

Projelerimiz ile ilgili geniş bilgi ve göreseller için web sitemizi ziyaret edebilirsiniz.

PROJE ORTAKLARIMIZ

				
Türkiye	Slovenya	İspanya	Avusturya	İngiltere
Konevi İşitme Engelliler Ortaokulu	Zavod za gluhe in naglusne	Instituto Enseñanza Secundaria La Rosaleda	Equalizent	The University of Warwick



Erasmus+



TEORİDEN PRATİĞE

FROM THEORY TO PRACTICE

KULAK SAĞLIĞI ve İŞİTME BAKIMI İLE İLGİLİ ÖZEL EĞİTİM OKULLARINDA KAPASİTE GELİŞTİRİLMESİ

CAPACITY BUILDING IN SPECIAL
EDUCATION SCHOOLS
CONCERNING HEALTH AND
HEARING CARE



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PROJE KILAVUZ KİTABI

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ÖNSÖZ



Mustafa BAHAR

We are about to finalize the second EU project works which started about five years ago on behalf of our school. Our project work started with the energy that patience and perseverance bring at a time when we were stuck a little bit mentally. This strenuous, and exciting work that started five years ago on a winter day gained 3 projects for our school. Our anxiety and eagerness increased with the adoption of our first project, Like an "Amok Runner", our run continued with love, without stopping, without giving up any obstacles. When all projects are over, a large budget will be used by our partners and our school. This project we made on behalf of our middle school and our other two projects were our primary goal to contribute to and serve the world of hearing impaired people. Of course, we think that these projects indirectly or directly affect everything from the teacher to the student and gave us another horizon.

Greetings from "Konevi family" to all hearing impaired ones

The search for meaning in a person's life lasts until death. Every satisfactory answer we find about life contributes our meaning world. In this sense, if we could open a window of meaning for our hearing-impaired students, we feel ourselves really happy. If our students primarily recognize their strengths, opportunities, weaknesses and, therefore themselves, we will have a touch that will affect them throughout their lives. But if we fail do this, if we cannot teach that life is not just material, if we cannot fill their void inside, besides Empedocles, Socrates, Seneca, Hemingway dramatic ends like Stefan Zweig, the writer of the story of the "Amok runner", are waiting for them. Our third project was actually done to provide the development of hearing impaired people in this sense. First to understand the matter and then to understand the spirit and live a peaceful life A person with hearing impairment is deemed to have solved many problems and recognized the importance of knowledge. For this I recommend that the hearing impaired individual follow our Web site where we want to meet all educational needs.

In this project we concentrated on ear health and hearing care and education. We have tried to collect information in this booklet. We have shown more visual materials on our internet site. We will continue to publish all information that may be necessary for hearing impaired person through this site. If you would like to contribute to the topic, we will gladly try to publish it on our site. Briefly, we aim to turn our site into a knowledge bank for the hearing impaired ones.

We would like to express our gratitude to Professor I. Feast Pleasant, Assistant Professor of Warwick University, who supported our school in all our projects. We are grateful to all of our employees who actively support our work within the scope of our projects. We would like to thank Musa Tunç specially, our teacher who has coordinated all of our projects.

ABOUT THE PROJECT

ABOUT THE PROJECT

According to our initial research, there is not an EU project carried out before to enable doctors-academicians-speech therapists-and audiologists to work together and support/ educate the special education teachers of students with DHI. We envision to support professionals to work together, study and analyse specific health and hearing related issues about students with DHI, provide lectures for special education teachers, for students with DHI and their families. This project also offers an innovative approach differing from other projects such as recruiting outside professionals to give lectures about their professions as a part of EU project and specific to our targeted population. These professionals are experts in their fields including professors, doctors, teacher trainers, education advisers, and other health field experts who will also contribute to online lecturing. Also, during our partner country visits, we will have professionals to physically attend our training sessions to educate our special education teachers in situ. Also, our partner university academicians will conduct scientific studies with special education teachers in their school institutions to investigate health care and related issues to hearing. This complements other projects because, typically, academicians work with their colleagues rather than with special education teachers to generate scientific articles or research reports. We believe that it is crucial to involve special education teachers as research partners to widen their understanding and professional capacities regarding health care issues of children with DHI. Furthermore, we will work on bridging the gap between health field workers, academics, special education teachers, students with DHI and their families in a strategically planned partnership.

Because of the lack of practical support and implementation to boost the capacity of special education schools, we are determined to pursue the objectives of bringing together the strengths and knowledge of schools-families-students-universities-social advocacy groups - governments-companies-hospitals-and volunteers in our partner countries and disseminate the emerging knowledge to relevant parties. We have planned to work with special education teachers of the children with DHI in each partner country to ensure that they benefit from the best educational and practical interventions in the form of materials, professional training, and offering guidance to families and students with DHI, specifically providing training regarding health and hearing care issues related to deafness and hearing impairments. Our planned activities include step by step training for special education teachers in partner countries: Professional academicians and hearing care experts such as ear doctors, audiologists and speech therapists will give specifically designed lectures about the structure and function of the ear, the outer, middle and inner ear examination, treatment, cleaning of devices / tools, the requirements of cochlear implant and hearing devices and their proper care and usage.

Lessening the impact of disability on children with DHI requires a multidisciplinary approach with professionals from diverse disciplines working together. Furthermore, we will address an important way of bridging the gap between health field workers, academics, special education teachers, students with DHI and their families in a strategically planned partnership as a complementary project by compensating other individual EU projects' untouched sides regarding our targeted population of people. We will provide concrete intellectual outputs not hiding in theories, rather we will publish educative lectures in 5 different languages and their corresponding sign languages. Therefore, by using open online module, which is also distance learning, thousand of people will practically benefit out of our outputs and trainings in the partner countries and also Worldwide since we will use English, German, Spanish, Turkish and Slovak along with their sign languages as well.

Furthermore, practical cooperation for producing intellectual outputs will play a significant role for widening opportunities that special education teachers can conduct in schools



THE PROJECT SUMMARY

The primary objectives of this project are to bring together the strengths and knowledge of schools-families-students-universities-social advocacy groups - governments-companies-hospitals-and volunteers in our partner countries in terms of health and care issues related to hearing abilities of students with deafness and hearing impairments. We pursue the objectives of training special education teachers in primary and secondary schools through intensive training programs as being our direct target group. Our direct target group also includes students with deafness and hearing impairments and their families. Indirect target groups are university institutions, academics, in-service teachers, mentors, tutors, education authorities, rehabilitation services for students with deafness and hearing impairments and health field workers. Another objective is to increase the service capacities of special education schools, addressing proper integration of health and hearing care components into school service, identifying best practices of partner countries, investigating hearing and health care practices of partner countries, empowering professional work between academicians and special education teachers to provide better developed teaching and variety of activities.

Our mobility activities are short terms joint staff trainings where special education teachers will be trained via a specifically designed course subjects by professionals. Each single day of training will be particularly designed to examine and convey certain project objectives. Doctors, academicians, speech therapists, audiologists and teacher trainers will employ these mobility activities by presenting their own expertises.

Intellectual outputs are open online module where it covers lectures from health and hearing field professionals regarding to deafness and hearing impairment. Lectures will be recorded in 5 languages including English, German, Spanish, Slovak and Turkish and their corresponding sign languages to be published in our interactive, multilingual and deaf accessible web site. Another intellectual output is study and analysis covering crucial health and care issues of hearing such as prevalence, causes and prevention of deafness and hearing impairment, examination of the ear, detection, screening and testing of hearing impairment, ear operations, rehabilitation and education, hearing aids, cochlear implants usage, effectiveness and misbeliefs, what families of students with DHI should primarily know and apply in house settings about hearing care, and possibilities of health condition variations of these children with DHI. We will follow the methodology of data collecting about above mentioned subjects by employing interviews, questionnaires, document analysis and scientific articles and reports analysis. Qualitative and quantitative methodologies will be employed by our partner academics in cooperation with special education teachers.

Dissemination activities are final conference and workshops where project outcomes will be disseminated through conference presentations, journal articles, and website including open online module, publications and output package as in DVD format. Evaluation will serve to examine the progression of the project outcomes by conducting internal and external evaluations in interview and survey formats.

The project's envisaged results are bridging the gap between the works of health field experts/institutions and special education schools/teachers in terms of combining the strengths of these people and institutions to provide better service, health care and care related to hearing of students with deafness and hearing impairments. Also, empowering service capacity of special education schools in diverse ways will provide long term benefits for these schools to diversify the quality of education/service that they utilize in the future. It will furthermore encourage health field experts, academics, teacher trainers, education advisers or authorities to collaborate actively in the education process of students with deafness and hearing impairments, their families and special education teachers in real classroom and school settings



PROJECT ACTIVITIES

01/09/2015
31/12/2017

DATE	ACTIVITIES	DISTRIBUTION OF ROLES
SEPTEMBER 2015	Creating a project management and evaluation team Informing the project partners	Konevi İşitme Engelliler Ortaokulu Zavod Za Gluhe In Naglusne The University of Warwick, Instituto Enseñanza Secundaria La Rosaleda, Equalizent
OCTOBER 2015	Joining the project introduction and grant contract meeting Signing a contract with Turkey National Agencies	Konevi İşitme Engelliler Ortaokulu
NOVEMBER 2015	Signing a contract with the project partners Determining the teachers who will join the project	Konevi İşitme Engelliler Ortaokulu
DECEMBER 2015	Creating the website (Turkish/English) Creating a Facebook page Determining the activity dates by consulting with the partners	Konevi İşitme Engelliler Ortaokulu Zavod Za Gluhe In Naglusne The University of Warwick, Instituto Enseñanza Secundaria La Rosaleda, Equalizent
JANUARY 2016	Updating the website Making the printings and designing fabric poster, signboard, paper poster and hand brochure for the purpose of introducing the project	Konevi İşitme Engelliler Ortaokulu
FEBRUARY 2016	A meeting with project management team and participator teachers Determining the topics of the videos	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
MARCH 2016	A meeting with project management team and participator teachers Preparation of Slovenia Ljubljana activity	Konevi İşitme Engelliler Ortaokulu The University of Warwick, Zavod Za Gluhe In Naglusne Instituto Enseñanza Secundaria La Rosaleda, Equalizent
APRIL 2016	11-15 April the activity of Slovenia Ljubljana Monitoring activity, project meeting, reporting and activity evaluation with the participators	Konevi İşitme Engelliler Ortaokulu
MAY 2016	Malaga mobility preparation in Spain 09-13 May 2016 Spain Malaga mobility Meeting with the participants, project meeting, reporting and evaluation	Konevi İşitme Engelliler Ortaokulu The University of Warwick, Zavod Za Gluhe In Naglusne Instituto Enseñanza Secundaria La Rosaleda, Equalizent
JUNE 2016	The opinions of the guardian about the video contents Team working at preparing the brochure The website updtings	Konevi İşitme Engelliler Ortaokulu Equalizent Zavod Za Gluhe In Naglusne
JULY 2016	Determining the activities The opinions of the teachers about the video contents	Konevi İşitme Engelliler Ortaokulu Equalizent Zavod Za Gluhe In Naglusne
AUGUST 2016	Working of the team of preparing a book Translating the articles	Konevi İşitme Engelliler Ortaokulu The University of Warwick
SEPTEMBER 2016	Meeting with the project management and participator teachers Writing the project article Preparation of the activity of Austria Vienna	Konevi İşitme Engelliler Ortaokulu
OCTOBER 2016	10-14 December 2016 Austria Vienna activity Monitoring activity, project meeting, reporting and activity evaluation with the participators Sharing with our school's teachers	Konevi İşitme Engelliler Ortaokulu The University of Warwick, Zavod Za Gluhe In Naglusne Instituto Enseñanza Secundaria La Rosaleda, Equalizent
NOVEMBER 2016	Preparing the interim report and presenting it to Turkey National Agency Website updates	Konevi İşitme Engelliler Ortaokulu

