Disability and Faith-Based Development through Sport

An Honors Thesis (HONRS 499)

by

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May 2013

Expected Date of Graduation

May 2013
Abstract

People with disabilities make up about 20 percent of the population in developing nations (Yuen, 2003). Even though this is a substantial proportion of the overall population, people with disabilities have been routinely omitted from the development process. Much of this can likely be attributed to the stigmatization and marginalization of people with disabilities in many nations (Feinstein and D’Errico, 2010). The present analysis argues that it is in the interest of human rights for people with disabilities to be included in development programs and that this inclusion benefits not only people with disabilities but also the community as a whole. In order to facilitate meaningful, culturally responsive, and empowering inclusion there is a need for the creation of a development approach which embodies these values. Adaptive sports are presented as one potential approach.

Keywords: disability, culture and development, adaptive sports, human rights
Acknowledgements

The inspiration for this thesis came during an internship with Christian Missionary Fellowship in Nairobi, Kenya. It was here that I came to understand the realities of life with a disability in many developing nations. I will be forever indebted to Nancy, Simon, Maria, Joel, Aden, Brian, Dennis, Curtis, Vincent, Joseph, and their families for sharing their lives with me and for allowing me to know the barriers they face on a daily basis as well as the ways they have eliminated those barriers. This foundation was further developed through an internship at the Kampala School for the Physically Handicapped (KSPH) and I am grateful for my colleague Katie Dickey’s collaboration on the creation of a Power Soccer clinic and the teachers’ enthusiasm to learn about Power Soccer and how it might be developed in Uganda. More importantly, I am grateful to all the students at KSPH for showing me that it is not the disability that is the problem but the barriers in society.

I would like to thank my thesis advisor, Richard Clark, for his wisdom and guidance throughout the research and writing process. I am extremely grateful for the time you invested to read and provide feedback on my drafts. I would also like to thank Phillip Keck, Department of Counseling Psychology and Guidance Services, for reviewing the conceptualization of disability section and providing other invaluable advice. I would like to thank the Honors College for providing this opportunity, and specifically, Dean Ruebel for his patience throughout the many changes which occurred over the past year.

I would also like to thank my friends and family for their support throughout the process. I appreciate your patience and encouragement as I spent countless hours researching and writing this thesis. I know that with your support this will become more than just a research thesis, but a reality in implementation.
Disability and Faith Based Development through Sport

Introduction

The present era is characterized by an avid pursuit of social justice, with organizations and movements emerging to target nearly every oppressed group of the global population. The amelioration of poverty and injustice are on the forefront of many individuals' and communities' mindsets. This trend is especially salient within the Christian community as issues such as human trafficking, AIDS, and extreme poverty are becoming a prominent topic of discussion. Stemming from this discussion is a greater level of engagement in global poverty reduction by Western nations and non-governmental organizations. Thus far, however, people with disabilities have been vastly underrepresented in development programs, particularly in regards to the leadership within the program (Yoshida, Parnes, Brooks, & Cameron, 2009). This should be an especially disturbing omission as it is estimated that 20 percent of the population in some developing nations has a disability (Yuen, 2003). Additionally, people with disabilities experience injustice and poverty at a disproportionate level to their able-bodied counterparts (Barclay, 2011). People with disabilities experience challenges in the social environment, the medical environment, and in many cases there are enormous societal barriers to basic survival (Feinstein & D’Errico, 2010). Given this understanding, the oversight in inclusion of people with disabilities in cross-cultural, faith-based development is indicative of a major issue.

One might assume that a good-intentioned development program would be inclusive of all people, particularly the most marginalized individuals of the population, but this inclusion is not as straight-forward as one might presume. This is because the barriers which prevent the inclusion of people with disabilities in society are ingrained at cultural and systemic levels. Therefore, there is a need for the intentional formulation of sustainable, empowering, and
culturally responsive development programs with a focus on disability (Hoy et. al., 2010). The literature devoted to this topic, however, is lacking. Therefore, an initial analysis should be conducted. It is important to analyze not only the complexities of disability in developing nations, but also those intricacies which are associated with cross-cultural, faith-based development. This work is intended to suggest a framework by proposing the usage of adaptive sports as an empowering, culturally responsive, and effective cross-cultural, faith-based development program.

**Nature of Disability in Developing Nations**

Poverty and disability are intrinsically linked, as the presence of one increases the likelihood of encountering the other (Mont, 2007). Higher levels of disability have been shown to be associated with higher illiteracy, higher unemployment or underemployment, lower immunization coverage, and poor nutrition ("Mainstreaming Disability in," 2008). Nonetheless even with this information, determining the statistical picture of people with disabilities in developing nations is difficult as research is lacking in quantity and quality (Maulik & Darmstadt, 2007). There have been a limited number of studies conducted in developing nations targeted at achieving reliable statistics, and the studies that have been conducted have varied dramatically. The explanation for the differences in statistics can be attributed to a number of factors including differing definitions of disability, study methodologies, the lack of records of diagnoses and treatment, and social stigma which labels individuals with disabilities as cursed (Durkin, 2002; Mont, 2007). Some scholars believe that stigma may be the primary explanation as it leads both to underreporting of disability as well as to acts of negligence and abuse that result in the premature deaths of people with disabilities. Therefore, when faith-based
development practitioners are working in the community the goal of stigma reduction must be integrated into any disability-focused development program.

Even with the difficulty of data collection, it is estimated that 80 percent of people with disabilities reside in developing nations (United Nations). This statistic cannot be simply explained by the differences in population size as prevalence rates differ distinctively between developed and developing nations. For example, it is estimated that 90 percent of childhood blindness and low vision occurs in Africa and Asia. It is also estimated that 90 percent of people with developmental disabilities live in developing nations (Durkin, 2002). Research has shown severe mental retardation to be more prevalent in developing nations, even despite the higher child mortality rates of that population. The severity of mental retardation is also greater in developing nations, leading to increased demands and difficulties (Fujiura, Park, and Rutkowski-Kmitta, 2005). While the occurrence of diagnosed cases of epilepsy in countries in Europe and North America ranges between three and seven per 1,000 people, diagnosed cases of epilepsy in developing nations range from three to 57 per 1,000 people (Durkin, 2002). This statistic does not even consider the number of undiagnosed cases of epilepsy in developing nations. Even with the lack of reliable data on disabilities in developing nations, it is clear that there are a significant number of people with disabilities; therefore, more emphasis should be placed on creating resources devoted to this population.

Causes

In order to understand the prevalence of disability, one must understand the causes. Many cases of disability in developing nations could be avoided with the use of simple preventative measures (Durkin, 2002). An effective development program will work to prevent future disability, and not just treat already existent disability. The causes of preventable disability in
developing nations can be attributed to two primary components: a lack of knowledge and a lack of access to resources. Examples of deficits in knowledge include childbearing in older mothers, which is associated with Down syndrome, the practice of consanguinity which can cause numerous genetic disorders, and improper prenatal care and nutrition practices. An individual must be knowledgeable about nutrition and healthcare, but even with that knowledge the individual must have access to the necessary resources. A lack of available medical advice, nutritious food, and prenatal care can be especially damaging to a developing fetus and a lack of access to healthcare throughout the lifetime can cause irreversible disability.

