Theme : Practices in Early childhood Education (E.C.E.)

Sub theme : A) Phase wise – Phase II

Topic : Home based

Title : Home training to hearing Impaired Children in Rural Area.

Introduction :

Since 1997 Cochlea Pune for Hearing and Speech in collaboration with Ashwin Medical Foundation is conducting preschool speech training programme for hearing impaired children. At present there are about 30 children coming to us for this programme.

Incidentally we came across one Teacher for Deaf who at present is working in a normal school as a regular teacher. This teacher was working at 15 km. away from our centre in Hinjavadi.

Her only daughter has congenital hearing impairment. She suggested that a centre can arrange deafness detection camp followed by regular training to H. I. preschool children in area of her school. The records were checked and found that no child was coming to us from the said area. Hence it was thought that the centre could conduct a deafness detection camp in that area.

It has been recognized both here and abroad that children with impaired hearing need to start their education early. Lack of opportunities to learn can restrict development in many ways and in some cases result in intellectual retardation or

emotional disorder. This shows the earliest years of life have enormous significance for all aspects of child's development.

Cochlea Pune for Hearing and Speech took this opportunity to do a research project to detect H. I. children in rural area away from Pune city.

Vast area, difficulty in access:

Unfortunately camp was attended by older age group people only and we could not find any preschool H. I. child. Then it was observed that this village was spread over a vast area. One has to walk for 3 to 5 km. to come to camp site and this appeared to be the cause of absence of hearing impaired children.

Role of multi purpose health worker :

To overcome this difficulty, we decided to take help of multipurpose health worker from primary health unit in that area. The ENT camp was organized and no children came to that camp. When we asked the multipurpose health worker from primary health unit in that area to give the details of any abnormal children, it was really a pleasant surprise to note that he was having very detail information about all abnormal children in that area. From his registers he could give the name of twelve children in that village who were not speaking. He was not in position to tell the cause why they were not speaking. That is to say he was not knowing which of these children were H. I. Never the less he was having names and detail addresses of these children, which helped us a lot.

House to house survey:

It became essential to conduct house to house survey to detect the H. I. children. We undertook this survey with the help of enthusiastic villagers. Significant number of children were not speaking because of mental retardation, but we came across about five children who were deaf and hence were not having speech. This survey was really a unique experience for us.

One of the shocking experiences was one deaf child we found was inside a locked house and his hands and legs were tied. Reason given by parents was this deaf baby was a hindrance for working and nobody was there to attend the baby.

Further Assessment:

The deaf children observed in this house to house survey were eventually further assessed. They were taken to our centre. Their exact hearing status was confirmed by B.E.R.A. test and they were given suitable hearing aid. Proper mould was also given along with hearing aid. Counseling was done by psychologist. Parents were given exact idea about hearing condition of their child. The need for regular training was emphasized. Repercussion of dark future, if training was not attended was informed.

Trial of Centre:

We decided to call these H. I. Children at one particular place in the same village (i.e. near to their living place) for

further training. Authorities from the school of the village were kind enough to give classromm for the speech therapy, but to our great dismay, none of these children came for training. We were really surprised. Out of curiosity and also as last effort to train these children, we again visited the houses of H. I. Children.

Reasons for non-attendance:

We had a frank discussion with the parents about non attendance. As such it was our 5^{th} or 6^{th} visit with them. Hence they were also free in talking with us. Main reasons for non-attendance were as follows:

1) Distance from living place to the school was too much for a mother to come along with H. I. baby.

2) Parents or the members in the family were engaged in the work hence they could not attend (farming, home dairy, small shop, bricks production unit).

3) Parents of one baby were illiterate. We could not convince them to attend the training in spite of lot of counseling.

So it can be concluded that difficulty in conveyance, poverty and illiteracy were the causes of non attendance for training, in spite of giving all the facilities (Investigation, Hearing Aids and Training) totally free.

Considering all these factors we ultimately concluded to arrange house to house speech training programme.

Modus Operandi:

1. Period and frequency:

   Considering our resources we decided to conduct a programme once a week for two years.