PROJECT ACTIVITIES

01/09/2015
31/12/2017

DATE	ACTIVITIES	DISTRIBUTION OF ROLES
DECEMBER 2016	Brochure preparing team's preliminary study Writing project article Translating the articles	Konevi İşitme Engelliler Ortaokulu The University of Warwick
JANUARY 2017	Shooting and preparing the scenario and texts which about the scheduled video contents	Konevi İşitme Engelliler Ortaokulu Zavod Za Gluhe In Naglusne Instituto Enseñanza Secundaria La Rosaleda Equalizent
FEBRUARY 2017	Determining appropriate doctors and experts for what have been scheduled as topics for the shootings Making dialog with the appropriate doctors and experts for what have been scheduled as topics for the shootings	Konevi İşitme Engelliler Ortaokulu Zavod Za Gluhe In Naglusne Instituto Enseñanza Secundaria La Rosaleda Equalizent
MARCH 2017	Intermediate conference preparations Reviewing the video contents	Konevi İşitme Engelliler Ortaokulu
APRIL 2017	Slovenia Ljubljana activity preparations Meeting with project management team and participator teachers Website updates	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
MAY 2017	15-19 May 2017 activity of Slovenia Ljubljana The intermediate conference has been made Evaluating the conference outputs and sharing it on the website, facebook and other social media tools	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
JUNE 2017	Shooting the identified topics with the related doctors Shooting the identified topics with the related field experts Preparing the shooted topics's text by sign language	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
JULY 2017	Shooting sign language videos to be added to the experts videos	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
AUGUST 2017	Preparing the brochures which includes our project outputs Translating The assembly work of the videos which've been shooted	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
SEPTEMBER 2017	The obtained information and experiences in the project scope have been shared with the students and the guardians. Preparing a book which includes our project's outputs Website updates	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
OCTOBER 2017	Publishing the videos on the website, Youtube and EBA The seminar about the topics anatomy of the ear, the ear's working system, ear health and care, have been organized for teachers and students in an appropriate way to the project by the experts who are invited to our school.	Konevi İşitme Engelliler Ortaokulu Instituto Enseñanza Secundaria La Rosaleda, Equalizent
NOVEMBER 2017	Writing project article Translating articles Preparation of the final conference	Konevi İşitme Engelliler Ortaokulu
DECEMBER 2017	Printing, distributing book and brochure Final conference Website updates Preparing the final report	Konevi İşitme Engelliler Ortaokulu

1- SLOVENIA - LJUBLJANA MOBILITY-1

REPORTS

A visit was made to ZGNL the central Slovenian institution for the comprehensive treatment of deaf and hard-of-hearing children, people with speech and language disorders, and people with Autism spectrum disorder in Ljubljana, the capital of Slovenia.

1 Day: A briefing about the school and its running system was given by school authorities.

1st day: Language therapy and physiotherapy rooms were visited.

2nd day: The school for the hearing impaired in Portoroz, a city in Slovenia, was visited.

3rd day: A Seminar given by a clinic specialist and a professor about "Ear Health and Care" was attended.

4th day: School and Class observations were made and subsequently a Project Evaluation Meeting was held.

Contribution of the Project to Our School (What we do not have at our institution)

- A clinic within the school facility
- Vocal training books
- Vocal training rooms
- Cooperation with Universities
- Cooperation with health institutions and rehabilitation centers
- A TV channel and units for the students to shoot films and make recordings
- Vocational courses and classes

At the end of the Project Features that we do Have but they do not (We have)

- They do not have brain stem surgeries.
- Hearing Impaired and autistic students have common classes.

Features of the Institution:

Name of the School: ZGNL Lubljana Deaf Institute

There are 250 students enrolled in this institution with a semi-autonomous complex structure receiving education and health services. Out of these students, 75 are hearing impaired, 50 are autistic, and the remaining have language and speaking disorders. There are 200 personnel working in the service of these children. All of them have to know sign language at least at third degree. There are 2 social service experts, 2 for project management, 2 psychologists, and 1 librarian.

In order to become a teacher in primary school, an education of 5 years after high school and in order to become a teacher at secondary school extra course for two years are compulsory.

1st Day:

- 1) Toddlers are enrolled after the age of 11 month. Until the age of 2, these children receive with together with their families' sign language education and vocal training.
- 2) Children, who can speak after kindergarten well, are enrolled to regular schools. In order to follow up these children, there are monthly school visits for two hours.
- 3) An aide is provided to the teacher at kindergarten and 1st class of primary school by the state.
- 4) At the second stage, autistic children, children with language and speaking disorders, and hearing impaired children are educated together. Along the basic compulsory courses, they also receive courses related to their skills (metal, wood, media design, computer skills).
 - The curriculum in this school is the same as in regular primary schools. In common exams, there is a translator who translates the instructions into sign language. At the 6th grade there is a TEOG like exam.
 - According to their departments these students are sent to different companies for internships. They are sent abroad with EU projects.
 - Foreign languages are compulsory.
 - The primary school has to be finished in time. There are no extensions to the period. However, the education period can be extended during secondary education.
 - Certificate courses and educational activities that could be useful in the future vocations of the students are organized.
 - Out of the school facilities, two flats, rented by the government, are provided for social activities financed with EU projects (Taka-tuka)
 - An extensive library is available at school.
 - Vocal training books have been created.
- 5) At the dormitory female and male students stay together. In the mixed dormitory, the students stay four days a week. Their expenses are covered by the state. Families do not receive any money.
- 6) There are vocal training and pediatric physiotherapy rooms. Here, the education and training is provided by sound therapists (20 sound therapy rooms, 1 physiotherapy room).
- 7) The vocal training rooms are supervised. School principal, a psychologist, and a member of the family can watch behind a glass pane.

1- SLOVENIA - LJUBLJANA MOBILITY-1

REPORTS

· The physiotherapy room can also be used by patients who are not enrolled at the school.

8) There is a clinic providing health service, within the school premises. (At the 4th day information about the clinic is provided.)

9) Four hearing-impaired specialist teachers are working in the school. These teachers support other teachers about how the subjects in the curriculum can be taught in sign language. These specialist teachers have a TV channel for the hearing impaired (TIPK TV). There are rooms assigned for TV shootings. They are nominated as sign language translators by the state. In order to become a translator, a one year education in sign language is compulsory.

10) The state provides cochlear implants. These are attached to the ear by the teacher. The batteries for the implants are brought by the families. The teacher supervises the implementation of the batteries (at the 2nd day information about cochlear implants have been provided). The ear implant is provided by the state in pairs. If there is a difference in the prices, the families have to offer the differing amount. They have the right to change the device in 8 years. FM systems at the primary school are funded by the state.

11) There are no brain stem surgeries in Slovenia.

2nd Day: Information about cochlear implants and hearing aids:

- The hearing test is conducted when the baby is 3 months old.
- According to the decision of the doctor, cochlear implant is implemented before the first age. The state is funds only one.
- The cost of the surgery and necessary devices sums up to 50 000 Euro.
- Out of three different devices, one is chosen by the doctor. The families do not have a choice.
- FM systems at primary school are funded by the state.
- A brief education about hearing aids and FM systems are given both to the families and the children.
- The batteries of the implants are to be bought by the families. The teachers help in the placement of the batteries. If the families pay the difference, the state implants two devices. They have the right to change these in eight years.
- The trademarks used are to 75 % Nukleas and 25 % Model.
- Only the external equipment is being controlled. If there is a problem with the device, it is sent to London. The device returns in a week.
- The implant of each student is controlled with various programs. Accordingly, these are calibrated.

3rd Day: The school for the Hearing Impaired in the Portoroz Province of Slovenia was visited. Information about the school was given by the school director.

3rd Day: The specialist working in the clinic within the school premises gave the following information:

- Education is given in the clinic to infants, children, and adults. Families can participate in the education sessions as well.
- Besides the hearing impaired, autistic children and children with problematic behaviors are also educated.
- Students from the school and from other schools can visit the clinic.
- In order to become a clinical vocal trainer an education of 8 years (5+3) is compulsory.
- There are three health centers in Portoroz, Maribor, and Lulijana. Surgical interventions are made only in Maribor and Lubljana.
- There is a card system indicating how much the state has to pay with the EU health service card.
- 20 vocal therapists are providing service.
- Children are sent to the clinic according to a common report, ear nose and throat specialist, pediatrician, and child psychologists, indicating how many vocal training sessions they will have.
- 20 vocal trainers are serving 230 children receiving inclusive education at various schools.
- The families bring the report to the clinic and education starts immediately.
- Before they continue with compulsory education, they undergo a compulsory health screening.
- At the age of 15 they undergo again a health screening and with it, their health insurance is over.
- At primary education (6-15 years) the FM device is provided free of charge.
- Students can have implants according to the doctors' decision.

v Professors: Within the scope of Net-Guest Project they have established this department and came together with the academicians from 31 countries.

v They are training teachers at the Faculty of Education within the field of hearing, health, and care. They are training voice and vocal therapists (SLT) along with teachers for the hearing impaired. According to their preferences they have elective courses.

v They have to study 4 years at BA level and 1 year at M.A. level in order to become a teacher for the hearing impaired.

v These specialists and teachers can be employed at schools, health centers, clinics, and guidance and counselling centers.

v The MA students focus on the problems of the teachers working in these schools.

v They have 22 students.

v There are three federations for the hearing impaired.

v They are able to choose any curriculum they want.

v There is no special education department.

v They have developed their own training program over the last 5-6 years.

5th Day: The classes were visited in the school. The Project Evaluation Meeting was held.

2- SPAIN – MALAGA MOBILITY

REPORTS

School visit to IES La ROSALEDA Malaga; it is a school where children with every kind of hearing impairment is educated. Education is provided according to the preference of the students. Students are divided into groups and according to the degree of hearing loss various resources are determined. Increasing self esteem of the students is among the main aims of the school. Psychological counsellors prepare plans according to varying students' levels. Language development is determined with a language test and education is provided accordingly. Students are under the follow from the birth on until the end of secondary school. Students' families are provided with support and the necessary education if required. Various activities are planned for the development of students' intelligence and psycho motor skills. All education is given by teachers of hearing impaired students. The school councillor and therapists are responsible for speaking, language development and determination of students' levels. Teachers are obliged to know sign language. Beside the professional teachers for different branches, there are also teachers who know sign language. Teachers in the secondary are divided into two groups as language development, social classes and technical classes. If the students receive education from other institutions as well, the school cooperates with these too. Early diagnosis and treatment is of utmost importance and if there is a handicap in education, this is attributed to the system not the child.

The president of Spain's education and psychologist made a general speech; he stated that they do not provide psychological guidance and counselling, family education but support the families if required. With the tasks they have accomplished, inclusive education has become more effective and more important. Schools for special education needs children are closing one after the other slowly. The system that is being now applied is directed for the socialization of the children and hence inclusion is given more importance. In cochlear implant surgeries, only one device is funded by the state. In children with a hearing loss of 55dB and above, four different committees consisting of doctors decide for surgery subsequent to the use of a hearing device for a period of three months. Otherwise, surgery can not be performed. One and half months following the surgery, the children and their families are informed about vocal training. Later on there are annual meetings with the family for evaluation.

CEIP – Garcia Lorca Malaga Primary school was visited. It is a school with a total of 700 students. There are six hearing impaired children. They receive education in Spanish sign language. This school was established in 2007 and there are sign language translators present. It serves to the middle and upper classes. It is a state school free of charges. The hearing impaired students are taught sometimes individually or in groups. They receive inclusive education. Prior to 2007 sign language was forbidden and the educators did not know sign language. They have learnt it afterwards. Before that there was a school for the hearing impaired but it was closed later. There are only two classes in a school continuing their education informally with 7-8 students in each class. Three students at the school are using FM systems. They are spending 14 hours a week with a child who knows sign language. They consider that there is no need to spend that much time with the others. Whereas there are teachers for the hearing impaired at primary school level, at secondary school there are teachers for different branches. In the school there are also children with different types of impairment. Autistic children also learn sign language and children without any impairment have sign language courses. The classes were visited. The students with the implants can speak well and next to the teachers desk they are educated by the teacher aide. The hearing devices are maintained and repaired on a regular basis by the institution and families who want to be educated on this topic are given courses.

A school giving religious education named collegio "la purisima" was visited. This school served hearing impaired children from 1905 to 2013. The school for the hearing impaired was changed into a regular school. Education for children aged between three and fourteen. There are two classes for the hearing impaired. There are 33 hearing impaired students. Four of them are inclusive education classes; the others are in their own classes. They are using sign language as a means of support and give importance to sign language. They begin the lesson with sign language and continue with regular talking. The problems are the same; education until the fourth grade. After that, speaking is abandoned and they return to sign language. After the school they remove the implant and begin to speak in sign language. There are ghetto groups making the school tasks more difficult as they claim to continue the culture and language of the hearing impaired.

Hence, as advantages, the emphasis on inclusive education, presence of hearing impaired teachers of sign language, being a day school, and teaching a second foreign language to hearing impaired and normal children together can be counted.

3- AUSTRIA - VIENNA MOBILITY

REPORTS

The name of the center we went to was Equalizent founded in 2004. In the early days, it was very difficult to manage the center and have it approved by the authorities. However, whereas there were 12 employees at the beginning, as a result of the growth experienced there are now 52 employees. Out of these 52 employees, 15 are hearing-impaired. These 15 employees are currently employed to become educators.