Micronutrient deficiencies and infections are the most common cause of developmental disabilities worldwide and are especially prevalent in developing nations where nutritious food is often scarce since many families are living on one dollar or less per day (Durkin, 2002). A deficiency in Vitamin A, a nutrient which is fairly easy to get, is a cause of childhood blindness which could potentially explain the reality that 90 percent of childhood blindness occurs in developing nations. Iodine is another nutrient that when deficient in the diet of the mother often causes irreversible brain damage to the fetus, leading to mental retardation. In addition, low folic acid levels have been linked to higher incidence of spina bifida and other disorders in the nervous system. Iron deficiency leading to anemia is especially damaging as it can lead to all of the previously mentioned deficiencies by blocking absorption of nutrients, especially Vitamin A, as well as causing low birth weight which is also associated with disability. These micronutrient deficiencies can be easily prevented with either nutritious food consumption or the use of supplements (Fujiura et. al, 2005). For example, ensuring proper levels of folic acid has been found to prevent 70 percent of cases of spina bifida and anencephaly. The use of nutritional
supplements such as Vitamin A, folic acid, iodine, and iron are an inexpensive and extremely effective manner of disability prevention.

Another form of prenatal exposure which can be prevented that is not common in developed nations, but is common in developing nations is the use of commonly known teratogens such as Thalidomide (Durkin, 2002). Thalidomide has been introduced as a treatment for HIV and leprosy in developing nations, but because women often do not seek prenatal medical support they do not know to discontinue use when pregnant thereby causing harm to the fetus. Other toxic drugs that are not commonly used in developed nations have been found to be common in developing nations, potentially due to the lower financial cost of these medicines. Even if a child receives all the proper prenatal care and the mother avoids usage of toxic drugs, the child is still at risk during the birthing process as women in developing nations often do not have access to professional birth support. Many problems during birth can also cause disability, such as asphyxia or birth trauma and injury, and are mostly preventable with access to trained birth facilitators such as midwives, registered nurses, or obstetricians (Maulik & Darmstadt, 2007).

After birth, proper nutrition and access to healthcare remains incredibly important as malnutrition is widely understood to cause disability (Patel & Kleinman, 2003). Infections such as meningitis, measles, rubella, and febrile illness are also more common causes of disability in developing nations (Maulik & Darmstedt, 2007). Infections such as these rarely cause disability in developed nations due to the easy access of immunizations and effective treatments. It is, however, rare for people in developing nations to have access to immunizations, even though they are inexpensive, as access to healthcare is notoriously lacking for people living in poverty (Durkin, 2002). Prevention, however, can be extremely inexpensive and has dramatic effects. In
fact, in Thailand it has been found that simple preventative measures and proper treatment decreased the incidence of hearing impairment as a result of chronic ear infections (Jauhiainen, 2001). Poverty is also associated with pollution, inadequate housing, accidents, and poor sanitation, all of which can lead to disability.

**Barriers Particular to Developing Nations**

Not only are people in developing nations at higher risk for developing a disability, but people with disabilities in developing nations also face a variety of additional barriers in their daily lives. The majority of people with disabilities in developing nations do not have access to proper healthcare and treatment, even for those with disabilities who can be greatly impacted by medication (“World Report on”, 2011). One study found that between 13 and 38 percent of children with epilepsy in developing nations had never been given anticonvulsant medication (Durkin, 2002). The same has been found in children who are hearing impaired, as they frequently lack access to very basic audiology services and to simple adaptive devices such as hearing aids (Jauhiainen, 2001). Another study in Brazil found that 40 percent of the children with disabilities not attending school were not enrolled because of vision problems that could be easily corrected by glasses (Mont, 2007). In this case, the lack of access to a basic and relatively inexpensive treatment, glasses, could provide children with the ability to attend school which would in turn increase their community involvement and future employment potential. Mental impairments, including intellectual disability and mental illness, are extremely unlikely to be treated as between 75 and 85 percent of people globally receive no treatment for their impairment (Ngui, Khasakhala, Ndetei, & Weiss Roberts, 2010). For those with mental illness, the lack of treatment could be attributed to the lack of psychiatric care; in Southeast Asia there is
one psychiatrist for every 100,000 people, and the situation is much worse in sub-Saharan Africa which has only one psychiatrist for every one million people.

The issues expand beyond the basic medical realm though, as children with disabilities are less likely to attend school. One study in India found that the number of students not enrolled in school among children with disabilities was five times higher than their non-disabled peers (Braithwaite & Mont, 2008). It is possible that parents are unable to send all of their children to school due to limited finances available for school fees which would lead parents to send only their most academically inclined children, however, the benefits of schooling for children with disabilities extends beyond knowledge development as it allows for children to learn the basic life skills needed to lead an increasingly independent life. A lack of life skill education may partially explain the finding that people with disabilities are also much less likely to be employed (“World Report on”, 2011). This is especially true for people with intellectual impairments, as research has indicated that greater levels of intellectual impairment are associated with lower levels of employment (Fujiura et. al, 2005). It has been shown that people with disabilities are not hired by employers because of misconceptions regarding their work ability. It is believed that they will not be as productive or reliable, but in fact the reverse has been found to be true; people with disabilities are more reliable and productive than their non-disabled peers (“Mainstreaming Disability in,” 2008). While other factors are certainly influential, the finding that people with disabilities are less likely to attend school and less likely to be employed is likely attributed to stigma.

Prejudiced attitudes toward people with disabilities are widespread in developing nations (Maulik & Darmstadt, 2007). There is, however, a minimal amount of understanding regarding these attitudes in academia. As the term “stigma” implies, disability is associated with shame and
dishonor, and in some case it may extend beyond the individual to the entire family. This stigma likely originates from a lack of information, but it is often more than that. In many developing nations people with disabilities are considered to be cursed, possessed, or suffering for the actions of either their family or their own actions in a previous life (Ngui et al., 2010). Stigma often begins in the individual’s home, with parents holding negative attitudes toward their children (Maulik & Darmstadt, 2007). Parents who do not understand all the information regarding their child’s disability or who hold negative beliefs about disabilities will limit the activities in which they allow the child to participate. Anecdotal evidence suggests that it is not uncommon for people with disabilities to be hidden in the home and never seen by the community. The practice of limiting activities and of hiding children impairs the integration of people with disabilities in the community as well as impairing the child’s development, which only perpetuates the stigma. The presence of stigma does not just lead to social isolation, but has many other consequences to the individual’s health and well-being. Stigma has even been found to affect children’s physical health in the aftermath of natural disasters, a common occurrence in developing nations, with some individuals being intentionally abandoned post-disaster (Peek and Stough, 2010).

Vulnerability

The final conclusion regarding the analysis of the status of people with disabilities in developing nations is, therefore, that disability creates an environment of vulnerability for the person with the disability and in some cases the individual’s family. This environment of vulnerability affects every area of the individual’s life: physical, educational, spiritual, financial, psychological, and social (Mont, 2007). Therefore, a disability focused development program must address the vulnerability of people with disabilities within the context of each of those
areas. If one component of an individual is ignored, he or she cannot develop to his or her full potential. All of these components must be developed and implemented with the support and wisdom of people with disabilities, their caregivers, public health experts, and social workers (Coleman, 1999). It is also important to note that vulnerability is not an innate component of the individual but rather a socially constructed component, and therefore by utilizing development practices one eliminates vulnerability and invites opportunity. Additionally, this work will later emphasize the importance of development as opposed to relief as relief fuels vulnerability rather than eliminating it.

**Conceptual Basis for Understanding**

It should thus far be obvious that people with disabilities are an important population for emphasis in development. Given that this population has largely been omitted from previous development programs, there is a need to develop culturally relevant and effective practices for the manner in which those development programs are conducted. In order to understand the best development practices for people with disabilities, it is important to recognize the context in which these methods are utilized. This includes a thorough understanding of how to enact development programs respectfully in a cross-cultural context, an understanding of disability, and the intersection of the two components.

