The use of the confessional tale as a tool to enter the critical tale and become an advocate for those at the margins — a researcher's journey and reflection

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ABSTRACT

In this article the author describes her journey and reflection during the process of conducting qualitative research on homeless people with mobility impairments. After having entered the environment of the homeless people with mobility impairments, the researcher's previous assumptions and stance regarding the role she is required to play during research and afterwards is closely examined.

The author uses the confessional tale to map out her journey and reflection including the experience of conducting ethnographic research with homeless people with mobility impairments. At the core of the researcher's reflective confessional tale is the display of how she grapples with trying to draw lines between her own assumptions regarding the participants and the need for her to find the critical tale for this marginalised group of people — the homeless people with mobility impairments. The paper ends by making recommendations on the key principles that a researcher should take cognizance of on becoming a conscious advocate.

Key words: homeless people, mobility impairments, realistic, confessional, critical tales

Introduction

Much as rehabilitation professionals have recognised the need to work with vulnerable groups and those at the extreme margins of society, such as children, older people and people with disabilities, a paucity of knowledge still remains regarding research on disability and homelessness. Homeless people make up an increasingly vulnerable group of the population and are at high risk for preventable diseases, progressive morbidity and premature death[1]. Murray[2] maintains that researchers agree that all people, if left homeless for a sufficient period, will develop some type of mental disorder or disability. Plumb[1] ascertains that chronic disease is seen more frequently in homeless persons and that these chronic illnesses may remain silent until late in their course. Because of limited medical and rehabilitation attention they often go unrecognised and untreated.

People with disability often experience insurmountable problems in their daily lives. There is a general awareness that both homeless people and people with disability are marginalised by society. Being homeless and disabled would thus appear to be a double burden to those who experience such a situation. In the Republic of South Africa, it is the constitutional right of disabled people to access the fundamental rights of all citizens, for example, equal rights to access health services, housing, water and sanitation, employment opportunities and education. It remains a question whether homeless people with disabilities are able to gain access to these fundamental rights and whether they are included when resources are being distributed. Social organisations and social networks are some of the basic needs, which connect the person with outer society and which give the individual social power[3]. This also raises the question as to what are the social networks of adult homeless people with disabilities. Murray[2] asked the question: *"Who speaks for homeless persons during health care reforms? What are the needs and resources of the homeless persons?"* Friedemann[3] further asserted that it might be necessary for external agencies to act as a voice for those at the margins.

Tryssenaar, Jones and Lee[4] quoting Townsend[5] emphasise the need for rehabilitation professionals to promote social justice by enabling people to participate as valued members of society despite diverse or limited potential. Townsend further challenges educators, clinicians and researchers to include a social vision in their practice. It is in this light then that I decided to explore primarily the impact of disability on adult homeless people with mobility impairments, and secondarily to advocate for their inclusion in rehabilitation services in South Africa.

Literature review on methodology

Although an extensive review of literature regarding homeless people and disability was conducted, the research focus for this paper will be based on the work done by Miller, Creswell and Olander[6] on writing and retelling multiple ethnographic tales. Their article is based on the narrative of three tales about a soup kitchen for the homeless and near homeless people. Miller et al.[6] maintain that there are numerous ways of telling ethnographic data. Arising out of their review of the literature they suggest using some combination of description, analysis and interpretation. They also make reference to tales that incorporate different research perspectives, such as *realistic*, *confessional* and *critical tales*.

Miller et al.[6] also suggest that *confessional tales* reveal, "How [a] fieldwork odyssey was accomplished by the researcher". The primary audience for confessional tales is students of fieldwork – those who are in search of guidance and reassurance regarding the fieldwork 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 view things at the beginning of the study, and see things differently at the end of the study. They provide researchers with an avenue for confessing their personal biases, for 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".

