven Night Shelter
- Future studies that could be done with regard to adult physical disabled homeless people

#### **7.1 The following recommendations are suggested for the manager of the shelter**

The homeless people with physical movement disabilities in the Wynberg Haven Night Shelter have a right to access health and rehabilitation services. It is assumed that such access will enable them to resume their life roles and enhance their quality of life. As part of the process of equalisation of opportunities, provision should be made to assist them to assume their full responsibility as members of the society through programmes that give them social and work skills. Physical disability within the homeless population is a reality: 20% of the population of the Wynberg Haven Night Shelter had physical movement disabilities, the assistant manager says that 20-25 % of shelter residents have physical movement disability, the Street Field Worker project confirms that in the Cape Metropolitan Council, 11% of street dwellers have physical movement disabilities. The manager should try to therefore:

- Develop a conducive environment where the physical disabled persons can be able to communicate their needs and frustrations.
- Demonstrate and foster a spirit of confidence in the abilities of the residents with physical movement disability.

- Develop a comprehensive strategy to access rehabilitation services for residents with physical movement disability and include them in the planning phase, as the assistant manager saw that rehabilitation could happen within the shelter.
- Tap into the existing structures (hospitals surrounding the shelter) for knowledge and advice about how to implement comprehensive rehabilitation for her residents.
- Network with organisations for street people e.g. Co-ordinated Action for Street People (CASP) and develop strategies of addressing disability within the street population.
- Develop a strategy whereby the voice of homeless people with disability could reach the Western Province organisations of disabled people and organisations for disabled people (Disabled People of South Africa (DPSA), South African Federal Council for Disability (SAFCD), and Disability Desk. These bodies are on an ongoing process of addressing the needs of people with disability within the Province (*equalisation of opportunities*). Establish how these groups can support people with disability from the Wynberg Shelter.
- Develop a communicative strategy to improve the image of the shelter to the Wynberg community, the business people and the police.
- Develop a clear anti-poverty strategy and goals with a clear purpose of re-integrating the people with physical disability back into their communities. This could be done in collaboration with other organisations with a “hand up approach” and to learn from their strategies.
- To see disability as a human rights issue rather than a medical problem and to advocate for people with disability in the Wynberg Haven Night Shelter.

## 7.2 Disability movements in the Western Province

There is a strong reciprocal relationship between disability and poverty, poverty makes people more vulnerable to disability, and disability reinforces and deepens poverty (White Paper on Integrated National Disability Strategy, 1997). Some of the adult homeless people with physical movement disability mentioned that disability was the main cause of their homelessness. They mentioned that they were discharged from the hospital and did not have a place to stay. This view is also reflected by Plumb (1997), *"The working poor live on a precipice that can tumble them into homelessness any time. An illness, or an unexpected layoff, brings missed pay checks which lead to skipped utility or rent payments, which snowballs into penalties, which ends in shutoffs or eviction. That leaves a Hobson's choice between no place at all or city run homeless shelters, which often are dirty, noisy and unsafe (Plumb, 1997p973)"*. For those people with a stable home disability can be a major obstacle to overcome both physically and psychologically. So the question has to be asked, how much more will disability affect one without a home?

The researcher visited some of the disability organisations in the Western Province (SAFCD, Disability Desk of the Western Province), and when the issue of disability and homelessness was raised, none of these organisations seemed to have thought about the inclusion of the homeless people with disability in their disability strategies though as discussions continued they seem to see the connection between disability and homelessness. Therefore the following recommendations are presented to the disability organisations for their consideration:

- Communicate and network with the existing organisations for street people on the present developments on equalisation of opportunities for people with disability within the Western Province and South Africa
- Develop a strategy with the organisations for street people on how to support and include the homeless people with disability in the present dispensation so that their voice can be heard
- Read the existing research, and facilitate research on poverty and homelessness within the disabled population
- See disability, poverty, and homelessness as inter-linked and human rights issue and develop strategies to support people with disability from tumbling into homelessness
- Become advocates for homeless people disability

### **7.3 Physical rehabilitation health professionals close to the Wynberg Haven Night Shelter**

Though the Wynberg Haven Night Shelter is very close to hospitals where people with physical disabilities are rehabilitated, the manager of the shelter and homeless people with physical disability did not have a clear knowledge and an understanding about the available resources for rehabilitation of the people with physical movement disability. The researcher recommends that the rehabilitation professionals in this area should:

- Be aware about physical disability that exists within the homeless population with special reference to the Wynberg Haven Night Shelter
- Approach disability within this shelter as a combination of their out reach program and community based rehabilitation (CBR) as a CBR programme should be based on the principles of equality, social justice, solidarity, integration and dignity (Hellander, 1992) which would be suitable for the homeless people with physical disability
- Use this shelter as a centre for their rehabilitation, as the assistant manager had already said rehabilitation resources are within the shelter
- Implement a multidisciplinary rehabilitation strategy to meet the diverse rehabilitation needs of the people with physical disability of this shelter

- To see rehabilitation beyond the hospital bed. Some of the people with physical disability from the Wynberg Haven Night Shelter said that they were discharged from the hospitals after a motor vehicle accident without being fully rehabilitated, they were unable to resume their work and were evicted from their residence and did not have a place to stay.

#### **7.4 Homeless people in the Wynberg Haven Night Shelter**

Though the assistant manager describes homeless people as friendly and supportive to each other, some of the homeless people with physical movement disability mentioned that they felt so unsupported by other homeless people and were very lonely. I recommend that the homeless people could support the homeless people with physical movement disability by listening to the problems they are experiencing as a result of their disability.

#### **7.5 Homeless people with physical movement disability in the Wynberg Haven Night Shelter**

- The homeless people with physical movement disability are encouraged to communicate their needs to the manager of the Wynberg Haven Night Shelter, though this may be easier said than done considering the managers' authoritarian managerial style
- They have recognised a need to form a disability group, they can start by being friendly to each other and support each by listening to each other. This could be the first entry towards developing a disability group
- They also need to adopt a friendly attitude to other homeless people as other homeless people mentioned that they are afraid to help homeless people with disability as they just "explode"

#### **7.6 Future studies**

- The results of this study on the Wynberg Haven Night Shelter are not generalisable to other shelters; hence there is a need to implement this research in other shelters
- Disability, poverty and homelessness is a triad that still needs to be understood, hence a need for further studies on the inter-relationship of these concepts
- Future studies should be multi-disciplinary, as this study had alluded to mental health concerns of the adult homeless people with physical movement disability and it was clear that the problems experienced by the homeless people with physical disability are multi-faceted
- The research approach should be developmental -type action, and participatory to enable the shelters to meet the needs of the residents where by as issues are being

- researched, strategies and implementation are taking place
- Finally, academic institutions with rehabilitation programs should encourage students to embark research on disability and rehabilitation issues within the homeless population

### CLOSING REMARK

As a closing remark of this study, I thought it would be suitable to use an unreferenced poem that was on the covering page for the report written by physiotherapy students on the pilot study. It rhymes this way:

*A hobo is a lonely sorrowful person – it's so sad.  
Because he is here today through circumstances- not because he is bad.  
Not so long ago he was a man of worth and was respected.  
Working hard and doing all that was expected.*

*He laughed he danced and found life was great.  
He had no time for greed and hate.  
He never wished to pick a fight.  
Then something happened and things went wrong.  
And in his heart he could find no song.  
For things got worse from day to day.  
And sadly he realized he had lost his way.*

*So do not judge this man with words too strong.  
Perhaps we could help him undo the wrong.  
Give him a smile and a helping hand.  
He needs courage to take a stand.*

*Life is a challenge we must face.  
Some need more courage to keep the pace.  
So next time you see a hobo so sad.  
Try to remember he is lost - not bad.*

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**APPENDIX 1****CONSENT FORM.**

I,....., hereby give my consent to partake in the research project conducted by Gubela Mji. I understand that this will take place in the form of an interview and that there will be no intervention from the researcher. I understand that all information gathered here will be highly confidential and will only be used in this study.

**Signature** .....

**Date** .....

University of Cape Town

**APPENDIX 2**

**TABLE 2. 1: OVERVIEW OF COMPONENTS OF ICIDH-2**

|  | <b>Body Functions &amp; Structures</b>        | <b>Activities</b>                      | <b>Participation</b>                        | <b>Contextual Factors</b>   |
|--|---|--|---|---|
| <b>Level of Functioning</b>                  | Body<br>( <i>body parts</i> )                 | Individual<br>(person as a whole)      | Society<br>( <i>life situations</i> )       | Environmental Factors<br>( <i>external influence on functioning</i> ) +<br>Personal Factors<br>( <i>internal influence on functioning</i> ) |
| <b>Characteristics</b>                       | Body function<br>Body structure               | Performance of individual's activities | Involvement in life situations              | Features of the Physical, social, And attitudinal World +<br>Attributes of the person   |
| <b>Positive aspect (Functioning)</b>         | Functional and structural integrity           | Activity                               | Participation                               | Facilitators  |
| <b>Negative aspect (Disability)</b>          | Impairment                                    | Activity limitation                    | Participation restriction                   | Barriers/<br>Hindrances   |
| <b>Qualifiers:</b><br><i>First Qualifier</i> | <i>Uniform Qualifier: Extent or Magnitude</i> |  |   |   |
| <i>Second Qualifier</i>                      | Localisation                                  | Assistance                             | Subjective satisfaction (under development) | (under development)   |

TABLE 2.2: UNIFORM QUALIFIERS

| Dimension                 | First qualifier   | Second qualifier   |
|---------------------------|---|--|
| <b>Body Functions (b)</b> | Uniform qualifier with the negative scale used to indicate the extent or magnitude of an impairment<br><br><i>Example: b175.3 to indicate a severe impairment in specific mental functions of language</i>  | To be developed to indicate duration, growth and development   |
| <b>Body Structure (s)</b> | Uniform qualifier with the negative scale used to indicate the extent or magnitude of an impairment<br><br><i>Example: s730.4 to indicate the total absence of the upper extremity</i>  | To be developed to indicate region.<br><br>Suggested scheme:<br>0 = more than one region<br>1 = right<br>2 = left<br>3 = both sides<br>4 = front<br>5 = back<br>6 = proximal<br>7 = distal<br>8 = not specified<br>9 = not applicable<br><br><i>Example: s730.41 to indicate the total absence of the right upper extremity</i>  |
| <b>Activity (a)</b>       | Uniform qualifier with the negative scale used to indicate degree of difficulty in accomplishing an activity. If only the first qualifier is used, it implies the level of difficulty without the use of Assistive devices or personal help. If the first qualifier is used in conjunction with the second qualifier then the first qualifier now implies that this is the level of difficulty using an Assistive device or personal help | Assistance<br><br>0 = no assistance used<br><br>1 = non-personal assistance (this includes use of Assistive devices, technical aids, adaptations, prostheses, wheelchair, cane and other material help)<br><br>2 = personal assistance (where the task is carried out with the "help" of another individual, where "help" includes supervision and cueing as well as physical help)<br><br>3 = both non-personal and personal assistance |

|                                  |  |  |
|----------------------------------|--|--|
|                                  | <p><i>Example: a5101.2 to indicate moderate difficulty with bathing the whole body and implies that there is moderate difficulty without the use of Assistive devices or personal help</i></p>   | <p>9 = level of assistance unknown</p> <p><i>Example: a5101.11 to indicate mild difficulty with bathing the whole body with the use of Assistive devices</i></p> |
| <b>Participation (p)</b>         | <p>Uniform qualifier with the negative scale used to indicate the degree of restriction experienced in Participation. Reference point is the <i>UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities</i></p> <p><i>Example: p730.4 to indicate a total restriction of Participation in remunerative employment</i></p> | To be developed possibly to denote subjective satisfaction   |
| <b>Environmental Factors (e)</b> | <p>Uniform qualifier, with negative and positive scale to denote extent of barriers and facilitators respectively</p> <p><i>Example: e145.2 to indicate that products for education are a moderate barrier. Conversely, e145+2 would indicate that products for education are a moderate facilitator</i></p>   | To be developed  |

**TABLE 2.3: UNIFORM QUALIFIERS AND A TABLE OF DIMENSIONS WITH CATEGORIES FOR EVALUATING PHYSICAL MOVEMENT DISABILITY**

|                                 |                              |           |
|---------------------------------|------------------------------|-----------|
| <b>xxx. 0</b> NO problem        | (none, absent, negligible, ) | 0 - 4%    |
| <b>xxx. 1.</b> MILD problem     | (slight, low)                | 5 - 24%   |
| <b>xxx. 2.</b> MODERATE problem | (medium, fair...)            | 25 - 49%  |
| <b>xxx. 3</b> SEVERE problem    | (high, extreme)              | 50 - 95%  |
| <b>xxx. 4.</b> COMPLETE problem | (total)                      | 96 - 100% |

| Dimension   | First Qualifier         | Second Qualifier   |
|---|-------------------------|--|
|   | <u>xxx. 1 2 3 4 (-)</u> |  |
| <b><u>Function of the joints and bones</u></b>          |                         |  |
| 1) Mobility of joints                                   | b710.                   | 0 = more than one region<br>1 = left<br>2 = right<br>3 = both sides<br>4 = front<br>5 = back<br>6 = proximal<br>7 = distal |
| 2) Stability of joints                                  | b715.                   |  |
| 3) Mobility of bone                                     | b720.                   |  |
| <b><u>Muscle functions</u></b>                          |                         |  |
| 1) Muscle power   | b730.                   |  |
| 2) Muscle tone  | b735.                   |  |
| 3) Muscle endurance                                     | b740.                   |  |
| <b><u>Movement functions</u></b>                        |                         |  |
| 1) Motor reflex   | b750.                   |  |
| 2) Involuntary movement reactions                       | b755.                   |  |
| 3) Control of voluntary movements                       | b760.                   |  |
| 4) Involuntary movements functions                      | b765.                   |  |
| 5) Gait pattern   | b770.                   |  |
| 6) Sensations related to muscles and movement functions | b780.                   |  |
| <b>BODY STRUCTURE(S)</b>                                |                         |  |
| <b><u>Impairments (b)</u></b>                           |                         |  |
| 1) The shoulder region                                  | s720.                   |  |
| 2) The upper extremity                                  | s740.                   |  |
| 3) The trunk  | s760.                   |  |

|   |   |  |
|---|---|--|
| 4) The lower extremity  | s750.   |  |
| <p><b>ACTIVITY</b></p> <p><u>Limitation</u></p> <p><u>Maintaining and Changing</u></p> <p><u>Body Position</u></p> <p>1) Maintaining body position</p> <p>2) Changing body position</p> <p>3) Transferring oneself</p> <p><u>Carrying, moving and manipulating objects</u></p> <p>1) Lifting and carrying</p> <p>2) Moving objects with lower extremities</p> <p>3) Fine hand use</p> <p>4) Hand and arm use</p> <p><u>Moving around</u></p> <p>1) Walking around</p> <p>2) Moving around using an equipment</p> <p><u>moving around using transportation</u></p> <p>1) Transportation as a passenger</p> <p>2) Transportation as a driver</p> <p><u>Self care activities</u></p> <p>1) Washing and drying oneself</p> <p>2) Caring for body parts</p> <p>3) Toileting</p> <p>4) Menstruation</p> <p>5) Dressing</p> <p>6) Eating</p> <p>7) Drinking</p> <p>8) Looking after one's health</p> | <p><u>Xxx. 1 2 3 4 (-)</u></p> <p>A310.</p> <p>A320.</p> <p>A330.</p> <p>A340.</p> <p>A350.</p> <p>A360.</p> <p>A370.</p> <p>A410.</p> <p>A430.</p> <p>A440.</p> <p>A450.</p> <p>A510.</p> <p>A520.</p> <p>A530.</p> <p>a540.</p> <p>a550.</p> <p>a560.</p> <p>a570.</p> <p>a580.</p> | <p>0 = no assistance used</p> <p>1 = personal assistance<br/>( this includes use of Assistive devices, technical aids, adaptations, prosthesis, wheelchair, cane and other material for help.</p> <p>2 = personal assistance</p> <p>3 = both personal and non personal assistance.</p> |

|  |                |  |
|--|----------------|--|
| <b><u>Domestic Activities</u></b>                                    |                |  |
| 1) Acquiring a place to live   | A610.          |  |
| 2) Acquiring daily necessities                                       | A620.          |  |
| 3) Preparation of meals  | A630.          |  |
| 4) Housework   | A640.          |  |
| 5) Caring for possessions  | A650.          |  |
| 6) assisting others  | A660.          |  |
| <b>PARTICIPATION</b>   |                |  |
| <b><u>Participation in personal Maintenance</u></b>                  |                |  |
| 1) Personal care   | P110.          |  |
| 2) Nutrition   | P120.          |  |
| 3) Necessities for oneself   | P130.          |  |
| 4) Health  | P140.          |  |
| <b><u>Participation in mobility</u></b>                              |                |  |
| 1) Within the Shelter  | p210.          |  |
| 2) Within buildings either than the shelter                          | p220.          |  |
| 3) Outside the shelter and other buildings                           | p230.          |  |
| 4) Mobility with transportation                                      | p240.          |  |
| <b><u>Participation in Shelter life And assistance to others</u></b> |                |  |
| 1) Housing for self and others                                       | p510.          |  |
| 2) Management of the shelter and other possessions                   | p520.          |  |
| 3) Caring for others   | p530.          |  |
| 4) Nutrition for others  | p540.          |  |
| 5) Health maintenance for others.                                    | p550.          |  |
| 6) Mobility and transportation for others                            | p560.          |  |
| <b><u>Participation in education</u></b>                             |                |  |
| 1) Informal setting  | p610.          |  |
| 2) prior to primary school   |                |  |
| 3) In school   | p620.          |  |
| 4) In vocational training  | p630.          |  |
| 5) In higher education   | p640.<br>p650. |  |

|  |       |  |
|--|-------|--|
| <b><u>Participation in work and employment</u></b>             |       |  |
| 1) In work preparation   | p710. |  |
| 2) In self-employment  | p720. |  |
| 3) In remuneration employment                                  | p730. |  |
| 4) In non-remunerative work                                    | p740. |  |
| <b><u>Participation in economic life</u></b>                   |       |  |
| 1) Basic economic transactions                                 | p810. |  |
| 2) Complex economic transactions                               | p820. |  |
| 3) In economic self-sufficiency                                | P830. |  |
| 4) In economic life  | P898. |  |
| <b><u>Participation in community social and civic life</u></b> |       |  |
| 1) In community  | P910. |  |
| 2) In recreation and leisure                                   | P920. |  |
| 3) In religion and spirituality                                | P930. |  |
| 4) In human rights   | P940. |  |
| 5) In citizenship  | P950. |  |
| <b>ENVIROMENTAL FACTORS</b>                                    |       |  |
| <b><u>Products and technology</u></b>                          |       |  |
| 1) Buildings, constructions                                    | E125. |  |
| 2) Products of education                                       | E145. |  |
| 3) Employment  | E150. |  |
| 4) Recreation and sport  | E155. |  |
| 5) Culture and religion  | E160. |  |
| <b><u>Support and relationships</u></b>                        |       |  |
| 1) Immediate family  | E310. |  |
| 2) Extended family   | E315. |  |
| 3) Friends   | E320. |  |
| 4) Other homeless people                                       | E325. |  |
| 5) Managers of the shelter                                     | E335. |  |
| 6) Health care providers and personal assistance               | E340. |  |
| 7) Strangers   | E345. |  |

|  |                |  |
|--|----------------|--|
| <b><u>Attitudes and beliefs</u></b>                                |                |  |
| 1) Individual attitudes  | E410.          |  |
| 2) Individual values   | E420.          |  |
| 3) Individual beliefs  | E430.          |  |
| 4) Societal attitudes  | E440.          |  |
| 1) Societal values   | E450.          |  |
| 6) Societal norms  | E460.          |  |
| 7) Social norms and ideologies                                     | E470.          |  |
| <b><u>Services</u></b>   |                |  |
| 1) For the consumer goods  | E510.          |  |
| 2) Architecture, building and<br>Construction services             | E520.<br>E520. |  |
| 3) Open space planning services                                    | E525.          |  |
| 4) Housing services  | E530.          |  |
| 5) Utilities services  | E535.          |  |
| 6) Communication services  | E540.          |  |
| 7) Transport services  | E545.          |  |
| 8) Civil protection services                                       | E550.          |  |
| 9) Legal services  | E555.          |  |
| 10) Associations and organised services                            | E560.          |  |
| 11) Media services   | E565.          |  |
| 12) Economic services  | E570.          |  |
| 13) Social security Services                                       | E575.          |  |
| 14) Health care services   | E580.          |  |
| 15) Education and training services                                | E585.          |  |
| 16) Labour and employment services                                 |                |  |
| <b><u>Systems and policies</u></b>                                 |                |  |
|  | E610.          |  |
| 1) Architecture, building and<br>construction systems and policies | E615.          |  |
| 2) Open spaces planning systems and<br>policies                    | E620.          |  |
| 3) Housing system and<br>policies                                  | E670.          |  |
| 4) Health system and policies                                      | E625.          |  |
| 5) utilities systems and policies                                  | E630.          |  |

|   |       |  |
|---|-------|--|
| 6) Communication system and policies                    | E635. |  |
| 7) Transportation systems and policies                  | E640. |  |
| 8) Civil protection systems and policies                | E645. |  |
| 9) Legal systems and policies                           | E650. |  |
| 10) Association and organisational systems and policies | E655. |  |
| 11) Media systems and policies                          | E660. |  |
| 12) Economic systems and policies.                      | E665. |  |
| 13) Social security systems and policies                | E670. |  |
| 14) Health systems and policies                         | E675. |  |
| 15) Education and training systems and policies         | E680. |  |
| 16) Labour and employment system and policies           | E685. |  |
| 17) Political systems                                   |       |  |