**Conceptualizing Cross-Cultural Issues**

Faith-based development has not become a prominent area of research in cross-cultural development until recently. The issue of cultural relativity is gaining notoriety and significance in many professions, but it can be argued that in none is it more important than cross-cultural, faith-based development. In this realm, there is the potential for exploitation as well as the destruction of individual and community identities. This, however, is not an automatic and
inherent component of cross-cultural, faith-based development, but is rather an indicator of the ethnocentric attitudes of practitioners. These attitudes originate deep within the annals of history but are no less present in the modern era of development.

While vast improvements have been made in some respects over the colonial era, the modern day evangelical movement is strikingly similar to the missionary activity during the colonial era. These similarities hold the potential to cause the same negative effects which are catalogued by historical analyses (Lazreg, 2009). The colonial movement was not value neutral; it was composed of White, wealthy individuals entering into another country and dictating the manner in which the country should be run, ultimately conforming people to their own standards of civilization. Therefore, while the genocidal violence utilized at the time has been rightfully villainized, a greater genocide has been ignored—the destruction of cultural and ethnic identity (Dossa, 2007). The effect is not simply a historical reality, but has endured even into today as much of the poverty which exists in many countries in Africa and other colonized locations can be attributed to ill-advised colonial era development strategies. It is popular to believe that a progression has occurred and the modern era is distant from these effects; but in fact global inequality is on the rise. While globalization is touted as an agent of global cohesion, the reality is that there is a burgeoning gap between the rich and poor (Litonjua, 2010).

Foreign aid has been proposed as a means of closing this gap; however, instead of fixing the problem of poverty, aid has only exacerbated it (Lupton, 2011). A vivid illustration of this reality is that a doctor in the Democratic Republic of the Congo, considered rich within his community, will have less money each month than an individual considered to be poor in the United States ("The Poor: The", 2005). This impacts not only economic status, but also has a profound effect on individual human lives. Preventable diseases are needlessly killing people in
developing nations simply because the resources are not present within the community; as a global statistical picture, each day 40,000 children die of a preventable disease, and 98 percent of those children are living in a developing nation (Rowland, 2001). The resources needed for prevention are not advanced, in fact, 80 percent of all disease in developing nations could be prevented if access to clean water, immunizations, and use of proper sanitary techniques were widespread such as in developed nations. The same could be said of the factors leading to disability which were previously discussed. Therefore, given these disparities in health and finances it is difficult to say current development programs are eliminating the global inequalities.

This global inequality is still rooted in the colonial practices which constructed systems for the benefit of the colonizing nation rather than the local people, stripped nations of natural resources, and established a global hierarchy which further degraded the colonized nations (Litonjua, 2012). While in modern times these practices are readily decried in an attempt to distinguish current practices from the colonial, the differences may not be as vast as desired. Even with the cautionary precedent of colonialism, development programs continue to perpetuate the same dominating relationships which further establish dependency (Dossa, 2007). This is reflected even through the usage of the terms “developing country” and “developed country” as though the developed country sets the universal standard of achievement. Development today, then, is still anything but value neutral as the West has once again taken on the paternalistic role of benefactor for other nations. In order to achieve these levels of “development” and, therefore to receive status within the global community, countries are forced to abandon many of their cultural values and practices. All of this is done in the supposed interest of the local people’s economic development. Often forgotten, however, is that economic development cannot operate
in isolation from other components of culture and when the point of reference is the West, it is
the cultural components of the West which become the ideal in the developing nation (Chiu,
Gries, Torelli, & Cheng, 2011). This not only harms the identity of local communities and
individuals, but also leads to the disappearance of global cultural diversity, a cornerstone of our
humanity. As long as the values and goals of development are defined by the West, modern day
development is no different than colonialism.

The colonial attitude exists in more ways than one would like to admit, but nearly
everything about an individual’s attitudes, thoughts, and lifestyles are culturally determined.
Therefore, due attention must be given to how culture permeates understandings of all
components of interaction in the development environment. What is viewed as a fact may simply
be a fact within one given culture during one particular time (Watters, 2010). This is not to say
there are no universal truths or commonalities between people and cultures, it is, however, to say
that much of what is believed to be universal may not be so in actuality. One needs only to
examine the vast diversity which exists in the physical environment to find it reasonable for the
human race to be just as rich in diversity. When practitioners working in cross-cultural settings
conform the unknown culture to their own mindset or worldview some of this diversity is lost, a
travesty which is arguably just as great in the human mind as it is in the physical environment.

In fact, concern is mounting in regards to the damage this assumption of universality has
on the local cultures. Psychologists are beginning to note the degree to which their understanding
of mental illnesses relies on Western models and assumptions and the devastating effect this has
in other countries, mainly the appearance of particular mental illnesses, such as PTSD and
anorexia in cultures where they previously did not exist (Watters, 2010). This could potentially
be explained by the self-fulfilling prophecy in that the Western practitioners come in expecting to
find the illness, which in turn creates the mental illness within that culture. These assumptions originate from the Western practitioners false belief that their understanding of mental illness is the only accurate understanding and that the same approaches to intervention will work in another culture. There is, therefore, an extreme need to understand all components of the individual within the culture in which that person functions.

Within the context of development focused on people with disabilities this issue of culturally-bound understanding and practice is of the greatest importance. There is currently a false dichotomy which exists in Western medical and psychological theory which differentiates culturally-bound illnesses and disabilities from "real" disorders and disabilities (Watters, 2010). This is a value-laden assumption of mental illness and disability; mainly that the Western manifestation of disability and illness is more "real" than other cultures' expressions. While disabilities and disorders may be manifested differently in different cultures and environments, this does not determine the reality of a disability or disorder. By declaring how the mind works from solely a Western perspective, the West is essentially forcing the rest of the world to think in a Western manner. It goes beyond the understanding of mental illness and disability though, for if the mind and body works in a culturally determined manner in regards to mental illness and disability, it is only reasonable to conclude that in all components it operates in culturally determined ways. The assumed, or forced, cohesion with the Western mentality disparages the local identity, but even more importantly declaring their reality as false is at its core a denial of their humanity.

While this declaration is disturbing and it is unlikely that any development practitioner would consciously agree with the degradation of the local community's humanity, the approach of development thus far has been to essentially heal the developing nations of their allegedly
primitive lifestyle, thereby converting humans into pathologies (Dossa, 2007). The local culture’s supposedly mistaken assumptions about the world, be it in regards to illness or otherwise, are replaced with the “proper” understanding; thereby targeting and eliminating the pathology to the great admiration of the development program and its supporters. All the while, the explicitly described goal of many development programs, the empowerment of the local people, is completely missed. While empowerment is the catch word of the time, more often than not, the influx of development practitioners into developing nations rather than leading to increased status of the local people, has further elevated the status of the developed nation just as it did during the colonial era (Lazreg, 2009). Christian development programs are especially vulnerable to this attitude as the salvation mentality begins to permeate beyond the eternal sector and subjugates the local people to inferior status in all segments of the self. It does not take long for the Western Christian, as opposed to the biblical Christ, to become the savior. With the best of intentions, rather than promulgating a religious belief there is an assault on all things different. The result is an increased polarization between Western Christianity and the local people.

Faith-based development, however, does not have to be imperialistic. Christianity was not a Western religion at its origin and its manifestation as such now should serve as an example of its ability to transcend cultures. In order to do this, though, there needs to be a revolution in the attitudes and methods of cross-cultural, faith-based development. In order to recast Christian development as culturally responsive, one must first delineate and understand the various components of one’s own culture. Culture is composed of individual difference variables such as religion, gender, sexual orientation, disability, and race as well as the means of communication, values, thinking, and social and personal expression (Baruth and Manning, 2012). Under this definition, culture is not a fixed construct, but is instead dynamic in nature. With any contact
between cultures there will undoubtedly be a change in cultural identity; however, it is imperative that this change is made freely and does not occur only in the local people but also in the development practitioner. This requires an open and teachable attitude on the part of the development practitioner.

