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ABSTRACT

Every child is born with expectation of living and fulfilling life's expectancy. The 'quality of life' approach focuses on what is most important to every individual. However, each child is born with different challenges and peculiarity in the area of intellectual capacity. The condition could be present at birth, as a congenital abnormality. An individual may be physically fit, with no brain or body abnormalities and yet be mentally disabled. The terms 'mild', 'moderate', 'severe' and 'profound' are often used to classify intellectual disability. In view of this, it has been observed that poor motor control, high physical demand, fear of accident and social exclusion could limit the involvement of persons with intellectual disability in activities related to sports or physical activity. Therefore, it is needful to achieve social inclusion and quality of life for persons with intellectual disability through sports and physical activity.

Keywords: social inclusion, quality of life, intellectual disability, sports, physical activity

INTELLECTUAL DISABILITY (ID)

Disability is a reality of life that has relatively become a global challenge. Kidd (2011) reported that almost 650 million people are living with one disability or the other all over the world, and more than 430 million of these affected population are resident in the developing countries. Incidentally, persons with disability are often con-fronted with stigmatisation and struggle for political acceptance (Le Clair, 2011). It has been estimated on a global scale that 1:100 person suffers from ID (Maulik et al., 2011). Proportionately, more of these people live in low- and middle-income countries; mainly because diseases and living conditions that result in developmental disabilities are more common at the grassroots. According to UNICEF (2013), the highest risk factors of this condition are attributed to environmental and socio-economic factors.

An ID is a form of disability that is defined by the behavioural disposition, and not necessarily by bodily impairments of an individual. ID is also referred to as learning disabilities, learning difficulties or mental retar-dation. The condition could be present at birth as a congenital abnormality. An individual may be physically fit, with no brain or body abnormalities and yet be mentally disabled. There are four different terms often used to describe the severity of ID. The terms are mild, moderate, severe and profound ID. These classifications are based on the outcome of intelligence scores. However, there is no quick and fool proof way of testing for an ID, in contrast to testing for deafness or sight loss. Experienced professionals do disagree among themselves as to whether or not a person has an ID. This can obviously be very frustrating for parents and can be detrimental to the child's educational provision. ID could cast a dark shadow over self-image and self-confidence.

ID is characterised by social impairment, lack of coordination and need to depend on helping hands for per-sonal needs. Department of Health (2001) added that the condition could increase learning difficulty. Further-more, the problems associated with ID could limit physical and social development. In most cases, persons with ID require more physical support than their contemporaries in the work environment, educational setting, and any other living condition. Jahoda et al. (2010), in their research on young people who had mild IDs, concluded that people with the condition tends to manipulate the perception of reality as much as possible in order to es-tablish a new identity while dealing with stigma. Failure to meet this level of perception often threatens their mental well-being and the resulting low self-esteem could lead to depression and withdrawal.

ID AND SOCIAL INCLUSION

This social model of disability defines people in comparable ways to other groupings of people, where extra provisions are often provided (for example senior citizens, single parents, the unemployed). The problem then shifts to determining the adaptations that need to be made to the person's environment, so as to reduce the dis-abling effects of their condition. There are multifaceted factors militating against the social inclusion of persons with ID. First, the poor economic condition of the immediate environment which limits the available resources for life satisfaction tends to increase the propensity for social exclusion. According to the 'social cognitive mod-el' posited by Kahn et al. (2002), environmental conditions, personal attributes, and behaviours are important factors to get children with ID more physically active through the implementation of health education and promotion programs (Kahn et al., 2002).

Second, there are discriminatory societal beliefs against persons with ID. Some people believe that ID is a family problem and that social segregation will help to prevent the spread in the society. Most often, persons with disability are treated in the society as helpless, hopeless and mindless. Some also believe that ID is a cross gifted by God to the family. The aforementioned societal beliefs related to ID could negatively impact on the quality of life, social adjustment and health status of persons with disability in the educational setting and work environment, the social classification remains a norm (Ferguson, 2008; Jahoda et al., 2010).