2. Nature of work:

   A Teacher for Deaf was given responsibility. A suitable time for visit to house of H. I. baby was pre-decided. Teacher for Deaf conducted regular training sessions during this time. Homework for one week till next visit used to be given to the mother. On every visit execution of this homework was first looked for and then training of that session was carried.

3. Lesson Plan:

A child was taken out side the house for auditory training. The child was introduced to the voice of an animal like Goat, Cow, Dog or Buffalo.

And any bird like pigeon, Crow, Sparrow was given as auditory sensation through hearing aid given by the centre. They were made to repeat the sound again and again. For language training the objects from nature like leaves, flowers, bird's vegetables fruits were shown and the pronunciation was vocalized from them.

4. Team work:

Audiologist, Speech Therapist, Psychologist, Hearing Aid technician and Social Worker were the members of this team. We fixed the plan of training with the

help of Speech Therapist. These members by rotation were accompanying teacher for deaf during her weekly visit.

One social worker was a regular member for every visit. Speech Therapist and Audiologist use to accompanying once in two months, Psychologist once in three months. Hearing Aid Person once in six months or as and when required. E.N.T. Surgeon was involved every six months.

Data interpretation and Results:

1. No. of babies participated- 4
2. Total visits conducted for four children were 104 sessions.
3. Age of the babies when Project started.
    1. 2 yrs. 6mth.
    2. 3 yrs. 6mth.
    3. 3 yrs. 6 mth.
    4. 5 yrs.

Results after two years.

1. - 2½ yrs Female : This baby did well, she acquired reasonably good speech and is integrated in normal school. She had profound hearing loss.
2. - 3½ Male : This child also did well. This boy was introvert and took much more time to get involved in programme. As his hearing loss was moderate to severe, speech development was really rewarding.
   Today he is integrated in normal school.

3. - 4½ Male : This child has profound hearing loss. After four months training it was found that this child has some psychological problems besides deafness. This child used to become violent during training hence improvement was average.
4. - 5½ Male : Hearing loss was moderate to severe. Parents were involved in such a job that the baby was not available for regular training. But this child was exceptionally brilliant and his loss was also not profound. Hence in spite of irregularity this child acquired reasonably good speech. Though because of familial conditions he is not attending school. Because of whatever speech he has achieved he can mix up with other children in society and do his routine without any problems.

Advantages of home training:

1. Involvement of family:

   In our training centre usually only mother was accompanying H. I. babies. But when we were going home to home, all the family members were present in the surrounding. They automatically got involved in training. So we were in a position to use all of them in training which definitely helped in the progress.

2. Definite Training:

   As we were going to the homes babies were definitely available for training, hence no question of gap or absence. Hence regularity was maintained and we could achieve good progress.

3. Participation of neighbours:
   As this was some different experience and as such there always is close relationship between neighbors in the villages, we experienced active and very useful participation from neighbours in all the above cases.
4. Use of familial objects for training:
   As it was a home training, objects used for training were in the house or in the surrounding. Hence baby was quite accustomed to these objects. We feel that this may be an important factor in progress of the babies.

Difficulties of home to home training:

1. Availing manpower:
   Special Educator, Social Worker and Driver were three mandatory members for every visit. Besides periodical visit of Audiologist, Speech therapist, Psychologist, Hearing Aid Person and E.N.T. Surgeon to arrange these all for manpower was very difficult.
2. Transport:

   A vehicle along with a driver was a must for this project.

3. Cost or economics:

   Cochlea Pune for Hearing and Speech being a social charitable trust it is advisable to avail this manpower and transportation at very low cost (by means of donation etc.) But otherwise it is a very costly programme.

Conclusion:

Home to home Speech Training Programme for Preschool children undertaken by organization is described. Its advantages disadvantages and exact nature of functioning is mentioned. Three children acheived, satisfactory level of speech though efforts taken but expenditure made for the same were of high magnitude.

We feel that this project may prove more useful and economical if perhaps more surrounding population can be covered.

Still it is recommended that in rural areas of our country such type of efforts should be done by different organizations to find out H. I. Children and train them for education and rehabilitation.

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