Individuals working in a cross-cultural setting should express a great interest in immersing oneself in the local culture. It is through immersion that the individual discovers the unique cultural knowledge and practices of the community, thereby developing a profound sense of respect. This is a long and potentially challenging process for the development practitioner, but it is important that immersion in the local culture is prioritized above development (Lupton, 2011). Immersion involves a restructuring of one’s understanding and worldview which is neither easy nor comfortable. Every culture, however, has something to learn from another and there is nothing wrong with an individual choosing to incorporate components of another culture into their own, but again, the incorporation must be a result of choice and not pressure. When two cultures meet there is a collision of understanding and the individual is in a position of recreating his or her identity in a more direct and conscious manner than before (Arnett, 2002). The burden of re-creation of personal identity should fall not on the local people but the development practitioner, as the development practitioner acknowledges his or her foreigner status. The development practitioner’s approach as a genuine learner will not only serve as a method of building rapport in the local community but also as a means of personal and spiritual growth.

In addition to understanding one’s own culture, Christian development practitioners must delineate their religious beliefs from their culture. In this way, the individual can identify what is American Christianity and what is the true spiritual and religious value and meaning they desire
to share with others. From there it is important that religion and spiritual beliefs are shared openly and collectively. By doing so, Christian development practitioners are not only sharing their worldview but are also listening to the view of the local people (Lupton, 2011). When the mutual sharing of beliefs and worldviews occurs in the confines of a healthy and respectful relationship, the chance of imperialistic practices is minimized.

This avoidance of imperialism is why the most effective development practices are not formulated approaches applied in a variety of contexts and cultures, but culturally specific and community driven. Viewing the community’s knowledge and practices as an asset as opposed to a barrier is, surprisingly, a new concept in development practices, but it should become the norm (Sandler, 2007). By seeking out the assets in each realm of capital—human, physical, social, financial, and natural—the practitioner is taking the first step in a culturally relevant development approach (Sakar & Uddin, 2011). The implication behind this approach is that one begins by identifying the community’s strengths (Lupton, 2011). This is not done in order to solve a problem which has already been identified, but to develop a holistic and empowered understanding of the community. This should also impact the way in which the individual discusses and shares the community with others. Robert Lupton in his book *Toxic Charity* makes the point that individuals typically introduce themselves by leading with their accomplishments, not their failures, and therefore, this is the attitude one should take when introducing the community. This brings the focus to what is positive about the community, rather than the weaknesses, thereby transforming one’s development approach from one of paternalistic and ethnocentric ideas of development to a truly empowered, community-driven approach.

**Conceptualizing Disability**
In order to best empower people with disabilities it is important not only to demonstrate a concerted effort to understand the culture and worldview as it relates to development, but also its impact on the understanding of disability. An individual and a community’s understanding of disability is an issue of worldview, in that it is not only a part of the worldview but is also determined by the worldview. An individual’s worldview is composed of one’s individual experiences as well as the religious, economic, educational, social, moral, and political inputs which then impact the manner in which one interprets the information and events in one’s life (Baruth and Manning, 2012). When a practitioner has a flawed, stereotypical, and disempowering understanding of disability, the practitioner may do more harm than good (Tower, 2003). The practitioner’s understanding of disability is a primary determinant in the effectiveness of a development program, but an even more powerful force is the manner in which the individual and the local community conceptualize disability.

It is important to acknowledge that disability is often associated with deviance or deficiency, which is sometimes defended as a simple reality but is in actuality a result of one’s worldview. The manner in which one views disability is largely determined by cultural understandings of what defines a good quality of life (Adya, Samant, Scherer, Killeen, & Morris, 2012). Historical views, as well as current sociocultural conditions, have developed this understanding and continue to perpetuate it. The equivocation of impairment with deficit, therefore, is at its core culturally determined. This worldview places a value on perceived wholeness through an external intellectual, cognitive, and physical measurement rather than a value on differences or variability. In many ways, it could also be considered a result of a culture’s value of productivity over relationship. Equally as devaluing though is the opposite, supposedly freeing, denial of the disability experience. This is not only blatantly inaccurate, but
also would be categorized as a microaggression in that it denies the individual of his or her personal experience (Keller & Galgay, 2010). Disability is an individual experience which occurs within a context teeming with other influences. Therefore, the determination of meaning should be determined on an individual basis but with close attention given to the contextual factors which impact the disability.

There are a number of models of disability, all of which attempt to accomplish the complicated task of defining disability by determining cause and effect. There are three predominant models from which an understanding of disability is created, the moral, medical, and minority model (Olkin, 1999a). The moral model is the oldest model of disability and attributes the cause of disability to sin, failure, or demonic forces (Olkin, 1999b). The greatest harm of this model is that it promotes shame as part of the individual’s identity as well as the family. While at a surface level this model would appear to no longer be a factor, the reality is that in the United States many adhere at least partially to this model. Take for example when an individual proclaims that someone might have a disability because their family is strong enough to handle it, this is at its essence an adherence to the moral model. In many developing nations, however, the moral model is more than just a component of the understanding, but it may be the only understanding of disability. A second understanding of disability which remains prominent today is the medical model. This model posits disability as pathology, labeling the organic impairment as the problem. As should be apparent, both of these understandings of disability place the burden of the problem within the individual, either through the individual’s biology or morality. Conversely, the third model, the minority model, conceptualizes disability as a function of the social environment. More specifically, disability is a minority group, such as any other,
with the problems of disability arising from prejudice, discrimination, and the denial of civil rights.

For the purposes of development, it should be clear that the most effective model from which to operate is the minority model. Through the lens of development, the minority model becomes a disability-affirmative model (Olkin, 1999a). It accepts the disability as a clear and present reality but does not isolate the individual from the complexities of the environment but offers an empowering alternative. This, however, is still far from a solid conceptualization of disability which allows the development practitioner to understand an individual’s experience. Therefore, it is important to develop a conceptualization of the minority model by utilizing four sub-models which are common in literature.

The biomedical model, the environmental model, the functional model, and the sociopolitical model are the seminal models which can be used to formulate this conceptualization (Smart, 2009a). The moral model is entirely excluded as a piece of the understanding as it is generally understood to be disempowering for the individual with the disability as well as the community at-large (Olkin, 1999a). The power of each of these models to guide and direct the individual’s identity, the public’s response to the individual, as well as the course of treatment is enormous (Smart, 2009b). It is, however, important to remember that none of these models encapsulates the experience of an individual with a disability, therefore within this work it will be argued that a holistic understanding of disability can only be developed by utilizing components from each model.

Biomedical model. Potentially the most controversial model, the biomedical model is solely defined by the individual’s diagnosis (Smart, 2009a). The etiology of the disability is based upon pathology, and the resulting consequences are exclusively physical as factors outside
of the individual are not considered (Smart, 2009b). The greatest benefit of this model is that it allows for a standardized method of assessment and diagnosis which can, in many cases, aide in the effective usage of medical interventions which often minimize or eliminate disabling features of disability; the disablement associated with an inability to walk is minimized through the usage of a wheelchair. Though this model is more categorical in nature, there is some opportunity for understanding along a continuum in that measurement of severity is possible. These benefits, however, are closely associated with consequences. The benefit of the ease of diagnosis is overcome quickly with the fragmentation of the disability community along diagnosis lines, as it does not allow for a collective disability cultural identity. This model is also too reductionistic in nature as it ignores other components of the individual’s identity such as gender or ethnicity. The fatal flaw of this model, however, is that it relegates people with disabilities to an inferior status within society which is entirely void of fact. It is considered a deficit or deviant model of disability as it searches for, and describes differences in ability as negative which therefore ascribes the individual to deviant status within society. The impact of this fatal flaw is profound, it places the responsibility for adaptation to the disability, as well as the environment, solely on the individual and does not consider that societal barriers may be what is disabling, not the disability alone. While it is important to take into consideration the biomedical components of disability for the purposes of medical treatment and individual wellbeing, it is incomplete to limit the definition to this narrow of a perspective.