The center serves the community in four ways:

Merkez 4 şekilde hizmet veriliyor:

1. Education for total hearing impaired.
2. Education for those with difficulty in hearing.
3. Sign language education for all.
4. Administrative orientation for the hearing impaired from other cultures.

Their aim is to provide all students an environment without handicaps. They introduce sign language to the students and in general convert oral education into education using sign language.

Students are reenrolled to the center after the age of 14-15.

There are schools for the hearing impaired in Austria; however, 70% of the teachers do not know sign language. Education is mainly in form of inclusive education.

The center provides sign language education.

The center received state funds first and in the 2000 years. The state seeing the benefits of sign language is still supporting the institution. Today they are quite strong and do not have any problems in terms of infrastructure.

Sign language translation began in Austria for the first time in 1998. Today there are 456,000 people with hearing loss in Austria and 8,000 to 10,000 of them have totally hearing-impaired. Most of them know sign language.

The equivalent of that institution in Turkey would be a mixture of public education center, rehabilitation center, and employment agency. 95% of the babies born with hearing impairment have implants funded by the state. The cost is € 70,000 per person and was paid entirely by the Austrian state. Every year 200 operations are conducted and organized all by a single professor. Yearly, about € 1.7 million is spent on this issue.

In Austria, education was not given orally until 1880. Last year, oral training was initiated in a meeting last year. In the schools for the hearing impaired, 70 % of the teachers who can not communicate with sign language tried to give oral training for the hearing impaired in order to enable them keep up with the social milieu. However, according to the center visited, this system in theory does not function in practice. The children did not make any progress in terms of education.

There are five classes in the center. The first language in the center is sign language. Likewise sign language is the first language in the USA and Canada. The first priority is to enable students to learn sign language which is like their mother tongue. They state that the mother tongue of the Turkish population is Austria; hence they should learn first Turkish and then German.

In the center, the education provided for those interested in sign language is the same given to the hearing impaired. According to relevant research, the level of the hearing impaired, regardless of how old they are, is that of 8-10 years and after the sign language received they are able to bring it to the age level of their own.

Throughout Austria, there are 1422 and in Vienna 209 educational institutes providing basic education. Out of the hearing impaired students enrolled in these schools, only 7% can enter tertiary level education at universities through the support of sign language translators.

Although the first stages of education are problematic, the state grants support at later stages. Unlike normal children who have a repertoire of 3.500/19.000 words, hearing impaired children know only 250 - 500 words. At the age of 14-15 the repertoire has expanded to 12.000 words in normal children; however, in the hearing impaired it can not surpass 2.000 words. In Austria if an adult knows less than 7.000 words, it means that he does not know anything.

Hearing impaired in Austria has to work after school either at hard labor jobs or for very low wages. Hearing impaired have two groups of workmanship; namely the first group earns enough to be self-sufficient, the other group has to work at a very low cost. The unemployment rate, of 61% in the hearing-impaired youngsters soars up to 100% at the age of 46 and above. Only 35% of the hearing impaired is working with a salary, while the remaining 65% continues to work without a regular payment.

3- AUSTRIA - VIENNA MOBILITY

REPORTS

There are 115 sign language translators in Austria. Most of them work part-time. Compared with Switzerland with the same population, there are 450 sign language translators.

Since 2016 in Austria at every public conference, the presence of a sign language translator is according to the law compulsory. Sign language translators receive € 100 in total, € 20 + 20 € for transportation and € 60 for translation, at every event.

Among the future goals of the center is to teach hearing impaired babies sign language. They argue that bilingual teachers are more successful in their classroom. The state has a special curriculum for the hearing-impaired students. However, this program is not approved by the center visited. They want the same program used for regular students also to be used with the hearing impaired.

A student with a hearing impairment receives per week 10 hours speaking courses; however out of the class. A hearing impaired student attending a normal school can also receive 10 hours of speaking course weekly; yet, throughout the inclusive education process.

The center visited claim that due to bilingual teachers, students can make more progress and students in the same class with the hearing impaired students are also to receive sign language education.

The budget of the center consists of three items:

1. 70% government funds
2. 20% sign language course incomes
3. 10% European projects

Yearly, € 1.5 million government funds are given to the center; however, they have to apply for this fund each year anew. This amount is given for 120 students. As the expenses of the center are quite, 80% of the money is used completely.

Students who have learned in their school up to 2.000 words are brought to the center where they try to build up and strengthen the self esteem of the student.

The center has a video shooting studio where technicians are preparing various programs and videos for the hearing impaired.

The classes in the center have at most eight students. They are forming special groups and give instructions with 2-3 students. Moreover, for those students who can not come to the center; the center is providing education via videos.

In the center there are courses for the hearing impaired in order to specialize within a field. Sign language education is provided only for those who are hearing impaired. For regular students, all classes (mathematics, physics, chemistry, etc. ...) are taught with the sign language.

They have three buildings. The first building is used for education, the second for individual education, and the third is reserved for technical tasks.

The youngsters coming to this center do so in order to find a salaried employment. Their new project is to help the hearing impaired find jobs.

The center wants all the hearing impaired to feel like an equal member of the Austrian society.

Normally the job facilities of state for sign language are very low. They wanted to give more support to people with hearing impairment since the center provides more opportunities.

The young people who start to work are supported for the first 1-2 weeks. They are enabled to communicate with their colleagues. The students who have begun working continue their education by participating in various courses. The center continues to support them.

The students who have begun working come back for 1-2 hours a week for their education at various courses.

The center considers continuing the movement of specialization opened up every year. They got permission from the state for kindergarten teacher next year. Normally a hearing-impaired person is prohibited from being a teacher at a kindergarten.

Former specialization courses were the following:

- 2012 – Nursery
- 2013 – Sanitation & Cleaning
- 2014 – Dentist Assistant
- 2015 – Kindergarten Teacher Aide
- 2016 – 2 and 3 Dimensional Animation

3- AUSTRIA - VIENNA MOBILITY

REPORTS

Every year a ball for the hearing-impaired people from different cultures is organized. There are around 2 thousand attendants of the ball and the number is increasing year by year.

If there are hearing impaired personnel at private companies, the center provides support for these people too. The center has special activities. They are developed a variety of applications for companies in order to intertwine hearing-impaired personnel with the others.

The center is preparing books for both adults and children. Up to now, 18 books have been translated into sign language.

They were shooting videos in cooperation with SiMax Company. They are also preparing apps together with SiGame. In order to enable hearing-impaired individuals to find jobs easier a "Video CV" is prepared. Whereas in Austria, normal schools are giving 4 + 4 education, for the hearing impaired, it is 5 + 4.

In the class visited for observation German was taught. The lesson subject was the adjectives. Two teachers were working simultaneously. One was able to speak, the other was hearing impaired. The students were studying on the worksheets. Several worksheets were on the students desks. Students could choose any worksheet they wanted which they considered to be appropriate for their level. After the tasks, they were able to correct their own mistakes by seeing looking at the answer sheets themselves. The teacher was not asked any questions.

The teachers too did not interfere too much, they were only guiding.

The course being given is a 6-month course. Students have 30 hours a week classes. At the center, open learning and distance education is also provided. This enables the students to see their own deficiencies by working at their own levels. This is also considered to be the best method for students with differing levels.

After 6 months, hearing impaired who could not have the job they have demanded, come again to the center and change to another field of specialization.

Although the certificates obtained from this center are definitely not equivalent to diploma from a university, it is beneficial jobs started.

In the center, as a new project they turned normal books into sign language books. There are three different parts in these books: picture, text, and sign.

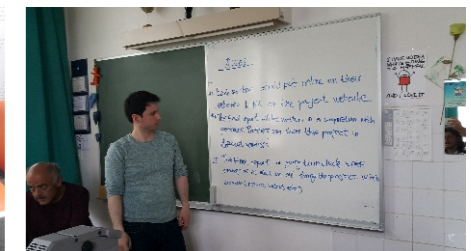
Most of the materials used by the center are available at www.signlanguage-school.eu. On examining the web site, it became obvious that the majority of the content was uploaded in 2012 and the web site was almost untouched in the years after.

Based on our observations; besides the advantages listed below,

1. Effective coordination established between institutions,
2. Potential of the institution to find workplace for students who have successfully completed the education,
3. Acquired trust and support by the state,
4. Making the sign language accepted as a language by institutions and organizations,
5. No problems in obtaining financial support from public institutions and organizations,
6. Employment of former students who can express themselves and realise themselves by the institution,
7. No difficulties in finding relevant personnel,
8. Constant progress through integration with technology,
9. Performing only the function of guide by the teachers with the students,
10. Presence of materials for every level,

There were also some inherent disadvantages such as the following:

1. There is the impression that hearing impaired individuals do not have any job opportunities, if they do not continue with education provided by the institution,
2. Individuals who have more than one impairment are not allowed to the institution,
3. The sign language educators who are able to hear partially and have a minimum of hearing impairment give training as if they are unable to hear at all.



4- SLOVENYA – LJUBLJANA HAREKETLİLİĞİ -2 REPORTS

A mobility program was organized to Zavod Za Gluhe In Naglusne Lubljana School in Slovenia between 12.05.2017-23.05.2017 with the aim of putting our theoretical studies into practice within the context of ongoing ear health and care project. This school is a school that acts together with a hospital.

Jiva, female personnel, was the director of the European Office at the school visited. At the time of our meeting they were carrying our 13 T1 and T2 EU projects.

Everyone attending the meeting introduced himself and his/her role at school and thus a short conversation was made.

Our school principal, Mustafa Bahar, said that the children in the world of the hearing impaired can be directed as demanded and thus videos that will help them should be prepared. He emphasized that there is a need for the preparation of a web page for the hearing impaired in our country and thus to equip them with more concrete information. He added that there are some difficulties for hearing-impaired people, especially with a genetic origin, and emphasized that these videos aim to bring different perspectives to the world of hearing-impaired people.

It was said that the videotapes prepared should aim to transmit information to the hearing impaired without being too professional. It was said that there should be videos with sign languages, English subtitles and subject titles. It was said that a format should be prepared and sent to Turkey within the next 15 days.

The videos to be send, in line with the decision resulting from the discussions with our partners, should be according to the format below:

1. The videos prepared should be for the hearing-impaired students and their families.
2. Each country will determine 3 issues of the hearing impaired in their own country and experts will inform about these problems.
3. The subject and duration will be free, but it will not exceed 10 minutes in order to prevent it to be too boring.
4. The videos to be prepared will have the logo of the European Union and of the respective national agency.
5. Prepared videos will be sent to our school and these will be published on our project website.
6. In the main screen of the video sign language will be employed. However, if the speaker is a specialist, he too could be on the main screen
7. The subtitle language will be English.
8. As the sign language, international sign language will be used.
9. The name of the project and contributors will be at the beginning of each videa.
10. Videos could be prepared later to and uploaded to the project web site. The web site will be a source of information for hearing-impaired children and their families.
11. Already written articles will be translated into English and posted on the website.
12. The image quality of the videos to be prepared will be in 720p (HD) format.
13. Each partner will be able to use the links on the common web site.
14. Before the final report, our partners will be asked to hand in their their ideas and products.
15. At the final report, everything made throughout the project will be demanded in summary; however, with exsamples..

Within the same day, our reportage with Asst. Prof. Dr. Mithat ARICIGIL at Necmettin Erbakan University Meram Medical Faculty on implants and hearing impairment was shared with our project partners. Moreover, our activities, student events, and various celebrations shared via our school social networking site were presented to the partners.

We came together at the Conference Hall of Slovenia Ministry of Science, Art, Sports and Education. We have listened to various presentations throughout the conference. We were informed about the treatment and therapy modalities of handicapped individuals aged 0-23 years and employment opportunities before and after education. Then we listened to presentations made by an English pedagogue on "Disabilities and Problems, Autism and Awareness". Furthermore, we were informed by a neurologist about "The Structure of the Child Brain, Relationship between Education and Development".



4- SLOVENYA – LJUBLJANA HAREKETLİLİĞİ -2 REPORTS

Again trips to schools in Slovenia were organized. In these visits we were informed that the school visited consisted of three parts, the kindergarten, the primary school, and the secondary school. 250 people, including education and health personnel, were employed. There are about 170 students in the school. Problematic students can be dropped in secondary school; however, primary school is compulsory. In the school there were speech therapy, psycho-therapy and physiotherapy sessions. These sessions are provided within their schools; yet can also be received by children until the age of three provided that the families bring them to school. There are four month old toddlers who came to school with their families in order to be educated. After the age of six, the children can stay in boarding school.