Lastly Miller et al.[6] maintain that with the *critical tale,* there is concern for representing the social structure as seen through the eyes of a disadvantaged group, and that 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: a commitment to an emergent relationship with participants; a set of stance about positionality and subjectivity; and a vision of research that promotes social justice. Miller et al.[6] continue to argue that, to be more specific, the researcher advocates for giving voice to the participants, sharing rewards and privileges, and for a heightened writer's subjectivity. Although the three types of tales are intertwined and closely related, the focus of this paper is on the *confessional*, and *critical tales*. For the research process to be understood, the researcher needs to give an overview of the realistic tale as both the confessional and the critical tale are based on the realistic tale. The realistic tale provides an account

that had not been written, whereby the researcher stands back and gives an objective account of events or a descriptive analysis and interpretation of the culture of a situation.

The Research process

The realistic tale

The researcher's story

I was born in a rural village, which by today's standards would be described as impoverished, even though as young people at the time we did not think of ourselves as such. Sharing with others was the norm and was not questioned. There was no sense of competition among us.

There were disabled people in our village and they lived with their families. Among disabled children, those without severe impairments attended the local school. Unfortunately, as in the rest of the country, disabled people in our village were stigmatised and deliberately marginalised by some people in our community. Disabled children were called *umntwana karulumente*, a child that belongs to the government because it was seen as the government's responsibility to care for disabled children.

I was particularly close to my grandmother whom I like to remember as a human rights activist. She was a teacher by profession but was incapacitated because of asthma. She was an ardent reader and listened to the news on her little battery operated radio every day. Many people used to come to her for advice. This advice ranged from calming down a young wife who was challenged with problems of administering her household, to use of simple herbs for children's illnesses and even simple things like not cooking certain vegetables as by cooking them one could lose certain vitamins. She gave this advice with a quiet voice in the safety of her home. She never openly told us to feel passionate about issues of social justice and social development, but she was an important influence on our beliefs and attitudes.

How did I come to be a physiotherapist? My grandmother used to drum it into me again and again that to succeed in life you need a professional training of some kind. I wanted to help injured people get back on their feet again and since that was my understanding of physiotherapy, that it is a helping profession, that was the direction I chose. Today I am an educator in the field of physiotherapy and rehabilitation, living and working in Cape Town. I always thought that professions shape individuals, and yet, as I have grown in my profession, my grandmother's nurturing has stayed and grown with me. I realise now that there is a powerful interplay between the profession and the individual, and this interplay is more powerful than I previously recognised. I feel I chose physiotherapy for my profession because of it bringing me into contact with many people with disabilities who are marginalised and disadvantaged. I knew that the interaction with these individuals would allow me the room to promote social justice, a desire already planted deep inside me by my grandmother. Consequently, I also feel that I was just waiting and ready for a situation described in this paper to emerge as I was also emerging and turning to face myself. What I did not realise was how profoundly this situation was going to affect me.

The student's story

I was approached by fourth year physiotherapy students to help them with their mini-research project. The topic, *The Impact of Disability on Homeless People*, excited me very much as I saw in it a new line of enquiry for physiotherapists. At that time, I was still very much caught up in the medical model of rehabilitation and research. I had not yet been exposed to the methods of qualitative research and the importance of examining the relations between people and contexts and considering these relations as producing meaning[7]. Mine was a far more clinical approach. My training had focused on describing the pathology and treatment of a great variety of impairments brought about by medically defined conditions, including stroke, cerebral palsy and head and spinal chord

injury. This approach was the best I could afford the students at that time. However, not only did my clinical training unwittingly disadvantage me, but my many assumptions about homeless people would also soon be challenged. Most of the homeless people to whom I have been exposed irritated and disturbed me by knocking at my door and asking for something. My stock response to these intrusions into my life was detached tolerance. Having committed myself to supporting the fourth year students, I reflected upon the seemingly insurmountable challenges faced by disabled people who *had* homes, such as asserting ones voice within the family and beyond, access to buildings and financial resources. I could thus not imagine how a disabled *and* homeless person would meet his/her needs on a daily basis, let alone make his/her voice heard.