Environmental model. The environmental model moves past the simplistic biomedical understanding of disability as it acknowledges that an individual’s environment has a profound impact on the effects of the disability (Smart, 2009a). The environment can either exacerbate or alleviate the disabling components of the disability. Under some interpretations of this model it
does not exacerbate the disability, but rather it creates a disability from an impairment (Masala & Petretto, 2008). Environments which are inaccessible to people with disabilities are disabling for the individual; conversely environments that are accessible to people with disabilities are not disabling (Smart, 2009a). Important to note is that accessibility within this context should refer not only to physical accessibility but also to social inclusion, education, and work. The benefit of this model is that responsibility for the effects of disability are ascribed to society collectively rather than to the individual with the disability. This model, however, is not an entirely conclusive model of disability as it does not directly confront the physical presence of the disability which should be recognized within a definition of disability. The environmental model is still lacking as a conclusive model in that the context of the environment is primarily physical and does not include social, structural, or attitudinal contexts.

**Functional model.** The functional model focuses on the individual’s economic capacity and ability to function (Smart, 2009b). The primary emphasis within this model is the individual’s economic capacity and the core argument on which this model rests is that some disabilities are more disabling for some than for others (Smart, 2009a). This model is the first of the models thus far to define disability at a personal level, thus affording the dignity of an individual identity. This model offers an explanation as to why an individual with an impairment in mobility that desires to be physically active will experience more disability than the individual with an impairment in mobility that does not desire to be physically active as the first individual’s goals may be impeded but the second’s goals are not. A classic example of this is the concert pianist who loses a finger, for this individual this specific disability is extremely disabling; this, however, would not be the case for the individual uninterested in the piano. A major benefit is that this model does take into consideration the usage of adaptive technologies,
but again it is incomplete as it does not the social implications of adaptive device usage which is potentially limiting. The abject flaw of this model is that it diminishes an individual’s personal identity to one’s economic capacity, which is not only incomplete but also a culturally-bound determination as the individual is defined exclusively by measurable units of production which may or may not be true in different contexts. In fact, in most cultures the individual will derive his or her identity from a variety of influences outside of occupation.

Sociopolitical model. The sociopolitical model is potentially the most perceptively radical model of disability as it places the responsibility of disability on society alone (Smart, 2009a). It defines disability not as problematic, but rather defines society’s perception of disability as problematic (Smart, 2009b). The etiology in this case is neither a biomedical understanding, nor an environmental or functional understanding but is instead understood entirely outside of the individual. This model argues that society is not only responsible for creating universal accessibility for people with disabilities but that it also causes disability. Therefore, this model is primarily focused on eliminating the socially constructed prejudice and discrimination directed at people with disabilities through political and legislative acts. It does not seek to cure the individuals with the disabilities but rather seeks to cure the society by advocating for civil rights and necessary accommodations for people with disabilities. While this model is once again not fully encompassing of the experience of the individual with the disability, as it does not acknowledge a physical basis or an individualized understanding, it is changing attitudinal barriers which can exacerbate an individual’s disability. The greatest benefit of this model is that the explicit desired end result is equal social status and participation within society.
A collective understanding. Given that no model of disability presented thus far has fully encompassed the holistic nature of disability as a minority population, it is important for development practitioners to generate a collective understanding of these models of disability in order to best empower and equip people with disabilities (see Figure 1). There should be an understanding not only of how the society views disability, but also how the individual views one's own disability. It is from this understanding the practitioner is able to develop a culturally relevant and empowering model of disability which will serve as a foundation for all development work.

It can best be understood by beginning with the final premise of the sociopolitical model: disability is a normal and acceptable part of the world and is not a deficit or deviance in value (Smart, 2009b). It is acknowledged that in many ways this is a worldview in and of itself, however, this admission is readily made in the interest of equality in human rights and value. While individual cultures may not agree with this declaration, it is imperative for the practitioner as it eliminates paternalistic attitudes, placing people with disabilities on an equal level as those without. This claim must be foundational in order for the overarching definition to be empowering and humanizing of people with disabilities. From this foundation, a collective understanding will expand to include all contexts of disability.
The components of etiology that exist within the individual are accounted for by the biomedical model as it allows for a biological understanding of disability. It is important to acknowledge that disability is a difference variable, but that this variation is not associated with a negative valuation. While this contribution must be closely monitored, it allows the individual to know the medical interventions that are available and to seek those out if desired. Organic factors, however, should be considered and accepted solely as a component of the definition. The organic or biomedical component of the definition only becomes problematic when it is isolated from other factors. It is the isolation of this component which controls an individual’s ability to choose to seek or decline medical intervention and which creates negative valuation of an individual difference.

The environmental model then offers a societal perspective, in which the practitioner can examine the disabling components of the environment which exacerbate the disability. Through a thorough examination of the physical barriers in society one can analyze how the environment affects the individual. A community without ramps is inaccessible to people who use wheelchairs; and an environment with high levels of pollution will be more disabling for people with disabilities that include respiratory issues. Therefore, by expanding out from the biomedical understanding of the individual’s disability, a more inclusive picture of that individual’s disability is created. This understanding, however, remains incomplete as the individual’s functional level within that environment and the societal understandings have yet to be fully included.

Mediating the effects of the environment and then organic level, the functional model allows a closer examination of the individual’s earning capacity, and therefore the individual’s ability to maintain economic independence. In other words, the expansion to include the
functional model not only examines the individual’s interaction with the environment but also how that interaction yields production. A strict understanding of the functional model of disability understands production solely as economic contribution and gain, but according to sociologist Saad Nagi, it should be understood more broadly to include the various roles and tasks performed on a daily basis (Masala & Peretto, 2008). Total functioning includes not only the vocational production but also potential for access to opportunities outside of employment, such as religious participation, engagement in sport activities, or familial participation. The opportunity for total functioning is not possible without societal and structural support.

The sociopolitical model, which was the original basis, is also the final influence as it includes the addition of societal components such as prejudice and discrimination (Smart, 2009a). This is a critical component of any definition of disability, and maintains a multilateral impact. Every other component of the individual’s definition of disability is impacted by external sociopolitical forces. This is where it becomes clear that disability cannot be solely the responsibility of the individual but is the responsibility of the community and the greater society. It is through the incorporation of all of these models that the practitioner and the individual are able to develop a culturally relevant and individually empowering definition of disability from which development can occur.

Formulating a Culturally-Responsive Development Program

Understanding cross-cultural development and disability is just the beginning of the creation of an empowering development program. A synthesis of this understanding must be found and can then be used to interpret and transform pre-existing development frameworks. In general, cross-cultural, faith-based development practitioners would do well to adopt the mentality of the Hippocratic Oath, “Do no harm” (Lupton, 2011). This means a number of
different things when it comes to development, but most important is the submission of one’s
own desires, goals, and programs in favor of the local community’s desires, goals, and methods. It has frequently been found that when an individual or community has done for them what they could have done of their own accord there is a reduction of personal initiative and destruction of their identity. Therefore, paramount in the quest to “do no harm” is to be liberal in beliefs about the community’s ability and never do for the community what the local people have the ability to do. Empowerment, rather than aid, should be the focus of all development programs. In order to empower the community, one must listen to the local people. This does not refer to simply hearing, but listening closely to the individual’s spoken thoughts and feelings as well as those that remain unspoken but nonetheless communicated.