**APPENDIX 3**

**TABLE 3.1: AGENCIES INVOLVED WITH HOMELESSNESS AND DISABILITY**

| Agency and brief discription  | Objectives of the Agency  | Objectives for the visit  | Information gained that might contribute during discussion in this research   |
|---|---|---|---|
| <p><b>Co-ordinated Action of Street people (CASP)</b></p> <p>This is a community organisation of street people. Its membership comprise people from all walks of life who are involved with issues dealing with street people</p> | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Support work done for street people</li> <li>- Develop programmes that help street people through networking</li> <li>- Acquire information through research that affect street people</li> <li>- Interact with communities, government and street people on burning issues</li> </ul> | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Understand their functioning as an organisation for street.</li> <li>- Investigate what their approach is on disability issues within the homeless population.</li> <li>- Investigate the role played by Wynberg Haven Night Shelter in this organisation</li> </ul> | <ol style="list-style-type: none"> <li>1. CASP appeared to be an organisation which co-ordinates the work done by communities, NGOs with the hope of raising awareness about the needs of street people to the government.</li> <li>2. Support is given to new agencies dealing with street people as it was demonstrated in the meeting by work shopping various emerging problems.</li> <li>3. There is no clear disability strategy within the organisation though disability was included in their recent research on street people (Yeka Bantu bathethe report, 2000). Amongst its' members 2x persons had disability (mental and physical)</li> <li>4. Wynberg Haven night Shelter was not attending CASP meetings during the period of my visit</li> </ol> |
| <p><b>Napier Street Shelter</b></p> <p>This shelter is under the Haven Night Shelters' organisation. Its' goals are the same as that of the Wynberg Haven Night Shelter</p>   | <p><b>To :</b></p> <p>Help homeless people re-enter society by assisting them with employment, learning of basic skills and involvement in maintenance of the shelter.</p> <p>For the destitute at night this could be a place to draw ones breath and</p>  | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Compare the environment of the Napier Street Shelter with the Wynberg Haven night Shelter</li> <li>- Investigate number of people with physical movement disability</li> <li>- See if they have made a plan for physical</li> </ul>                                  | <p>.Napier street Shelt appeared to be a progressive Shelter that seemed to be fighting the plight of homeless people and does have success stories.</p> <ol style="list-style-type: none"> <li>1. Its' manager is the chairperson for CASP</li> <li>2. Disability was</li> </ol>   |

|   |  |  |   |
|---|--|--|---|
|   | think.   | rehabilitation of their residents with physical disability<br>- Evaluate how their environment was accommodating people with physical disability   | quoted at 27% ( 7% physical and 20% mental)<br>3. There is no clear disability strategy   |
| <p><b>The Big Issue</b></p> <p>The Wynberg Big issue is a member of the International Network of Street papers. There are also branches in Woodstock and in Bergvleit. There are 320 vendors active and semi-active within the CMA</p>                    | <p><b>To:</b></p> <p>Create jobs for street people, long term unemployed and ex-prisoners. They also run rehabilitation programmes like counselling, management of saving account.</p>   | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Investigate if there were people with disabilities employed by the Big Issue.</li> <li>- What difficulties are they experiencing at work and had their working environment made any adjustments to make the working environment more accommodating.</li> <li>- Investigate if any of them had been integrated back into society.</li> </ul> | <p>In this area where there were 320 vendors employed by the big issue, only one person had physical movement disability</p> <ol style="list-style-type: none"> <li>1. It was not clear whether this person was experiencing movement problems in his work.</li> <li>2. It was also not clear what the company was doing to support him.</li> </ol>   |
| <p><b>Provincial Disability Desk.</b></p> <p>The Provincial disability desk was established in July 1999 in the office of the premier to try and implement the strategies from the White Paper on an Integrated National disability Strategy of 1997.</p> | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Inclusion of people with disability in the job market to people with disability.</li> <li>- Mainstreaming of people with disability in education</li> <li>- See vulnerable groups like children and women as a priority.</li> </ul> | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- gain an understanding of what has been done by the provincial government in integrating the White paper on Integrated National Disability Strategy of 1997.</li> <li>- Investigate if homeless people with disability are included in their plans</li> </ul>  | <ol style="list-style-type: none"> <li>1. An Integrated Provincial Disability Strategy (IPDS) document had been developed and completed in October 2000.</li> <li>2. There is no clear inclusion of homeless people with disability.</li> <li>3. There is a strategy on CBR, and the director for the disability desk felt that this could be the entry point for homeless people with disabilities.</li> </ol> |
| <p><b>The South African Federal Council on Disabilities (SAFCD).</b></p> <p>SAFCD is an NGO and sees itself as an organisation that is committed to the promotion of equal</p>  | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Co-ordination of combined activities made by disability sectors and assist with interface at government as well as external agencies and institutions both</li> </ul>   | <p><b>To:</b></p> <ul style="list-style-type: none"> <li>- Understand the role played by SAFCD in disability issues.</li> <li>- Investigate whether issues on homeless disabled people were considered with in their organisation</li> </ul>   | <ol style="list-style-type: none"> <li>1. A lot of work is being done on facilitation of equalisation of opportunities for people with disability.</li> <li>2. Major trust is on education (mainstreaming) and</li> </ol>   |

|   |   |  |  |
|---|---|--|--|
| rights and social integration for all people with disabilities in South Africa. | -<br>at national and international level. |  | employment.<br>3.Homeless people with disability have not been considered. |
|---|---|--|--|

University of Cape Town

## APPENDIX 4

### COMMON CATERGORIES IDENTIFIED FROM THE MANAGER AND ASSISTANT MANAGER'S INTERVIEWS

The information below, was gathered by the researcher as explained in Chapter 3 (Methodology part 3):

#### Manager's interview

##### **Lack of family support and abuse by family**

Ah-ah, things went terrible wrong in his life, and he doesn't have support system.

Though he will boast about a brother here and family that will do things for him, he will be buried here.

His first grant was a some of R5000-00, his son collected it, and he never saw his son again. He hasn't given his father a sent of that money. Moonshine has got a sister, but I don't see Moonshine getting out of the shelter.

His family won't take him, he will probably die here, and his family will bury him.

They never come to see the old man, he will die here he is having nobody.

I am not going to get that protection from my family because they have abused me and they have mentally abused me so I am not going to go to my family.

Yes, and when he didn't have money they pushed him out into the streets.

It's very sad, it's very sad, but looking at the backgrounds you can understand why it is so.

##### **Exploitation by employers and society**

They all come from employees who had exploited them in paying them with drink and then they come out being alcoholics.

It's the system which have made them, if you come and work for me today, I just give you R10, the next thing you go to the bottle store with that R10, what can you do with R10?

One of the service providers had been drawing Morning-Dew's money. Malgas has to give him a percent of his money.

He received his pension, and his pension book was with a certain lady, a certain prominent

### **Strict institutional regulations**

You see the imprisonment its for their own good, because there are programs they can work in the garden, they can do a bit of woodwork, painting, everything is there for them.

You see if you drink too much, I am not going to let you out I am going to keep you in the shelter and dry you up for a week.

I cannot allow them to further destroy their lives, once they become so ill or so incapacitated or incontinent it will become my problem.

You see money is not a problem, but if you do get a state grant we will not allow you to take advantage of it, because you use the money on substance abuse.

They get pocket money every weekend, I have cut it down from R30-00 to R25-00, Strength is very unhappy about the decrease of the pocket money.

If they drink today I won't let them go out for two days.

I cannot let them waste their lives like that; it's for their own benefit.

You can not handle her so if she is in that condition she is not allowed to enter that gate.

I don't see her staying long out of the shelter, because we will put her out of the shelter if she doesn't improve her life style.

She also need to be told that you must go and work for those people but their things are theirs, it's not to be taken from their homes.

I am very strict sometimes, they call me a dragon, and it's fine if they call me a dragon.

### **Manager's stressful workload**

Sometimes the workload is so big but I still need to find time for each individual. All the time everybody wants my attention and I have to try and give it to them at the best of my capabilities.

My stressful situation is this Christmas party; I don't think I am going to do it all.

They came, we served them, but it's a very stressful situation

We didn't get everything we need; they were very upset with me.

I take all those juices and yoghurts and give them to people in the streets and the people from inside become unhappy about it.

I was accused 2 weeks ago of giving out blankets with lice.

### **Racial tensions and power struggle**

It is fine for you to say what you have done for people in the street, but if you tell other people what you are doing you have done absolutely nothing. You don't tell other people what you do.

All I can tell you is that it's very politically. Its whites against blacks, because I am not white and my committee is not white, its terrible. They call us an old age home.

The white people in this area don't want us here. There are a lot of white people involved in the shelter but they still don't want them accommodated here.

The white people think that they have to know how and the experience and they think they know more than what you know. We don't buy that; we don't buy that, so we sitting on a political time bomb here.

Moonshine is white, white people would give Moonshine money, because he is an old face in the area.

What I am trying to say is that we have surrounded ourselves with very important influential people and that is very good for us.

### **Relationship with Wynberg Community and Police**

We know our rights, I also want to tell you that we don't receive donations from the Wynberg business people, the only person who is wonderful to us is Woolworth's.

So the story had gone that my husband and myself live in a mansion, because of my husband and I what we do in the shelter. I do live comfortable but not from the donations from the shelter.

I don't have a good relationship with the police, the police goes around to business people saying the homeless people don't benefit from the donations, the R's benefit.

We are sad because they are actually with holding things from the people that actually need them. Things like that can break you terrible, but if you know it's the truth, the police had actually opened a docket against me It's a sad situation, but we persevered because we are here for the people here not for ourselves.

Such things were said that the money that comes here goes to our bank accounts.

Neighbours are not interested in the shelter, though we are strategically situated; the community rejects the shelter. 90% are whites; most homeless are black and twice coloureds. This is a nationalist government area.

### **Relationship with other organisations for homeless persons**

The resources for rehabilitation are within the shelter but I want to say to you there are lots of politics outside the shelter. **What do you mean by that?**

I want you to record this, are you recording. When I am being asked to relocate because they want to use this centre and that land.

Big issue, word provider for the homeless and also support system for the homeless, which to me is a good idea. So they want us to relocate, but they will still accommodate 40 people here, why must we relocate and they take over, we will lose our whole donor base.

They don't want to because we are very strong committee we have same people serving in this committee right from the beginning, it's gone be 10 years next year. They have got lots of white people serving on this committee. South Peninsula has a clause, which states that when our contract finishes in 2003 we can renew it for another five years.

### **Relationship with other shelters**

Oh yes we have relationship, very close relationships with other shelters. Should we have a problem with a client we phone other shelter and ask if we could take that person to them, we have that network.

Also, if we receive donations in bulk we share among other shelters. They will support you when you have a shortage.

### **Types of jobs the disabled homeless persons do in the shelter**

He must see that the tiles, the toilets and the, bathrooms and urinary shine.

Once a month we do blankets for the shelter, Sunshine and Hope help with that, also hope helps with the washing.

Eagle, Star and Morning – Dew, they are the gardeners, and when people phone for gardening services, those are the people I will send.

She sees that the clothing in the containers are packed up nicely, she also see to the women's bedroom is kept clean. Sunshine is an artist in her own right, these wire little ornaments she can make them.

Dawn sees to the birds, and when I feel I can trust him he sees to the gate.

### **Improvement on substance abuse and physical disabilities**

If they cannot get of the drink, there is no reason why their physical disability cannot be rehabilitated because I think the drink is making it worse. Their physical status would improve.

Eagle has improved; I can understand why he has improved. He lost a job last month; he was boarded last month, so he has no money to drink.

Moonshine is of the drink completely, I am very glad. **Oh that is wonderful.**

Moonshine was discharged from the hospital and later had a stroke, then he was off the drink for 2 years.

### **Lack of improvement in substance abuse and physical disabilities**

They are beyond rehabilitation. **Why do you say that?**

I would take them in and dry them and they would still go back and drink. **What about physical rehabilitation?**

There is no improvement, Star, Dawn, Morning -Dew, there will never be an improvement in them unless they are locked up and dried up.

Dawn, Star and Morning-Dew's physical disabilities have gone worse

Since he got his disability grant he has gone worse.

But where the drink is concerned they are beyond rehabilitation.

### **Assumed education and activity prospects and lack of motivation**

Jewel because of his disability he can do very little for us

He can do nothing, he doesn't even read.

You can educate and educate there is nothing you can do.

They have lost interest in life.

### **Negative perceptions about some of the disabled homeless persons**

The manager responded for them and said "You see amongst the physically disabled, there needs to be a strong one that can carry this through, somebody with leadership skill need to come out of this group, but among them there is not one with leadership skills, not one. I think you must speak to them now about leadership skills"

During this time an uncomfortable silence sets in and then the manager has to attend to somebody at the gate.

He is a very rude man, he will say the most hurting things to you, and things you would never think or say to other people. The next day he will blame that to drinking.

He doesn't have remorse for what he did for those two people he murdered, he will still

take you, he will sleep with a knife under his bed, he doesn't care, he has no respect, he has no remorse for the things he did, and he will tell you that he will do it again.

Because they are residences here they get so much more and they become selfish that they don't want to share. They become selfish and not want to share food with anyone. They will not share. I also want to tell that they are very territorial. They are very ungrateful and they expect more.

Eagle is a big liar too, he has told a lot of liase, he has gone around saying the shelter imprison him.

Street people for them to survive on the streets they must be absolutely shrewd for what they can get out of it.

She is a very aggressive child, we set Sunshine, but the tools disappear.

Hope is a very lazy person

Star is the worst and the dirtiest of them all.

It's shocking to see how these people live.

#### **Lack of infrastructure to support the disabled homeless people**

When you come in you are told that you are on your own, no body is responsible for you, and I am responsible for you ultimately.

I want to tell you something, they come here and are responsible for their own things, we don't have the infra structure to look after their things. You are responsible to look after your clothing, wash your own clothing, and see to yourself.

That we don't have an infrastructure to look after them; they pay us R300-00 a month.

**I talked to them about a support group for the disabled, and they may require somebody from outside to come and help them start the support group, what are your feelings about that**

It will be good, but I am not going to be involved in that, I have too much in my hands.

I will sat up everything for that, I will sat up the weekly meetings, I will keep them for the weekly meeting, but somebody else must come and co-ordinate that an outsider.

#### **Perception of the impact of disability**

So all of them they manage somehow with their disability, its only when they are drunk, things become more difficult, and in terms of rehabilitation.

We are trying to get him a wheelchair. **Do you think he is a candidate for a wheelchair? Yes. Why do you think that? Why can't he use crutches?**

Because he doesn't want to. **Do you think if he can get support he cannot manage?**

We have tried with people here in the hospital, he prefers to just slide. He gets around, He gets up and down the stairs. We will not be given a wheelchair, we will have to get him a wheelchair, we tried that he should use a walker, I think he has given up on the idea. Because he has given up, he is a candidate for a wheelchair, otherwise there are many people in the street like him who can walk, but also he has toes amputated on the other leg.

### **Positive attributes of the disabled homeless people**

Sunshine is a very hard worker. She is very reliable in that, she follows instructions and sees to it that they are carried. Sunshine can be an excellent dissent girl, when she is dissent she can be an excellent worker. I would recommend her any day to go and work for people.

He is actually one of my dearest old people. He does not give me a problem, he will wash, and he is a clean man. If he tells me this morning, he tells me in a very ugly way sometimes, he wants to go out. I let him go out because he is not like Star, Dawn or Eagle

and Jewel. He does not mess, if he needs to go to the toilet on the street, he will find a toilet, whereas others they won't find a toilet they will sit and mess on the street.

He is very willing to work in the men's area. When he does it, he does it thoroughly.

Eagle is a very intelligent man, and he is an educated man, and the day he wants he can be a true gentleman in both manners and dress.

He is also a very intelligent person, Star will first read all the news-papers, and Star is an intelligent person.

### **Rehabilitation services in the shelter**

We have a social worker.

AA intervention.

We also have discussion for HIV and AIDS.

### **Lack of rehabilitation facilities for physical disabilities**

I don't have rehabilitation facilities for physical disabilities, because we don't cater for disabled people.

So all of them they manage somehow with their disability, its only when they are drunk, things become more difficult, **and in terms of rehabilitation?**

I have got Star, Morning – Dew, Eagle, and Dawn doing gardening service. I have got Sunshine involved in getting jobs.

**When I speak about....** Oh you mean about learning a skill?

I actually mean looking and addressing their needs as disabled people through comprehensive rehabilitation.

If I want to be honest with you I have never tried that avenue yet.  
Because we don't have an infra structure, I don't have the staff to do that.  
I know this doesn't answer your question.

Yes, "They are protected more than people here and when they need to go to the hospital I remind them, in that sense they are actually protected by me. They will get the beds closest to the toilet. I don't know how to put it, we pamper them."

**So you pamper them but you have never thought of physical rehabilitation for them?**

No.

I cannot answer that; it's a very difficult question, what I would like you to do is for you to make recommendations to me. We are going to need your assistance; we are busy with big projects.

**Awareness about ill-health on some of the disabled homeless people**

He is an asthma sufferer and his epileptic and he had a stroke but his disability doesn't hold him back

She had a car accident; she had a terrible leg, which needs to be dressed daily for the past six years.

He has got cancer of the oesophagus; he doesn't go for check- ups. Sometimes they go beyond appoint, where they don't care anymore. He have got TB 3<sup>rd</sup> time around and I think because they drink and not want to eat, they share with friends bottles when they drink, its easy to spread, he is lazy to take his medication but this time around we see that he takes it.

Sunshine I suspect is HIV positive. **This is strictly confidential.** Yes, I suspect she is HIV positive. Why I suspect, because we had a person here who died of AIDS that person and Angelo had sexual relationship with the same man. You can only talk to them, when I realised that this person has died of AIDS I had to talk to all of them. I had to say for your own safety, for your own good, have a test, if it is negative or positive, if it is positive then we can start with life change, just to ensure that you have a longer life span. Sunshine will also just go off, I strongly suspect she is HIV positive

There was a time we thought she was going to die, you see they share the same sexual partners.

### **Awareness about sexual needs**

They are all sexual human beings, How and where sex comes in such old people, but he will still not sleep here and when I ask him where were you last night, he won't say anything just smiles. He spent time with the girl friend. I find this so amusing, I studied sexuality, and we are all sexual human beings until we die.

