Dentistry for Indonesians with special needs: A commentary

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ABSTRACT
There are approximately 20 million residents with disabilities in Indonesia. Despite national legislation to assure individuals with disabilities needed services, including education and employment, social inclusion of these individuals is difficult since societal views exclude them from functioning as members of a community. While there are no national studies of the dental needs of individuals with disabilities in Indonesia, one report of the general population indicates limited use of dental services and the need for increased oral hygiene and restorative services. Examples of dental education accreditation standards in other countries are used as models for the improvement in the preparation of dental students to provide services for individual with special needs.

The World Health Organization reported that Indonesia has a population with disabilities of approximately 20 million individuals (about 8 percent of the total population of 245 million persons): including 1.3 million children, only 50,000 of whom attend school. “The actual number of children with disabilities is believed to be much higher.” 1 Out of the total population with disabilities:
• 40 percent have locomotion disabilities
• 17 percent are visually impaired
• 13 percent have intellectual disabilities
• 12 percent are hearing impaired
• 7 percent have a speech impairment
• 7 percent are identified as having a mental illness
• 3 percent have multiple disabilities. 1
In addition, almost two thirds of individuals with disabilities live in rural areas where services are limited. In terms of the cause of disabilities, 35 percent occurred at birth, 33 percent by disease, 20 by accident and 12 by natural disaster. 2

PERCEPTIONS
“(Indonesia is) a country where people with disabilities and their families are stigmatized, people with intellectual disabilities are the most stigmatized and the least likely to receive adequate services or funding.” 3
“People with disabilities are more often considered an embarrassment. A significant barrier faced by people with disabilities is the belief that their disabilities are a punishment from God for sin.”

These kinds of judgment and attitudes affect the lifestyle of people with severe disabilities. They are not considered valuable members of their community and many remain housebound, uneducated and unskilled. In extreme cases, the family member is tied up at the back of the house. This treatment is called dipasung (to be held in stocks). But these attitudes and actions are contrary to the basic tenets of the religion of most Indonesians.

Islam and disabilities: Indonesia is home to the largest Muslim communities in the world. Although 88 percent of its population is Muslim, Indonesia is not an Islamic state. Indonesian Muslims are well-known for their moderation and being tolerant.

"The word "disability" cannot be found within the Qur’an or Hadis (religious texts of Islam), but the concept of Muslims having inabilities or special needs and how they interacted in society can be found throughout the history of Islam.” The belief of Muslims is that individuals are created with different abilities and disabilities with the objective for a Muslim to focus on their abilities and show gratefulness rather than focus on the disability. "A Muslim has the right to improve the situation of their disability through prayer, medical, educational and advocacy resources."

There are allowances for Muslims with disabilities and the aged to be exempted from some of the Islamic practices such as prayers, fasting and performing hajj – the pilgrimage to Mecca. It is the fifth pillar of Islam, an obligation that must be carried out at least once in their lifetime by every able-bodied Muslim who can afford to do so. It is a demonstration of the solidarity of the Muslim people, and their submission to God.

Due to the diversity of medical conditions and disabilities, “… it is a preferred practice to refer to a Muslim religious leader to determine what (if any) exemptions of Islamic practices are placed upon a person with a disability or the aged. The community as a whole is enjoined to be accepting of all people regardless of their disability and Muslims are required to support them in addressing their needs…” Caring for a family member with a disability is viewed as being highly rewarding. In general, Muslim care providers prefer to remain with the individual in need at all times and prefer to have activities that involve the whole family.

In Islam, the body is a gift from God and needs to be looked after and not abused. Keeping the body healthy is part of one’s religion. Any illness is to be received with patience and prayers and Muslims are strongly encouraged to seek treatment and care. Essentially, “… Islam sees disability as ‘morally neutral’. It is neither a blessing nor a curse... It is simply a fact of life which has to be addressed appropriately by the society of the day.”

The reality is that legislation in Indonesia for people with disabilities requires government departments and private companies to employ people in their organization. However, the laws are overlooked because the application, enforcement and sanctions of laws and regulations are weak and easily breached. Indonesia's struggling economy is a significant factor in the minimal health, education, employment and public access services and facilities for people with disabilities. “In the current ideological context of disability and society... it is certainly a big challenge to implement the Western concept of deinstitutionalization.”

WHY THE CONCERNS FOR ORAL HEALTH CARE?