**Relief, Rehabilitation, and Development**

Within the context of cross-cultural, faith-based development, there are three types of outreach: relief, rehabilitation, and development. In each sector it is important to ensure that there is ownership by the local community and not the development organization (Lupton, 2011). Relief is aid given in response to an emergency; relief is intended to be a short-term solution (Corbett and Fikkert, 2009). Relief often comes in the form of a hand-out such as financial assistance, tasks done for another, or food given as gifts. Conversely, development is a long-term solution. It involves a hand-up rather than a hand-out and there are many more expectations of the individuals and community involved. The goal of development is to empower the people to solve their own problems and to achieve their full potential. In development, colonial and paternalistic attitudes are eliminated with the intent of respecting the knowledge, skills, and ideas of the local community. Rehabilitation is the bridge between relief and development; it is any work that is focused on recovery and restoration. Each of these approaches can be valuable in
their own right, when utilized at the correct time and in the right context, but each can also be
damaging when utilized in the wrong time or context. It is, therefore, incredibly important to
critically analyze the situation to determine what the best course of action will be, because the
wrong remedy could exacerbate the problem.

**Relief.** Traditionally, people with disabilities have been classified by development
practitioners as exceptions to the development rule, allowing for the utilization of a relief
approach indefinitely (Corbett & Fikkert, 2009). This, however, should not be the case. The
majority of the time the situation will call for development, with a heavy emphasis on the
empowerment of the individual. There are, however, times in which relief will be necessary.
These are the times in which the individual or family system is in crisis mode. This is an
individualized circumstance as every individual and family system will experience different
events, and react to them differently. There are, however, certain times in which one might
generally suggest a more relief based approach. Those times are when the child is diagnosed, the
beginning of school or day care outside of the home, the transition time after schooling is
complete, and when the family must make long term care decisions (CCFH Ministries, 2010c). A
fifth potential time of relief could be after the child’s death if that should occur. For adult onset
disability there are also general times where relief may be necessary. The first is once again at
the initial diagnosis; after that it is when the individual begins rehabilitation, when the person
begins working, and when the person must enter alternative care arrangements.

As a general rule, relief should only be provided when the situation is a crisis and when
the individual or the family cannot help themselves (Corbett & Fikkert, 2009). Many people with
disabilities in the community will need relief intermittently as severe illness is more common. It
is nonetheless important that the situation is fully analyzed before relief is given. Overutilization
of relief leads to dependency which serves only to disempower the local people (Lupton, 2011). Haiti is a prime example of this disempowerment as aid prior to the earthquake in January 2010 amounted to more than $8.3 billion, yet the country was 25 percent poorer than before the aid began. In order to avoid these drastic results on an individual level, the development program should develop a standardized approach to when relief will be given, how much will be given, and how it will be given because the scenarios will arise. Additionally, the way in which relief is conducted is important. Relief must be done in a manner that sets the individual or the family up for rehabilitation and development in the future. For example, if a person with a newly acquired disability must spend most of the day doing therapy and is therefore unable to work, this is a time in which relief may be needed temporarily. With the relief, however, there must also be a plan formulated for helping the individual find employment so that they can support themselves in the future. In this way, the transition from relief to rehabilitation is outlined from the beginning. Individuals who are genuinely invested in lives of the community will know when a family is in need of relief. There are some people who will appear to need relief all of the time, but even then it must be done in a developmental manner (Corbett and Fikkert, 2009). People with severe and multiple disabilities can often be affected by their disability to the degree that independence is never an option, however, that does not mean that there cannot be development in their lives. It is important for the disability focused development program to determine what behaviors the individual could develop and to work toward achieving those behaviors.

**Rehabilitation.** Rehabilitation is the crux of most work with people with disabilities in developed nations and would appear to be a valuable approach for working with people with disabilities in developing nations. There is, however, an important caution which must be considered when utilizing rehabilitation with people with disabilities in developing nations. Far
too often, rehabilitation is associated with value-laden assumptions which declare when an individual can be considered rehabilitated. Therefore, while a valuable approach, it must be utilized with extreme caution when deciding end goals. Rehabilitation is done by looking at where the individual is presently, the relief situation, and then the goals for the individual such as long-term development goals, and finally, determining a plan to assist the individual or community to reach that point (Corbett and Fikkert, 2009). This plan can be enacted through scaffolding the necessary skills. If the person with the disability is currently receiving food from the organization because they have been unable to have a job for a particular reason, the first step in the rehabilitation plan may be attending a job training program every day while still sending food home with the individual. This is rehabilitation, as it is helping the individual meet their present needs but preparing them to be able to meet future needs.

There are many ways in which an organization can create and manage plans for rehabilitation, and each organization should work with their local community in order to develop a culturally responsive and effective format. The intention should be to discover the individual’s abilities, identify the barriers the individual is encountering in the community, and determining a way to utilize the individual’s abilities to overcome the barriers. This can be done in a holistic manner by examining all components of the individual: physical, psychological, educational, family, and social/community. Some American churches are utilizing a similar approach within their programs through the Individualized Christian Education Plan (ICEP) (CCFH Ministries, 2010d). The ICEP is inspired by the Individualized Education Plan (IEP) used in the American school system. While not directly applicable to development in a developing nation, the benefit of the ICEP is that it allows the organization, the individual, and the family to work together to formulate a plan, track progress, and celebrate success. This is a critical component of
rehabilitation in a culturally and individually respectful manner—it is done with, not for, the individuals and communities involved.

**Development.** Development is the final mode of outreach. While the term has already been criticized for its imperialistic implications, development when defined by the local community’s perspective is not imperialistic in nature but empowering. It requires active community involvement, and therefore, thorough analysis on the part of the development practitioner and the community to determine if a community is a good fit for a faith-based development program (Kenney, 2010). The inclusion of people with disabilities as a part of this community involvement is absolutely essential. It is a primary way through which human rights conditions are improved and all people are valued equally (Kindornay, Ron, & Carpenter, 2012). The focus of development is not just economic, but is holistic in nature (Hefferan, 2007). Bryant Myers, a Christian development expert, explains that every individual’s life is made up of five relationships, each of which must be redeemed in the process of development (2011). Every individual has a relationship with themselves, their community, the people they consider the “other,” the environment, and with God. Any development program working with people with disabilities should consider what these five relationships are for each individual. The individual with the disability may have a flawed perception of self as societal misunderstandings relegate people with disabilities to an inferior status (Wright, 1983). In developing nations, the individual with the disability is likely also to have a broken relationship with his or her community as he or she may have been rejected and marginalized from the community. The “other” could be individuals without disabilities in their community or another group but this can only be identified within each individual situation as the “other” will be culturally and individually specific. (Myers, 2011). The person with a disability also likely has a broken relationship with
the environment just as the rest of the community does, as improper sanitation practices have led to pollution in most of the developing world. Lastly, the individual’s relationship with God or religion could be broken due to the societal beliefs regarding disability. If people with disabilities believe that their disability is a consequence of their actions in the present life or a previous life, or if they believe that their disability is a form of demonic possession then their relationship with God is almost certainly broken. For this reason, it is incredibly important for people working with people with disabilities to understand how the prominent religion of the community views disability and how they themselves view disability.

Ultimately, the goal of any faith-based development program focused on people with disabilities in a developing nation should be to restore “shalom” which Myers defines as “just, peaceful, harmonious, and enjoyable relationships with each other, ourselves, our environment, and our God” (2011, pg 174). Within a community experiencing extreme poverty the idea of shalom is distorted and difficult to identify (Corbett and Fikkert, 2009). This distortion is especially true for people with disabilities as their marginalization intensifies the brokenness in all relationships. In order to work towards shalom alongside people with disabilities, one must embrace one’s own weakness. All people involved in development programs must be equal; there can be none elevated above another. To act as though an individual with a disability is weaker than one without a disability only ensures that the development program will do more harm than good.