### **Assistant manager's interview**

#### **Mission and approach of the Wynberg Haven Night Shelter**

You see the shelters are almost similar and the rules are the same. I must say this shelter, is one of the few shelters where people stay in during the day. Where as in other shelter people leave at 7 and come back at 5. That is part of the skills programme is to keep people in so that they can be used to be in one place for a space of time. Here there is skills training, they do welding, gardening.

#### **Disability issues**

In the shelters you were in did you find a lot of people with disabilities?

Oh! Yes, round about 20 two 25 percent, you see here there are about 40 homeless people and more that 10 have got physical disabilities. Its is a combination of both mental and physical disabilities including TB.

#### **How the needs for disabled homeless people could be addressed:**

There should be a social worker that supports them in how to deal with their disability money. The money must be deposited in their personal accounts; they must pay boarding and lodging then weekly get pocket money. Their money must be administered in a proper way.

Equipment is a big problem, you see the guy with an amputation must get a wheelchair, you see socialising is a big problem. Even if we take them for rehabilitation into the hospital, there is no carry over here because of problem of time. They need care people like that; they require special care and motivation.

#### **Do you see this building being conducive to people with disabilities?**

Its not, you see for instance, the guy without the leg, still sleeps upstairs, and had to shift himself up the stairs.

**Here in the shelter there is no plan for rehabilitation strategy and no connection with the disability movements from outside? No. and in future. I don't have a clue.** The shelter requires a professional skilled officer, a social worker to tackle the issue of alcoholism within the shelter, in conjunction with AA.

#### **Abuse by family members and employers**

You see we do take care of those people. Yes, you might have been staying with a family, once you are disabled you don't bring enough into the family and you are thrown out of the family, and where do they go to, they go into the streets, and try to take away their problems by using alcohol.

Also I have said this over and over, you see in the wine farms some people don't pay their workers with money but just give them alcohol, and this still exists in some farms, up to four five times a day they get a mug full of wine. This also has contributed to homelessness as gradually the health status of the person would decline up to a level where he is not productive and would be kicked out of the farm then he would be homeless.

Another problem is the improvement of machinery with in the farms where by they are kicked out of the farms by modern machinery. Where do they go to, they run to Johannesburg and Cape Town and they still find it difficult to find a job, and find here that its even worse and they become street people.

#### **Potential of the disabled homeless people**

I saw him cleaning the wash basin, and then I could see that he wants to do something. Then I asked him to clean the showers.

The other day he came and he said he wants to scrub the dining room, he scrubbed the whole dining room.

He participates well where he could but there is room for improvement, there is lots of potential.

Yes he did it slower and longer than the other people did, but he did it well. He felt very proud, he is doing something.

Well motivated with good self-image and independent.

Good activity and participation levels.

She has a lot of potential and a big self-image.  
Very intellectual person.

#### **Managers role on the disabled homeless persons**

**You as the manager?** Ja ! That is the main thing. If you can adopt a certain schedule of approach towards these people, not snubbing them what so ever, talk gently, talk nicely help them that way, so they start to feel confidence building up. Then start confiding to you and they run to you if they have little problems.  
So you see he wants to do something.

Approach is very important, with good approach you can get more out of them.

He is always laughing, that also depend on your attitude towards them.

Trust is very important, so there you are.

He needs motivation and trust.

### **What the disabled homeless people can contribute towards their rehabilitation**

**To go outside and look for rehabilitation, a lot of rehabilitation can happen here within the shelter.** That is why I say a lot of these people with a bit of mentality which is left, of course a lot of it is killed by alcohol, they can be trained to help.

If you can get them organised so that will give them a feeling of worth, as they will be caring for the others. That is what life is all about one caring for the other.

You see street people are a funny lot of people, there is sort a mutual bond between them, and there is someone who will help out.

Already this girl has perceived that this is a need for this girl. So there is a lot of support, they take care of each other. There is the pregnant woman, she takes this one for a walk outside, to see outside.

**Do you see that, this element of them taking care of each other could be transferred be used for rehabilitation, that those who are not disabled could help those who are disabled?**

Sure, definitely. It is a possibility, but they need lecturing. This would help because the managerial staff doesn't have time.

### **Needs of the disabled homeless people**

**Will she ever leave the shelter?** Yes, provided she is given guidance and support. It is a pity there is no social worker. She needs motivation from the social worker or professional.

He needs professional quality time. I am positive about his rehabilitation prospects.

I think he should get into one of the disabled workshops, and do certain manual skills.

In terms of his walking, he is very slow, I wonder if he wouldn't be better with crutches, I saw him the other day using one crutch.

The major draw back is his speech, movement and poor eyesight. He doesn't get out of

the shelter.

### **Environmental constraints in the shelter**

He had tried to adapt into the environment of the shelter.

### **Perceptions about their social needs**

He likes socialising in the evenings sitting talking to other people.

I do not think any of the disabled people are isolated.

John is always to me in high spirit.

### **Poor prospects for change**

He will never change, this environment suits him.

He will never change. Had been homeless for seven years

Difficult self image when drunk.

His self-image becomes distorted when he is drunk.

Eagle is a loner with a twisted self image and will never fit in the society.

Lacks will power needs a lot of motivation. He has poor self image

Quite person, more into self, very lazy.

### **Perceptions about their activity level**

He doesn't experience many problems, he can still move around but slowly.

Outside the shelter he operates well and the environment doesn't inhibit his participation level.

His level of activity and participation is good and the environment is not restricting him.

He is quite active and has his own circle of friends he participates with Star and Eagle (three musketeers).

He doesn't have problems with the environment.

Working all the time.

**Alcohol dependency**

Star is a very able person, its only when he is drunk that the disability comes to the front.in any way.

Very nice person when sober, alcohol is the big problem.

Alcohol is the downfall, can be difficult while drunk.

Alcohol is the problem.

**Control on their money**

Star and Morning-Dew, are the people I send out regularly to do little jobs. Both of them have got thousands of rands, but they also know that they will still get the same pocket money as the others and the weeks they work they don't get pocket money they can use the money from their jobs.

**Awareness about health condition**

Not very active, he is frail due to TB and alcohol.

## APPENDIX 5

### ***IDENTIFIED THEMES N(4) WITH CATERGORIES UNDER EACH THEME FROM STORY-TELLING FOR ADULT HOMELESS PEOPLE WITH PHYSICAL MOVEMENT DISABILITY.***

#### **Theme 1: Problems experienced**

##### **(1) Poverty – (not enough money for basic self-care): N=6**

Other people have money and I don't want to ask people for money. All I ask Money for in the streets is money to buy tobacco.

Being without money, I had to sign all the required forms by Doctor's and I. You must buy your own sugar and coffee, I don't have money to buy those items.

Have also signed for unemployment.

Other people are working for money; it is very hard for me.

I don't have an income.

I need perfume and a watch.

##### **(2) Unstable shelter conditions: N=6**

People will tell you a lot of shit. Sometimes it's good, you see they always pick on me, they forget what they do. I don't feel I am part of what is going on here. Everyone must help himself. Some people are very difficult. Nothing to learn here.

Oh, people are the same, today they are like this, the next minute they Change, so you can not trust people completely. It is easy to talk to you.

Even here you must be selective about people you choose; outside you must stay in One place, it is difficult to be selective about people.

If you ask people why they insult other people. This makes me not like to ask people for something.

When people make me cross, that makes me sad.

Quarrel between us, always arguing.

**(3) Absence of meaning, sadness and despair: N=5**

Sometimes I think to kill myself. It is the only time then I won't have any problems.

Not all people are good for me here, homeless people are not good, and I am very lonely.

My heart is sore, when I tell people about my life story it make me very upset, that is why I like to keep it behind me.

I see my life not as usual, my life has changed, I am not normal like other people. Initially saw myself as the only person with a disability, then I remember the guy with an amputation, I see myself in a bad condition.

I can do nothing for myself, I sickle only God can help, des swaar vir ons.

**(4) Lack of support/abuse by family: N=6**

My family doesn't treat me nicely; they don't treat me like a brother, and they treat me like a stranger.

I find papers, which showed me that I did receive disability grant and all the time she was drawing money from my account without my knowledge. All my documents were in this bag.

I cannot live with the relatives, as some of them they smoke dagga and madras

I used to stay with my daughter, and she is married to a man who doesn't work. When he is in the house and I am out he steals my money; I couldn't take it anymore.

My child's father wants to fight me when I visit my child.

I had a car accident; I stayed with my mother. I couldn't help her because of the accident. I didn't have money or place to stay.

**(5) Strict institutional regulations and lack of trust: N=6**

There is only one complaint; we must sit here the whole day, we must walk up and down. Its is important to walk up and down because there are people who give you things and money.

I feel very unhappy. I am still here, I am not given good treatment, and I cannot go out I have to stay here like a child. I must stay here like a convict that is not nice.

I am a big person, I take my drink, it is not anybody's business, and it's my business.

This woman Mrs X say we must stay inside, why should we stay inside. I could be her father, why should she treat me like that. She wants to control you. I want dignity, care and respect.

If I sit here the whole day my legs become stiff.

Sitting here the whole day is a big problem.

Though the manager of the shelter is not aware of it yet, we are looking for a place to stay. I do not want this woman to hear this, as you kept in here and you are given work, sometimes the work, the domatries. This leg is very painful, I don't say anything because I feel I might be chased out. Sometimes you are kept here the whole day. If you are left alone and not be given too much work then I would be fine.

**(6) Substance and alcohol Abuse: N=7**

I am trying to stop drinking, if I think about my problems, just to forget about it and I have money in my pocket, then I drink, the next day it's all right again.

I have got a drinking habit

Especially me I am a drinker if somebody comes and fools with me I get aggressive and thus not nice.

"It's only when I have drunk that I am a different person, and tomorrow when the drink is up I am again a different person."

The problem with myself, maybe I go out doesn't want to drink, and then I get angry and go and drink.

Smoking  
Drinking

Drinking  
Smoking

**(7) Activity limitation: N=9**

I cannot do things other people can do (walking fast, my arm is not feeling all right and I cannot do things I normally do).

I can not walk, I was a painter and driver, and I cannot do any of those things.

Cause I don't see properly. I cannot walk properly, and my eyesight is poor. They stay far from here, I must travel by Taxi and then walk, and I get tired from walking and short of breath.

I cannot pick up heavy things

Outside the leg is very bad in moving and going through the stairs sometimes had to be transported by the van to get to the hospital When you are outside, its not like being here, here you are sheltered.

I am used to walking and going to church, if I was not staying, it would be difficult for church ministers to pick me up somewhere else. They do come and pick me up here.

I cannot walk without this thing (walker) and I can walk for a short distance without that thing. Lots of people walk out in the street and him and me cannot.

I try to walk without a stick but I could never be able to walk outside the shelter.

Sometimes I can't walk properly, sometimes when it's cold it's difficult

Sometimes outside the shelter I get tired and sit down.

**(8) Participation restriction in work-related aspects: N=9**

I have been a worker all my life, now I cannot work except doing odd household Chores.

I feel that if I was not that old, you see I was a switch board operator if it was not for this leg I would be in a good job.

Sometimes in the shelter, I cannot work in the garden, I cannot do hard work.

I can do any kind of work with my hands, but there is no job.

I still want to work, I love my work very much, and I was in the finishing department, and we made desks and cupboards for the schools and hospitals. My biggest problem is that I cannot do the work anymore.

I used to drive big trucks but now that is not possible.

It makes me feel very sad because I cannot work with other people

Outside the shelter I cannot help other people, if people come with bags seeking for people to carry them to the taxi, I cannot.

**(9) Feeling vulnerable on the streets: N=4**

I set on the pavement and took out a cigarette, and then this guy came and passes me and took my cigarette, I couldn't run after him, I cannot even walk properly. I cannot run after people, I am paralysed.

Outside you need to take care of yourself and avoid being friendly with everybody.

I also cannot run if I am chased in the streets. That makes me feel bad, If I am attacked I cannot run but just ward off.

I don't trust myself with cars and wind, you see since I have been out of the hospital I haven't gone shopping, but I would also think the lifts are okay,

**(10) Environmental restriction in the shelter: N=4**

I sleep in the lower bed, not involved in cooking nothing to hold on to.

You see we stay upstairs, sometimes its okay and many times its very painful to take stairs.

Going up the stairs make me feel tired, coming down its alright and the roads sometimes its difficult.

The stairs I got used to sleeping upstairs, you see we are 26, I am an active person but I get tired when I go up the stairs also my arms become swollen

**(11) Concern about health: N=5**

This other problem make me upset, I have got e epileptic fits. I am on treatment from the hospital.

I see myself as a disabled person, in summer I can be able to do a bit of housework, but in winter it is even difficult to get out of bed, it is so painful. I also have a painful stiff back one of the things wish make me aware that this is TB spine, why is it so painful.

In winter, its cold, my leg and this arm become very painful.

I had a pain on my chest and I thought it was cold and I had to go to the hospital, they had to take X-ray and they discover I had TB so I had to take tablet daily. ime and again I had to go through chest X-rays and they discover great improvement.

Saw a lot of damage, the spinal cord is damaged and they cannot I got TB, I started coughing blood and my legs and arms were swollen. Has doctor checked your back? Yes, they even operated.

**(12) Difficulty in getting access to health services: N=1**

They ask too many questions, and they don't trust when you say you don't have work.

**(13) Lack knowledge about physiotherapy and rehabilitation: 3**

I can do nothing about rehabilitation; I can do nothing about this.

No there is no place for that here.

No future plan about walking.

**Theme 2: Needs identified****(1) Need for Respect and Dignity: N=4**

I want a little bit of respect. If you are drunk, and I am not, don't talk to me. If I am drunk and want to be happy, and then I go to the room.

I value respect that is good for me and those close to me,

I also respect those who respect me

I mix well with other people because they like me, they respect me, and I like that too.

**(2) Accessibility needs at the shelter (or outside): N=3**

I need rails to get in and out of transports.

The stairs should have a rail.

I need rails to hold on. In the shelter I hold on to tables and walls.

**(3) Need for family and relationships: N=6**

I will go back to Knysna where my family and people are; I have love and respect for that place.

I wish I could have my parent's back.

What would you do if you can have your parent's back? I could stay under their roof.

Since my parents died, we were staying in the council house, if I was married I could have stayed in that house.

I see that people, who are married, I think I should have got married, my life could

have been better.

My children are the most important aspect of my life I want to see my family.

My sister was here for about three times and I must go and visit them

**(4) Need for housing: N=2**

That is good that you have asked me that question, I don't intend to stay long here, if possible, some other person and me we are going to go out of here. There is a place we are going to. **Where is this place?** In Parkwood, already she has been promised a place, and because she is alone we will go together

I don't see myself being able to get out of this place at the present time if I can get an old age pension as next year I will be 65 then I can go to an old age home.

**(5) Need for forming a disability group: N=7**

Mr Star said that if you are in the same post and all have the same problem as far as movement is concerned then you feel happy being in the same atmosphere.

Mr eagle responded that, "It would be very nice if we could form a group here but the atmosphere here to one another is not nice.

"As far as I feel if somebody from outside knows how this works he or she can come, help us get it started and give us a guideline, he can advice us."

One of them asked, "In a group like that what could each one of us contribute?"

Mr Moon responded that, they could contribute their love for each other, they will give each other advice how to handle disablement and how to love one another, as brothers or friends not as enemies.

Some of them said simultaneously, "When we come together we must converse with each other and we all have an ailment and being one suffering as a team we will overcome this (this was said with such spirit and vigour)."

The other respondent felt in a group like that he can listen and believe them, after some motivation he responded that he could talk to the group grand.

The other person responded that he doesn't know how to put it but I can say what is right and what is wrong.

I will be interested to join a disability group and listen to what they say about

disability and homelessness.

It would be good for people with disability here to form a group; they will help each other, love each other with their disabilities and no arguments.

Yes, but not now while I am still getting my problems sorted out. I have seen on the TV, they stand together because they have the same ailment.

I would be interested to join a disability group.

A lot. Why? You see as we are talking now, as you are disabled sometimes you lack somebody to talk to.

Mr Star mentioned that he saw the whole issue of a support group happening slowly, in the first instance they need to stay away from each other.

### **Theme 3: Positive attributes**

#### **(1) Spirituality: The hope source: N=9**

Oh Yes! I believe in God thus all. I ask Jesus to help me, guide me, and give Strength, keeps my life, and keeps me safe in the hands of man

But then I think again that I must thank God that he is still looking after me in spite Of all the problems I have, he is still looking after me

I believe in God, I believe so much in God. If it were not for him, I wouldn't be Here today. He shows me the present life.

To be free with anybody makes me happy like talking to you. To be a Christian, to Love everybody and everybody loves me.

I cannot say I respect richness. If I want to be rich, I must believe in God and God will help us all.

I wish the rest of my time on earth would be pleasant irrespect of whatever Happens and whatever ailments I have got, I will take it as it comes

My greatest wish is for you to tell your God to spare me for many years.

I ask god to help me carry without this thing you cannot do nothing for yourself.

I wish for luck and that will make me happy.

My greatest wish is prayer

Only god can help. My wish is to get my strength back again.

**(2) Acceptance and satisfaction with current circumstances: N=9**

The good things about this place are that you have got your bed and you have got your food.

This woman and Mr R give us good treatment.

You see there is nothing we are complaining about here, but it is not a home.

The lady from this place help me with sugar, other people from this place do not, you see there is nothing wrong with this place.

I am prepared to stick out in the shelter whatever conditions are.

They helped me in a lot of things, if it was not for them, I wouldn't be alive

Do they give you pension?

Yes, I am getting pension, but now I am getting disability grant. Have they Stopped the pension then? Let me say that they come to visit me and they don't forget my birthdays.

There are people, who are more severe than me, but still sleep upstairs.

But anyway I just bite through because I am under the roof.

The environment is okay except the stairs

So far I am lucky.

**(3) Relationship with government: N=6**

The government we have now is better that the national government, The National government didn't treat us nice, like we coloured people and the Bantu people were treated the same, hey you Hottentot, hey you kiffar, but now it is no longer like that. Look at the pension we have now, before with the national government we had very little then. They give us money now, R540.

The government is doing something for me.

The government is doing something for disabled people but there are lots of channels one had to go through and many forms to fill.

The government is doing a lot for disabled people

The government is helping many people who are disabled.

You see if it was not for the government I would no longer be living, the Government had than a lot.

**(4) Relationship with the society: N=1**

Oh yes, they give us nice presents, they give us nice Christmas.

**(5) Awareness about individual strength: N=4**

I see myself as a good person.

I believe in one using his common sense and working hard, then you will live better. Another thing I am grateful about is that mentally I am still all right.

**Why do you it is important that you have not lost your mentality, how is that going to help you?**

That is going to help me in many things? Like what?

As we are talking, I am in a position to question you, as you are in a position to question me and we can conduct a dialogue. If my mentality was affected, that was not going to be possible.

I feel all right, I am not lying I stay nice and no worries for me.

**(6) Knowledge about physiotherapy and rehabilitation: N=1**

People who train other people to walk, yes at a day hospital in Retreat.

**(7) Gratitude from disabled homeless people: 2**

“I have got no questions, I am really grateful, I am really grateful for your assessment and your talk. I am also very grateful for the input you gave me that was quite something.”

Mr Eagle said at the end, “I don’t want to ask questions, but want to respond and say, as far as we are concerned having you talking to us today and having you visiting us we feel very proud, and having this problem discussed we feel there are people who are interested who feel we need help and time, coming together as a group we could get this straightened out.”

### **Theme 4: Negative attributes**

#### **(1) Short tempered N=1**

You see I am very short tempered, if somebody tells me this and that I tell that person straight.

#### **(2) Fighting and arguing among each other N=4**

Quarrel between us, always fighting and arguing.

If you ask people why they insult other people. This makes me not like to ask people for something.

He replied and said, "If we can't understand one another it's no good to stay together."

When people make me cross, that makes me sad.

#### **Being short tempered N=2**

I have got a bad temper, if you tell me this and that, I become cross

People who are drunk make me angry

#### **Not supporting each other N=1**

I am ver lonely hear, homeless people do not support me

#### **(3) Substance and alcohol Abuse: N=7**

I am trying to stop drinking, if I think about my problems, just to forget about it and I have money in my pocket, then I drink, the next day it's all right again.