I started reading about homeless people. I discovered that homelessness resulted from a combination of factors, such as loss of job, family problems and health problems[8, 9]. The majority of homeless disabled people identified disability as the main contributor to their poverty and homelessness. Some complained that after their discharge from hospital following an accident or other incident, they had neither work nor a place to stay. Their employers were not prepared to re-employ a disabled person and their lessors evicted them for overdue rent. These complaints are supported by Plumb[1], who notes the snowballing effect that underlines the vulnerability of society's poor: "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. This leaves a Hobson's choice between no place at all or city run homeless shelters, which often are dirty, noisy and unsafe"[1].

Initially there was a need to locate and ascertain the prevalence of mobility impairments among the homeless population. Doing research on the homeless population is not a straightforward activity because of their constant mobility. Tryssenaar[4] indicates that researchers need to explore homelessness from the perspective of persons who are homeless and obtain views regarding the impact of their situation from themselves and from within their own environment. Among the homeless people there is a general mistrust and concern regarding any form of authority or strangers, including the experience of being questioned. Initially the idea was to approach the homeless population in their most natural environment: the streets. However, the physiotherapy students and I identified many obstacles eg, lack of private space to hold a private discussion with the homeless people as well as their constant mobility. All these obstacles rendered this approach less desirable. We thus opted for the shelters. There are 34 shelters and homes for adult homeless persons in the Western Cape. Of these, 10 shelters from the Cape Peninsula were conveniently selected to ascertain the prevalence of mobility related physical disability. Of the 136 participants, 19 (13.7%) of the homeless people in these shelters had mobility impairments. The majority of those had mobility impairments as a result of varying factors even before they became homeless. These individuals experienced a wide variety of functional limitations in their activities of daily living.

After the physiotherapy students completed their study, we had a reflective session. The students were sad. They wanted reassurance from me that I would take their research further and actually begin to address the needs of homeless disabled people. I wanted to explore this topic further, but was struck by the realisation that although I was also feeling sad, I did not feel the depth of the students' sadness. I realised that I had yet to spend time with homeless disabled people and had yet to experience their lives beyond my own irritations and prejudices. I realised that I had to listen to the homeless people themselves. I then chose to further explore the impact of mobility impairments from the shelter with the highest numbers of homeless people with mobility impairments[8].

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My perception was that by the time I entered the life stories of the homeless disabled people I had already perceived myself as an activist and an advocate. However, I still needed to go through a long process of self-reflection before I could become a conscientised advocate for homeless people with mobility impairments.

The confessional tale

Drawing lines between biases, facts and hearsay

I lived for a week in a shelter for homeless people. There were a total of 51 residents in this shelter. Ten of these (20%) had impaired mobility and 13 (25%) had mental disabilities of various kinds. During my stay, I assisted with the daily functioning of the shelter. In the afternoons I spent time with some of the disabled residents, speaking with them and listening to their experiences. A suitable private environment was created where I could conduct interviews and record their life stories undisturbed.

I found the experience was more profound than any other in my life. Try as I might to be open-minded when I began my internship, already at the first few one-on-one interviews, I noticed my fear and a sense of danger at being in a personal and intimate space with a kind of person I had always taken to be rude, violent and drunk. And yet when I listened to their life-stories, the person's problems, fantasies and struggles, something began to change. I was faced with the dilemma of wanting to hold on to something to distinguish 'this kind of person' from the kind of person that I am. At the same time, I found myself recognising myself in their problems, fantasies, and struggles. These biographies did not fit the stereotypes of homeless people; they spanned the continuum of real life. I had difficulty containing my emotions and feelings. I felt angry at what I saw as the exploitation of homeless disabled people and discomfort at recognising my own complicity in it; sadness at what I saw as lost opportunities; agitation because I could not find a quick solution to both the social and rehabilitation problems experienced by the people with whom I was living. And I felt a deep concern at how far I had travelled from my rural childhood into the abstract violence of urban Cape Town, a social violence underpinning and underpinned by the abstract violence of my professional training and its attendant medical scientific categorisations, codifications and pathologies. I was rediscovering in my conversations with homeless disabled people a capacity that I recalled from my childhood to recognise myself in others, a capacity that had been slowly eroded by the rationality and instrumentalism of my medical model training and the bureaucracy and alienation of urban living.