Samadi et al. (2012) opined that apparent social exclusion of persons with disability stemmed from special services and attention mainly given to them right from childhood. Verdonschot et al. (2009) observed that per-sons with ID in the developed nations also experience social exclusion and segregation in spite of the well-structured welfare and support services. Akrami et al. (2006) noted that different forms of stigmatisation against persons with ID also lead to social stratification in the work environment and educational settings. This societal classification negatively redefines interaction and friendships (Lippold & Burns, 2009).

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Fig 1.1: Quality of life domain

less and mindless. Some also believe that ID is a cross gifted by God to the family. The aforementioned societal beliefs related to ID could negatively impact on the quality of life, social adjustment and health status of persons with ID. Even though there are policies supporting the social inclusion and acceptance

of persons with disability in the educational setting and work environment, the social classification remains a norm (Ferguson, 2008; Jahoda et al., 2010).

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ID AND QUALITY OF LIFE

All humans are entitled to quality of life. Quality of life addresses aspects of life that all humans share and that are unique to each individual. The quality-of-life approach focuses on what is most important to every individual. Every individual is entitled to indicate what quality means for them and how they wish to achieve it. A quality-of-life approach helps to sustain personal well-being despite the possibility of increasing number of people with disabilities or declining abilities. Quality of life is ever-changing. It creates a link whereby the environment is interconnected with personal goals and values. Patterson and Pegg (2009) reported that leisure and sporting experiences contribute to the quality of life of people with disabilities, helping to relieve tensions, and build and maintain relationships with family and friends (Dattilo, 2017). Furthermore, recreational activities create environment that promote emotional well-being and work habits. This holistic aspect of quality of life expounds on the need to look at an individual across all functional areas of life. The quality-of-life domain is broken down into the state of man (about the individual), the activity of man (about what the individual does), and the component of their immediate environment (about the environment) (Fig 1.1).

ID AND PHYSICALLY-RELATED HEALTH CHALLENGES

Physical inactivity

Physical inactivity refers to a lifestyle that is characterised with minimal physical efforts and no physiological changes capable of promoting optimal living. Physical inactivity is also known as sedentary lifestyle or lifestyle related disease. Physical inactivity is one of the leading causes of morbidity and mortality globally. Involvement in physical activity could play a significant role in reducing the health challenges of persons with IDs (Van De Vliet et al., 2006). It has been widely reported that persons with ID are highly prone to sedentary lifestyle (Mcguire et al., 2007; Frey et al., 2005; 2008). Beange et al. (1995), in their study on adults with mental retarda-tion, reported low active lifestyles for persons with ID when compared to the general population. In a study on children and adolescents with IDs in Britain, Emerson and Hatton (2007) found a lower level of physical and psycho-social well-being among persons with ID than others in the study. Individuals with IDs were found to have lower level of physical fitness than that of their peers (Todd & Reid, 2006; Skowroński et al., 2009).

Some studies also reported an increase in morbidity and mortality rate associated with physical inactivity among persons with ID (Fernhall et al., 1996; Lotan et al., 2004; Draheim, 2006). The systemic illnesses such as diabetes mellitus, congenital or acquired cardiovascular diseases, hypertension, asthma, epilepsy, obesity and several postural problems are relatively common among people with intellectual disabilities. However, Golubović et al (2011) observed that poor motor control, high physical demand, fear of accident and social exclusion could limit the involvement of persons with ID in activities related to sports or physical activity.

OBESITY

The potential negative health consequences associated with obesity in young people are significant and remain high should obesity persist into adult life. Incidence of obesity among persons with ID has also been associated with physical and social abuse and exclusion (Lobstein et al., 2004; Liou et al., 2005; Reilly & Wilson, 2006). Obesity has been associated with diverse health risks amongst persons with ID, as well as a range of genetic and environmental factors (Jinks et al., 2011). Environmental factors associated with obesity were found in persons with ID, who do not have access to facilities for physical activity or exercise and in addition, they experienced lack of independent mobility, side effects of medication and poor eating habits increasing the risk (Jinks et al., 2011).