I have got a drinking habit

Especially me I am a drinker if somebody comes and fools with me I get aggressive and thus not nice.

"It's only when I have drunk that I am a different person, and tomorrow when the drink is up I am again a different person."

The problem with myself, maybe I go out doesn't want to drink, and then I get angry and go and drink.

Smoking

Drinking

Drinking  
Smoking

**Conclusion of the interview for the homeless people with physical movement disability**

**Homeless disabled people being more than labels:**

As the interviewer of the disabled people having talked to them that morning I felt as if I already knew a bit about them and identified with their experiences and stories and for me they were quite touching:

I asked them if among all of them they don't see somebody with leadership skills, I tried to motivate them by saying, "I think within yourselves you do have leadership skills and I think everyone was born to be a leader."

I replied by saying, "You see thus wonderful, you see, you already have a plan and taken charge."

I responded to this by reassuring them that, All of them in their own right they are leaders, and everybody wears the crown.

I concluded by saying, that one of my objectives were to go out and enquire from disability groups about what are they doing about disability within homeless people.

## APPENDIX 6

### INTERVIEWS FOR NON-DISABLED HOMELESS PEOPLE FROM WYNBERG HAVEN NIGHT SHELTER

In a one to one private interview categories from the ICIDH-2 relating to the dimensions of activity (a) participation (p) and environmental barriers (e) were asked. These were coded using uniform qualifiers. Below in Tables 6.1-6.4 and figures 6.1-6.4 are combined responses from these categories.

**TABLE 6.1: COMBINED CODED RESPONSES FROM THE CATEGORIES UNDER THE MOVEMENT RELATED ACTIVITY DIMENSION FOR THE HOMELESS NON-DISABLED PEOPLE.**

| Uniform Qualifiers | xxx.0 no restriction | xxx.1 mild restriction | xxx.2 moderate restriction | xxx.3 severe restriction | xxx.4 complete restriction |
|--------------------|----------------------|------------------------|----------------------------|--------------------------|----------------------------|
| Combined responses | 68                   | 8                      | 44                         | 6                        | 6                          |

Table 6. 1 represented below by figure 6. 1

**Figure 6.1**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six non disabled homeless people from categories relating to activity dimension.

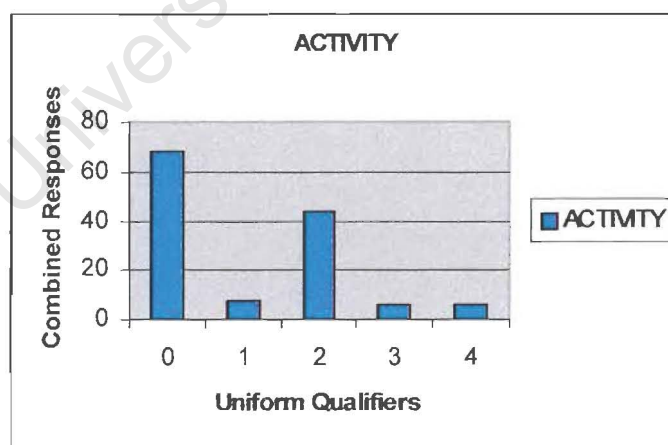


Table 6.1 and Figure 6.1 show that the homeless people with no disability had high responses under the no problem uniform qualifier followed by moderate. It was noted that the activities that were coded as moderate were complex activities e.g. using transportation or taking care of ones health.

**PARTICIPATION RESTRICTION OF NON-DISABLED HOMELESS PEOPLE**

**TABLE 6.2: COMBINED CODED RESPONSES FROM THE CATEGORIES UNDER THE PARTICIPATION DIMENSION**

| Uniform qualifiers | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>moderate restriction | xxx.3<br>severe restriction | xxx.4<br>complete restriction |
|--------------------|-------------------------|---------------------------|-------------------------------|-----------------------------|-------------------------------|
| Combined responses | 57                      | 20                        | 57                            | 51                          | 30                            |

Table 6.2 is represented by figure 6.2

**Figure 6.2:**

Key: X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the Six non-disabled homeless people from categories relating to participation restriction dimension.

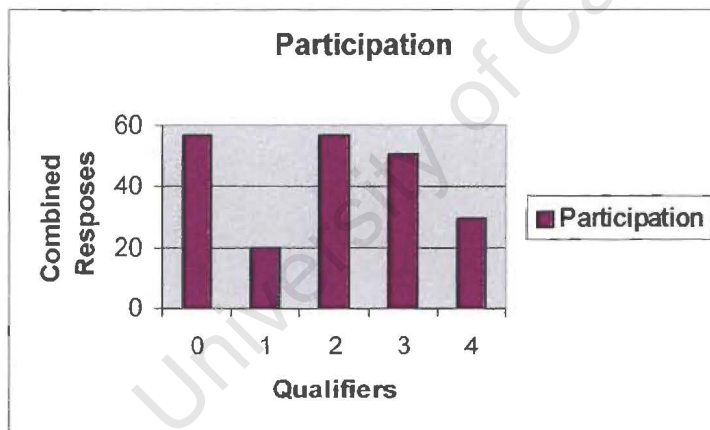


Table 6.2 and figure 6.2 shows an even distribution of responses under the uniform qualifiers of no problem, moderate problem and severe problem. Minimal responses were under minimal problem and total problem. Categories the homeless people responded negatively for were those related to relationships, family support and interaction with society.

**ENVIRONMENTAL BARRIERS FOR NON-DISABLED HOMELESS PEOPLE**

**TABLE 6.3: COMBINED CODED RESPONSES OF THE HOMELESS NON-DISABLED PEOPLE FROM THE CATEGORIES UNDER ENVIRONMENTAL BARRIERS**

| Uniform qualifiers | xxx.0 no restriction | xxx.1 mild restriction | xxx.2 moderate restriction | xxx.3 severe restriction | xxx.4 complete restriction |
|--------------------|----------------------|------------------------|----------------------------|--------------------------|----------------------------|
| Combined responses | 20                   | 10                     | 61                         | 141                      | 61                         |

Table 6.3 is represented in figure 6.3

**Figure 6.3**

Key: X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the Six non-disabled homeless people from categories relating to environmental Barriers.

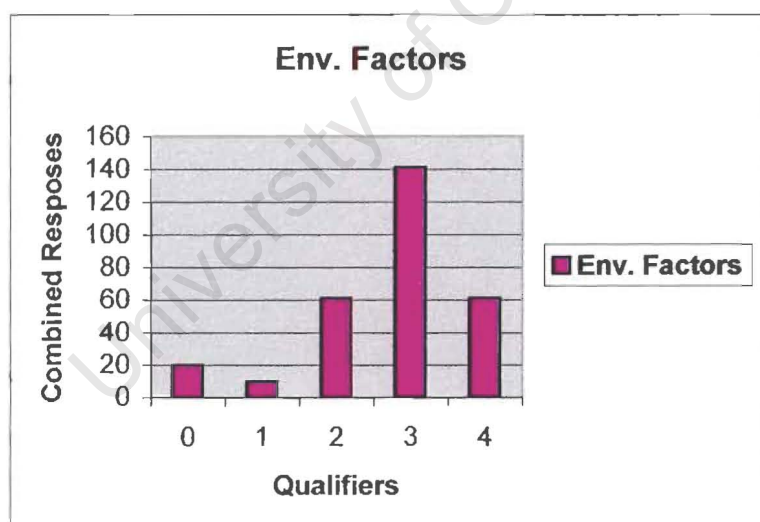


Table 6.3 and figure 6.3 The highest responses for environmental barriers were under severe barriers followed by moderate and complete barriers having the same number of responses. The list responses were under no barriers and minimal barriers.

**TABLE 6.4: COMBINED RESPONSES OF SIX HOMELESS NON-DISABLED PEOPLE FOR ACTIVITY LIMITATION, PARTICIPATION RESTRICTION AND ENVIRONMENTAL FACTORS**

| Uniform qualifiers           | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>moderate<br>restriction | xxx.3<br>severe<br>restriction | xxx.4<br>complete<br>restriction |
|------------------------------|-------------------------|---------------------------|----------------------------------|--------------------------------|----------------------------------|
| Activity                     | 68                      | 8                         | 44                               | 6                              | 6                                |
| Participation<br>restriction | 57                      | 20                        | 57                               | 51                             | 20                               |
| Environmental<br>barriers    | 20                      | 10                        | 61                               | 141                            | 61                               |

Table 6.4 is represented by figure 6.4

**FIGURE: 6.4**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six non disabled homeless people from categories relating to activity dimension, participation restriction and environmental barriers.

**ACTIVITY LEVEL, PARTICIPATION RESTRICTION AND ENVIROMENTAL BARRIERS OF THE SIX NON-DISBLED HOMELESS PEOPLE**

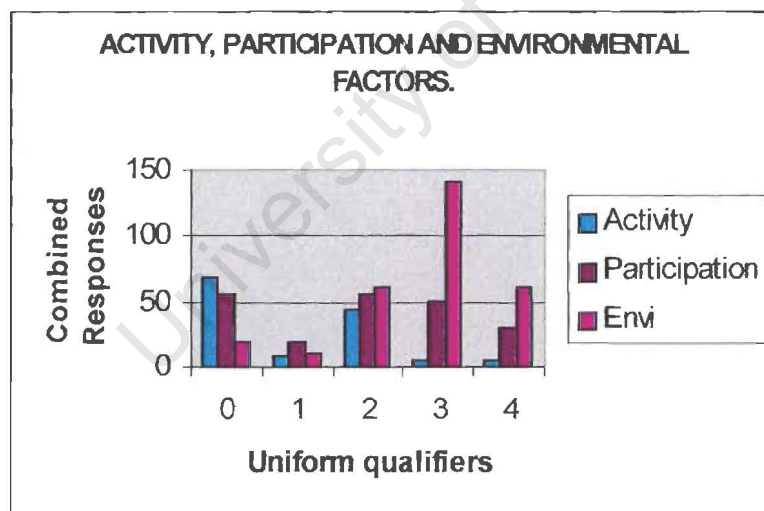


Table 6.4 and figure 6.4 shows that though the majority of homeless persons responded highly under no problem and moderate problem, in the activity dimension, their responses were evenly spread for participation restrictions under no problem, minimal problem and severe problem uniform qualifiers whereas environmental barriers scored high under severe barriers, followed by total environmental barriers and moderate barriers.

## APPENDIX 7

### RESULTS OF INTERVIEWS OF SIX PARTICIPANTS WITH PHYSICAL MOVEMENT DISABILITIES WHO ARE NOT HOMELESS ON ACTIVITY LEVEL, PARTICIPATION RESTRICTION AND ENVIROMENTAL BARRIERS

In a one to one private interview at home, demographic details and ICIDH-2 aspects were asked from the six people with disability staying at home.

Description of the Sample: Six males and one female. The participants were between the age of 30-40 years. Three had quadriplegia and three had tetraplegia, the level of impairment varied in severity. Three males were staying with their parents and two males and the female were staying on their own. The female had a ten-year-old daughter. All the participants had been disabled for more than 10 years. Two males were working in stable jobs. ICIDH-2 aspects: categories from the ICIDH-2 relating to the dimensions of activity (a) participation (p) and environmental barriers (e) were asked. These were coded using uniform qualifiers. Below in Tables 7.1-7.4 and figures 7.1-7.4 are combined responses from these categories.

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**TABLE 7.1: COMBINED CODED RESPONSES FROM THE CATEGORIES UNDER THE MOVEMENT RELATED ACTIVITY DIMENSION FOR DISABLED PEOPLE STAYING AT HOME.**

| Uniform Qualifiers | xxx.0<br>no restriction | xxx.1mild<br>restriction | Xxx.2<br>moderate<br>restriction | xxx.3<br>severe<br>restriction | xxx.4<br>complete<br>restriction |
|--------------------|-------------------------|--------------------------|----------------------------------|--------------------------------|----------------------------------|
| Combined responses | 5                       | 9                        | 25                               | 45                             | 53                               |

Table 7.1 represented below by figure 7.1

**FIGURE:7.1**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six disabled people staying at home, from categories relating to activity dimension.

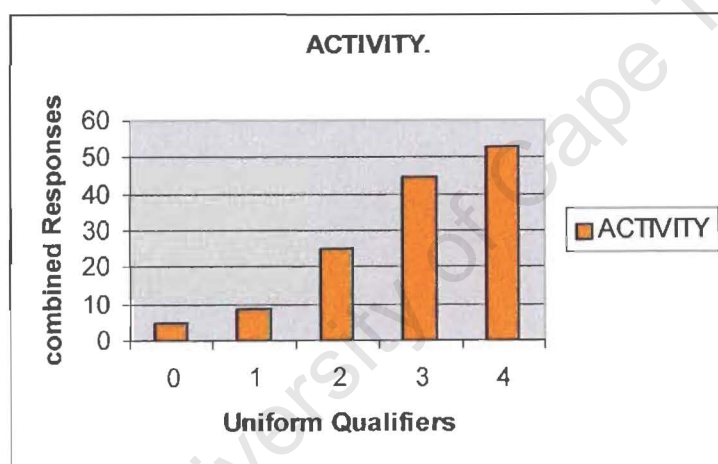


Table 7.1 and figure 7.1 shows the lowest number of responses were under no problem and minimal problem and were highest under severe and total limitation for categories under activity limitation dimension. The six people with disability staying at home had severe disabilities hence their responses on aspects related to movement showed severe to total limitation.

**PARTICIPATION RESTRICTION OF PEOPLE WITH DISABILITY STAYING AT HOME**

**TABLE 7.2: COMBINED CODED RESPONSES FROM THE CATEGORIES UNDER THE PARTICIPATION DIMENSION**

| <b>Uniform qualifiers</b> | <b>xxx.0<br/>no restriction</b> | <b>xxx.1<br/>mild restriction</b> | <b>xxx.2<br/>moderate<br/>restriction</b> | <b>xxx.3<br/>severe<br/>restriction</b> | <b>xxx.4<br/>complete<br/>restriction</b> |
|---------------------------|---------------------------------|-----------------------------------|---|---|---|
| <b>Combined responses</b> | 65                              | 28                                | 39  | 34                                      | 41  |

Table 7.2 is represented by figure 7.2

**FIGURE: 7.2**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six disabled people staying at home, from categories relating to participation restriction.

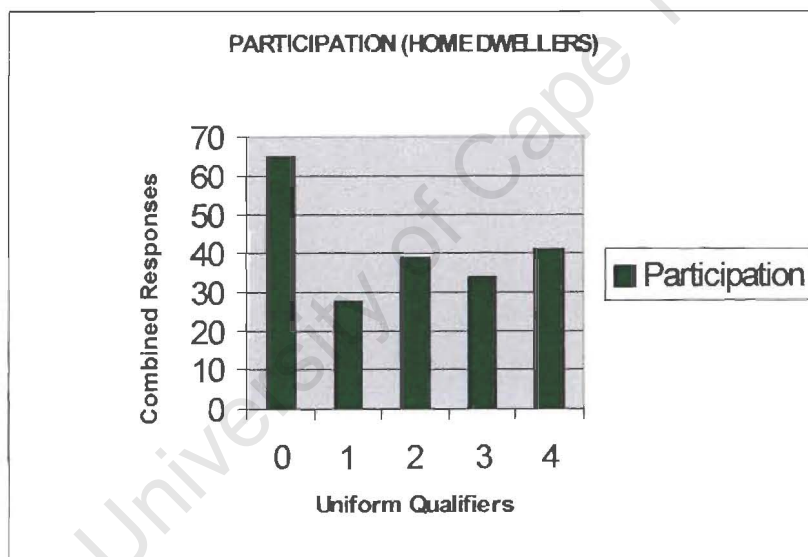


Table 7.2 and figure 7.2 shows that the six disabled persons living with their families in participation restriction had the highest responses under no problems followed by severe and moderate problems with severe and minimal restrictions having the lowest number of responses respectively.

**ENVIRONMENTAL BARRIERS FOR PEOPLE WITH DISABILITY STAYING AT HOME**

**TABLE 7.3: COMBINED CODED RESPONSES OF PEOPLE WITH DISABILITY STAYING AT HOME FROM THE CATEGORIES UNDER ENVIRONMENTAL BARRIERS**

| Uniform qualifiers | xxx.0<br>no restriction | xxx.1<br>mild restriction | xxx.2<br>moderate<br>restriction | xxx.3<br>severe<br>restriction | xxx.4<br>complete<br>restriction |
|--------------------|-------------------------|---------------------------|----------------------------------|--------------------------------|----------------------------------|
| Combined responses | 44                      | 26                        | 78                               | 76                             | 26                               |

Table 7.3 is represented by figure 7.3

**FIGURE: 7.3**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six disabled people staying at home, from categories relating to environmental barriers.

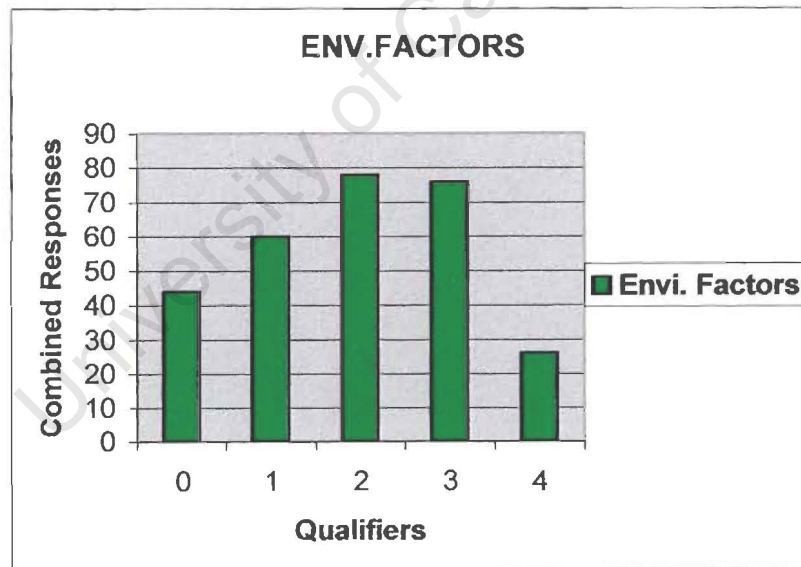


Table 7.3 and figure 7.3 show moderate environmental barriers, followed by severe environmental barriers, then minimal, followed by no barriers, complete environmental barriers had the minimal responses for the home dwellers.

**TABLE 7.4: COMBINED RESPONSES OF SIX PEOPLE DISABILITY STAYING AT HOME FOR ACTIVITY LIMITATION, PARTICIPATION RESTRICTION AND ENVIRONMENTAL BARRIERS**

| Uniform qualifiers        | xxx.0<br>no restriction | Xxx.1<br>moderate restriction | xxx.2<br>moderate restriction | xxx.3<br>severe restriction | xxx.4<br>complete restriction |
|---------------------------|-------------------------|-------------------------------|-------------------------------|-----------------------------|-------------------------------|
| Activity                  | 5                       | 9                             | 25                            | 45                          | 53                            |
| Participation restriction | 65                      | 28                            | 39                            | 34                          | 41                            |
| Environmental barriers    | 44                      | 60                            | 78                            | 76                          | 26                            |

Table 7.4. represented by figure 7.4

**FIGURE: 7.4**

X-Axis = Uniform qualifiers (0-4)

Y-Axis = Combined responses according to the uniform qualifiers asked from the six disabled people staying at home from categories relating to activity dimension, participation restriction and environmental barriers.