Submergence into the life stories

The life stories and experiences of the people I interviewed and with whom I spoke tended to revolve around the barriers that impeded what they saw as their 'progress' or their ability to participate in the shelter community and the world beyond. Interestingly, health services were not seen as a priority in the hierarchy of needs, a finding supported by Murray[2]. The most frequently reported needs were: more shelter, more contact with friendly and responsive people, speeding up the processing of disability grants, food and clothing and discounts for homeless disabled people. The majority of the people I spoke to did not consider themselves to be any different from able bodied homeless people and suggested that lacking a limb is insufficient reason to set them apart. They argued that concentrating on what they can do gives them a positive outlook on life.

Despite broadly similar concerns and basic needs, the people I spoke to did not all share the same problems and concerns and did not all respond to these in the same way. I was beginning to realise that through my assumptions and prejudices I had gathered a diverse group of people together around the criteria of homelessness and disability, which were also neither homogenous nor abstract categories, thereby erasing the group's heterogeneity and essentialising their difference from myself as drunken, rude, violent, etcetera. By essentialising their difference, I had failed to recognise the essence of their humanity and once again I was reminded of how far I had travelled from my childhood.

All of this was brought home to me towards the end of my stay at the shelter. As I came to know my participants better, I began engaging them about their individual strengths and weaknesses and they engaged me about what my interest in their problems meant to them. We started relating on an equal level. One person had this to say:

I see myself as a good person. I believe that if you use your common sense and work hard, then you will live better. Another thing I am grateful about is my mentality. I am still all right, 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 would not be possible.

Other participants were concerned about the negative qualities they recognised in themselves. These included bad moods, hot tempers and aggression. Most participants mentioned alcohol abuse and identified alcohol as a significant contributor to violence and fighting.

Finally, the homeless disabled people appreciated that I sat down and listened to them:

I don't want to ask questions, but want to respond and say, as far as I am concerned, you're talking to us and that makes me feel very proud. As we discuss these problems, I feel that there are people who are interested in us, who feel we need help and time. Coming together as a group of disabled homeless people helps us get this straightened out.

The state of chaos and confusion

At the end of my stay and having completed my interviews and focus group discussions, I interviewed the manager of the shelter. I was shocked at her lack of understanding of the plight of homeless disabled people. I wanted to see other shelters, meet more homeless disabled people and the people who work with them. I also wanted to talk with people in the disability movement about interconnections between disability, homelessness and poverty. I wanted to know what is being done to support disabled people within the homeless population.

I began interviewing managers at other shelters with homeless disabled people and it quickly became apparent that the shelter I had stayed at was not unique in its lack of support for disabled residents. In one Cape Town based organisation for disabled people that I visited there was great concern about poverty within the disability sector and efforts were focused on trying to create opportunities for disabled people to participate in the job market. Yet they had not thought about interconnections between disability, poverty and homelessness. Increasingly, I felt that this was a crucial area in need of research and advocacy.

Feelings of reciprocity

I came back to the shelter to give feedback workshops to all the participants and hoping that **I could fix** some of the issues that **I felt** were not happening and that **needed to be fixed**. Again there were some hard lessons to be learnt. In my professional judgement I felt I could assist the adult homeless people with mobility impairments with some of their rehabilitation needs. I wanted to build parallel bars for the homeless man who had one of his legs amputated above the knee, and I thought the homeless people could assist me. I was surprised that through the research questioning and dialogue during the interviews with the manager of the shelter and the homeless disabled people some awareness had been raised about some of their basic needs. There were already 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 impaired mobility had made – already rehabilitation was taking place through art and extramural activities.