The negative impact of this type of attitude can then exacerbate the strain in the individual’s relationship with self, others, community, and ultimately God. Poverty affects more than just an individual’s material well-being, the detrimental effects of poverty extend beyond their material well-being to affect all five of the foundational relationships (Myers, 2011). An
individual's poverty leads to a poverty of being where individuals believe that they are of no value and that their material poverty is a reflection of their capabilities as human beings. Jayakumar Christian calls this the "marred identity" of the poor and Myers explains that once the individual accepts his or her marred identity, one's poverty is complete. When individuals believe they are of no value and they do not have the capability to change their life situation, they have lost hope and become complacent in their situations. This is where the Christian Gospel has evident power to make a change in people's lives; the message of the biblical Christ gives people hope and an understanding of their identity as an individual made in the image of God. Each person has a unique set of gifts and abilities; those gifts and abilities should be embraced and exercised within the context of unity (Hubach, 2006). This, however, is also where a distortion of the Christian Gospel message has the potential to do the most damage as inappropriate overtures and disrespectful attitudes toward local religion can destroy hope and belittle the individual, their community, and their beliefs.

Therefore, there is an extreme need for relationships based on respect, particularly in Christian development programs. It is true that not only do people in developing nations not receive the respect they deserve during development programs, but it is also an unfortunate reality that people with disabilities generally do not receive the respect that they deserve. This compounded situation creates an imperative for respect in development with people with disabilities, not only of their dignity as individuals but also of their culture and religious beliefs. This has the power to be transformative in the way in which people see people with disabilities and also the way they see the Christian Gospel message (Hubach, 2006). When the emphasis is on relationships and respect instead of conversion, one can be certain dignity and autonomy is afforded to individuals and the community. Therefore, the best plan in development for the
purpose of poverty alleviation and individual empowerment is to work with the community so that, together, everyone develops their own unique identity and discovers their individual abilities so that they can work and provide for themselves and their families materially, as well as spiritually and emotionally (Corbett and Fikkert, 2009).

**Adaptive Sports Programs as a Proposed Solution**

The above basis of understanding should make it apparent that development from an empowering and culturally-driven perspective can be done from a variety of different specific approaches. Development is a growing field with many different methods gaining attention in both academic and public sectors. Microenterprise and child sponsorship are two of the most notable; however, there is another method which is mounting in professional recognition, development through sport. The concept of sport is nearly universal with the Olympics highlighting the cohesive and universal nature of sport. Therefore, it should be of no surprise that development practitioners have begun utilizing this common ground in order to engage with and empower people from other cultures. According to the United Nations Office of Sport for Development and Peace (UNOSDP), “sport plays a significant role as a promoter of social integration and economic development in different geographical, cultural, and political contexts. Sport is a powerful tool to strengthen social ties and networks, and to promote ideals of peace, fraternity, solidarity, non-violence, tolerance, and justice.” Thus far, sport for development and peace (SDP) has been used to promote the realization of the United Nations’ Millennium Development goals such as the prevention of HIV/AIDS and reduction of the associated stigma, gender equality, and child and maternal health (Kidd, 2011). People with disabilities, however, are once again routinely precluded from participation. It is this preclusion which creates a potentially transformative development program as the participation of people with disabilities in
sports programs surprises community members, thereby challenging preconceived ideas which prevented the inclusion of people with disabilities in society.

**Sport, development, and culture.** Similar to any other development technique, the utilization of SDP can be just as damaging as it is empowering when the motivations or processes are not analyzed and controlled. The popularity of sports, such as soccer, in many developing nations make the utilization of sports in development programs susceptible to corruption or the manipulation of community members for the sake of certain agendas (Mchombo, 2006). In fact, many SDP programs to date have been hegemonic and hierarchical in nature (Kidd, 2011). Whether intentional or unintentional, working from Western ideas of development as well as Western ideas of sport can lead to the demise of an effective SDP program (Darnell & Black, 2011). Thus far it appears Western ideology has been ingrained within the SDP structures which teach values inherent in Western culture but not necessarily within the local culture. This imposition of values from Western worldviews onto the local culture through sport subjugates individuals within the community to the status of “other” and elevates the development practitioner to “hero” or even “savior” status (Tiessen, 2011). These values have also emphasized stereotypic athletic preferences and tend to favor children who are physically robust, thereby ignoring an entire segment of the population—people with disabilities.

Historically, sport has often been used to civilize or indoctrinate oppressed groups such as the role of sport in the British and French empires when sport was used not only as a means of religious conversion but also to further the colonialist agenda (Tiessen, 2011). This type of SDP program will only damage the community identity and will not be effective long-term. It is important to note that these hegemonic and colonial messages can be avoided and that these are issues faced by all development programs. Sport is not necessarily an inappropriate means for
development, but sport is prone to all the same pitfalls as other means of development. The manifestation of sport in one culture will likely be different than another culture. For example, it has been found that Chinese students have a more cohesive and egalitarian approach to athletic competition than American students (Lau, Cheung, & Ransdell, 2008). Therefore, an effective SDP program will be community-driven, holistic, and culturally responsive.

In order to do this, the SDP practitioner must first understand the dual power of sport, as there is an equal and opposite potential for negative outcomes as there is potential for positive outcomes (Darnell & Black, 2011). In the realm of peace, sport can mitigate conflict, but the competitive atmosphere can also aggravate conflicts between groups. In the case of sports with people with disabilities, it has the potential to lead to the inclusion of people with disabilities but it could also marginalize the group even further because of the segregated atmosphere. It will, therefore, be incredibly important to develop a set of best practices for development through adaptive sports. These practices should address the relationship in SDP programs, such that inequality is questioned and hegemonic relationships do not exacerbate the community’s challenges (Darnell, 2010).

Adaptive sports and development. Adaptive sports programs are, at a surface level, opposed to the typical sport ideation of bodily perfection and physical strength (Brittain, 2004). These ideals, however, are rooted in the value of physical strength which is common in Western nations as well as developing nations. For this reason, the use of adaptive sports programs is a prime opportunity to highlight the biases present in this valuation and develop a greater acceptance and inclusion of people with disabilities in developing nations. In addition to contradicting societal misconceptions of ability, adaptive sports empower people with disabilities
and facilitate physical, psychological, and social wellbeing. Yet, this type of programming is nearly non-existent in developing nations.

While the United Nations has highlighted the need for people with disabilities to be included in sports based development programs, there has yet to be any action taken to implement adaptive sports programs (United Nations Office of Sports for Development and Peace). International adaptive sports competitions are in existence, but developing nations are not participating in these games to the same level as developed nations. In fact, 23 percent of developing countries had not participated in a single international adaptive sport competition between 1991 and 2006 (Lauff, 2011). There are many benefits of sports for people with disabilities, including the fostering of independence, empowerment, and inclusion. Sport provides the platform for people with disabilities to take control of their own lives and not allow parents or other community members to determine their present or future. In addition, it provides a means for people with disabilities to develop skills in self-advocacy such that they will be able to not only identify the needs for change in their own lives but work within their communities to make that change. By including people with disabilities in sport programs, there is the potential to change the stigma and marginalization of people with disabilities from the community due to misconceptions about the person’s ability. When people with disabilities can be included in typical sports programs the impact is even greater as it increases contact between people with disabilities and people without disabilities thereby helping to reduce the myth that disability is understood as a curse. This transition in mentality happens because as two groups interact with one another the demonization of the “other” is challenged (Giulianotti, 2012).