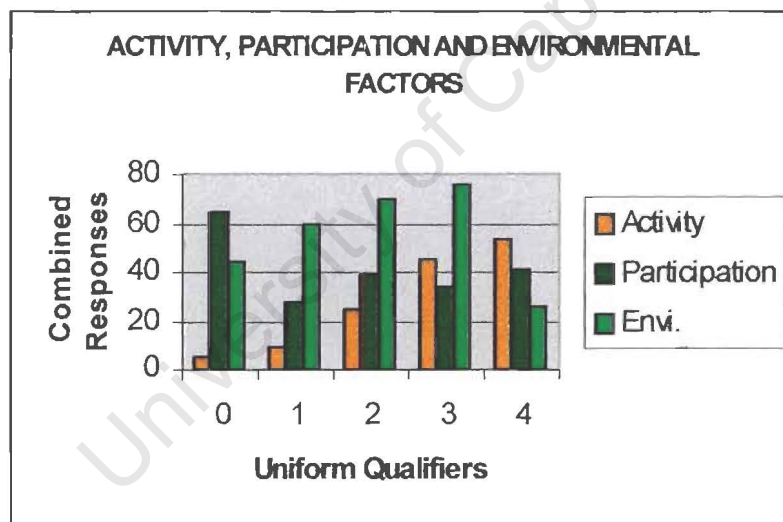


Table 7.4 and figure 7.4 show that For home dwellers when comparing activity limitation participation restriction and environmental barriers, the home dwellers have the highest number of responses under severe to total limitation in categories under the activity limitation dimension, the highest responses under no participation restriction and the lowest number of responses under total environmental barriers. Though disabled home dwellers had severe disabilities, they had the list barriers as compared to the other groups homeless disabled people and homeless people and hence their level of participation was higher.

**APPENDIX 8****THE RESEACH PROPOSAL****THE IMPACT OF PHYSICAL MOVEMENT  
DISABILITY AMONGST HOMELESS  
ADULTS IN THREE SHELTERS IN  
CAPE TOWN**

**Research Proposal for MSc in Physiotherapy**

**RESEARCHER**

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## DEFINITION OF TERMS

1. **IMPAIRMENT:** Any loss or abnormality of psychological, physiological or anatomical structure or function (WHO, 1980).
2. **DISABILITY:** Any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO, 1980).
3. **HANDICAP:** Is a disadvantage for a given individual, resulting from an impairment or a disability that prevents the fulfilment of a role that is considered normal (depending on age, sex, social and cultural factors) for that individual (WHO, 1980).

*Handicap will not be used to describe participants in this study. Only the people with physical movement disability will be part of the study. People with mental, cardiopulmonary, visual, hearing and other sensory impairments will not be included.*

*Therefore to be more specific about the sample with movement disability, anyone having problem with the following will be considered as physically disabled:*

- Movement Related Functions.
  - 
  - Structures Related to Movement.
  - Movement Related Activities (including dexterity, fingering, gripping and holding).
  - Participation Restriction
  - And encountering environmental Barriers.
4. **HOMELESS PEOPLE:** People who lack a stable home and the personal Resources, such as work, family and friends to assist in acquiring a home (Abdul-hamid, 1996).
  5. **SHELTER:** A place which provides emergency housing and meals for Women or Men who have no other place to eat or sleep. The shelter provides three different types of accommodations: emergency shelter, transitional accommodation, and permanent or semi-permanent accommodation (Tryssenar et al, 1999).

## 1.1 THE PROBLEM

*“Not until the creation and maintenance of decent conditions of life for all men are recognised, and accepted as common obligation of all men and all countries, not until then shall we, with a certain degree of justification be able to speak of mankind as being civilised (Hellander, 1992 cover page unnumbered)”.*

Much of the Medical literature has concerned itself in describing the pathology and treatment of a great variety of physically disabling problems of stroke, cerebral palsy, head and spinal chord injury. However few studies have been conducted which focus on disability and its impact on a specific group of people. This study concerns itself with the impact of physical movement disability on the homeless adult people living in the Wynberg shelter. Both homeless and physical disabled people are marginalised by society, to be both homeless and physically disabled would appear to be a double burden to those who experience such a situation. The White Paper on Integrated National Disability Strategy published in 1997 highlighted the importance of recognising that there are sectors within the disabled community which are experiencing greater discrimination than others.

Homeless people make up an increasing vulnerable population, which is at high risk for preventable diseases, progressive morbid and premature death (Plumb, 1997). Little is known about the physical movement disability of homeless adults and how disability impacts on their daily lives. People with disabilities are excluded from the mainstream of society and experience difficulty in accessing fundamental rights. There is furthermore, a strong relationship between disability and poverty; poverty makes people more vulnerable to disability, and disability reinforces and deepens poverty (White Paper on Integrated National Disability Strategy, 1997).

Plumb (1997) Argues that the working poor live on a precipice that can tumble into homelessness anytime. An illness or unexpected layoff, bring missed pay which lead to missed pay cheques which lead to skipped utility or rent payments, which snowballs into penalties, which ends into shutoffs or eviction. That leaves a Hobson’s choice between no place at all or city run homeless shelters, which often are dirty, noisy and unsafe.

Researchers agree that all people, if left homeless for a sufficient period of time will develop some type of mental disorder or disability (Plumb, 1997). Little is known about physical movement disability and it’s impact amongst the homeless people.

Murray (1996) asked this question, *“Who speaks for disabled homeless people then during health care reforms?”* *“What are the needs and resources of the homeless and disabled people?”*

Plumb (1997) ascertains that chronic disease is seen more frequently in homeless persons; these chronic illnesses may be silent until late in their course, and because of limited medical attention, often go unrecognised and untreated. Even if the condition is detected and treated, lack of compliance and consistent follow-up often results in disease progression, disability, morbidity and premature death.

Disabled homeless people should be able to access the same fundamental rights i.e. equal rights of access to health services, housing, water and sanitation, employment opportunities, and education as stipulated in the constitution of the Republic of South Africa. The United Nations declaration of the rights of disabled persons of 1975 asserted the rights of the disabled people to be self reliant, to live as they choose, and to participate in the social, creative, and recreational activities of their communities (Swain, 1993).

Providing effective primary health care for homeless persons is a formidable task. This is largely because of the homeless persons experiencing both internal and external barriers to health care. Internal barriers include those inflicted by the homeless people on themselves; denial of health problems by the person or pressure to fulfil competing financial needs, such as those for food, clothing and shelter. External barriers include unavailable, fragmented, costly health care services and misconceptions, prejudices, frustrations on the part of health care services for homeless persons.

This view is supported by Plumb (1997, p974) “ *As health-care policies continue to encourage the transfer of the medical care of the poor (including homeless people) into managed health care systems, gate-keeping mechanisms designed to ration care may lead homeless adults to further avoid seeking care in the early stages of illness if the care-seeking process becomes more arduous or time-consuming*”.

The disability movement envisions the future structure and social mores of a future society which would indeed be free from oppressive structures and negative social attitudes held by the society at large, thereby enabling disabled people to attain the legitimate status of full citizenship.

According to Lang (2000) altering the environment is an obvious way to start. He sees the role of able-bodied professionals as that of a “ facilitator” enabling disabled people to make effective choices for themselves in determining the kind of life style they wish to lead. To coin the phrase of a well-known activist, David Werner, “the role of the able-bodied professional is to be “on tap, not on top”.

Murray (1996) says that, “ to listen to the homeless population is the first step in meeting what we consider is their health needs, certainly then the homeless population can be considered more realistically in health care reform.

Ascertaining the impact of physical movement disability on adult homeless could be an entry point for both the abled-bodied professionals, and adult homeless disabled people to interact in a meaningful way.

## **1.2 RESEARCH QUESTION.**

What is the impact of physical movement disability among adult homeless people in three shelters in Cape Town?

## **1.3 SUB QUESTIONS.**

- 1.3.1. How does the three shelters for the homeless people function?
- 1.3.2. What use do homeless disabled adult people make of these shelters?
- 1.3.3. What processes occur in these shelters, which involve disabled homeless people?
- 1.3.4. Do adult homeless disabled people feel supported by the shelters?
- 1.3.5. Do they think their environment is facilitating or inhibiting participation in the shelters?
- 1.3.6. Do they think the shelters meets their needs?

## **1.4 QUESTIONS WHICH APPEAR TO BE IMPORTANT TO THE RESEARCHER.**

- 1.4.1. Are the adult physically disabled homeless people aware of their movement disability?
- 1.4.2. Do they have activity limitations?
- 1.4.3. Do they experience participation restriction?
- 1.4.4. What are the attitudes of other people in the shelter to disability?
- 1.4.5. Do the adult homeless people in these shelters receive disability grant?
- 1.4.6. How long have they been homeless?
- 1.4.7. How long have they been disabled?
- 1.4.8. What are the causes of disability?

## **1.5 PURPOSE (AIM)**

This research seeks to gain an understanding of the impact of physical movement disability of adult homeless people in three shelters in Cape Town and to make recommendations with regards to their needs which have been exposed by the study to managers of the shelters, disability movements and health care professionals.

## **1.6 SIGNIFICANCE OF THE STUDY**

Poverty and homelessness are inextricably linked, and subgroups of persons who live in poverty have a particularly high risk of becoming homeless (Plumb, 1997). Schwartz *et al.* (1996) and Plumb (1997) stated that there are heterogeneous groups from all levels of society with a variety of acute and chronic health problems. Homeless men, women and children make up a growing vulnerable population that has an unacceptable high risk for preventable disease, progressive morbidity, and premature death and up to date there has been a lack of initiatives by hospitals, to take part in their healthcare. Institutions had shown reluctant attitude in treating homeless persons and other clients who lack financial resources.

The disabled homeless people should be able to access the same fundamental rights, e.g. equal rights of access to health care services, housing, water and sanitation, employment opportunities and education as stipulated in the Constitution of the Republic of South Africa. The United Nation's Declaration of Rights for Disabled persons of 1975 asserted the rights for disabled people to be self-reliant, to live as they choose and to participate in the social and recreational activities of their communities (Swain; *et. al.*, 1993).

According to the draft summary paper of the Conference for homeless persons held in October 1995, growing unemployment, lack of affordable housing, social disintegration, social, economic and political policies are contributing factors to the phenomenon of homeless in South Africa. The Haven newsletter written in April 1996 mentions many other reasons that drive people into the streets, i.e. alcoholism, divorce, abuse, and mental disturbances.

However, the fact that homeless people do not have a home does not mean that they do not have a home environment. They mark out for themselves particular neighbourhoods, blocks, buildings and doorways whilst others find refuge in night shelters which they may frequent on a regular basis (Haven Newsletter, July 1991).

Under the new constitution, the homeless have a right to protection, freedom of movement and choice, access to housing, legal aid and health. These rights are provided but not upheld by the relevant parties (Homeless whose responsibility, 1995). On the other hand, the structural/physical limitations require that some of the services for attaining social independence be provided as a necessity and as a right for both the disabled and the homeless people.

Barton (1996) demonstrated that disabled people, both individually and through their organisation are campaigning demands for a greater choice in the nature and amount of services provided. She maintains that disabled people want more control over allocation of resources, especially in relation to independent living and new forms of accountability of service providers to disabled people. More important disabled people want to control their own independence, which gives them a choice as to how they will live.

During this process of disabled persons organising themselves and advocating for their rights, the question that is asked by the researcher is, "Can also the voice of the disabled homeless person be heard, where do the disabled homeless people feature in the new dispensation.

According to Shakespeare (1996, p210), "*We must enable disabled people to speak for themselves, and must recognise that it is the expertise of having lived this experience which is needed, not the professional technical knowledge*".

Coleridge (1993) describes how disabled people expressed oppression by health professionals in that they are encouraged to depend solely on the health care providers. Disabled people stated that the medical model of disability tends to see them as a 'problem' (Swain; *et. al.*, 1993). As one of the disabled people pointed out, therapists and

other health professionals did not meet his needs as a whole person and everyone sees him as an incomplete person (Coleridge, 1993). He also maintains that the disabled movement does not reject the role of the professionals but what they reject is the inappropriateness of so much of the work that is being done and the inappropriateness of their attitudes, and the complete inappropriateness of their seeking to represent them.

Disabled people are marginalised in almost every sphere of their lives as indicated by the White Paper on an integrated National Disability Strategy (1997). For instance, Swain *et al.* (1993) showed that most decisions regarding disability are taken with less participation from the disabled people. The implementation of policies derived from these decisions further alienates the disabled people from participating in their activities of daily living.

Under the new constitution of South Africa, the disabled are entitled to substantive dignity and equality which means the right to affirmative action to overcome the effects of past discrimination and a right of access to health care services. The White paper (1997) also indicates that disabled people often have additional needs that add to cost, more space to move around the home, accessible entrances, and pathways for wheelchairs, rooms for caregivers and personal assistants, adapted security systems etc. It further highlights the importance to recognise that there are sectors within the disabled community which have experience greater discrimination than others have. These sectors still experience comparatively higher levels of exclusion from social, economic and the political environment.

For those people with a stable home disability can be a major obstacle to overcome, both physically and psychologically. So the question has to be asked, how much more will disability affect one without a home? What has been done about disability in the shelters? What can be done? What is the role of the managers of the shelter, the disability movements and the professional able-body in this field? These are some of the questions the researcher wishes to answer in this study.

Finding out the impact of physical movement disability among adult homeless people in three shelters in Cape Town will open a doorway whereby the managers of the shelters, the disability movements, the able-bodied professionals and the adult disabled homeless people can understand each other and interact in a meaningful way.

## **1.7 OBJECTIVES OF THE STUDY.**

The objectives of the study are to:

1. Describe the functioning of three shelters in Cape Town.
2. Describe physical movement disabilities of adult homeless people from the three shelters .
3. Record and analyse the perceptions and beliefs of the homeless adult people in the

three Shelters.

4. to make recommendations with regard to the needs of the disabled adult homeless people in three shelters to the managers of the shelters, the disability movements within the Western province, abled-bodied health professionals and future studies that could be done with regard to adult physical disabled homeless people.

## 1.8 LITERATURE REVIEW

### Poverty and homelessness

The trouble is we think we know poverty, and all that remains to think is better ways to do what? Eradicate it? Cope with it? Manage it? We need to know what cause poverty, we are wrong to think that combating poverty simple boils down to knowing how, without at the same time understanding the what of poverty, (Friedemann, 1988). There is urban and rural poverty and, for a few, poverty might be a chosen way of life. Others may live poor by some standards, don't think themselves as poor.

### Bureaucratic poverty.

Poverty is traditional defined by those who regard themselves as the social superiors of the poor, hence it comes about that the poor are widely regarded with suspicion. The 19th century called them dangerous classes. Harbours of indolence and vice. To be poor is still widely perceived to be dirty, dumb, wanting in skills, drugged, prone to violence, criminality and general self-irresponsible. People with these traits must be controlled, institutionalised and managed. They are regarded as an eminent treat to the established order.

At least one well-known commentator wanted to put them all in detention camp (Friedemann, 1988). Government handle the poor, ordinary citizens are relieved of their responsibility, confident that the problem is being handled by qualified professionals, for most part they are regarded as incapable of taking care charge of their own lives.

In 1976, the International Labour office identified five basic needs, which lead to poverty:

- Minimum requirement of a family for private consumption (food, shelter, clothing)
- Essential services of collective consumption provided by and for the community at large (safe drinking water, sanitation, electricity, public transport, health and educational facilities).
- The participation of people in decisions that affects them.
- The satisfaction of an absolute level of basic need within a broader framework of basic human rights and employment as both a means and an end in a basic needs strategy.

When needs are not satisfied, individuals become frustrated. There are needs that are regarded as a right by populations, e. g. free public education, health services, clean

drinking water, public transportation, and social security and when these are not satisfied, this set out popular outrage.

When the question of poverty is considered the following points come into mind:

- Poverty is multidimensional phenomenon and does not signify merely a relative lack of income.
- Greatly improved statistical systems are needed to assess people's quality of life and to contribute toward defining appropriate standard of living.
- The poor must take part in the provision of their own needs and they must first acquire the means to do so. Effective anti-poverty programs cannot be devised at the top, for implementation downward through a complaint bureaucracy, but must emerge from the from the hurly-burly of politics in which the poor continuously press for the support, at the macro level, of their own initiatives.
- The poor are no longer regarded as wards of the state but as people, whom despite
- enormous constraints are actively engaged in the production of their own lives and livelihood.

### **Poverty and disempowerment**

The disempowerment model is a political variant of the basic needs approach. The starting point of the model is the assumption that the poor households lack social power to improve the condition of their member's lives. It places the household economy into the centre of a field of social power in which its relative access to the bases of social power may be measured and compared.

### **Poverty as lack of access to bases of social power**

Associated with civil society, it is limited by contrasting forms of state, economic and political power. The state has law on its side and a monopoly over the legitimate use of violence, have substantial access to financial resources, the power to shift the capital from one place to the other and the power to hire and fire. The political parties, social movements, political action committees has the power to vote, to stage demonstrations and rallies, to pressure politicians through lobbying. The power of civil society finally is ganged by differential access of households to the bases of social power. 'Where is the power of the homeless people based'?

**There are eight bases of social power:**

#### Defensible space

Physical spaces, in which household members cook, eat, sleep and secure their personal

possessions. In a wider sense it extends beyond the space called home to the immediate neighbourhood where socialising and other life supporting activities take place. Gaining a secure and permanent home in a supportive urban neighbourhood is the most highly prized social power of all and households are prepared to make almost any kind of sacrifice to obtain it.

#### Surplus time

This is the case in which basic consumption items such as food, water, fuel can be obtained. The frequency of illness in the household and the access to medical services. The gender division of labour. Without access to surplus time, household options are severely strained. It is the second most prized social- power.

#### Knowledge and skills

Poor households correctly perceive that education and technical training for at least some of its members are essential for enhancing its long-term economic prospects. They are therefore willing to heavily invest their time and energy and money in the development of household's "human resources".

#### Appropriate information

Without the continuing access to relevant information, knowledge and skills are virtually useless as a resource for self-development, e.g. improved sanitation practices, proven methods of infant care, standard health practices, access to rehabilitation facilities, available public services opportunities for wage paying work.

#### Social organisation

Formal, and informal organisations, to which household members may belong including churches, sports clubs, neighbourhood improvement associations.

#### Social networks

Essential for self-reliant actions based on reciprocity. Households with extensive horizontal networks among families and friends and neighbours have a large space of manoeuvre than household without them. Vertical networks up through the social hierarchy give households a chance to access other forms of power but may lead to dependant patron client relationships.

#### Instruments of work and household

These are the tools of household production including vigorous healthy bodies.

#### Financial resources

These include the net monetary income of household as well as formal and informal credit arrangement. Acting in collaboration with others and beyond state reach, households can increase their chances of gaining access to the remaining bases of power. The constraints on the poor are therefore structural in the sense that the system of power relations that sustains capitalist production also acts to keep the poor disempowered. It shuts out the

'under class' from effective political participation. Those relatively disempowered will want more power and are indeed engaged in a life long struggle to improve their situation with respect to one or more bases of social power. The very poorest, eg. famine victims, landless rural labourers, women-headed households in squatter areas of big cities may simply lack the means to help themselves. They require help from religious organisations, labour unions, and even the state. But even for the less destitute, collective self-empowerment is a rarely spontaneous process of community action, external agents are needed. Poverty and homelessness are inextricably linked according to Plumb (1997) the working poor live on a precipice that can tumble them into homelessness any time. An illness, or an unexpected layoff, brings missed pay checks which lead to skipped utility or rent payments, which snowballs into penalties, which ends in shutoffs or eviction, that leaves a Hobson's choice between no place at all or city run homeless shelters, which often are dirty noisy and unsafe.

### **The homeless people and their health status**

According to Friedmann in 1988 the territorial base of the household economy included the physical space in which household members cooked, ate, slept and secured their personal possessions, was the most highly prized social power of all and households were prepared to make almost any kind of sacrifice to obtain it. The homeless people already had lost that social power.

Clarke et. al. (1995) sited that homeless people he interviewed felt that reasons for homelessness were a combination of factors such as loss of job, family problems and health problems. Homeless persons are socially, economically, and politically vulnerable (Jezeski, 1995).

Homeless people need emotional support, caring professionals and resources that work within their frame of reality. Each homeless community will have different demographics and health needs. The common denominators are the obstacles encountered when trying to assess the health care: bureaucracy, transportation, accessibility, time orientation, limited resources, all these lead frustration and anxiety and avoidance to access these commodities.

Homeless persons are a population at risk. They are increasingly suffering from many health-related problems and to date there has been a lack of initiatives by hospitals to take part in their health care. In fact many institutions have had, reluctant attitude in treatment of homeless persons and other client who lack financial resources.