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(3) For the one homeless person I had thought that I could assist with rehabilitation, a wheelchair had already been made available by the manager of the shelter, though again in my professional judgement, I doubted if this was what he required. However, he seemed to be very happy with his newfound mobility. It would appear that in this shelter the time I had spent gave them time to reflect and had also given them impetus to respond to some of their basic needs. The question arose: Was I still needed in this shelter? Rather than trying to **fix** basic things that the residents of this shelter had already sorted out, I needed to concentrate on what this research has shown – the need for advocacy for homeless disabled people within the disability, rehabilitation and human rights debates.

The state of pausing, being still and reflecting

In this heightened state of subjectivity, I needed some solid ground under my feet so that I could develop some objectivity while I tried to negotiate *the critical tale*. Miller et al.[6] 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, I needed to be quiet and still and connect with who I am, and the lessons I learnt during my childhood days under the mentorship of my grandmother and the critical incidences that had made me change. I needed and wanted to see my world through the eyes of the homeless disabled people and their needs. These needs were not different from the needs that were easily afforded from my grandmother's village. I felt I had gone full circle through this journey. I have asked myself questions regarding the homeless disabled people and their environment, including how this could fit within the rehabilitation work that I was training the physiotherapy students to excel in. I have questioned myself about my own biases regarding homeless people being different and my position in this journey. I have doubted my initial stance regarding this marginalised group of people. In all of this, there is one thing of which I am sure. The homeless people with disability from this specific shelter and the physiotherapy students required from me a radical shift from the narrow medicalised approach that was the centre of my training to an approach that puts first and foremost the humanity of every individual and responds with rehabilitation programmes that are underpinned with *ubuntu (*humanity).

The critical tale

The emergence of an advocate for the homeless people with mobility impairments

The Integrated National Disability Strategy[10] notes the strong relationship between disability and poverty: poverty makes people more vulnerable to disability, and disability reinforces and deepens poverty[10]. To be homeless and disabled would appear to be a double burden.

That homeless people make up an increasingly vulnerable population is beyond doubt. As Plumb observes, homeless people are at higher risk of contracting preventable diseases – leading to progressive morbidity and premature death – than people with homes[1]. Yet, while Plumb is correct, the persistence of medical discourses of disability and the entrenchment of welfare and care-based approaches to respond to this vulnerability have established the view that disabled people are different from abled people and are in need of care because they are ill. Emphasis on the medical needs of disabled people obscures their broader social needs, and perhaps more importantly, diverts critical scrutiny away from the systems and relations of power that contribute to perpetuating their vulnerability.

As a social group, homeless disabled people are so marginalised from the economic, political, social and cultural forces that reproduce society, as well as that generate society's social concerns,

that it is barely accurate to speak of homeless disabled people as peripheral. While it is important to recognise that this group is not homogenous and that there are sectors of the disabled community that experience greater discrimination and marginalisation than others, it is also true to say that disabled homeless people as a group lack both political influence and social power to improve the condition of the group members' lives. Although it bodes well that over the past 15 years, disabled people's organisations all over the world have worked to reposition disability as a human rights and development issue, the benefits of these intellectual shifts in activism still need to be realised for the disabled people on the streets of Cape Town and other urban centres in South Africa.

Having said that, the question remains: how does one bring the issue of homeless disabled people to the centre of discussions? The shift to positioning disability as a human rights and development issue is a useful beginning. However, new intellectual, analytical and critical resources for 'thinking through' the issues and 'positioning' the debates can only be the beginning. For although interventions must proceed from an appropriate concept of the issues, we must ensure that intellectual labour informs action rather than substitutes for a lack of action.