We observed a classroom for individual education from the parent observation room. The place we were in was a place where the parents and the attendant could observe the student at any time, separated by a mirror, and the teacher and the learner could not see the observers. Inside, a child between the ages of 5 and 6 was matching pictures. The teacher was gentle and gentle about the student. During the time we were in, he made painting-painting, painting-color, painting-adaptation activities with his students. The student seemed quite willing and happy.

We observed a classroom for individual education from the parent observation chamber. The place we were in was separated by a mirror. It is a place where parents and school administration could observe the children at any time; yet, the teacher and the learner could not see the observers. Inside, a child between the age of 5 or 6 was matching pictures. The teacher was gentle and keely engaged with the student. During the time we were in, he made picture-picture, picture-color, and picture- harmony matching activities with his students. The student seemed quite willing and happy.

Another class we went to was a handcraft class. There were 7-8 sewing machines inside. Every April, they had a festival, and every year they set a topic and worked on it. They are exhibiting their products at this festival. The topic of this year is rain. Therefore, there were a lot of raincoats and raincoat tasks. In this class, the students were having 20 hours each. The number of girls studying in here was more than boys. We were informed that the boys were given carpentry and technical training in other fields. Some of the tools, equipment, and furniture in the school were made by students themselves. Moreover, in a shop affiliated with the school, these products were sold.

In the dormitory shown to use were 4 male and 4 female students. The dormitory was built with the concept of apartment buildings. The students answer all their needs by themselves. There are 3 teachers who work at shifts. The students living here are at the age of 17 and over. After 9 o'clock pm phones and computers prohibited. The devices and equipment they are going to use are used in sequence after making a program for their use. They cook their daily menu by themselves. They take the materials needed from the school kitchen and cook themselves. The teachers working at their shift do not help them. Students staying at the dormitory are going to their home on weekends.

We have learned from our observations and exchanged ideas about how we would integrate these in our institutions in our own countries. Among the advantages of the school are;

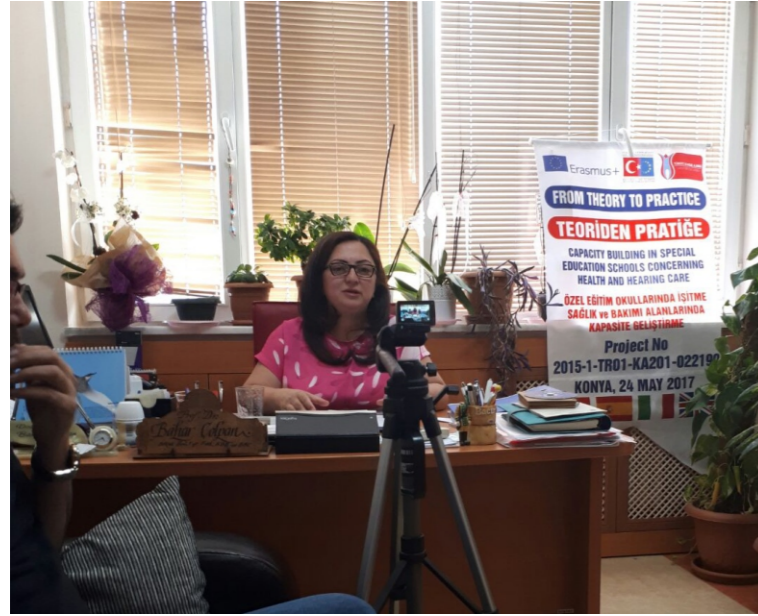
1. Cooperation of the school with a clinic or hospital,
2. Presence of speech therapy, psycho-therapy, and physiotherapy sessions,
3. Increasing vocational tasks and duties,
4. Increasing the hours of vocational lessons rather than theoretical classes,
5. Sanctions for students' misbehaviors,
6. Continuity with tertiary, university, education,
7. Teachers assigned to the school board are only responsible for their shift at the school board, they do not have to enter classes,

Considering all the observations made, the students in need of special education do not differ much from the students in Turkey. However, the presence of vocational courses and classes prepares them better for their future jobs. Likewise, the ability to continue with higher education at tertiary level is an outstanding advantage that the hearing impaired in Slovenia have.



INTERVIEW

Prof. Dr. Bahar ÇOLPAN



I am Dr. Bahar ÇOLPAN. I am an ear, nose and throat and head and neck surgeon specialist. I have been working in Konya Selçuk University for 10 years. I will give you information about the Cochlear implant today. Cochlear implants are applied to persons with hearing loss in situations where the hearing aid is not adequate and the sounds are not sufficiently transmitted to the brain.

Who are applied Bionic ear (Cochlear implant)?

An adult patient who has not seen enough benefit from a hearing aid but who can speak. We can do this surgery if there is the ability to talk to a patient over 4 years old who has a hearing loss or a different illness.

If babies with newborns and hearing loss cannot benefit from hearing aids, bionic ear (cochlear implant) surgery can be performed starting from 1 year old. We do not do this surgery before first age (one year old). We want them to use hearing aids for at least 6 months. We want them to get rehabilitation services. If there is still no benefit from the hearing aid, we carry out bionic ear (cochlear implant) surgery.

We first try hearing aids for ones who have hearing loss after 2-4 years, we apply cochlear implant surgery if the hearing aid is not enough.

There are some conditions for the state to pay for cochlear implant surgery.

If this procedure is done until the age of 4, there is a state pension for patients.

If he / she is later lost hearing, can speak, and the hearing aid does not provide enough benefits, for the patients Later hearing loss, no talk, no rehabilitation training was received the state does not pay for this surgery. Because these people will not only hear some voices even if they are operated on.

Pre-evaluation of cochlear implant surgery:

1. Audiological evaluations. In these patients, device and device-free audiological tests are performed.
2. We determine how much hearing or hearing aid is available.
3. It is checked whether there are other illnesses such as eyesight, heart, kidney.
4. We carry out genetic researches.
5. Radiological evaluations are carry out to check that the patients' inner ear structures are capable of implantation and that the hearing nerves are full. If there's a problem here, brain stem surgery can be done.
6. Psychologically, it is checked whether the operation is appropriate, whether they can receive post-operative rehabilitation training, whether there is a mental (mental) problem.
7. After 4 years of age there shouldn't be more than 4 years between the age of their own and language development.

Expectations of families:

After the surgery, the child is not expected to hear, understand or speak everything. It's a process. For this, your child will need a rehabilitation training. If the parents are willing in this process

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Prof. Dr. Bahar ÇOLPAN

if they receive a good rehabilitation training they can get good results if they follow doctor examinations regularly. Good education and right follow can make children understand and talk like their peers. These patients must come to us without losing time so that good results can be obtained. How is surgery done?

After the preparations, we hospitalize the patients one day before the surgery. The duration of surgery can be 2 hours for single ear and 3-4 hours for double ear. State payment is made in two ears.

In patients with some additional problems, we do 2nd surgery after 2-4 weeks.

After surgery, patients are followed in hospital for 3 days.

We have a meningitis vaccine 1 month before surgery.

These devices are lifetime devices. But according to the developing technology, the state is able to change these devices every 7 years. There is no easy deterioration in the inner apparatus. Developing technologies and innovations in external apparatuses can be applied immediately.

Recommendations to families:

The surgical area needs to be protected of hard ball hits, bumps and falls.

They need to protect the devices from water and moisture.

The devices need to be plugged in whenever they are awake.

Because the outer apparatus is held with magnets, they must take preventative measures and make children aware of it.

The choice of device is chosen according to the preferences of the families and the suitability of the child.

* Children should be equipped and heard early so that the hearing and speaking center can develop.

Our biggest goal is to make the children feel sensitive and to make them speaking individuals through rehabilitation services.

Cochlear implant surgery has begun in our hospital in 2012. In the first years we did this surgery on 20-30 patients. Later on, this number continued to increase. Especially since January 2017,

If the state pays for 2 ear surgery our operation number is expected to reach 100 patients.

This surgery can be done in all the provinces that have a faculty of medicine or education research center in Turkey. Hospitals with sufficient staff can perform this surgery.

There is no harm in doing this operation n double ears. In the first few months of adaptation (acclimatization) a little trouble, but later it is customary. The advantage of being on two sides is that you can hear both ears, patient can determine the direction of voice.

If there is a problem with one ear, he/she will continue to be hear with the other ear.

Permission is required from the Ministry of Health for those who wish to have this operation performed on the 2nd ear. Our Ministry help on this matter.

It's easy to use this device. Magnetic part can be removed while sleeping, bathing and swimming in the sea.

It is not easy to break and destroyed. After surgery, we give a form to the family. In this form we describe the problems they will encounter and what they will do. We want them to have their checks regularly.

We want them to consult the doctor in ear infections. Installing the device is as easy as wearing a pair of glasses.

I suggest to you that you do not stay in quiet world. you need to make an early diagnosis and look for treatment. If you have a hearing problem, we want you to come to us.

We want to be the voice of your silent world.

Prof. Dr. BAHAR ÇOLPAN

INTERVIEW

Prof. Dr. Esra YÜCEL



Hello. I am Esra YÜCEL. I am a faculty member in the audiology department of the faculty of health sciences at Hacettepe University. I continue pre- and post-operative evaluations and educational follow-up of children with cochlear implant users and educational follow-up of children using hearing aids.

Children's hearing needs are more than adults. Because children do not develop predictive skills, they have to take all the details of the hearing.

In children, a hearing problem should be detected in the first six months and a hearing aid should be fitted. Rehabilitation education should be started immediately. Hearing aids should be a quality device for children to hear all sounds in the best possible way. The appliance must be started at the earliest age and must be used in pairs. Installing the device is not enough. Children need to start their listening skills immediately. In order for speaking to be realized, perception, memory, and mental skills must be normal as well as hearing and listening.

Can a person who can hear distinguish - understand everything he/she hears?

We can hear the voices. For clarification, the voices must be experienced in frequent and up-to-date lives. This is necessary for normal people, also for hearing-impaired children. Sounds and experiences need to be combined during children's auditory training. The children will learn how quickly they meet with the sound in real life. But every child is different from the other and must be different in our expectations.

Who can benefit from cochlear implants?

If the hearing aid is not able to give enough speech warnings to the child,

In situations where the hearing aid and auditory perception system is not developed, the child goes through a lot of evaluation.

In addition to medical evaluations, cognitive and learning methods need to be identified.

It is then decided whether or not the child will benefit the hearing aid of the Cochlear implant.

Before the surgery, the family is also interviewed to learn about the expectancy of the family after implantation.

It is necessary to perform cochlear implant surgery by making evaluations between one and two years which is ideal.

A cochlear implant is a device that helps to hearing. Never substitute normal hearing.

Listening skills are very important in this period. Children who do not have the ability to listen with a hearing aid should definitely wear a cochlear implant. In this period, parents are also required to make activities to improve children's auditory knowledge and create environments.

After implantation

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Prof. Dr. Esra YÜCEL

The parents need to do activities that will listen to all the voices for children. The child who starts to gain listening ability can give different responses to the voices. He/she may be uncomfortable with sounds not known before, and he/she may be totally unresponsive. They are all normal. In this process, parents may be skeptical about whether their children have heard of it.

The parents should not test the children and test them with voices. If the child realizes that they are being tested, they start to fail to respond. Families need to observe the children by preparing suitable environments.

As the listening skill develops in the child, he/she finds the source of his voice and records these voices in memory. The more experience (again) with sound, the easier it will be to remember what these sounds are.

In this period, the children want to have their parents do whatever they want. The parents must act according to their child's age and not have to do whatever they want.

Children after cochlear implant or device;

1. Start to react to the voices,
2. Start searching for the source of the voices,
3. Begin to separate the voices,
4. Begin to distinguish what the voices belong to,
5. Begin to respond to commands as behaviors
6. Begin to answer verbally.

In this process, the child needs to be trained for cognitive development.

What should the family do;

Special education for their children is required. Children and parents learn methods in educational institutions. The main job is to work together with your children about what they will do together. For this reason, parents should also participate in the trainings. The parents should not act like teachers at home. They need to treat other normal children as they behave. They need to apply what they see in education at home.

Educational institutions

The quality of special education institutions in our country is increasing day by day. In particular, special education faculties hearing impaired teachers, pre-school teachers, audiology graduates provide a major contribution to this field. Families need to know who will train their children in institutions where they will receive special education.

Trainers are required to prepare programs for families to apply at home. they need to show practices and provide consultancy services.

The parents are very confused and startled at the beginning of this process. Parents should tell that each child has individual differences, so that each child has a special programmer. It must be told that they can not compare children and that they need to be calm down.

