

Delivery of ear health and hearing services to remote communities in the NT as part of the Australian Government Intervention Hearing and ENT Project

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Amarjit Anand has been an Audiologist for over 30 years. Her career as an audiologist commenced in India where she was employed as an audiologist and speech pathologist at a large public hospital.

In 1992 Amarjit moved to Sydney and subsequently to Darwin in 1996 working for the NT Department of Health and Families (DHF) where she practiced as a clinician initially and was then appointed as Principal Audiologist and manager for the NT wide hearing services.

During this time she has been involved in the development of guidelines aimed at improving the hearing health of Aboriginal people in the NT. She also completed her Masters in Public Health in 2002.

Background

The prevalence of ear disease and hearing loss in the Indigenous population of the Northern Territory are amongst the highest in the world. Otitis media and associated hearing loss has lasting impacts on early childhood speech and language development and can adversely affect their long-term educational and social potential. It can also lead to permanent hearing loss when parts of the middle ear and eardrum are damaged.

Over the past two decades the Northern Territory's Menzies School of Health Research has undertaken a lot of research in this area. Audiological services have looked at various service delivery models to address the overwhelming burden of otitis media and hearing loss. Recruitment and retention of audiologists has been a constant challenge among other issues.

More recently, the Australian Government funded the Northern Territory Emergency Response in 2007 to carry out child health checks on Indigenous children under 16. These checks identified hearing and middle ear disease as a significant health issue and 30% of over 10,000 children were referred for audiology and/or ear nose throat (ENT) services.

Method

A workforce was built by recruiting visiting audiologists and ENT specialists on short-term contracts. A service delivery model was implemented that included enhanced primary health follow-up, recruitment and training of local hearing workers to support treatment compliance, coordinated audiology and ENT outreach visits, and increased capacity for ENT surgery through local hospitals, supported by a pre- and post-operative protocol to assist families and remote health staff.

Results

Since 2008 a large number of children were seen for audiology services and ENT consultations in remote communities across the territory. In addition, the program also provided ENT surgery. These services were delivered by a range of audiologists and ENT specialists, mostly from interstate. Infrastructure for hearing services was improved through the deployment of hearing booths, and the provision of new ENT and audiological equipment.

Conclusions

The AGI Hearing and ENT follow-up has been a catalyst to influence workforce and intervention models for ear disease and hearing. It has contributed to raising awareness about the extent of ear and hearing problems and the need for integrated services to meet this need. The outcomes of the coordinated multidisciplinary model for hearing health service delivery in a rather challenging and complex environment can be considered as best practice for mainstream practitioners aiming to improve health care through a multidisciplinary approach.