Homeless persons struggle to adapt to their environment and difficulties arise. When adaptation fails, life's stresses may cause or exacerbate physiological/psychological disorders and violence. As stress increases, more energy is needed to meet life necessities, coping with bizarre behaviour of others and defending ones street territory, this is a vicious circle.

Three factors have contributed to homeless expansion and differentiation. Initially unemployment leads to economic hardship, decreased entitlement benefits, loss of housing and lack of medical insurance. Lack of community resources and family social support fosters the homeless plight for those unable to cope with societal demands.

Personal factors such as substance abuse, physical and mental disability and family disruption prevent individual from positively adapting to stress of life.

These unprotected individuals with no social network are unemployed, powerless and have low self-esteem. Inadequate self-care, and health problems unique to their environment. Some of the environmental extremes such as temperature, noise, pollution, violence are common in their environment.

Plumb (1997) ascertained that chronic diseases are seen more frequently in homeless persons. 40% of who report at least one chronic illness. These chronic illnesses may be silent until late in their course and, because of limited medical attention, often go unrecognised and untreated.

Even if the condition is detected and treated, lack of compliance and consistent follow-up often results in disease progression, disability, morbidity and premature death. The homeless experience internal and external barriers to care. Internal barriers include the denial of health problems by the homeless persons and the pressure to fulfil competing non-financial needs, such as those for food, clothing and shelter. External barriers include unavailable fragmented and costly health-care services and misconceptions, prejudices and frustrations on the part of health professionals who care for homeless home-less persons.

### **Disability, disability models and disability movement**

#### Disability:

The simplest and maybe the initial, definition of a disabled person appears to be the following:

A person who in his /her society is regarded as disabled, because of difference in appearance/ and or behaviour. People " know " who is " disabled", and there are in all societies one or several terms to indicate this. There seems to be a tradition of what is and what is not "different (Hellander, 1992).

Hellander continues her argument by saying that when one discusses disablement, one should be aware of the cultural and developmental factors which will influence the concept of disability in developing countries, eg in Northern Mali, the most "disabling condition" for a woman is to be seen as being ugly, while in Somalia a women was classified as "disabled and labelled a fool "because she refused an arranged marriage by her father to an elderly while she was eleven"

What then is meant by disability?

The literature draws a crucial distinction between 'impairment', ' handicap ', and

'disability'. According to Lang in 2000, these terms are easily confused with each other, he continues to try and define the three terms cited on the WHO definition of 1976 which draws a three fold distinction between impairment, disability and handicap, defined as follows:

**An impairment** is any loss or abnormality of psychological, physiological or anatomical structure or function.

**A disability** is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.

**While handicap** is a disadvantage for a given individual, resulting from either a handicap or a disability, that prevents the fulfilment of a role that is considered normal (depending on age, sex and social and cultural factors).

According to activists in the disability movement, WHO has confused between the terms 'disability' and 'impairment'. The Disability Movement maintains that impairment refers to physical or cognitive limitations that an individual may have, such as the ability to walk or speak. In contrast, disability refers to socially imposed restrictions, i.e. the socially imposed restrictions, that is, the system of social constraints that are imposed on those with impairments by the discriminatory practices of society.

Thus the Union of the Physically Impaired against defined Impairment and Disability in the following manner: An impairment [is] lacking part of or all of a limb, or having a defective limb, organism or mechanism of the body' " Disability [is] the advantage or restriction of activity caused by contemporary organisation which takes no or little account of people who have physical impairments and thus excludes them from the main stream of social activities (Bickenbach; et. al., 1999).

Hellander in 1992 continues to argue that it should be pointed that not all people - not even those with visible disability - will be perceived as disabled. She further maintains that an adult who is amputated, receives a prosthesis and then continues his or her normal adult social role may not be seen as "disabled".

### **Disability Models**

If it is accepted that disability is located solely within the mind or body of an individual, but rather in the relationship between people with a particular bodily and intellectual difference and their social environment, then greater focus may be placed on ameliorating disability through changes in social policy, culture, and institutional practices, (Marks, 1996).

### The Medical Model

Initially, the medical model dominated rehabilitation services (Bauer 1989 and Correll 1981). The current medical system in South Africa is also strongly based on the medical model, which is biased towards curative and institution based care, which the doctor plays a dominant role within the hierarchy (National Health Plan for South Africa). Within the Medical model, all rehabilitation efforts are prescribed and closely supervised by the doctor.

Rintala (1986) maintains that this model has many inadequacies when used in the field of rehabilitation, as rehabilitation deals not only with functional impairments and disabilities, but also wider issues of handicaps, societal limitations, life satisfaction and quality of life.

While the disability activists give the following comments about the medical model:

- The medical model classifies 'disability' as essentially a 'problem' focusing on the individual. It is perceived as a deviation from the 'norm'. Therefore the role of the medical and paramedical professions is to cure, correct or ameliorate this problem, so that the disabled person can be as 'normal' as possible.
- Secondly, the medical model assumes that disabled people are biological and psychological inferior to those who are able bodied. Therefore they are considered to be 'not fully human' and by implication, do not have the competence to make decisions for themselves.
- Thirdly disability is seen as personal tragedy, which occurs on an individual random basis, it is misfortune. However, the disability movement maintains that disability is a cultural construct. Impairments do not just happen by chance but are the results of structural factors within the society. In many countries disability is a result of poverty.
- Fourthly, the medical model assumes that there is an objective state of 'normality' which gives professionals, especially within the medical, a dominant role. Furthermore, social and economic development and advances in medical technology will change the portfolio of impairments that occur.

There is little scope for disabled people and their families to participate in decision-making. Within most institutions staff have vested interest in not questioning the quality of the patient's environment too radically, as they themselves are part of the environment.

According to Brisden in Lang (2000) disabled people are seen as 'abnormal' because they are different, they are lacking the equipment for social integration. But the truth is, like everybody else, they have a range of things they can or cannot do, a range of abilities, both mental and physical that are unique to them as individuals. The only difference between them and other people is that they are viewed through spectacles that only focus on their inabilities, which suffer automatic blindness a sort of medicalised social reflex regarding their abilities.

Given that disability is perceived to be at root an individualised problem, undue power has been given to able-bodied professionals to make decisions on behalf of disabled body.

Lang, 2000 concludes by saying, "*The model imposes a presupposition of inferiority, both physical and intellectual upon disabled*"

### The Social model

The social model, in contrast, is the antithesis to the medical model. The focus here is placed upon the community and society rather than the individual. It is the social barriers, such as inaccessible buildings, unusable transport systems social attitudes and prejudice and institutionalised discrimination that are the real concerns of disability.

According to the Physically Impaired Against Segregation it their view that it is the society that disables physically disabled people. Disability is something imposed on top of their impairments by the way they are unnecessary isolated, excluded from full participation in society. **"Disabled people are therefore an oppressed group"**.

Protagonists of the social model assert that disabled people live in a 'disabling world'.

In contrast with the medical model, the social model maintains that disablement has nothing to do with the body, as it is exclusively the consequence of social oppression.

Furthermore, disability is seen as a human rights issue, in which progress is made through disabled people collaborating together to achieve common mutual objectives.

Lang (2000) thus states "Disabled people have started to come together to challenge the 'right' of charities and professional people to control their living conditions; in order to do this, disabled people have had to fight against the power which these groups have held on them."

Under the medical model, independence is not seen in terms of whether disabled persons can perform activities of daily living for themselves. In contrast, the social model perceives independence in terms of the ability of disabled people to make choices of how, emotional and spiritual needs are to be met, and it is concerned with disabled people having control in the manner, which they live.

### **Disability Movements in South Africa**

Disabled People International (DPI) is a recognised by the United Nations as the international assembly of disabled people. DPI recognises Disabled People South Africa (DPSA) as the national assembly of disabled people in South Africa. DPSA is a national organisation of smaller community-based disabled people's organisation.

The South African Federal council on Disability (SAFCD) is the national umbrella body for all national disability NGOs. It is the national forum where all national welfare organisations as well as national organisations of disabled people, parents, come together and negotiate and develop common visions for equalisation of opportunities for people with disabilities. The national welfare councils concentrate on service delivery and are part subsidised by government. There are many organisations for disabled people affiliating with SAFCD.

The National Co-ordinating Committee on Disability (NCCD) played a key role in the establishment of the Disability Programme in the Ministry without portfolio in the office of the State President which was responsible for the Reconstruction and Development Programme (RDP). On the closure of this ministry, the office on the status of Disabled Persons was moved to the Office of the Deputy President where it now has a directorate status.

The disability movement has been successful in raising the profile of disability on the political agenda, by poignantly highlighting the social, economic and political structures, as well as the pejorative attitudes that have contributed in ascribing disabled people the status of second citizenship. Notwithstanding the significant contribution that the disability movement has made during the past thirty years, there are nevertheless a number of issues, both with regard to the thesis and with the disability movement itself.

The thesis presented by the disability movement has provided a penetrating analysis as to the oppression and discrimination that disabled people have been subjected to in the past, as well as providing a lucid account of the subjective experiences of what it is like to be a disabled person within a contemporary society.

However, the literature emanating from the disability movement is somewhat parsimonious in delineating and envisioning the future structure and social mores of a future society which would indeed be free from oppressive structures and negative social attitudes held by society at large, thereby enabling disabled people to attain the legitimate status of full citizenship.

According to Lang 2000, altering the physical environment is an obvious place to start, but there is far more that is required, the disability movement had campaigned for anti-discrimination legislation, analogous with that passed reference to race and gender within the United Kingdom, to be enacted by all countries throughout the world, that would prohibit blatant manifestations of discrimination in the areas of employment, education, health and housing. Such legislation has already been enacted in countries like United States, Zimbabwe, India and South Africa.

However anti-discrimination legislation is necessary, but in no manner sufficient in achieving a non-disabling society. Even with those countries where anti-discrimination legislation has been enacted, there had been much discussion regarding efficacy of such measures. Assuming the premise that disability is essentially concerned with attitudes, such legislation is a blunt instrument, since it is impossible to legislate the change the manner in which individuals think or behave.

A further question arises concerning the appropriateness and applicability of the western-base notion of empowerment, which presupposes that are exercised and decisions are made in accordance with the preferences and wishes of an individual, to developing countries, such an individualised notion of empowerment as espoused by the international disability movement runs contrary to accepted social customs and practices that are found

in many developing countries.

Upon the supposition that disabled people are indeed an oppressed group, the movement has advocated that conflict should be used in combating such oppression and discrimination. While appreciating the foundation of such sentiments, and without denying the validity in the assertion that disabled do indeed face discrimination and oppression, it is contended here that disability is far more complex phenomenon that can be solely and adequately explained by social oppression.

According to Lang a vast numbers of people, rather than actively oppressing disabled people, are in fact fearful and ignorant of disability, which leads them to relate to disabled people in inappropriate and often demeaning ways, the more appropriate and pertinent strategy for the creation of a non-disabling society might be through the medium of education.

A related point concerns the controversial issue of the role that should be played by able-bodied professionals in the realm of disability. Those aligned with the radical wing of the movement would maintain that unless one has had personal experience of disability, there is no mandate to speak on disability issues whatsoever. The genesis of such sentiments stem from the past experiences of disabled people being excluded from decision making process, both at the policy level and within their own lives, where the medical model held the dominant hegemony.

Others within the disability movement adopt a more conciliatory stance, maintaining that the role of an able-bodied professional is that of a 'facilitator', enabling disabled people to make effective choices for themselves in determining the kind of life style they wish to lead. To coin the phrase of well-known disability activist, David Werner, the role of the able-bodied professional is to be "on tap, but not on top".

On the other hand, professionals feel threatened by the growth in the power influence of the disability movement. On the other hand, disabled people have been quite rightly worried about the undue influence and power of professionals have been having in debarring disabled people from having an effective mandate in setting disability policy agenda.

In the future, the strength of the influence of disability movement is inevitably going to increase, a trend that should be endorsed and encouraged. However the disability movement should be prudent and wise in the future development of the relationship it fosters with able-bodied professionals. Considerable care should be exercised to ensure that "the baby is not thrown with the bath water", so that those who were hitherto oppressed do not become the oppressors of contemporary society.

### **Human rights and disability**

Under the new constitution of the Republic of South Africa (1996), the right to have

access to health care services is under the Bill of rights, this implies that, both disabled and the homeless people should be able to access the same fundamental rights as any other South African. On the contrary, Riddell (1996) describes these rights and duties of citizenship, which accrue automatically to the non-disabled population may be granted only conditionally to disabled people.

During the International Year of Disabled Persons (IYDP) in 1981 and its theme 'The United Nations General Assembly' adopted "full participation and equality", a world programme of action in 1982 that outlined and summarised a modern disability policy. The Disability policy was for the first time structured in three main areas- *prevention, rehabilitation and equalisation of opportunities*. *Equalisation of opportunities means the process through which the various systems of society and the environment such as services, activities, information and documents are made available to all.*

The right to integration describes in the following rather the simple way: "Persons with disabilities are members of the society and have the same right to remain within their local communities, and they should receive the support they need within the ordinary structures of education, health, employment and social services"(Lindqvist, 1995). The white paper on an Integration National Disability Strategy of 1997 highlighted the importance to recognise that there are sectors within the disabled community, which have experienced greater discrimination than the others have. These sectors still experience comparatively higher levels of exclusion from social, economic and political environment. On the other hand structural/physical limitations require that some of the services for attaining social independence be provided as a necessity and as a right to disabled people. The most important point in the independence issue is that of choice.

### **The International Classification of Impairments, Disabilities, and Handicaps (ICIDH).**

The ICIDH-2 belongs to the "family" of classifications developed by the World Health Organisation for application in various aspects of health. The WHO family of international Classification provides the language to code a wide range of information about Health (eg. diagnosis, functioning, and disability and reasons for encounter) and uses a standardised common language permitting communication about Health and Health care across the World in various disciplines and sciences.

In 1980 the World Health Organisation produced a manual of classification relating to the consequences of disease for trial purposes (this was used in the pilot phase of this study). Ten years following the publication of the ICIDH-1, the WHO had initiated a revision process with the full version published of the ICDH - 2 in July 1999 (this revised version will be used for this study). Some parts of this version are still on the development process.

### Applications of ICIDH-2

Since first publication in 1980, ICDH has been used for various purposes, for example:

- As a statistical tool - in the collection and recording data (eg. in population studies and surveys or in management information system)
- As a research tool - to measure outcomes, quality of life or environmental factors.
- As a clinical tool - in needs assessment, matching treatments with specific conditions, vocational assessment, rehabilitation and outcome evaluation.
- As a social policy tool - in social security planning, compensation systems and policy design and implementation.
- As an educational tool - in curriculum design and to raise awareness and undertake social actions. (WHO, 1999).

### Scope of the ICDH - 2

ICDH -2 organises information according to three dimensions: (1) body level; (2) individual level; and society level. These dimensions are named: Body functions and structure (B); Activities (A); and Participation (P). These dimensions contain various domains of body functions and structure, performances of activities, and involvement in life situations. Briefly these dimensions cover the following areas:

#### ***(a) Body functions and Structure and Impairments:***

*Definitions: Body Functions are physiological or psychological functions of body systems.*

*Body Structure is anatomical parts of the body such as organs, limbs and their components.*

*Impairments are problems in body function or structure as a significant deviation or loss.*

- (1) "Body" functions and structure are classified along body systems; accordingly body structures are not considered as organs.
- (2) "Impairments" of structure can involve an anomaly, defect, loss or other significant deviation in body structures. Impairments have been conceptualised in congruence with biological knowledge at the level of tissues or cells at the sub-cellular or molecular level. However, for practical reasons these levels are not listed.
- (3) Impairments represent a deviation from certain generally accepted population standards in the biomedical status of the body and its functions, and definition of their constituents is undertaken primarily by those qualified to judge physical and mental functioning according to these standards.
- (4) Impairments can be temporary or permanent; progressive, regressive or static; intermittent or continuous. The deviation from the norm may be slight or severe and may fluctuate over time. These characteristics are captured in further descriptions, mainly in the codes, by means of qualifiers after the decimal point.

- (5) Impairment is part of a health condition, but does not necessarily indicate that a disease is present or that the individual should be regarded as sick.
- (6) Impairments are broader and more inclusive in scope than disorders or diseases, eg. a loss of a leg is an impairment of body structure, but not a disorder or a disease.
- (7) Impairments may result in other impairments.
- (8) Impairments are classified in categories using defined identification criteria (eg. as present or absent according to thresh-hold level. These criteria are the same for functions and structure. They are: (a) loss or lack; (b) reduction; (c) addition or excess; and
- (9) (d) deviation . Once an impairment is present, it may be scaled in terms of its severity using the uniform qualifier.

**(b) Activity/Activity Limitations.**

*Definitions: Activity is the performance of a task or action by an individual.*

*Activity Limitations are difficulties an individual may have in the performance of activities.*

- (1) The activity (A) dimension deals with an individual's activities associated with aspects of human life i.e. activities represent the integrated use of body functions, often in a purposeful manner, as **performed** in life tasks by the individual. In short, activity is what an individual does
- (2) The (A) dimension gives a profile of an individual's functioning in terms of activities, from simple to complex ones (eg. walking, obtaining food, or performing multiple tasks).
- (3) The classification is a neutral list of activities. It can be used to denote " activity limitations" (formerly "disabilities" in ICHD 1980) using qualifiers. Activity is limited when the individual, in the context of health condition, either has difficulty performing the activity in an expected manner. The *body* dimension comprises two classifications, one for functions of body systems, and one for body structure.
- (4) Difficulties with the activities can arise when there is a qualitative or quantitative alteration in the way in which these activities are carried out. Activity limitations are assessed against a generally accepted population standard relative to cultural and social expectations.
- (5) The use of assistive devices or personal assistance does not eliminate the impairment but may remove limitations on activity in specific domains, whereas

without the assistive devices, the individual's activity would be limited. Moreover, an individual with an impairment that affects normal activities (eg. eating) may perform the required activity in an alternative manner (eg. by means of tube feeding). The use of the first (uniform) and second qualifiers will provide information on whether an activity was performed, with or without assistive device or personal assistance.

- (6) The activity dimension refers to the performance of activities by an individual. The (A) dimension addresses the question "how does an individual actually do the activity?" This differs from the participation (P) dimension in that participation addresses involvement of the individual in a life area and in particular whether or not that involvement is restricted or facilitated by environmental factors. For an example - attending school is something a child does; so it is an activity; being allowed to attend and being included in all school activities however, is a matter of participation.
- (7) The (A) dimension can be used in clinical assessment, functional tests, questionnaires or self-evaluation. Activity can be assessed in many contexts, personal, professional, behavioural, social policy, legal and others.

(c) ***Participation/Participation Restrictions***

*Definitions: Participation is an individual's involvement in life situations in relation to health conditions, body functions and structures, activities and contextual factors.*

*Participation Restrictions are problems an individual may have in the manner or extent of involvement in life situations.*

- (1) The participation (P) dimension codes societal circumstances regarding functioning of an individual in various levels of life areas. It denotes the individual's level of functioning. That response may either facilitate or to hinder participation in various domains. Involvement refers to the lived experience of people in the actual context in which they live. This context includes the environmental factors - all aspects of the physical, social, and attitudinal world.
- (2) Participation may be characterised as the outcome or result of a complex relationship between an individual's health condition and personal factors and of the external factors, and of the external factors that represent the circumstances in which the individual lives. Because of this relationship, different environments may have a very different impact on the same individual with impairments or activity limitations. An environment with barriers, or without facilitators, will restrict participation, other environments that are more facilitating may increase participation. Society hinders participation because either it creates barriers (eg. inaccessible buildings) or it does not provide facilitators (eg. unavailable assistive devices).
-

- (3) Participation differs from the activity dimension in that the core effect of the contextual factors involved in participation at societal level. Participation answers the question:

"What is the lived experience of the individual with the health condition in societal context? This question leads to two other questions (a) how does the individual, given his or her health condition and functional status, become engaged in and take part in various life domains?, and (b) Do environmental factors facilitate or hinder the involvement of the individual in that particular domain? Identification of barriers and facilitators will assist in the development of interventions that aim at removing the barriers or providing facilitators.