They need to be social in this process. Other than educational institutions, they may consult to associations about their children. They have to participate in the seminars and have to improve themselves by going scientific studies.

Follow-up of educational development:

We make some evaluations at certain intervals. We perform audiological tests, auditory perception tests, psychological tests.

Most importantly, the information we receive from the child's education and family observations. We evaluate all of them. we do these evaluations once every 3 months when the implant surgery was made and every 6 months for other years. As a result of these evaluations, the child's education program give us an idea of what he can go to, such as the school he can go to. Teachers should be supported for the children going to the school and their opinions and impressions should be evaluated.

We do cochlear implant surgery when the hearing aid is not enough. Sometimes the best cochlear implant is not enough to wear and make the best program. While some children can talk like normal children, some children may experience problems with voice recognition, distinction and producing voices. For this reason, personalized equipment and personalized training programs should be prepared. Individual characteristics need to be evaluated appropriately. For good results, different areas are required to collaborate.

Prof. Dr. Esra YÜCEL

INTERVIEW

İşitme Engelliler Eğitmeni - Klinik Odyoloji Uzmanı Rasim ŞAHİN



1999 yılı Anadolu Ün. Eğitim Fak. İşitme Engelliler öğretmenliğinden mezun oldum. Çukurova Ün. Tıp Fak. KBB işitme engelliler eğitmeni ve klinik odyoloji uzmanı olarak göreve başladım. 18 yıldır bu meslekte çalışmalarına devam etmekteyim. Burada işitme engelli çocuklar ve aileleri ile çalışmalar yapmaktayız. Amacımız bu çocukları normal akranları gibi konuşan ve normal okullarda okuyabilen bireyler haline getirmek.

Duymak önemli mi?

Dil gelişimi duymaya bağlıdır. Kaliteli bir konuşma için kaliteli bir duyma gereklidir.

Cihazlandırma yaşı

Çocuklar ne kadar erken teşhis edilir ve cihazlandırılırsa konuşma gelişimi de o kadar kaliteli olmaktadır. Devletimiz çocuklar doğar doğmaz (doğum hemen) işitme taraması yaptığı için teşhis daha kolay ve çabuk olmaktadır. Yaşı büyük olsalar bile ne kadar çabuk cihazlandırılırsa, cihazın faydası okadar çok olacaktır.

Cihazın kalitesi

İşitme cihazının kalitesi, kaliteli bir dil gelişimi için önemlidir. Çocuklar cihazlandırılırken kaybına en uygun kazanç sağlayacak cihaz takılmalıdır. Piyasada birçok çeşit cihaz bulunmaktadır. Alacağınız cihaz işitme kaybınıza ne kadar uygunsa alacağınız eğitim o kadar etkili olacaktır. İşitme kaybında çeşitli derecede sınıflandırma var. Hafif, orta, ileri, çok ileri gibi. Hafif, orta, ileri derecede işitme kaybı çocuklarda işitme cihazı etkin biçimde kullanılabilir. Fakat çok ileri derecede işitme kaybı çocuklarda koklear implant daha faydalı olmaktadır. Her çocuk için işitme cihazı denenmeli, işitme cihazından fayda göremeyen çocuklar koklear implanta yönlendirilmeli.

Kimler koklear implant adayı....

İşitme cihazından yeterli fayda göremeyen çocuklar bir koklear implant adayıdır. Bu çocuklar çeşitli değerlendirmeler sonucunda bir ekip tarafından bu ameliyata karar veriliyor. 4 yaşından küçük olanlarda devlet ödemesi yapılıyor, yaşı 4 den büyük olanlarda ise kronolojik yaşı ile dil yaşı arası 4 yıldan fazla olmaması gerekmektedir. Sonradan kayıplı hastalarda ise konuşma varsa bu ameliyatı olabilirler.

Koklear implantta istenen çift kulakta olmasıdır. İşitme eşiklerinin (duyma) daha iyi olduğu, sesin yönünü bulmada faydaları vardır. Ayrıca bir cihazı arızalandığında ikinci cihazı ile duymaya devam edecektir.

İşitme problemi teşhisi konulan hastalar önce bize geliyor. Ailelere çocuğun problemi ve çözüm yolları üzerine eğitimler veriyoruz. Kaybına en uygun işitme cihazının çocuğa faydalı olup olmadığına bakıyoruz. İşitme cihazından fayda göremezse koklear implantı öneriyoruz. Bu konuda da bilinçlendirme eğitimi veriyoruz. İmplant takıldıktan sonra cihaza alışmaları için adaptasyon eğitimi veriyoruz. Burada önemli olan çocukların birincil bakıcılarının (anne, baba, bakıcı, yakın akraba) bilinçli olması gerekmektedir.

Eğitimci ve eğitim kurumu

İşitme cihazı takmak veya implant problemi ortadan kaldırmıyor (yok olmuyor). Gözlük gibi takınca problem ortadan kalkmıyor. Asıl iş implant takıldıktan sonra başlıyor. Çocuk dinleme eğitimini ne kadar başarılı yaparsa dil gelişimi de o kadar kaliteli (güzel) olacaktır. Bunun için de doğru bir eğitim kurumunda eğitim almaları gerekiyor. Bu konuda da klinik odyologlardan, eğitimcilerden ve bu alandaki okullardan bilgi alınabilir.

Ailelerin eğitimci seçerken, eğitimcinin mezuniyeti, tecrübesi, bu alandaki uzmanlığını araştırmaları gerekiyor.

Eğitimcilerin de birincil görevi, ailelere örnek olma çalışması olmalıdır. Çünkü çocukların ilk ve en önemli eğitmeni ailedir. Başlangıçta eğitimi ailelere ve aileler üzerinden çocuklara vermemiz gerekiyor.

Biz seminerlerimizde eğitimcilerimize bu konuda önerilerde bulunuyoruz.

Ailelere öneriler.

Bu süreçte aileler kesinlikle aktif olarak rol almalıdır. Çocuklarda dinleme becerilerinin gelişmesi için, sıra alma davranışı için çeşitli aktiviteler yapılabilir. Sesin varlığı- yokluğu, sesin yüksekliği-alçaklığı, hayvan, nesne, insan seslerinin ayrımı gibi çalışmalar yapılabilir. Örneğin evde bulunan ses çıkaran oyuncaklarla, eşyalarla bu sesin tanınması ve ayır etme çalışmaları yapılabilir. Çocukla keyifli vakit geçirmeleri gerekmektedir. Çocukların uyanık olduğu bütün zamanlarda cihazları takılı olmalı.

Cihaz takılan her çocuk normal çocuk gibi konuşabilir.

Her çocuk farklıdır ve gelişim aşamalarında farklı olacaktır. Bazı çocuklar hızlı gelişirken bazı çocuklar yavaş gelişebilir. Önemli olan çocuğun cihaz takılmadan öncesi ve takıldıktan sonrasının değerlendirmesidir. Cihaz takıldıktan sonra he alanda bir öncesine göre gelişim göstermesidir. Her çocuğu kendi gelişimi içinde değerlendirmek gereklidir.

INTERVIEW

Odyometrist Kemal AKGÜN



APPLICATION AND FOLLOW-UP OF HEARING AID ON HEARING-IMPAIRED

Hello! I am Kemal Akgün. I have been dealing with the hearing aid business as an audiometrist since 1996. will give you some information on hearing aids and on their use. People having hearing problems go to the Ear Nose Throat doctor. The ENT doctor examines, and if s/he would be in doubt about hearing impairment, s/he would require an audiometry test. Audiometrists perform hearing test in the quiet rooms. If there is a hearing loss, the patient will be prescribed the instrument required to be used and a report will be given by doctor. With these reports, the patient goes to the hearing centers in order to receive their device. Here the audiometrists examine the reports and determine the most suitable device for the child. They try types of hearing aids suitable for hearing loss on patient. Types of hearing aids; behind-the-ear, eyeglass type, in-canal and bone conduction. The type of hearing aid to be given to the patient is determined by the type of hearing loss, degree, age, social standing and preference of the patient.

After identifying the hearing aid, ear mold is obtained. After the hearing aid is installed in the ear, the hearing aid is adjusted according to the patient's hearing loss by a computer. The device that is made ready for use (adjusted) is attached to the patient. Batteries are different according to the types of hearing aids. Any battery cannot be used in the hearing aids. They should buy the battery from hearing aid centers.

Patients should carry out daily, weekly, and monthly maintenance on their hearing aids. They have to go to the hearing center every three to four months and have their hearing aids checked. If they cannot get the desired sound from the device, they have to go to the hearing center again and have audiological test made and have their hearing aid adjusted.

They have to protect their hearing aid from moisture, water and falling. They can use moisture tablets or moisture absorber devices. The hearing aid is removed during bathing, sleeping and in rainy weather. Hearing aids must always be attached at other times.

We recommend the person or children having problem in hearing or in understanding their sounds to go to the Ear Nose Throat doctor or audiologists as soon as possible.

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LANGUAGE AND PUBLIC POLICY

Ensuring language acquisition for deaf children:
What linguists and educators can do?

Mustafa Bahar Musa Tunç
Marisol Moreno Ziva Ribicic
Christopher Salzman Eli Gemegah

ABSTRACT

Parents of small deaf children need guidance on constructing home and school environments that affect normal language acquisition. They often turn to physicians and spiritual leaders and, increasingly, the internet. These sources can be underinformed about crucial issues, such as matters of brain plasticity connected to the risk of linguistic deprivation, and delay or disruption in the development of cognitive skills interwoven with linguistic ability. We have formed a team of specialists in education, linguistics, pediatric medicine, and psychology, and at times specialists in theology and in law have joined our group. We argue that deaf children should be taught a sign language in the early years. This does not preclude oral-aural training and assistive technology. With a strong first language (a sign language), the child can become bilingual (with the written form of the ambient spoken language and, perhaps, the spoken form), accruing the benefits of bilingualism. We have published in medical journals, addressing primary care physicians, in a journal with a spiritual-leader readership, and in a health-law journal.

Keywords: deaf children's rights, first language acquisition, brain plasticity, sign languages, ethics and activism in scholarship

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INTRODUCTION

1. The policy problem. We argue that beliefs about spoken and sign languages among underinformed professionals have serious consequences; parents are advised to make decisions and construct home and school environments that affect normal language acquisition among deaf children. In Turkey, around 90% of deaf children are born to hearing parents (Moore, 2011) who have no family history of using a sign language. The remaining 10% are born to deaf parents, and in most cases, though not always, the primary language of the home is a sign language. Many hearing parents are initially uninformed about fundamental language matters and turn to the medical profession, the internet, their spiritual leaders, and/or their friends and family for advice about the language choices they need to make for their children (Luterman 2009, Gregory 2008, Porter & Edirippulige 2007). Too often, those they turn to are under- or misinformed about the language needs of deaf children (Meader & Zazove 2005). Parents are often told that the best way for their child to acquire spoken language is to raise them without sign language. In many cases, parents are advised that sign is to be chosen only as a last resort (Petitto 2008, Johnston 2006), and that great effort should be devoted instead to the acquisition of speech. Given that these parents are hearing and unfamiliar with deaf people's lives and sign languages, many opt for the more typical oral and/or aural choice (speech and audition only).

In addition, over 80% of deaf children in developed countries receive cochlear implants (CIs), and the percentage is increasing (Boyes Braem & Rathmann 2010). CI is now the treatment of choice in the medical sciences for most children with sensorineural hearing loss (SNHL) (Niparko 2009), and sign language is seen as both a barrier to learning speech and a symptom of treatment failure (Broesterhuizen & Leuven 2008). The most frequent recommendation is to isolate deaf children from sign language environments during the important years of first language acquisition (Wrigley 1997, Padden & Humphries 2005, The Canadian Hearing Society 2005, Krausneker 2008). However, CI has a variable rate of success with respect to long-term language development. (Rather than interrupt the discussion with a long list here, we indicate these references with two asterisks in the bibliography.) The factors involved in CI success are not well understood, although age of the patient (Tomblin et al. 2005, Vermeire et al. 2005, Nicholas & Geers 2007, and many others), onset of deafness (Leung et al. 2005, Green et al. 2007), coding strategies (Skinner et al. 2002), family socioeconomic education level (Svirsky et al. 2004, Szagun 2008), and surgical technique (Meshik et al. 2010) are relevant. Even under optimal conditions, CI implantation does not guarantee first language acquisition. Many implanted children who are born deaf or become deaf in the first few years of life experience little to no success in language acquisition with a CI, and only turn to sign language after the early critical period. Unfortunately, this means these children run the risk of never having completely fluent use of either a spoken or a sign language.