The promotion and protection of the human rights of homeless disabled people is a cornerstone of the INDS. In this effort, the INDS takes its lead from South Africa's Constitution of 1996 that guarantees certain fundamental rights for every citizen. As Sheila Riddell[11] shows, some rights and duties that accrue automatically to the able bodied population are granted only conditionally to disabled people. Again poverty and lack of access to financial resources play a significant role in determining who can access their basic rights. An example cited by Plumb[1] demonstrates what is at stake here. It has already been suggested that homeless people are a population especially at risk of medical ailments. Lifestyle and exposure result in a higher incidence of chronic illnesses, and lack of access to medical care causes preventable illnesses to go undiagnosed and untreated until late in their course. Yet despite the new rights discourse and development paradigm, there has been a marked lack of action either at the level of political leadership within the national and provincial health departments or at the level of the public health care infrastructure. Quite simply, hospitals and health care institutions have been reluctant to provide quality care to homeless people and other clients who lack financial resources, despite the guarantee of article twenty-seven of the Bill of Rights to the right to health care, food, water and social security for everyone. This example is drawn from Plumb's discussion of the difficulties facing homeless people in general, but his example is equally applicable to disabled homeless people.

Of course, the lesson has long been appreciated that the legislating of human rights is not worth much if these are neither accessible nor monitored. Recent debates around the appropriateness of a notion of rights rooted in a Western liberal tradition in which the individual is the basic unit of political agency have also complicated the rights-based approach to empowering those on the margins[12]. Such an individualised notion of empowerment as espoused by the international disability movement runs contrary to social customs and practices that are found in many developing countries, where collective action is valued[13, 11]. That some kind of collective response might be a more appropriate strategy through which to address disability, homelessness and poverty in South Africa is intimated in Lang's argument that an appropriate intervention into disability should begin with altering the environment[12]. After all, if it is the systems and relations of social power that disempower and marginalise homeless, disabled and homeless disabled people, then it is these social relations that require reform[a]. From this point of view, increasing access to rights will

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[a] For an excellent analysis of how the interests of tourism and capital have systematically sought to erase marginalised youth and homeless people from Cape Town's 'city bowl', see Klopper 2003[14]

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mitigate the impact and to a certain extent defend marginalised groups against the constellations and alliances of power that disempower them. But how appropriate is it to place the burden of responsibility of promoting social justice on marginalised groups rather than seeking to promote social justice through dismantling those constellations and alliances that threaten it? Altering the environment does not mean building more ramps and widening doors (although that too). It means changing the social relations and attitudes that determine the kind of society in which we want to live.

Lessons learnt

My perception is that in the dimension of myself to which I will always go back, I have developed and added three guiding principles:

(1) Each area that requires advocacy is unique and I needed to connect with the uniqueness of the environment I was researching. I also needed to acknowledge my naivety about that area and allow those who are the participants to guide me. Listening to the stories of the homeless disabled people was the beginning of advocacy for this grouping as Murray[2] says, "*To listen to the homeless population is the first step in meeting what we consider are 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*".

(2) My perception is that growth in activism and advocacy happens when we allow ourselves to be vulnerable and immersed in the type of chaos that often surrounds marginalised and disadvantaged groups. 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[3]. Overall their lives are perceived as disorderly. The question remains whether homeless people with mobility impairments perceive their lives as disorderly? Or are these the assumptions of a bystander? Kirk[15] sees qualitative research as a particular tradition in social science that fundamentally depends on watching people on their own terms. To comprehend the depths of social life and lived experience, the researcher must understand the total man or woman in his or her total environment significantly. This extends the researcher's interest to emotionality, calling for a deep probe into the human soul. Douglas[16:5] 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[16:5] 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 the meaning that people exist in and emerge from and are consequential for those methods of life that cause and result in research*". Much as I had perceived the life of homeless disabled people to be chaotic, to become an advocate for their situation I had to allow my emotions to be chaotic too and my vulnerabilities to run loose so that I could see the link between lessons learnt in the past, and the biases and misconceptions regarding homeless people that I had allowed myself to become entangled in, and combine these with new lessons I have learnt from the homeless people with mobility impairments.

(3) The issue of reciprocity is a complex one. My perception is that sometimes we engage in reciprocity when we are feeling overwhelmed with the challenges ahead of us. Many of these attempts are patchwork approaches and sometimes the people themselves have discovered the missing link, but the core of the problem still remains. Over the past decade, disabled people's organisations all over the world have worked to reposition disability as a human rights and development issue[10]. They have approached this by looking at the way society disables people with disability. 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. The question is, as a rehabilitation advocate, should my concern be only on ensuring the provision of technical skills, or a holistic approach that will promote the societal integration of the disabled homeless people in societal debates that will link the homeless disabled people to the disability rights movement and society?