- (4) The standard or norm which an individual's participation is compared is that of an individual without disability in that particular society. The participation restriction records the discordance between the observed participation and the expected participation of an individual without a similar health condition.
- (5) A value is attached to participation (i.e. a participation restriction is a disadvantage). This value is dependent on cultural norms, so that an individual can be disadvantaged in one group or location and not in another place. As used in ICIDH - 2, the notation of participation incorporates as overarching, international standard that of the "*equalisation of opportunities*" for persons with disabilities as formally adopted by the United Nations in its standard rule on the Equalisation of Opportunities for Persons with Disabilities.
- (6) "Handicap", as formerly used, focused on seven scales which were defined as the most important groups of disadvantage in relation to peers in accordance with the norms of the society. The structure of the (P) dimension has evolved further to a "normal" classification instead of summarising only the most important domains. The new classification identifies the domain of societal involvement of the individual.
- (7) On the participation issue, individuals may be limited in terms of their access because of reasons other than health context (for example, religion, ethnic origin, social caste or class). The participation codes may equally be applied to these circumstances. However, the ICIDH - 2 participation dimension deals chiefly with the health context, reflecting the WHO constitution's broad conception of health as a fundamental human right - " a state of complete physical, mental and social well - being and not merely the absence of disease or infirmity".

(d) **Contextual Factors**

Contextual factors represent the complete background of an individual's life and living. They include environmental factors and personal factors that may have an impact on the individual with a health condition and that individual's functional

state.

**Environmental Factors** make up the physical, social and attitudinal environment, in which people live and conduct their lives. The factors are external to individuals and can have a positive or negative influence on the individual's participation as a member of society, on performance of activities of the individual or on the individual's body function or structure.

- (1) Environmental factors are organised in the classification to focus on three different levels:
  - (a) **Individual** - in immediate personal environment of the individual, including but not limited to settings such as home, workplace and school. Includes the physical and material features of the environment that an individual comes face to face with as well as direct personal contact with others such as family, acquaintances, peers, and strangers.
  - (b) **Services** - formal and informal social structures and services in the community or local setting, that have an impact on individuals in their specific setting. Includes organisations and services related to the work environment, community activities, government agencies, communication and transportation services, and informal social networks.
  - (c) **Systems** - the overarching approaches and systems established in a culture or subculture that set the pattern for the concrete individual and services levels. Includes laws, regulations and formal rules as well as informal rules, attitudes and ideologies.
- (2) **Environmental** factors interact with all dimensions of functioning and disability, namely body functions and structure, activity and participation.

**Personal factors** are the individual background of an individual's life and living composed of features of the individual that is not part of a health condition or functional state. These may include age, race, gender, educational background, experiences, personality and character style, aptitudes, other health conditions, fitness, lifestyle, habits, upbringing, coping styles, social background, profession and past and current experience. Personal factors are not classified in ICIDH - 2. However, they are included in figure 1 to show their contribution, which may have an impact on the outcome of various interventions.

The term "dimension" refers to level of functioning, whereas "domain" denotes categories in each dimension. The ICIDH - 2 dimensions are conceived as having two poles: At one end they can be used to indicate problems (eg. impairment, activity limitation or participation restriction); at the other end they can indicate non-problematic (i.e. neutral and positive) aspects of functional states." functioning " is used as an umbrella term for positive or neutral aspects of dimensions at body, individual and society level.

**"Disability" is used as an umbrella term for problems in these dimensions.**

It is important to collect data independently on these dimensions and thereafter explore

associations and casual links between them. Functioning and disability are conceived as a dynamic interaction between health conditions and contextual factors. Contextual factors include both personal and environmental factors. ICDH - includes a comprehensive scheme of environmental factors as an essential "component" of classification. As a component, these factors interact at all three dimensions.

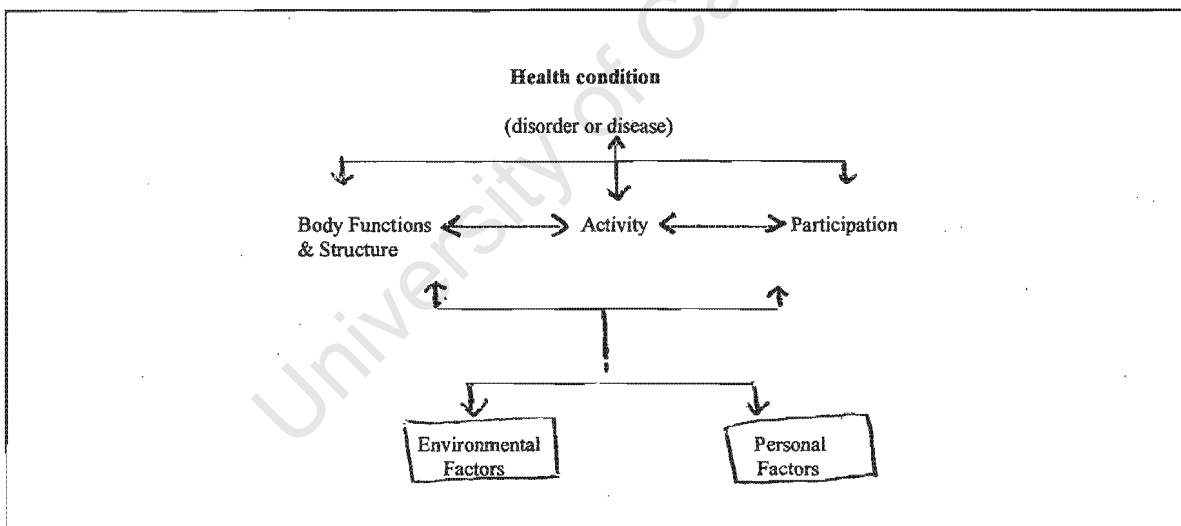
### Models of functioning and disability.

#### *Process of Functioning and disability*

As a classification, ICDH - 2 does not model the process of functioning and disability however, it can be used to describe the process by providing the means to map the three different dimensions and domains. ICDH - 2 provides a multi-perspective approach to the classification of functioning and disability as an interactive and evolutionary process. It provides the "building blocks" for users who wish to create models and study different aspects of this process. ICDH - 2 is a language: the texts that can be created with it depend on the users, their creativity and their scientific orientation. In order to visualise the current understanding of interaction of various components better the diagram presented in Figure 2 may be helpful.

Figure 1.

#### Current Understanding of Interaction between the Dimensions of ICDH-2



According to this diagram:

- Functioning and disability are seen as an interaction or complex relationship between the health condition and contextual factors (i.e. environmental and personal factors). There is a dynamic interaction among these factors: interventions at one level have the potential to modify other related elements. The interaction are specific and not always in a predictable one to one relationship to each other. The dimensions refer to an

individual's state of functioning and disability.

- The interaction works in two directions; even the presence of disability may modify the health condition itself. One may:
  - Have impairments without having activity limitations (eg. disfigurement in leprosy may have no activity limitations).
  - Have activity limitations without evident impairments (eg. poor performance in daily activities associated with many diseases).
  - Have participation problems without impairments or activity limitations (eg. HIV positive individual or an ex-patient recovered from mental illness facing stigma).
  - Have activity limitations with no participation problem (an individual with mobility limitations may be provided by society with alternative ways of moving around to participate in important life situations).
  - Experience a degree of influence in a reverse direction (e.g. inactivity of limbs can cause muscle atrophy; institutionalisation may result in loss of social skills).

## Use of the ICDH - 2

ICIDH - is a classification of human functioning and disability. It is systematically arranged according to dimensions at body, individual and society levels. At each level domains are grouped according to their common characteristics (such as their origin, type or similarity) and ordered in a meaningful way.

**The following are structural features of the classification that have a bearing on its use:**

- (1) ICDH - 2 uses an alphanumeric system whereby the letters b, s, a, p, and e denote the components body Functions, Body Structures, Activities, Participation and Environmental Factors. These letters are followed by a numeric code that starts with the chapter number (1 digit), followed by the second level (2 digits), and the third and fourth levels (1 digit).
- (2) Any individual may have a range of codes in each dimension. These may be independent or interrelated.
- (3) The coding also allows for addition of one or two numbers after a decimal point, which provide additional information. These additional places are called "qualifiers". Use of any code should be accompanied by at least one qualifier. Without qualifiers codes have no meaning when used for individuals or cases.
- (4) A uniform qualifier has been developed to describe the extent or magnitude of the problem in that dimension. This is to be used as the first qualifier. It can be used for the

three dimensions and environmental factors.

- (5) According to this uniform qualifier, all dimensions (B, A, P) and E component are coded in the same manner. Having a problem may mean an impairment, limitation, restriction or barrier depending on the dimension. Appropriate qualifying words as shown in brackets below should be chosen according to the relevant classification domain.

|                         |                            |           |
|-------------------------|----------------------------|-----------|
| xxx. 0 NO problem       | (none, absent, negligible) | 0 - 4%    |
| xxx. 1.MILD problem     | (slight, low)              | 5 - 24%   |
| xxx. 2.MODERATE problem | (medium, fair...)          | 25 - 49%  |
| xxx. 3 SEVERE problem   | (high, extreme)            | 50 - 95%  |
| xxx. 4.COMPLETE problem | (total)                    | 96 - 100% |

- (6) In case of Environmental Factors, this qualifier can also be used to denote the extent of positive aspects of the environment, namely facilitators. To denote facilitators, the same 0-4 scale can be used, but the decimal point is replaced with a plus sign: e110 +2.

- (7) Second qualifiers: For different users, it might be appropriate and helpful to add other kinds of information to the coding of each item. There are a variety of potential second qualifiers for each dimension and Environmental Factors as well as suggested second qualifiers to be developed.

**TABLE 1**  
Qualifiers:

| Dimension          | First qualifier   | Second qualifier  |
|--------------------|---|---|
| Body Functions (b) | Uniform qualifier with the negative scale used to indicate the extent or magnitude of an impairment<br><br><i>Example: b175.3 to indicate a severe impairment in specific mental functions of language</i>  | To be developed to indicate duration, growth and development  |
| Body Structure (s) | Uniform qualifier with the negative scale used to indicate the extent or magnitude of an impairment<br><br><i>Example: s730.4 to indicate the total absence of the upper extremity</i>  | To be developed to indicate region.<br><br>Suggested scheme:<br>0 = more than one region<br>1 = right<br>2 = left<br>3 = both sides<br>4 = front<br>5 = back<br>6 = proximal<br>7 = distal<br>8 = not specified<br>9 = not applicable<br><br><i>Example: s730.41 to indicate the total absence of the right upper extremity</i> |
| Activity (a)       | Uniform qualifier with the negative scale used to indicate degree of difficulty in accomplishing an activity. If only the first qualifier is used, it implies the level of difficulty without the use of Assistive devices or personal help. If the first | Assistance<br><br>0 = no assistance used<br><br>1 = non-personal assistance (this includes use of Assistive devices, technical aids,  |

|                                  |   |   |
|----------------------------------|---|---|
|                                  | <p>qualifier is used in conjunction with the second qualifier then the first qualifier now implies that this is the level of difficulty using an Assistive device or personal help</p> <p><i>Example: a5101.2 to indicate moderate difficulty with bathing the whole body and implies that there is moderate difficulty without the use of Assistive devices or personal help</i></p> | <p>adaptations, prostheses, wheelchair, cane and other material help)</p> <p>2 = personal assistance (where the task is carried out with the "help" of another individual, where "help" includes supervision and cueing as well as physical help)</p> <p>3 = both non-personal and personal assistance</p> <p>9 = level of assistance unknown</p> <p><i>Example: a5101.11 to indicate mild difficulty with bathing the whole body with the use of Assistive devices</i></p> |
| <b>Participation (p)</b>         | <p>Uniform qualifier with the negative scale used to indicate the degree of restriction experienced in Participation. Reference point is the <i>UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities</i></p> <p><i>Example: p730.4 to indicate a total restriction of Participation in remunerative employment</i></p>                                | To be developed possibly to denote subjective satisfaction  |
| <b>Environmental Factors (e)</b> | <p>Uniform qualifier, with negative and positive scale to denote extent of barriers and facilitators respectively</p> <p><i>Example: e145.2 to indicate that products for education are a moderate barrier. Conversely, e145+2 would indicate that products for education are a moderate facilitator</i></p>  | To be developed   |

## Human rights and disability

Under the new constitution of the Republic of South Africa (1996), the right to have access to health care services is under the Bill of Rights, this implies that, both disabled and the homeless people should be able to access the same fundamental rights as any South other South African. On the contrary, Riddel (1996) describes how these rights and duties of citizenship, which accrue automatically to the non-disabled population, may be granted only conditionally to disabled people.

During the International Year of Disabled Persons (IYDP) in 1981 and its theme The United Nations General Assembly adopted "full participation and equality" A World programme of action in 1982, which outlined and summarised a modern disability policy. The Disability policy was for the first time structured in three main areas - *prevention, rehabilitation and equalisation of opportunities*.

*Equalisation of opportunities means the process through which the various systems of society and the environment, such as services, activities, information and*

*documentation are made available to all.*

The right to integration described in the following rather simple way: "Persons with disabilities are members of the society and have the same right to remain within their local communities and they should receive the support they need within the ordinary structures of education, health, employment and social services (Lindqvist,1995)." The white paper on an Integrated National Disability Strategy of 1997 highlighted the importance to recognise that there are sectors within the disabled community, which have experienced greater discrimination than the others have. These sectors still experience comparatively higher levels of exclusion from social, economic and political environment.

On the other hand, structural/physical limitations require that some of the services for attaining social independence be provided as a necessity and as a right to disabled people. The most important point in the independence issue is that of choice.

## **Rehabilitation and Approaches to Rehabilitation Service Delivery**

### Rehabilitation

The original meaning of the term 'rehabilitation' is "to restore a person's dignity and /or legal status" (Hellander, 1992). An example of *a definition focusing on the individual* is the WHO definition of rehabilitation (1969) offered by an expert group, " the combined and co-ordinated use of medical, social, educational and vocational measures for training or re-training the individual to the highest possible level of functional activity"

Professional's early on recognised *the role the environment plays in rehabilitation*. This was of particular importance for people with moving problems. These individuals encounter difficulties climbing stairs, passing through narrow doors or passages, using ordinary bathrooms and kitchens or public means of transportation or moving outdoors on steep hills or in the terrain.

When rethinking the whole concept of rehabilitation the issue of "*equalisation of opportunities*" which draw attention to the widespread discrimination experienced by all disabled people in all societies. The World Programme of action concerning Disabled Persons (WPA) adopted by the United Nations in 1982 makes " equalisation " of opportunities a major point.

Another important concept in rehabilitation which is not identical to the preceding one - relates to "*equal access to and distribution of resources;*" in that context, many mottoes were created, for instance, "*new economic order* ", and "*health for all,*" "*education for all*".

Efforts to promote and protect the human rights of disabled people are seen as one of the corner - stones of the strategy of rehabilitation. Such rights are described in the constitutions of most countries.

For this study the researcher would like to adopt, the following operational definition by Hellander (1992):

*"Rehabilitation includes all measures aimed at reducing the impact of disability for an individual, enabling him or her to achieve independence, social integration, a better quality of life and self-actualisation. Rehabilitation includes not only the training of disabled people but also interventions in general systems of society, adaptations of the environment and protection of human rights".*

#### Approaches to Rehabilitation Service Delivery

Rehabilitation services can be delivered in several ways. It can be institution - based, outreach programmes can be delivered and it can also be community -based. These three ways of rehabilitation service were reviewed:

#### Institution-based Rehabilitation

The rehabilitation of the physically disabled client often takes place in an outpatient rehabilitation department of a hospital. On the other hand, clients with complex needs and problems, may be admitted to an in - patient ward. Outpatient rehabilitation is in most cases done in separate physiotherapy, occupational therapy and speech therapy departments (amongst others). A client with severe disabilities and complex problems frequently requires treatment in more than one of these departments. Communication between these departments may be limited or absent. The client's appointments with different therapists may also be on different days of the week, which can become very costly for the client (Goodwill & Chamberlain).

Clients in need of in-patient rehabilitation are sometimes scattered throughout the hospital in different wards. Bringing them together in one unit is advantageous, if a consistent policy for rehabilitation is available (Goodwill & Chamberlain 1990). However, in-patient rehabilitation has a limited time as the client can only be admitted for a reasonably short period of hospitalisation. Goodwill and Chamberlain (1990) aptly stated on in-patient rehabilitation that " rehabilitation is a learning situation and most re-learning is done outside therapy department"

In South Africa institution-based rehabilitation services are provided mainly in large urban areas such as the metropolis of the Cape Peninsula. These institutions are inundated with clients on long waiting lists and they are inaccessible to the majority of disabled clients and their carers from rural communities.

#### Outreach programmes for rehabilitation

The WHO defines outreach service delivery systems as such that professionals leave the institution, in teams, to carry the service to the disabled person. Some contact with and involvement of the family and community is possible. However, this kind of service is regarded as being costly (WHO Rehabilitation Unit, 1995).

The services of the specialist rehabilitation team are inaccessible to a large number of disabled as discussed earlier. Such teams are non-existent in some areas due to inadequate funds and lack of service provision. However, other health care workers in these

communities could be utilised in providing relevant, be it limited, rehabilitation services under the guidance and with the help, training and support of such a specialist team.

#### Community-based rehabilitation

"Community-based rehabilitation (CBR) is a strategy within the community development for the rehabilitation, equalisation and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health education, vocational and social services" (WHO Rehabilitation 1995). Successful CBR programmes are based on the following principles; equality, social justice, solidarity, integration and dignity (Hellander 1992).

A special category of health worker needs to be trained for this kind of service delivery. The professionals at district level are responsible for the CBR workers and they act as referral resources. More people with disabilities can be reached with this approach, even though it renders only a fairly basic service.

Although it is recommended by the WHO and is being discussed as part of the general health plan for a South Africa and has already been implemented in places like Tinswalo in the Northern Transvaal, this type of service is not freely available in our rural communities; neither are professionals at district level.

#### **Brief article review on some of the tools that will be used for data collection and analysis:**

Dana miller and colleagues 1998 wrote an article on writing and retelling multiple ethnographic tales of a soup kitchen for the homeless. The article is based on the narrative of three tales about a soup kitchen for the homeless and near homeless. She maintains that there are numerous ways of telling ethnographic data. She goes ahead and quote Wolcott (1994) who suggests using some combination of description, analysis and interpretation. She maintains that there are numerous ways of telling ethnographic data. She refers to (Van Manen, 1998) who maintains there are tales that incorporate different researcher perspective such as realistic, confessional, and critical tales.

#### *The realistic Tale:*

The realistic tale employs an impersonal point of view, conveying a concrete, scientific, and objective perspective. They are characterized by the absence of the author, representation of the native's point of view, and a documentary style focussed on minute, sometime precious, but not thoroughly mundane details. Dana miller and colleagues wrote the realistic tale of the soup kitchen to provide an objective account that had not been written, and one that presents a descriptive, analysis and interpretation of the culture of one of the soup kitchens. The soup kitchen becomes a microcosm for studying the homeless Homeless population, and we can learn much from an ethnographic study that explores alternative narratives about the culture of a soup kitchen. Three research questions

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emerged during the study: How might the soup kitchen, as a cultural setting, be

Described? What are the cultural themes of the soup kitchen? How can we become advocates for the soup kitchen, day shelter and homeless population.

Issues on cultural description might include: description of the soup kitchen; the complex and the community whereas cultural themes included: inside and outside perspectives, stories and rituals.

The realistic component of this paper will assist the researcher during observation and description of the shelter.

### The confessional Tale:

Van Maanen (1988) suggests that confessional tales reveal “how field work odyssey was accomplished by the researcher”. The primary audience for confessional tales are students of field work – those who are in search of guidance and reassurance regarding the field work experience. Confessional tales to some extent reveal, the researcher’s vulnerability because they demonstrate “the human qualities of the researcher”. Confessional tales explore how researchers viewed things at the beginning of the study, and saw things different at the end of the study. They provide the researchers with an avenue for confessing their personal biases, revealing their shock or surprise, blunders, character flaws, and bad habits. Confessional tales are also increasingly used as “vehicles ... to launch into self-reflective encounters with hermeneutic and representational issues”

Activities that could be included by the researcher might include:

- background of the researcher and motives for the study
- drawing line between biases, facts and here say
- safety of the researcher
- issues of reciprocity

The researcher intends to include some paragraphs of reflection on the journey she travelled during the process of visiting the various dimensions of this study.