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Further, not meeting the language needs of deaf children can mean harm to their psycho-social health, putting them at risk for depression, behavioral problems, social disorders, and juvenile delinquency (Northern & Downs 2002, Andrews et al. 2003, Schick et al. 2006, Leigh 2009). They are more likely to engage in criminal behavior in later life (Kleimenov & Shamkov 2005, Miller et al. 2005), to be the target of abuse of various sorts (Sullivan & Knutson 2000, Knutson et al. 2004, Kvam 2004), and to rely on the social services safety net. Long term, language access is critical for the participation of deaf people in preventive health and health care services (Iezzoni et al. 2004, McKee, Barnett, et al. 2011, McKee, Schlehofer, et al. 2011), education (Oliva 2004), mental health care (Steinberg et al. 1998), the workplace (Rashid et al. 2011, Haynes & Linden 2012), and social relationships (Gerich & Fellinger 2012).

Additionally, failure to acquire language in the early years results in delay or disruption in the development of cognitive skills that interweave with linguistic ability. Such children have trouble with verbal memory organization (Rönnerberg 2003), mastery of numeracy and literacy (MacSweeney 1998), and higher-order cognitive processing such as executive function and theory of mind (Courtin 2000, 2010, Courtin & Melot 2005, Morgan & Kegl 2006, Schick et al. 2007, Courtin et al. 2008, Figueras et al. 2008, Marschark & Hauser 2008, Rimmel & Peters 2009).

Globally, SNHL is one of the most common among those birth conditions labeled 'defects' by the medical profession. Profound SNHL occurs in two or three out of 1,000 newborns in North America (National Institutes of Health 2011) and is as high as three out of 1,000, depending on the severity threshold used in a given study and whether unilateral hearing loss is included (Spivak 2007, Kozak et al. 2009). In Germany, profound SNHL occurs in one to three out of 1,000 newborns (Schnell-Inderst et al. 2006). In Nigeria, a striking number of twenty-eight per 1,000 infants have permanent congenital and early-onset hearing loss (Olusanya et al. 2008). Poverty, combined with many other factors, produces higher levels of SNHL; lower socioeconomic areas around the world are home to higher numbers of people with SNHL (for Canada, see Bowd 2005; for India, see Reddy et al. 2006; for Malawi, see van Hasselt & van Kregten 2002; for Pakistan, see Musani et al. 2011; for the United States, see many, especially Oghalai et al. 2002 and Prince et al. 2003). Most deaf and hard-of-hearing children live in developing countries (Jauhainen 2001, Tucci et al. 2010). Nevertheless, in developing countries, an increasing percentage of deaf children do get CIs, and there is an outcry among the medical profession for CI funding (Garg et al. 2011, Saunders & Barrs 2011). Postnatal causes of SNHL include bacterial meningitis, beta-hemolytic streptococcal sepsis, toxins, trauma, and late onset due to gene mutation (Paqarkar et al. 2006); by school age, six to seven out of 1,000 children have permanent hearing loss, most of which is SNHL (Bamford et al. 2007). Given all of these frequency data and the trend toward speech-only training in medical settings, it is clear that a significant number of children in the world with SNHL are likely to be given CIs and kept away from sign language during their early years, and, consequently, run a high risk of linguistic deprivation and related cognitive deficits.

2. The linguistic evidence that informs this policy problem. Before entering into the linguistic evidence, it is important to recognize nonlinguistic debates concerning language choices for deaf children. The Food and Drug Administration (FDA) approved the use of CIs in adults in 1984, in children aged two and above in 1990, and in children aged twelve months and above in 2000. Almost this entire time, there has been a controversy revolving around the question of whether CIs would remove a child from Deaf communities and eventually threaten Deaf communities with extinction (Winefield 1987, Grant 2008). There has also been much discussion over ethical concerns of CIs that go beyond linguistic issues and surgical-risk issues (Christiansen & Leigh 2002). Here, we set these debates aside not because they are wrong-minded, but because they obfuscate the linguistic issues, which, by themselves, are straightforward and compelling. With respect to the linguistic evidence, two points can be made, one involving recognition of the fact that both the oral-aural and the manual-visual modalities of language nourish the brain's language mechanism, and the other involving the recognition of changing plasticity in the brain with respect to first language acquisition.

2.1. Two modalities of language. First, language and the brain are flexible with respect to modality. Both spoken and sign languages can nurture brain development, as is shown by much research on the structure of particular spoken and sign languages and on language universals (see a multitude of articles in many linguistics journals, including Sign Language & Linguistics and Sign Language Studies, as well as more recently in journals that do not focus on sign languages, such as Language; and see a variety of comprehensive books, such as Sandler & Lillo-Martin 2006, Brentari 2010, Pfau et al. 2012), on language acquisition (Newport & Meier 1985, Meier & Newport 1990, Petitto & Marentette 1991, Lillo-Martin 1999, among many others), on language processing

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(Emmorey 2001, among many others), on neurolinguistics (Poizner et al. 1987, Neville 1995, among many others), on language pathologies (Corina 1998, among many others), and on second language learning (Newport 1990). (We have chosen to cite seminal works, which laid the foundation for much following research.) Too often in the relevant medical literature, we find the confused belief that language is equivalent to speech despite a half-century of research on sign languages. For example, consider this statement from Kral and O'Donoghue (2011:485): 'Nonetheless, the available evidence suggests that early intervention through sensory restoration offers the best hope of mitigating the pernicious effects of hearing deprivation on multiple levels of brain function'. The authors recognize that absence of hearing can lead to absence of language, which can, in turn, lead to cognitive deficits, but they see 'sensory restoration' (i.e. auditory restoration) as the only way to ensure language and to prevent cognitive deficits that follow from absence of language input. This quotation is representative of the basic misconception that equates language with speech. Published policy statements about deaf children recommend early screening; early intervention; close and continued monitoring of the child's communicative, language, motor, cognitive, and social-emotional development; and protection of infant and family rights through informed choice, decision making, and consent (Early Hearing Detection and Intervention Information & Resource Center 2004, Joint Committee on Infant Hearing 2007, Department of Health and Human Services 2009, and so on). Frequently, such recommendations discuss almost exclusively audio-verbal therapy (AVT) via habituation and vocal output, although more recent policy statements emphasize cognitive language development and the importance of nurturing and communicating with the child regardless of modality. Nevertheless, primary care physicians express a lack of confidence in discussing follow-up procedures and intervention needs for deaf newborns because of their lack of familiarity with deafness (Moeller et al. 2006), and thus immediately refer the parents to audiologists, whose primary concern is auditory input, often with no or only skeptical recommendations of looking into sign language options. Evidence that there are at least two modalities that offer a normal pathway to language acquisition is often disregarded, leading to a failure to understand and take advantage of the flexibility of the human brain.

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2.2. First language acquisition and plasticity. The second relevant linguistic point with respect to the policy problem is that first language acquisition takes place most naturally and successfully in the first few years of life; if a child is not exposed to accessible or learnable language on a regular and frequent basis before the age of around five years old, that child is unlikely to ever use any language with native-like fluency across the grammar (Lenneberg 1964, 1967, Mayberry 1994, 1998, Hall & Johnston 2009, Hudson & Newport 2009). Over the years we see a gradual decline in the ability to acquire a first language (note that a second language is a separate matter with distinct considerations—our concern here is first language acquisition). Some areas of the grammar seem to be resilient; that is, even in the absence of early input, they can be mastered later in life (see Goldin-Meadow 2003, 2005), such as word order, while other areas of language are more fragile and, without input in the very early years, tend to never get mastered, such as complex morphology, as in verb agreement (Wood 2007, 2011). Evidence for this sensitive (or critical) period comes from children whose language development is somehow special, and from children who have been neglected and/or abused.

Aphasic, bilingual, and deaf individuals. Lenneberg (1967) reported that children with acquired aphasia can recover completely, but adults cannot, concluding that there must be a critical period for language acquisition. Later research on aphasia shows variable recovery from aphasia with children (Woods & Carey 1979, for example), but worse prognosis for adults (Martins 2004). Other works on aphasia likewise support a critical period for first language acquisition (Alajouanine & Lhermitte 1965, and Goorhuis-Brouwer 1976, a study written in Dutch and reported on in English in Snow & Hoefnagel-Höhle 1978). Similarly, evidence on bilingualism supports the existence of a sensitive period. In a study of twenty-year-olds comparing monolinguals, early bilinguals (before the age of ten), and late bilinguals, early bilinguals and monolinguals displayed the same level of proficiency in English and a greater proficiency than that of late bilinguals. Further, the age of onset of bilingualism was negatively correlated to English proficiency across all bilinguals (Luk et al. 2011). Finally, and most important to us, studies of deaf children who did not receive accessible language until after the critical period due to lack of hearing aids (Curtiss 1994, Grimshaw et al. 1998) or because they were denied sign language (Mayberry & Fischer 1989, Emmorey & Corina 1990, Newport 1990, Emmorey 1991, Mayberry & Eichen 1991, Wood 2007, 2011, among many others) show reduced language facility. Deaf children who were first exposed to an accessible language (i.e. a sign language) at varying ages show varying degrees of mastery of language as they age, with early learners doing far better than late learners overall (Newport & Supalla 1987, Johnson & Newport 1989, Newport 1990, 1991, Boyes Braem 1999, Galvan 1999, Helmuth 2001, Newport et al. 2001, Singleton & Newport 2004, Morford & Hänel-Faulhaber 2011, Wood 2011, Cormier et al. 2012, Skotara et al. 2012).

CONCLUSION

2.3. Relevance to the policy problem. The combination of these two facts, that cognitive ability can develop in either language modality and that there is a sensitive period for first language acquisition (regardless of whether abuse or neglect is involved), is of

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crucial relevance to the problem. While the first fact is by and large ignored in the literature that favors CI, the second fact has long been accepted. Much research has shown better auditory results with earlier implantation; this has been the spur to implanting children before the age of two, and often before the age of one (Yoshinaga-Itano et al. 1998, Yoshinaga-Itano et al. 2000, Waltzman & Roland 2005, among many others). The crucial problem is that even with early implantation, the level of aided hearing is less than optimal, which makes acquisition of a spoken language imperfect and difficult and, most of all, unpredictable (Santarelli et al. 2008). The problem is magnified if the child's environment is noisy and unclear. The bottom line is that many children do not acquire a spoken language fully with a CI, and one cannot predict with reliability which children fall into that group. Even work that is explicitly supportive of CI includes statements such as 'there remains huge, unexplained, variation in outcomes from implantation and the challenges of ensuring life-long use and benefit remain (Archbold & O'Donoghue 2009:457). For this reason, the failure of the relevant medical professionals to recognize the viability of sign languages means that these children run a risk of, and indeed often experience, linguistic deprivation. But sign languages are viable human languages, with all of the cognitive benefits attributed to spoken languages. Further, sign languages are accessible to all deaf children, even to the deaf-blind child, since there are tactile versions of sign languages (Mesch 2001). If deaf children acquire a sign language during the early years of life, they will not risk linguistic deprivation and the consequent cognitive deficits. Many studies show that deaf children who sign achieve better in school than those who do not, regardless of other factors (such as whether their parents are deaf or hearing and whether they have assistive hearing devices and/or oral training) (Padden & Ramsey 2000, Strong & Prinz 2000, Mayer & Akamatsu 2003, Paul 2003, Schick 2003, Allen et al. 2007, Wilbur 2008). Indeed, ASL skill above other possible factors correlates strongly with reading achievement (Chamberlain & Mayberry 2008). Moreover, the deaf child who acquires a sign language and then learns the written and, perhaps, spoken form of a spoken language is bilingual. Bilingualism has great benefits for the deaf child in cognitive, social, and educational areas (Wilbur 2001, Christiansen & Leigh 2002). In fact, both the sign language and the spoken language of bilingual deaf children display more syntactic complexity than that of their monolingual peers (Klatte-Folmer et al. 2006). In addition, the evidence that high proficiency in two or

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more languages results in more creative thinking in problem solving, and better mental flexibility and cognitive control that persists through late adulthood, is firm (Cummins & Gulustan 1974, Prinz & Strong 1998, Bialystok et al. 2004, Baker 2006, Lightbown & Spada 2006, Bialystok et al. 2007, Kushalnagar, Hannay, & Hernandez 2010). All around the world children are raised multilingually, and the bilingual-bicultural trend for deaf education is a mega-trend (Munoz-Baell et al. 2008). Dual proficiency in a sign language, such as American Sign Language, and in a spoken language, such as English, affords the deaf child the benefit of adapting to both signing and nonsigning peer groups with greater ease, resulting in better overall socio-emotional and behavioral development (Marschark 2009). Information of this sort will, we hope, disarm those who are strongly attached to the promotion of CI-only choice

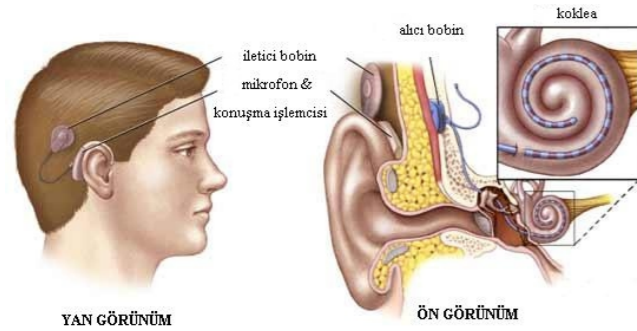
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BEST PRACTICES AND CRUCIAL RECOMMENDATIONS FROM THE EVIDENCE REGARDING DEAFNESS AND DEAF EDUCATION

Mustafa Bahar Marisol Moreno
Musa Tunc Ziva Ribicic
Christopher Salzman Eli Gemelah

ABSTRACT

This study has been supported by the generous funding of European Union Turkish National Agency as a part of Erasmus Plus program. Educators from 5 different countries investigated the best practices derived from the evidence of scientific studies worldwide. 9 most important recommendations have been outlined and explained in detail in this study. We believe that all educators in deafness and related fields must follow our recommendations in order to foster the development of educational practices.