Recommendations and conclusion

Primarily this paper aimed to explore the impact of disability on adult homeless people with mobility impairments, and secondarily to advocate for their inclusion in rehabilitation services in South Africa. In the introduction of this paper, I mentioned that Tryssenaar, Jones and Lee[4] quoting Townsend[5] comment on the need for rehabilitation professionals to promote social justice by enabling people to participate as valued members of society despite diverse or limited potential. Townsend further challenges educators, clinicians and researchers to include a social vision in their practice.

The life stories of the homeless disabled people with mobility impairments had raised some critical questions for rehabilitation professionals. Health services were not seen as a priority by the homeless people with mobility impairments. Instead aspects such as more shelters, family life, coming together as a group, contact with friendly and responsive people were seen as priorities. They also brought their own assets such as being a good person, having an intact mentality and gratitude to the discussion. They were also aware of their limitations. When rethinking the whole notion of rehabilitation for homeless disabled people, it would appear that rehabilitation professionals need to transcend the narrow medical institutionalisation of their professional training. Though for these professionals, it would be easy to start singing the tune of human rights, the implications and the applications of this on certain groups and cultures has already been questioned in this paper.

As I found myself grappling with the whole idea of the model that could be used for the integration of the voices of homeless people with mobility impairments within the disability and rehabilitation debates, my thoughts returned to my childhood days and I wondered whether some of my grandmother's teachings and the approach that was used in my village could be integrated in this model. My grandmother contributed to the social capital of our village by offering unlimited advice in the safety of her home, which was imbedded in the village. There was no distinction as to who should get this advice, everyone was seen as deserving. Plumb[1] has already explained about the gate keeping mechanisms that restrict homeless people from seeking advice from health institutions. The question that needs to be asked is whether we are not allowing community-based rehabilitation resources and assets that are carried by the family members of people with disabilities to lie dormant in the communities, while we as rehabilitation professionals complain of limited resources whereby we can only afford to render rehabilitation services for a few in selected institutions. In the meantime groups of people including the homeless disabled people are unable to access these services. Could it be that as professionals who have been trained in medical scientific pathologies we feel safe and secure in these

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institutions? It appears that some reflection is required regarding how we define our scope of practice.

The majority of the homeless people mentioned that they had mobility impairments prior to being homeless and that they saw disability and poverty as having contributed to their homelessness. Having a family and a home was seen as one of their primary needs. I have already mentioned that in my village there were no homeless people, although there were people with disabilities. Earlier in this paper Plumb[1] raised the issue of the working poor who live on the precipice which can tumble them into homelessness at any time. My perception is that this statement speaks more to the homeless people with mobility impairments. The close link between disability and poverty cannot be underplayed. My perception is that poverty eradication strategies need to be an integral part of rehabilitation programmes for homeless disabled people and other vulnerable groups of people.

The last aspect that came from the homeless people with mobility impairments which I would like to raise, and which I see as critical for the rehabilitation profession, is the issue of having more contact with friendly and responsive people. Could rehabilitation professionals see themselves within this paradigm? How do you continue being friendly and responsive when your training has drilled you to take a superior stance of informing people about their illnesses and deficits? As I reflected on this I again had to go back to my grandmother's village and I wondered what attitudes and beliefs were at work in producing and reproducing a community that accommodated impairments, while at the same time promoting an enabling environment, which is to say, a community where people with disabilities were not reduced to and defined by their disability. Again I wondered whether there are any lessons to be learnt here and how they might be transposed.

I will not try to provide a blueprint for how things should be, but my journey as a researcher, as a professional and, most importantly, as a person, has helped me see that two so-called marginal issues like disability and homelessness raise serious questions for disability, rehabilitation and human rights debates.

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