### The critical tale:

The critical tales have a concern for representing social structure as seen through the eyes of socially disadvantaged group. Something crusading spirit behind many critical stories, hence shedding light on larger social, political, symbolic and economic issues. Here the researcher claim her positionality and subjectivity with the vision of promoting social justice and critical enquiry on how to advocate for homeless people. Miller and colleagues 1998 continued to argue that, to be specific it is an area of giving voice to the participants, sharing rewards and privileges with them she concludes by saying this is an area of heightened writer subjectivity .

This approach the researcher will be used by the researcher during discussion and recommendations.

### **Other contributors:**

Ruth Beckmann Murray, 1996 in her article on The lived experiences of homeless people (needs and resources).

This exploratory, descriptive study was designed to describe the perceived needs and

resources of or services for homeless men who were either in situational crisis, severely and mentally ill, or alcohol or drug dependent. A stratified convenience sample of 150 men who attended the program constituted the study sample.

Instruments used was a questionnaire designed by the researcher based on literature and the researchers experience with homeless individuals. The tool obtained self-reported demographic data, open-ended questions obtained information about the subject's perceptions of the experiences of being homeless, health status and care, meeting basic needs, and available needed services. Results of the interviews were grouped into categories with common themes.

Ruth Beckmann's methodology will be used during data collection by using story telling to obtain perceptions and beliefs about disability and homelessness from the homeless people with physical movement disability.

Joyce Tryssener et al 1999, interviewed 25 persons at a shelter using the Canadian Occupational performance measure(COPM). Tryssener quoting Takashi and Wolch(1994) indicate that researchers need to explore homelessness from the perspective of the people who are homeless and obtain their views on the potential success of various strategies to alleviate deprivation in the homeless population. Not only do assessments need to be modified for the unique needs of this population, they also need to be client centered.

Tryssener's study was analysed using both quantitative and qualitative methods of data collection. The data was analysed using codes and themes from the data rather than structured before hand (Paton, 1990). The authors of this article independently identified main qualitative concepts using the detailed line by line approach described by Van Manen 1980. In this approach Van Manen suggests that we look at every single or sentence cluster and ask what reveals about the experience being described. This approach will be used in the analysis of data on story-telling of the homeless disabled persons, on their perceptions on how it is for them to be disabled and homeless.

### **Pilot Study:**

#### **Objectives were to:**

- Develop an understanding of the research topic
- Design the research question
- Evaluate the need of conducting a research of the nature
- Gain an understanding of the demography of the study sample and the shelters
- Develop a relationship between the adult homeless people from the selected shelters, and personnel staff including ethical issues during the time of conducting the study.
- Design and test instruments
- Discuss the findings and make recommendations for the study

## Study population and sample

10 shelters in the Cape Peninsula were conveniently selected from the 34 shelters and homes for adults in the Western Cape (Directory of Services for Street People, 1995).

The ten shelters were: Claremont, Carpenter's Shop, District Six, Loaves and Fishes, Woodstock Haven Night Flats, Heaven Night Frail and Cottages, Ikhaya Labantu at Langa, Khayelitsha missionaries of Charity and Wynberg Haven Night Shelter  
Study population. From these shelters homeless people of age 18 years and above will be chosen.

## Summary of results

### Description of the sample

There were 436 people in the 10 shelters when the pilot study was conducted. 139 homeless adult people agreed to participate in the study. The ages of the participants ranged from 20-80 years, with the average being 50 years. The residents were homeless for different duration of time. Some have been homeless for over 10 years whilst others had been just over a week in the street or shelters. There were more males than females.

### Prevalence of physical movement disability

From the 139 participants, 19 were physically disabled. The majority of those physically disabled were so before they become homeless. The disabled respondents were disabled as a result of varying factors. These individuals experienced a wide variety of functional limitations or activities of daily living.

### Contact with health care services

All respondents mentioned that they do use the hospitals, clinics and private doctors. A substantial number of respondents mentioned Groote Schuur Hospital as one of the hospitals they have consulted or still are consulting. Most indicated that they went to any health care centre. Many of them said "*Die laaste keer dat ek was daar was agter die ongeluk wat my gestremd gemaak*"

About 90% of disabled interviewees said that they were/ are treated with respect by the health care providers. They said the staff treated them with respect, patience and kindness irrespective of their disability. Only a few (n= 2) stated improper handling from the health staff. One respondent said "*I feel like I am being ignored by people who work in the hospital because I have more needs and require assistance*"

Most interviewees who responded positively to being given exercises as part of their therapy were also issued with some assistive devices. 22% of disabled people did not receive exercises, which they needed, as part of their treatment. A considerable portion was from Khayelitsha Missionaries of Charity. All disabled people from Khayelitsha Missionaries of Charity did not receive any assistive devices.

From the 63% of those who received assistive devices, 92% were shown how to use them.

A small number seemed not to know exactly who taught them. They said nurses and sisters gave them exercises and showed them how to use devices. When it comes to the question of asking for and receiving help, the overwhelming majority of interviewees reported that they prefer not to ask for help. Another interviewee said that she feels very angry when having to ask for help. She gets angry because she is unable to do what she used to do.

### **Perceptions of disabled homeless people**

A significant number of interviewees said that they do not feel vulnerable to attack. This was based on the religious beliefs that "*If you walk with the lord nothing can touch you*" Two of the participants said that they do feel vulnerable.

One of them said that she always feels like she will be attacked because she is slower and weaker due to her disability, and thus making it difficult for her to fight back.

Perceptions of the disabled differed widely from one another. Some said that disability have made them to be more broad - minded and to think more effectively.

One of the interviewees said that "*Being disabled makes you think thoroughly which makes you see things before they actually happen to you*" Others reported that being disabled influenced their behaviour as one said "*I was drinking but no more* "

Quite a few said that they have nothing to say about their disability. They stated that it brought sadness, anger, loneliness, neglect and rejection to their lives. All agreed that being homeless made it even worse. They said being disabled and homeless at the same time is the worst thing that ever happened to them. They said that homelessness added to the hardships that were already facing a disabled people. But most quickly pointed out that the shelters are contributing positively in alleviating the hardships and pain they had to endure in the street and for some even at home.

### **The needs of disabled homeless people**

The answers given by subjects varied. Some cited that they need houses and others stated that they wanted to go home (back to their families). On the other hand others mentioned the need for frail care centres and houses for disabled. In addition they noted that they wanted intervention from the government, respect and acceptance from the society in general. More participants cited houses and transport.

### **Perceptions of non-disabled homeless people**

Responses of non-disabled in relation to questions asked of them about physically disabled people, was very positive. Most of them reported that they related well to disabled people, they felt that we are all human beings and therefore there should not be any problem in relating to each other. One of the interviewees said that "*We are all the same and because we are homeless this brings us together, the fact that we are homeless makes us*

*to relate more to disabled people because we are in the same boat”*

They also mentioned that they felt sorry for them in the sense that they sometimes are functional limited in some of the things they want to do for themselves, but otherwise they are human beings – it is only that they are disabled. Some interviewees acknowledged this more by saying that *“I do not see them as different because I am also disabled in one way”* and another person continued to say *“ They are very remarkable people, they have a capacity to endure, they are disabled in one sense but of double capacity in the other”*

Non-disabled people in the shelter also said that they do not have a problem of interacting and helping disabled people. Most of them could recall instances from the past where they helped disabled people from the shelter and the street e.g making up beds, bathing, helped to push a stroke person in the wheelchair, helping a person with an amputated arm to cut onions and potatoes. Some of the people also emphasised that

*“We are all human beings but just that they are not physically fit, God made us for a purpose people must learn to love each other”*

However 10% of the non-disabled felt that it is sometimes difficult to interact with disabled people because sometimes they seem to be rude and therefore making them feel reluctant to help. As one of the interviewees said *“Disabled people are very rude, at times very independent when you want to offer help”* and the other person said *“ If disabled person is nice, I will help, disabled people think you are feeling sorry for them; sometimes I feel reluctant to help.”* While the other interviewee even said *“I prefer that a disabled person speaks to me first, I get scared that they will explode when I do first”*

There was a common trend of specific needs that were mentioned by non-disabled people which, they felt, should be included in the future plans of the country for disabled homeless people. They emphasised that more homes and frail centres should be built for disabled homeless people to provide a better environment for them; facilities to learn skills and creation of jobs.

They also saw a need for rehabilitation at all shelters. They also felt that disabled people need to be looked after by trained people, and thereby helping them rehabilitated to highest level of function - integrating them back into society. They mentioned other public facilities (eg. pavements, public transport) should also be upgraded in order to accommodate the needs of disabled people.

The needs for disabled people were summarised by one interviewee who said *“ The society should create a system where they can give people a value of being a human being, give them what they need, not what they think they need”*

### **1.8. Analysis of the instruments/methodology used in the pilot study**

The pilot study had managed to give the researcher an understanding of the demography of the sample and the environment they live in. Based on the results of the pilot study the researcher finds it valid to continue with the topic. It gave the researcher an opportunity to

implement the methodology on trial basis and be in a position to make the following remarks:

- (a) The World Health Organisation (WHO) *International Classification of Impairments, Disabilities, and Handicaps* (ICDH), a manual of classification relating to the consequences of disease used for the pilot study was the old version of 1980.
- (b) The questionnaires were design in such a way that it was not clear whether they are evaluating *Impairments, Disability, or handicaps*.
- (c) No grading system was utilised to show the severity of *physical disability*.
- (d) Positive attributes of the physical disabled homeless people were not clearly evaluated.
- (e) The time given for evaluation of the environment of the shelters was not adequate and the instruments used to evaluate this are not clear.
- (f) No clear guidelines were drawn on how to introduce the researchers and the topic to the homeless people; this might have resulted in some of the homeless people being reluctant in joining for the research.
- (g) During evaluation of perceptions of physically disabled people and other homeless people towards physical disability, the interviewees might have given answers they thought that the researchers wanted to hear.
- (h) The objectives for implementing the shelters are not clearly defined.

## 1.9 Methodology.

### 1.9.1 Improvement of the methodology used in the pilot study

The following aspects were adjusted to improve the methodology from the pilot study:

- (a) Research design: story telling was included to gain an in-depth understanding of the impact of disability on the participants.
- (b) Study sample: homeless people with physical movement disability were chosen from only 3 shelters instead of 10 as in the pilot study with the aim of having a smaller confinable sample.
- (c) The ICIDH-2 (Beta Draft-1999) was used instead of the ICIDH-1 of 1980, this is a more recent instrument and from this instrument environmental impact on the person with disability can be evaluated.
- (d) A day was spent in the shelters instead of just a visit for few hours as in the pilot study to gain a deeper understanding of the demography and functioning of the shelters.

### Research Design

1. A cross-sectional exploratory descriptive study will be done using both qualitative and quantitative methods of data collection.

2. Recorded demography and observation of the functioning of the selected shelters and their personnel will be done to gain understanding of the existing situation.

3. Structured questionnaire to evaluate the prevalence of physical movement disability.

4. Story-telling to evaluate perceptions and beliefs of the adult disabled and able homeless people.

### **1.9.2 Study population**

Homeless people, aged 18 and above, in the 34 adult shelters in the Cape peninsula.

### **1.9.3 Study sample.**

Adult homeless people living in the following shelters, Ikhaya Labantu Heaven Night Shelter, Loaves and Fishes in Mowbray and Wynberg Haven Night Shelter.

### **1.9.4 Sampling methods**

There are presently 34 shelters and homes in the Western Cape (Directory for Street People, 1995). From these shelters, only those situated in the Cape Peninsula will be used in this study. A pilot study was conducted on 10 of these shelters, and both the shelters and the study population were conveniently selected.

The 10 shelters were Claremont, Carpenter's Shop, District Six, Loaves and Fishes, Woodstock Haven Night Frail Care Flats and Cottages, Ikhaya Labantu at Langa, Khayelitsha Missionaries of Charity and Wynberg Haven Night Shelters. From the 10 shelters used in the pilot study, 3 were chosen for this study, viz. Ikhaya Labantu at Langa, Loaves and Fishes, and Wynberg Haven Night Shelter.

The three shelters were specifically chosen because of their varying and different characteristics and the researcher will investigate the impact these may have in the beliefs and norms including the everyday activities of the disabled adult homeless people. The study population will be the candidates who participated in the pilot study and the members of the shelters who didn't participate in the pilot study but might be willing to do so now.

### **1.9.5 Description of tools and how they will be implemented.**

#### **1.9.5.1 Description of the Demography of the shelters.**

##### Activities:

Observe and describe the internal environment of the shelters and the activities that are taking place. Analyse the location of the shelters.

Implementation: Time will be spent visiting the participating shelters to gain an understanding about the functioning and demography of the shelters and one day will be spent in each shelter to gain an understanding of a day in the life of a homeless person living in a shelter.

### 1.9.5.2 Measure the prevalence and incidence of physical movement disability among the homeless by:

#### Activities:

- (1) Describe the age, gender, number of years the participants have been homeless and disabled including the cause of the impairment.
- (2) Describe the type of physical movement impairment/disability (amputation, paralysis, deformity and others). Access the area and the severity of physical impairment and the level of activity.
- (3) Evaluate the level of participation in the various domains and the impact of environmental factors (barriers/hindrances) using tools.

#### Instrument for evaluating disability:

The World Health Organisation (WHO), International Classification of functioning and Disability (ICIDH-2, Beta-2 Draft, July 1999) will be used for evaluating Physical Movement Disability.

#### Application:

- (1) Initially body structure will be evaluated for structural integrity and impairment.
- (2) Questions will be asked to access:
  - (a) performance of individuals' activity and activity limitations.
  - (b) involvement in life situations ( participation and participation limitations).
- (3) Features of the Physical, Social and Attitudinal World + Attributes of the Person (Facilitators, barriers and hindrances).

**TABLE 2.**

**Aspects relating to physical Movement Disability selected from WHO ICIDH-@ (Beeta-2 Draft, July 1999) which will be used for Evaluating Movement Disability and Environmental Impact:**

| Dimension  | First Qualifier   | Second Qualifier   |
|--|---|--|
| <b>BODY STRUCTURE(S)</b><br><u>Impairments (b)</u><br>1) The shoulder region<br>2) The upper extremity<br>3) The trunk<br>4) The lower extremity | <u>xxx. 1 2 3 4 (-)</u><br><br>s720.<br><br>s740.<br><br>s760.<br><br>s750. | 0 = more than one region<br>1 = left<br>2 = right<br>3 = both sides<br>4 = front<br>5 = back<br>6 = proximal<br>7 = distal   |
| <b>ACTIVITY</b><br><u>Limitation</u><br><u>Maintaining and Changing</u><br><u>Body Position</u>  | <u>xxx. 1 2 3 4 (-)</u>   | 0 = no assistance used<br>1 = personal assistance<br>( this includes use of Assistive devices, technical aids, adaptations, prosthesis, wheelchair, cane and other |

- |                              |      |
|------------------------------|------|
| 1) Maintaining body position | a310 |
| 2) Changing body position    | a320 |
| 3) Transferring oneself      | a330 |

**Carrying, moving and manipulating objects**

- |  |       |
|--|-------|
| 1) Lifting and carrying                  | a340. |
| 2) Moving objects with lower extremities | a350. |
| 3) Fine hand use                         | a360. |
| 4) Hand and arm use                      | a370. |

**Moving around**

- |                                     |       |
|-------------------------------------|-------|
| 1) Walking around                   | a410. |
| 2) Moving around using an equipment | a430. |

**moving around using transportation**

- |                                  |       |
|----------------------------------|-------|
| 1) Transportation as a passenger | a440. |
| 2) Transportation as a driver    | a450. |

**Self care activities**

- |                               |       |
|-------------------------------|-------|
| 1) Washing and drying oneself | a510. |
| 2) Caring for body parts      | a520. |
| 3) Toileting                  | a530. |
| 4) Menstruation               | a540. |
| 5) Dressing                   | a550. |
| 6) Eating                     | a560. |
| 7) Drinking                   | a570. |
| 8) Looking after one's health | a580. |

**Domestic Activities**

- |                                |       |
|--------------------------------|-------|
| 1) Acquiring a place to live   | a610. |
| 2) Acquiring daily necessities | a620. |
| 3) Preparation of meals        | a630. |
| 4) Housework                   | a640. |
| 5) Caring for possessions      | a650. |
| 6) assisting others            | a660. |

**PARTICIPATION**

|   |
|---|
| material for help.<br>2 = personal assistance<br>3 = both personal and non personal assistance. |
|---|

**Participation in personal Maintenance**

- |                            |       |
|----------------------------|-------|
| 1) Personal care.          | p110. |
| 2) Nutrition               | p120. |
| 3) Necessities for oneself | p130. |
| 4) Health                  | p140. |

**Participation in mobility**

- |   |       |
|---|-------|
| 1) Within the Shelter                       | p210. |
| 2) Within buildings either than the shelter | p220. |
| 3) Outside the shelter and other buildings  | p230. |
| 4) Mobility with transportation             | p240. |

**Participation in Shelter life and assistance to others**

- |  |       |
|--|-------|
| 1) Housing for self and others                     | p510. |
| 2) Management of the shelter and other possessions | p520. |
| 3) Caring for others                               | p530. |
| 4) Nutrition for others                            | p540. |
| 5) Health maintenance for others.                  | p550. |
| 6) Mobility and transportation for others          | p560. |

**ENVIROMENTAL FACTORS**

**Products and technology**

- |                             |       |
|-----------------------------|-------|
| 1) Buildings, constructions | e125. |
| 2) Products of education    | e145. |
| 3) Employment               | e150. |
| 4) Recreation and sport     | e155. |
| 5) Culture and religion     | e160. |

**support and relationships**

- |                              |       |
|------------------------------|-------|
| 1) Immediate family          | e310. |
| 2) Extended family           | e315. |
| 3) Friends                   | e320. |
| 4) Other homeless people     | e325. |
| 5) Managers of the shelter   | e335. |
| 6) Health care providers and | e340. |

|                                     |       |
|-------------------------------------|-------|
| personal assistance                 |       |
| 7) Strangers                        | e345. |
| <b><u>Attitudes and beliefs</u></b> |       |
| 1) Individual attitudes             | e410. |
| 2) Individual values                | e420. |
| 3) Individual beliefs               | e430. |
| 4) Social norms and ideologies      | e470. |
| <b><u>Systems and policies</u></b>  |       |
| 1) Housing system and policies      | e620. |
| 2. Health system and policies       | e670. |

## Implementation

A day will be spent in each shelter accessing the type and severity of the disability and the impact of the disability on the activity level and participation including the impact of the environment using the ICIDH-2 (Beta-draft 2, 1999)

### 1.9.5.3 Record and analyse the perceptions and beliefs of the homeless people with no disability and staff personnel of the shelters.

#### Activities:

Assess the awareness about physical impairment by the above mentioned groups.

Implementation: This will be done by showing the homeless people with no disability slides of disabled people and immediately after that they will be asked to talk about their feelings towards what they have seen.

Structured interviews will be conducted for the managers of the participating shelters to gain an understanding of the functioning of the shelters, and their role in the management/prevention of disability.

### 1.9.5.4 Research Personnel.

The researcher and two research assistants will carry out the implementation of the methodology. These assistants have already been involved in the pilot study and will receive further training by the researcher on the improved methodology.

**1.9.5.5 Funding.**

A sum of R5000 has been promised to the researcher from the research fund in the Physiotherapy Department. This amount will be used to cover the payment of the researcher assistants and a statistician.

**CONSENT FORM.**

I,....., hereby give my consent to partake in the Research project conducted by Gubela Mji. I understand that this will take place in the form of an interview and that there will be no intervention from the researcher. I understand that all information gathered here will be highly confidential and will only be used in this study.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

University of Cape Town

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