Moran et al. (2005) identified 30–50 percent likelihood of incidence of obesity among the persons

with ID. From a study carried out on n=9678 children and young adolescents (8–18 years) with ID, it was found out that 30 percent of the sample were overweight or obese (Lloyd et al., 2012). Studies have found that persons with ID were more prone to gain weight and possibly become obese; and in addition, mobility problems were also reported to be fourteen times more probable than for the non-disabled persons (Draheim et al., 2002; Schrojenstein Lantman-de Valk, 2005; Lloyd et al, 2012). Henderson et al. (2008and comparing the rates of risk factors and appropriate preventive interventions with a sample of adults without ID from the same community. OS/O rates and CHD risk factors were ascertained in a sample of 100 adults with ID from a medical chart review. All participants were residing in group homes in Monroe County, New York. These rates were compared with age-peer rates in the local general population. In addition, physician practices regarding weight and CHD risk factors were compared in the two study groups. As expected, rates of OS/O were high in both groups. However, rates of obesity were proportionally higher in adults with ID. Hypertension rates were comparable in the two groups, although rates of dyslipidemia (high cholesterol) and Stewart et al. (2009) reported higher rate of obesity among persons with ID when compared with other groups in their studies. Whilst there are a number of predisposing factors to obesity amongst persons with ID— for example genetic factors and the use of certain medications—a lack of physical activity is identified as a significant contributing factor, which can be addressed through behavioural change (De et al., 2008)sex, weight, height, and severity of intellectual disability or global developmental delay were collected from medical records. Body mass index (BMI, weight/height2.

SPORTS AND PHYSICAL ACTIVITY INTERVENTION FOR ID

Sport for all is a popular parlance that has redefined the inclusiveness of persons with disability in sports participation. Coalter (2010) identified that the quality of experience in sports and the educational process could serve as the key elements of social transformation. Kidd (2011) observed that young adolescents are naturally attracted to sports with high level of interest and passion regardless of physical condition. Sports participation creates the opportunity to develop social skills and principles such as leadership, discipline, team spirit, respect, and cooperation (Galambos et al., 1994; Aitchison, 2003).

It has been reported that involvement in competitive sports has beneficial effects on athletes with disabilities, such as improvements in their physical coordination, strength, endurance, self-confidence and especially, opportunities for social interactions that help them to make friends (Davis et al., 2011) and potentially increase social inclusion (Westendorp et al., 2011). Kahn et al. (2002) observed that participation in physical activity and exercises tends to increase the level of group engagement of persons with ID along with others across all ages, in spite of the level of physical adaptation and supports (Abells et al., 2008). Health and well-being also improve as the body becomes fitter and more conditioned. A study also showed that physical exercises were effective in improving cognitive skills such as reaction time, as well as the social and communication skills in athletes with intellectual disability (Temple, 2009). Jinks *et al.*, (2011) reported positive effects of behavioural interventions on changing lifestyle of persons with ID through self-controlled techniques, such as monitoring food intake and retaining an active lifestyle.

Sports offer various opportunities beyond the usual support programmes provided for disabled persons. In terms of low-cost program of activities, sports have the potential to cater for all interests and abilities with maximum representation and attention. Social opportunities also arose, such as fostering friendships and social connections during the ongoing exercise programs (Temple, 2009). According to the United Nations (2005) inter-agency task force on sports for development and peace, it was concluded that sports can bring individuals and communities across ethnic or cultural divides together; thus promoting peace and tranquillity. Can sports take on this challenge? There is growing evidence that it can do so for various disadvantaged groups in rich and poor countries alike; giving participants greater self-esteem (Coalter, 2010).

CONCLUSION

This study identified that there is a need to further create an acceptable environment for ID individuals to participate in sports without social segregation. Even though ID is unlike other forms of disability, the individuals with this condition need adequate support in terms of social inclusion and physical activity intervention. This approach will help to alleviate health-related conditions, such as obesity, sedentariness and other related factors. It can therefore be concluded that quality of life of ID individuals can be enhanced through strategic adoption of sports in form of physical activities or recreational games.

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