Note: This article has been supported by European Union Turkish National Agency under Erasmus Plus program with a generous funding. The coordinator school Konevi School for Hearing Impaired (Turkey), partners Zavod za gluhe in naglusne Ljubljana (Slovenia), IES La Rosaleda, Instituto Enseñanza Secundaria La Rosaleda (Spain), University of Warwick (UK) and Equalizent Schulungs- und BeratungsGmbH (Austria) have been collaborated to write this study.

INTRODUCTION AND RECOMMENDATIONS

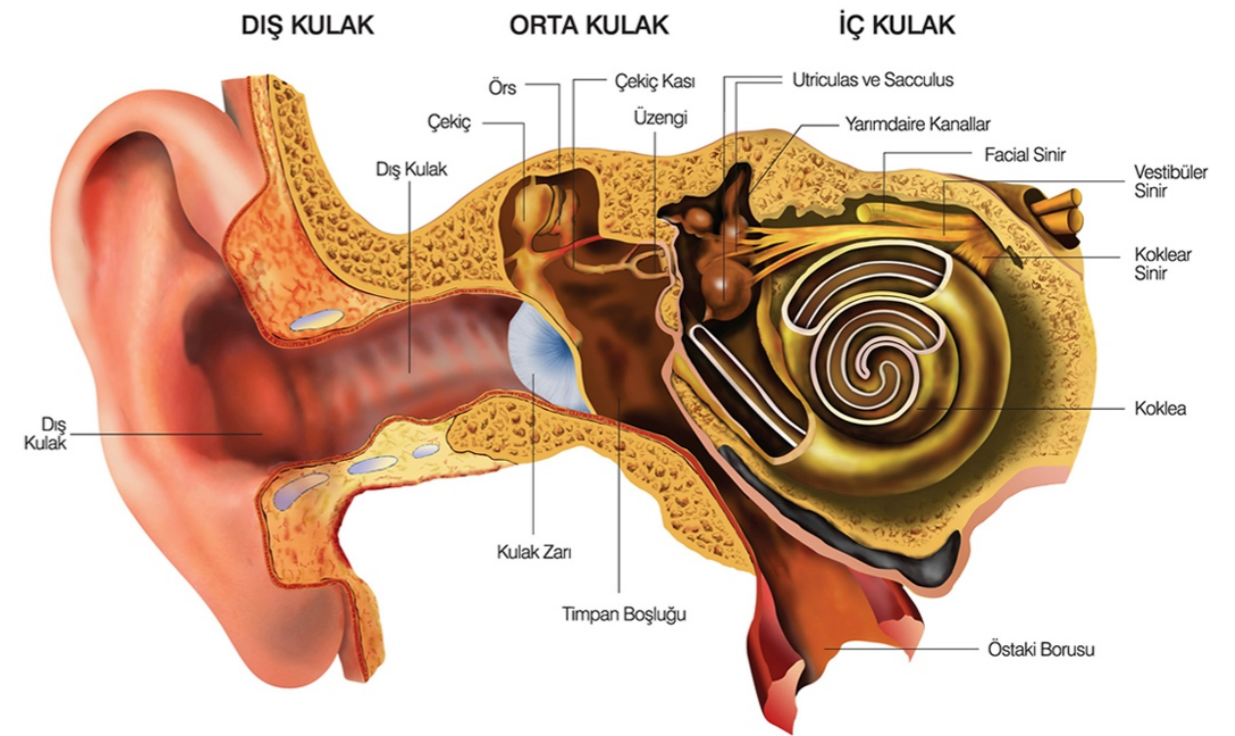
Overall recommendation: All deaf newborns and newly deafened small children should learn a sign language, regardless of whether they receive a CI or a hearing aid. Several more specific recommendations follow from this basic one.

- (1) Medical education must be updated and include linguistic considerations. Medical professionals should be trained in recent research about language acquisition, particularly with respect to the issues of linguistic deprivation for those children at risk, primarily deaf children. Medical schools, nursing schools, and schools of public health should include this information in their curriculum.
- (2) Delivery of medical care to deaf children should be coordinated across the relevant health professionals, including audiologists, psychologists, surgeons, and rehabilitation teams. These teams should stay in constant contact with and respond to input from parents, sign language teachers, and classroom teachers. This way, the risk of linguistic deprivation can be caught early and responded to appropriately.
- (3) Advice from medical professionals must be accurate and adequate. Parents of deaf newborns and newly deafened small children should be advised to teach their child sign language, regardless of whether the child also uses hearing aids or a CI. This means the entire family should learn sign language; and since the biological health of the language mechanism is at stake, this is properly a medical matter, so it is the medical profession's responsibility to tell the parents this. When the entire family uses sign language at the dinner table, for example, the deaf child has visual access and picks up on incidental information on a variety of topics. Developmentally, the inclusion of the child in family dialogues promotes healthy psychosocial and emotional functioning (Hauser et al. 2010). The deaf child is likely to feel included in family conversations and is less frustrated, as is commonly reported in other situations with communication barriers. This has been self-reported as having an important impact on the deaf youth's quality of life, and the perception of being included in family dialogues is associated with fewer reports of depression symptomatology (Kushalnagar et al. 2011). Deaf children whose hearing parents and siblings, particularly hearing mothers, sign with them demonstrate language expressiveness and theory of mind on a par with hearing children of the same age (Spencer 1993, Schick et al. 2007).
- (4) More research needs to be done on second language learning, especially in a second modality. Second language learning is difficult for adults (Krashen 1981 and later work by many), perhaps even more so when the new language is in a different modality. Hearing relatives of a deaf child are going to need help in learning a sign language. Projects such as VL2 at Gallaudet University, for example, should be adequately funded.
- (5) Deaf children should be brought into contact with deaf signing children and adults frequently. The family of a deaf child should not feel the burden of being good sign language models for the child. The important point is that family members engage in frequent, direct language interaction with the deaf child, but the family must understand that their own efforts will not be enough. Parents of deaf children should help them find other deaf children to socialize with in a common language—a community of others like themselves—without continual adult intervention in that communication.

Individual interpreters, who act as surrogate teachers or even parents in the classroom, often have little contact with the deaf community. As a result, deaf students can be limited to dyadic groups for communication, which do not approach the richness and complexity of language as used by a larger community. It appears the optimal way to ensure the needed exposure is to participate in

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group discourse.

Given this, medical advisors must inform the family that the deaf child needs to be brought into contact with a community of deaf signers so as to be exposed to consistent and multiple models of signing on a regular and frequent basis. Families need to become informed about the local culture of Deaf people and help their child (and the whole family) to participate in Deaf events. There are good publications out there to help, like Lane et al. 1996, Padden & Humphries 2005, Bauman 2008, Bauman & Murray 2009, Marschark 2009, and Marschark & Spencer 2010, 2011, all of which provide substantial references.

(6) Advice from others outside the hearing sciences and medical profession must be better informed about pertinent language matters. These advisors include spiritual leaders, particularly since the risk of depression or other psychosocial stress on the part of deaf children and their parents may bring them to these leaders for guidance (Spahn et al. 2003, Turner et al. 2007, Mellon 2009, Kushalnagar et al. 2011). So schools of theology should include information on first language acquisition particularly as it pertains to deaf children in their curriculum. Others in counseling professions need to be similarly informed.

(7) Make sign language accessible to hearing parents and their deaf child. If a family of a deaf child does not have easy access to a signing community, they must take a very strong active role in providing their child with a sign language. First, the family must try to learn a sign language in the best way possible, which may require driving a substantial distance to classes. If the local community is small, the family can enlist the whole community in the effort to learn a sign language and to communicate with the deaf child in that sign language. A community might want to advertise for and hire a sign language teacher to come and stay in their community for an extended period of time, teaching everyone who is willing to learn. There are also multiple online sites and DVDs to help someone learn a sign language (see the websites of Dawn Sign Press in the United States, Forest Books in the United Kingdom, or Karin Kestner Verlag in Germany, for example2).

Second, the family should find out about camps for deaf children, where sign language is used and deaf children learn about and get welcomed into Deaf culture. Many such camps exist: in the United States they are scattered across the states; in Germany the German Deaf Youth Association and German Deaf Association of Hard-of-Hearing annually organize camps for Deaf and hard-of-hearing children and youth. Some have scholarships available. Some are for the entire family. There are various websites with up-to-date information on such camps (in the US: Summer Camps for Deaf and Hard of Hearing Children and Teens; in Germany: Bundeselternverband gehörloser Kinder e.V.4).

Third, the family must be resourceful. Since it is important that others sign with the deaf child, the family could start a sign language class with parents and children who are not deaf. If the family has relatives in a city with a thriving Deaf community, visiting or even arranging to spend time there may be a significant act that makes a world of difference to the child's development. The family might want to get online (using current video technology: Skype, FaceTime, gChat, ooVoo, Facebook, etc.) with someone who knows many people in the Deaf community to see if a Deaf family might like to come visit them for extended periods. The deaf child in one's home makes the home eligible to obtain a videophone setup from a video relay service. Alternatively, one can install videophone



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software in a home computer. With this setup, the family and the deaf child can talk in sign language directly via video to deaf people whom they meet and form stronger relationships. Sign language tutoring via videophone might even be arranged. These setups often cost nothing to the family except an internet connection. If the family has opportunities to live in an urban area that has a Deaf community, now might be the time to realize those opportunities.

These family responsibilities can be costly in a number of ways beyond money and time. Knoors and Marschark (2012) argue that using sign language can hinder family dynamics and that learning a sign language can be beyond the abilities of some family members, particularly older ones. We would suggest that, regardless of whether family members learn a sign language, a deaf child born into a hearing family always impacts family dynamics simply by virtue of the fact that the child is deaf. Further, every deaf child is entitled to be recognized and accepted as deaf and to develop their own identity as a deaf person. The United Nations Convention on the Rights of Persons with Disabilities (2006) calls upon states to protect the rights of deaf children by 'facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community' and by ensuring that their education 'is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development'. Knoors and Marschark (2012) point out further that bilingual education for deaf children has not had uniform success. However, the questions of how to ensure access to language in the early years of life and how to educate deaf children are distinct. Many and complex educational issues arise regardless of which kind of program a child enters (whether one of the various kinds of mainstreaming programs or one of the various kinds of bilingual/bicultural programs; see Ramsey 1997, Stinson & Liu 1999, Oliva 2004, Marschark 2009, and many others). We are confident that present and future efforts (including more research) will lead to better-qualified teachers using more appropriate and efficacious methods and materials (see Humphries 2013).

The fact remains, however, that the cognitive factor that correlates best to literacy among deaf children is a foundation in a first language. Much earlier work shows this, and the most recent findings continue to confirm it: Davidson and colleagues (2014) show that children with CIs who also sign perform better in standardized language testing than children with CIs who do not have exposure to a sign language. (Again, we choose not to interrupt the flow of the argument with a long list of earlier works, so instead mark the relevant references with three asterisks in the bibliography.)

(8) Government sources must fund sign language instruction for these families. Every human has a right to language (as we argue in Humphries et al. 2013). Therefore, instruction in a sign language should be funded by federal and state governments for all deaf children and their families. This funding should continue at least until the age of twelve.