The many difficulties faced by millions of individuals with disabilities in Indonesia may seem endless. In such an environment, the need for dental care would at best seem to be a marginal afterthought. Nevertheless, the needs are real, especially for individuals with special needs. Kozol succinctly summarized the realities of inadequate oral health services for individuals with and without associated disabilities:

“Children (and adults) get used to feeling constant pain... (from) bleeding gums, impacted teeth and rotting teeth... They go to sleep with it. They go to school (and work) with it...The gradual attrition of accepted pain erodes their energy and aspirations.”

While there are no ongoing national studies of the oral health of the Indonesian, a summary report of oral health condition notes that, “Generally 39% of the Indonesian population (15 years and older) have oral health problems; only 29% had received treatment from a dental nurse, dentist, or dental
specialist. The prevalence active caries is 63%. The prevalence of periodontal disease is 42.8%. Obstacles for improvement include: difficult geographical access, dental health is considered a non-priority, limited education directed to oral health needs, low population income, various cultural barriers, a lack of an adequate dental workforce and an uneven distribution a quality services and equipment.

Special Olympics Special Smiles: The Special Smiles program is an effort to increase access to dental care for Special Olympics athletes, as well as people in general with intellectual disabilities. Dental screenings are used as a means to increase awareness of the state of the athletes’ oral health for the athletes themselves, as well as their parents and/or caregivers. Results from dental screenings (in 2004-05) at these Special Olympic events in Bali, South Celebes and North Sumatra indicated that 8%, 22% and 28%, respectively, of the athletes were in urgent need of dental care. (Special Olympics Special Smiles internal reports by S.A. Adiwoso)

It should be noted that these findings (of oral health needs) are for a population of individuals with intellectual disabilities with increased supportive programs and not necessarily representative of general population of individuals with intellectual disabilities.

Attitudes: As young men and women train for careers in the dental and other health professions, opportunities for contact with and care for individuals with disabilities are essential if they are to overcome the all too often standard perceptions and attitudes which result in the rejection, exclusion and discrimination against individuals with disabilities. “Only if early contact is established with patients (with disabilities), practical educational strategies are adopted, and the students are provided with information on attitudes about the disabled, will a social model of disability be introduced into the curriculum”

DENTISTS AND THE TREATMENT OF INDIVIDUALS WITH SPECIAL NEEDS

Numerous reasons are stated for not treating people with disabilities in private practice, including: “...too much time is required to perform procedures, the patient may have a life threatening medical emergency, funds for treatment are difficult to obtain, procedures are too difficult or there are difficulties of (physical) access to the (operator), the dentists neither received special training, nor have they the special equipment, and they are apprehensive dealing with disabled people, other patients may be offended (e.g. waiting room disturbances) (sic) and these disabled patients usually require hospitalization”.

DENTAL SCHOOL PROGRAMS

This need for “experience and contact with people with disabilities” was the basis for establishing dental school accreditation requirements to ensure adequate basic science and clinical experience in the predoctoral training programs in many dental schools in other countries. For example in Canada and the United States:

“Graduates must have sufficient clinical and related experiences to demonstrate competency in the management of the oral health care for patients of all ages. Experiences in the management of medically compromised patients and patients with disabilities and/or chronic conditions should be provided” (Standard 2.4.1)

“Graduates must (sic) be competent in assessing the treatment needs of patients with special needs” (Standard 2-26)

THE CHALLENGE

The need is for schools of dentistry to follow the accrediting steps taken by the dental profession in other countries to ensure the adequate basic science and clinical experience in predoctoral clinical programs to prepare graduates to provide for the wide range of individuals with special needs. However, developing such an effort is possible only if the profession and the general public can be convinced of the need for these programs. To this end:

- There is a need for a national health survey (including oral health) of people with disabilities with particular emphasis on the conditions in the rural areas. The current limited series of reports emphasize the conditions in the major urban areas.
- There is a need to identify the type and availability of current dental service centers for individuals with disabilities. Such an effort
to catalogue dental school and health department programs, as well as the number of private dental practitioners, would provide an essential basis for lobbying for improved educational programs and service arrangements.

- There is a need to enhance national organizations to stimulate an awareness of the varied needs of individuals with disabilities. Such organizations would serve as an advocate to raise standards, to support demonstration programs and lobby to increase the commitment to have children with disabilities (where possible) placed in the regular school system, to increase employment opportunities and to foster acceptance in the general community.

Only then can one anticipate the establishment of real programs in schools to prepare dental students to care for individuals with disabilities. Such an effort can not be relegated to small groups of trained specialists. The reality is that such an effort can be successful only with specially trained specialists (e.g. pediatric dentists) and the participation of the broad range general practitioners who have been prepared to provide these needed services. 15

REFERENCES