Attitudinal change facilitated through positive contact such as this is well supported by the contact hypothesis. Originally developed to promote the integration of minority and majority
members, the contact hypothesis theorizes that interaction between two groups decreases prejudice, discrimination, and stigma (Smart, 2009). In order to be effective, the contact hypothesis presents four necessary components of interaction including equal status, voluntary and natural conditions, individual—as opposed to group—identification, and mutual goals. Sport can be a platform for this type of interaction, as individuals on an athletic team are of equal status and participate voluntarily toward the same goal. The athletic context, by creating a new and separate community through the team, also provides each individual to be seen independently from all other societal identifiers. While it is difficult to meet all the requirements of the contact hypothesis through adaptive sports, as people with disabilities and people without disabilities are rarely involved in the same activities at the same status, in communities where individuals with disabilities are marginalized it can be argued that the elevation of the person with a disability to the status of athlete creates environments for equal and positive social interactions.

The social benefit, however, is not limited to only the bonds created between individuals with disabilities and individuals without disabilities but also the social cohesion which occurs within the adaptive sports community. The creation of an adaptive sports program is in many ways the creation of a new community and within this community there is a new definition of normal (Zabriski, Lundberg, & Groff, 2005). It becomes normal to have a disability which increases the individual’s sense of belonging, a critical component of everyday life and self-esteem. In addition to the positive effects for the individual with the disability, the entire family benefits from the creation of an adaptive sports community as it opens the door for mutual family and peer support. This support encourages the dissemination of information and resources for families affected by disability, which is particularly critical in developing nations. This
component of adaptive sports in the United States is valuable; however, in countries where resources are difficult to find and marketing might not reach those who need it the most, this component becomes critical.

As previously mentioned, sports do not just facilitate social cohesion, and the same is true of adaptive sports. There are a broad range of advantages to the use of adaptive sports in development programs including physical and psychological health (Harada & Siperstein, 2009). Participation in physical activity or sport promotes general health and physical development for people of all abilities (Kidd, 2011). Adaptive sports are by nature physical activity and therefore the physical benefit is the same as with typical sports for people who are able-bodied. This is especially important for people with disabilities as some disabilities, such as Down syndrome, make individuals particularly susceptible to some health conditions. The added susceptibility to these conditions heightens the need for physical activity and health programs for people with disabilities. In this way, adaptive sports can be an equalizer in the domain of health as adaptive sports promote physical activity and health. It has even been proposed that the disparities in access to healthcare could even be alleviated through adaptive sports (Zabriski, Lundberg, & Goff, 2005). As has previously been discussed, this disparity in access to health care is of great concern for people with disabilities in developing nations. Adaptive sports should be leveraged not only to increase the physical activity of persons with disabilities but also to raise awareness within the healthcare system. Adaptive sports have often been utilized in rehabilitation settings, however, in order for the adaptive sports program to be truly effective as a development program it will be important for the medical benefits to be minimized in favor of a recreational emphasis (Frantz, Phillips, Matheri, & Kibet, 2011). This reduction of a rehabilitation emphasis does not
eliminate the physical benefits; it simply equates the physical value of sport with that of typical sports programs.

Psychological benefits, such as improved self-concept and increased confidence are also byproducts of adaptive sports programs (Zabriski, Lundberg, & Groff, 2005). Sports have also been shown to help people with disabilities develop coping skills, not only for learning to cope with the disability but with the stressors inherent in life. The adaptive sports program helps to facilitate the value changes proposed by Wright (1983) including the subordination of the physique and transformation from comparative to asset values. These value changes can be supported by adaptive sports programs because the programs are designed to use the individual’s strengths and adjust for weaknesses. Sport provides tangible proof of the individual’s abilities and the importance of an environmental understanding of disability. The individual with the disability and those observing are able to clearly distinguish that the accessibility issue is within the environment, not the individual, as they are able to engage in sports structured in an accessible manner. This transformation of values is likely what leads to the widespread finding that adaptive sports increases the individual with disability’s perceived quality of life (Groff, Lundberg, & Zabriskie, 2009). While these studies have nearly all occurred in developed nations, it is likely the same will be found in developing nations when the programs are in place and the research can be conducted. Ultimately, these findings suggest a wholly positive impact of adaptive sports on psychological wellbeing for those who are interested in participation.

As illustrated by the discussion above, adaptive sports have the potential to be holistic in the empowerment of people with disabilities. This is one rationale for its usage in developing nations for people with disabilities. Generally, sport has been found to promote physical wellbeing and health, psychological wellbeing, and social inclusion (Chawla, 1994; Heidary,
Amiri, Ehsani, & Kenari, 2012). Holistic adaptive sports programs for people with disabilities, however, will not be holistic simply for individuals but for systems as well. Sport can be understood as a way to disrupt current power relationships (Darnell & Hayhurst, 2011). The degradation of people with disabilities is rooted in unequal power relationships and in the systems which perpetuate those relationships. Therefore, holistic development through adaptive sports will examine the biological, functional, environmental, and sociopolitical influences and incorporate components addressing each level into the adaptive sports program. Without addressing each of the influences, the adaptive sports program could be vulnerable to operating within a hegemonic system and therefore be ineffective in achieving its goals.

This omission of people with disabilities from SDP programs is a grievous omission as empowerment is at the core of most SDP programs, and empowerment is also the greatest need for people with disabilities. The typical approach is to increase participation of the disadvantaged groups in social activities and simultaneously provide education and training for domain areas in which the individual needs strengthened (Levermore, 2008). People with disabilities are capable of much more than society typically dictates, the only need is for them to be empowered to overcome those societal limitations. Adaptive sport is at its core empowering as it seeks to identify the strengths of each individual and leverages those strengths in competition. This is not only empowering within the context of sport but serves as an illustration for all other contexts of the individual’s life.

**Future Directions**

A foundational premise of this work is that the research regarding disability in developing nations is lacking in quality and quantity. Therefore, it would be irresponsible to ignore this reality as a limiting factor of the above analysis and adaptive sports as a proposed
solution. Much of the research utilized in this discussion was conducted in Western nations and therefore the generalizability to other nations and cultures is questionable. Future research should examine more fully the nature of disability in developing nations, particularly in those nations where people with disabilities are hidden and therefore the realities are salient to neither the community nor those conducting research.

The efficacy of adaptive sports as a culturally-responsive and empowering mode of development also needs to be examined and analyzed in an empirical manner. In order for it to be truly holistic as the proposed solution claims, research should observe the effects adaptive sports has on the physical, psychological, spiritual, educational, and social wellbeing of individuals participating in the program. In addition, the possible limitations associated with the contact hypothesis should be examined to determine whether adaptive sports does increase contact in actuality rather than just in theory.

Another important area of research which should be conducted is the examination of similarities and differences in the potential application in different cultures. If adaptive sports are found to be a culturally responsive, holistic, and empowering approach it will be important to describe and analyze how adaptive sports manifest these effects in various contexts. Not only will this assist in the formulation of an overarching framework, but it would also facilitate an understanding of the different means of application.

Conclusion

It should be clear that enacting development with people with disabilities in a cross-cultural context from a faith-based perspective is complex not only in understanding the issues but also in formulating a solution. Even with the potential limitations of this analysis and the limitations of sports as a means of development, it is nonetheless proposed that adaptive sports
may serve as an effective means through which hegemonic relationships can be eliminated and the rights of people with disabilities can be advocated. An effective program may be difficult in both design and implementation but it is argued that the benefits supersede the barriers. With the conceptual framework outlined here, faith-based practitioners are encouraged to work with the community to develop a culturally-responsive program to empower people with disabilities and the community either through sports or another means if the context deems it more appropriate.
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