(9) The current risks associated with CIs need to be reduced. The risks of harm associated with CIs should be more widely understood, and the current high risk of linguistic consequences due to using CIs only as a response to deafness in the family needs to be alleviated greatly by the use of sign language along with CIs. Cochlear implants run a host of risks beyond linguistic deprivation. All surgeries come with risks, and surgeries involving the brain may be particularly troubling. With CI surgery, many complications arise, including injury to the facial nerve, necrosis and breakdown of the flap, injury to hair follicles, improper electrode

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placement, postsurgery infection under the flap and in the middle ear, and meningitis (Cohen & Roland 2006, McJunkin & Jeyakumar 2010, Rubin & Papsin 2010, Thom et al. 2013). There is also a huge risk (40% to 74% of patients) of vertigo that can last for years (Steenerson et al. 2001, Walker 2008). The apparatus can fail, requiring repeated surgery with all of the same associated risks (Borkowski et al. 2002, Marlowe et al. 2010). Since many CI surgeries disable the cochlea (O'Reilly et al. 2008), the implanted ear loses whatever residual hearing it had; so if the CI does not offer language access to the child, then the surgery has, in fact, had a result contrary to its very intention. The harms of cochlear implant surgery are increasing as the popularity of binaural implantation goes up (Snow & Wackym 2009), while the claimed benefits have yet to be established (and see the results in Tyler et al. 2010). Further, some deaf and hard-of-hearing children are implanted even when they already recognize up to 30% of sentence material with or without a hearing aid (Tobin 1995), which is a better recognition rate than many children have post implantation. These children actually might be losing ground with respect to speech skills. And, finally, hearing aids do not present the surgical risks of CIs and may well offer comparable or better advantages with respect to speech development, depending on the particular needs of individual children (Figuera et al. 2008). We therefore believe that no child should be implanted unless implantation is accompanied by sign language, and there is a very strong chance that the child will have excellent oral communication skills as a result of the child's curiosity and motivation for speaking, the child's bias toward auditory learning style, and the child's neural response to implantation.

IMPLICATIONS

The implications of this study ensure that by following our recommendations, educators, parents, government agencies, students and so on can make great developments overall academically, socially and emotionally. Our recommendations cover all aspects of deaf education, therefore, it is an important source for all in deafness studies.

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THE ORETICAL PERSPECTIVES ON DISABILITY AND THE IMPORTANCE OF CAPABILITY MODEL

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Musa Tunc Ziva Ribicic
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ÖZET

Bu çalışmada, engelliler adına geliştirilmiş olan farklı teorik yaklaşım modellerini inceledik ki bunlar biomedikal, sosyal ve kapasite modelleridir. Bu modellerin güçlü ve eksik yönlerini tartıştık. İşitme engelli bireylerin ihtiyaçlarını göz önüne aldığımızda, kapasite modelinin diğerlerinden daha kapsamlı faydalar sağladığını gördük. Çalışmamız neticesinde vardığımız final kararına göre kapasite modeli, diğer modellerin en iyi yanlarını alması ve geniş bir spektrum da diğerlerinden fazla yararlar sağlamasından dolayı, işitme engelliler adına bu çalışmada yer alan uzmanların teorik method olarak seçimi olmuştur.

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INTRODUCTION

Theoretical Perspectives on Disability

The nature and challenges of disability and our approach to it differs in each society, which is likely to create different perspectives, practices, administrations and public investment. Hence, there have been many documented perspectives and approaches reflecting cultural points of references regarding disability. One of them defines disability as the biological defects of individuals who are mostly dependent on the support and care from others (Rioux & Valentine, 2006). According to this approach, the mobility of people with disabilities can be bounded on account of the reality of being dependant on the others' availabilities such as knowledge, resources, psychology etc. Another perspective determines disabilities as "normal variations of the human body" and describes it as follows: "it is not an aberration. It's a reality, not an anomaly or abnormality" (Potok, 2012). This approach has been supported by those who acknowledge disability as something that could happen during the lifetime of any human being. Supporters of this perspective especially welcome disability as normal, and support the designing and employing of adjustments to meet and accommodate the needs of the people with disabilities in society as far as possible (Iverson & Stahl, 2003). Universal adjustments, commonly called Universal Design, have been long discussed by governments and supporters of the rights of people with disabilities worldwide. Universal design in general concerns the full range of human diversity, not just people with disabilities, including physical adjustments, cognitive skills and the bodily differences in people. There is a wide range of possible adjustments that can be applied in universal design such as in architecture, urban planning, private residences, transportations and the digital and technological world, including computers, internet, educational materials, software and many of other areas. The most common examples of physical adjustments include curb cuts in pavements, automatically opening doors and door handles, visual alerting, sound alerting and signals such as in elevator or crosswalks, separate spaces for wheelchairs and guide dogs in buses, appropriately designed lifts and ramps in airports and public buildings, and many other adjustments. Universal design applies to all people by recognizing the full range of human diversity, and there might be times in which any person may use these designed facilities because of temporary or permanent illness, injury or old age.

The Biomedical Model

The biomedical model of disability has been investigated in the study of MacPherson, Pothiers and Devlin (2006) which stated that this model comprises the limitations and impairments of the human body and related treatments for the purpose of providing medical opportunities for transforming or curing disability. This approach has been supported in popular culture, where individuals with disabilities are considered to be biomedically different, and so called "defective" or "afflicted" in relation to normal people (Bohman, p.33, 2012). The doctrines of this approach advantages society in mainly medical contexts, to ensure that people with disabilities receive all the available treatments to be able to live in comfortable conditions. The criticism raised against this model is that the lack of cure for disabilities that people experience means that it has significant limitations. Since today's biomedical treatments cannot address all the health related problems of the people with disabilities, their current suffering might continue, which eventually restricts this model's effectiveness to meet the necessities of these people (MacOherson, Pothiers & Devlin, 2006).

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The Social Model

The core of this model is based on the idea that society itself creates and has to deal with the disabling conditions where individuals with disabilities experience social injustice or discrimination, known as "ableism" (Morgolis, 2001). The term "ableism" in this model refers to the discrimination of society against individuals with disabilities mostly in favour of typical people such as considering them as bodily or mentally different, strange or going beyond the politeness by referring to them as "inferior" (Morgolis, 2001).

The social model encourages society to rethink and redesign the physical and virtual environment to overcome the disabling conditions that create barriers for people with disabilities to fully participate in society. These conditions vary regarding the characteristics of the disability and the social environments. For instance, the absence of accessibility to public buildings causes physically disabling conditions, independent of the people with disabilities, such as for people with the inability to walk who need wheelchair accessibility, sound alerts, and visual alerts for individuals with deafness or hearing impairments. In terms of virtual environments, technology and any techno-related materials should be designed to focus on accessibility in a wider context to allow as many people with disabilities as possible to use technology in their lives. For instance, captioned and subtitled TV programs, educational videos, news, sign language converting materials, and so many other features of what the technology offer today can benefit people with DHI in various ways.

Hughes (2010) stated that technological and medical assistance may prevent discrimination against people with disabilities in a positive way, such as discovering some of the disabling issues before and just after the birth, so as to be able to deal with them more successfully without allowing them to suffer until it is too late. One example of this issue involves opponents of cochlear implants from the deaf culture, who consider medical devices as "an affront to deaf culture and their loyalty to sign language" (Bohman, p. 36, 2012).

The gap between the biomedical model and the social model may be closed to a significant degree by unifying both of their

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strengths in another model, referred to as the Capability Model.

The Capability Model

This model was first introduced by Sen in 1979 and last updated in 2009. He is one of the most influential supporters of this model through his studies in 1979, 1988, 1992, 1995 (Sen, 2009). The main standpoint of this model is based on establishing an environment where people with disabilities can take advantage of the strengths, social transformations and biological enhancements. Therefore, it offers a unified approach to both models by taking into account their strengths, and combines them to create a large spectrum of opportunities to benefit from. The main points covered in this model include developing social welfare and freedom for people with disabilities, ethical issues of justice, support for the human rights of these people, an interdisciplinary approach to unifying political and social philosophies, questioning economical conditions such as the level of poverty and inequality of economic power distribution, and improving the social relationships within societies (Bohman, 2012).

Sen (2002) addressed that the societies need to supply consistent freedom, such as healthy life, education, enhanced social relationships, opportunities to take part in politics and decision makings, improved economic welfare and general meanings of freedom (Sen, 2002). This model values the choices of people with disabilities to decide whether to accept, choose, or deny available freedoms in their lives since freedom means having 100% control over choices. Hence, this model appreciates any freedom, regardless of its source deriving from social channels or medical treatments.

CONCLUSION

Considering wide range of approaches, our team of experts in this study decided that capability approach is the best approach to enable disabled people fully participate in the society and receive necessary treatments and interest that they deserve. Social and biomedical methods lack significantly important points and adopting one of them will definitely create problems in different meanings. Also, people with disabilities must be given rights from a wide range of possibilities and we think that capability approach offer the best solution in this respect. Considering the disability form which is hearing impairment, we think that offering biomedical treatments are extremely important while clearing social discrimination and violation of rights of these people. We find that we can address both of these points in capability model, therefore it has a significant value in this respect. By adopting capability model, we can also address freedom of choice for hearing impaired people regarding choosing their mode of communication, whether they decide sign language or cochlear implant and aural mode of communication. This does not prevent them to also being a part of 'deaf culture' or 'hearing culture'. They can take advantage of them at the same time and do not have to decide for only one of them. This way of offering freedom of choice also benefit those who want to use both languages together as 'bilingual'. Because of above mentioned advantages, as a part of this study, we decided to adopt and implement capability approach in our institutions and advice those who work in disability field to consider adopting the benefits of this approach as well.

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PROJECT WITH PRESS AND SOCIAL MEDIA

KONYA Yenigün

Konevi işitme engellilerinden Avrupa Birliği Projesi



Konevi İşitme Engelliler'den YENİ BİR AB PROJESİ

Konya'nın merkez Selçuklu ilçesi'nde yapılan ve AB Bakanlığı Türkiye Ulusal Ajansı tarafından finanse edilen bir Avrupa Birliği Projesinde işitme engelliler ve eğitimi hakkında öğrenci, veli, öğretmen ve tüm diğer eğitimcileri adanacak herkese tavsiyeler çıktı. Proje, Konevi İşitme Engelliler Ortaokulu tarafından hazırlanıp yürütüldü.

Merhaba

Konevi'nden işitme engelliler projesi

Selçuklu'da yapılan ve AB Bakanlığı Türkiye Ulusal Ajansı tarafından finanse edilen bir Avrupa Birliği Projesinde İşitme Engelliler ve Eğitimi hakkında öğrenciler, veliler, öğretmenler ve tüm diğer eğitimcileri adanacak herkese tavsiyeler çıktı. Proje, Konevi İşitme Engelliler Ortaokulu tarafından hazırlanıp yürütüldü. Proje, Slovenya, İspanya ve İngiltere'den okullar, üniversiteler ve akademisyenler ile yapıldı.

PUSULA

Konevi'den yeni proje

Konevi İşitme Engelli Ortaokulu'nda yeni bir AB Projesi. Son iki yılda önemli başarılarla gerçekleştirilen Konevi İşitme Engelliler Ortaokulu şimdiki "Teoriden Pratiğe: Kulak Sağlığı ve İşitme Eğitimi" projesine imza attı.

Facebook page for Konevi İşitme Engelliler (Konevi EU Project). Includes profile picture, cover photo, and navigation tabs like 'Zaman Tüneli', 'Hakkında', 'Arkadaşlar', 'Fotoğraflar', 'Diğer'.

PROJECT WITH PRESS AND SOCIAL MEDIA

AVRUPA BİRLİĞİ PROJELERİ KONEVI SCHOOL FOR THE HEARING IMPAIRED EU PROJECTS. Includes logos for Erasmus+, Turkey National Agency, and social media icons.

Project overview cards for three projects: 1. 'WITH ICT WE ARE OVERCOMING THE WALLS OF SILENCE', 2. 'FROM THEORY TO PRACTICE TEORİDEN PRATİĞE', 3. 'DISPLAY OYUN TABANLI ÖĞRETİM'. Each card includes project details and logos.



KONEVİ İŞİTME ENGELLİLER OKULU AVRUPA BİRLİĞİ PROJELERİ KONEVI SCHOOL FOR THE HEARING IMPAIRED EU PROJECTS. Includes logos and navigation tabs.

Project video works section. Includes 'PROJEMİZ VİDEO ÇALIŞMALARINI (TÜRKÇE)' and 'PROJECT'S VIDEO WORKS (ENGLISH)' with video thumbnails and a clock icon.

