The 2019

Libby Harricks

Memorial Oration

Libby Harricks Memorial Oration number 21

Honouring
the Deafness Forum's
first president & profoundly deaf achiever

Elisabeth Ann Harricks AM 1945 – 1998

deafness forum of australia

2019 Libby Harricks Memorial Oration

Professor Andrew Smith

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Introduction to the 2019 Libby Harricks Memorial Oration

Catherine McMahon

I would like to acknowledge the traditional custodians of the Macquarie University land, the Wattmattageal clan of the Darug nation, whose cultures and customs have nurtured, and continue to nurture, this land, since the Dreamtime. We pay our respects to Elders past, present and future.

It is my great pleasure to Chair the 2019 Libby Harricks Memorial Oration. I wish to thank Deafness Forum for the invitation to take on this role and I follow on from the excellent work that Associate Professor Christopher Lind has undertaken as former Chair of the committee. On behalf of the all those who have been engaged with and by this series of orations, I thank Christopher for his efforts in maintaining this oration as one of the premier invited public presentations on hearing, hearing loss, and related matters in Australia.

This year's oration forms part of Macquarie University's Indigenous Hearing Health Symposium, and I would like to acknowledge and thank the Macquarie University Research Centre H:EAR [Hearing; Education, Application, Research] and our Australian Hearing Hub partners for their financial support for our Orator's visit to Australia and to develop the oration manuscript for publication. My name is Catherine McMahon and I am a Professor of Audiology at Macquarie University and the Director of H:EAR.

To understand the importance of this Oration series in supporting advocacy and empowerment initiatives for those with hearing loss, a brief introduction to the person for whom this oration series honours, Libby Harricks, is necessary. Libby Harricks grew up with apparently normal hearing. Subsequently, as a young wife and mother, she developed a profound hearing loss. She educated herself with skills to manage her own hearing difficulties and soon became committed to advocating for all hard-of-hearing and Deaf people. She was a founding member and long-term President of Self Help for Hard of Hearing People, Australia, now called Hearing Matters, and was the inaugural Chairperson of Deafness Forum of Australia.

Libby Harricks worked tirelessly to raise awareness of the need for equal inclusion for hard-of hearing and Deaf people, travelling widely throughout Australia to lobby for this on their behalf. In recognition of her advocacy work, Libby was made a Member of the Order of Australia in 1990. After her death in 1998, Deafness Forum of Australia, the national co-ordinating body which advocates for Deaf and hard-of-hearing hearing people, established the annual Libby Harricks Memorial Oration Series to honour her achievements.

The Oration series continues her vision of working towards gaining appropriate recognition, awareness, and access, for hard-of-hearing and Deaf people.

It is my great pleasure to introduce our 21st Libby Harricks Memorial Orator. Professor Andrew Smith is a world-renowned public health expert at the International Centre for Evidence in Disability, London School of Hygiene and Tropical Medicine. Before joining the London School, he was responsible for the Prevention of Deafness and Hearing Impairment programme at the World Health Organization from 1996 to 2008, an organisation he continues to support in this field. Prior to the WHO, he led the Hearing Impairment Research Group, Liverpool School of Tropical Medicine, worked for the UN High Commissioner for Refugees (UNHCR) in Pakistan amongst Afghan refugees; and also worked for the UK Medical Research Council in The Gambia.

He originally trained as a paediatrician in the UK, Canada and South Africa, before developing an interest in international public health. To gain a clearer perspective of the challenges of addressing hearing loss, Professor Smith will be presenting on his global experiences and insights in ear and hearing health, and the relevance this might have to our approach to hearing health for Aboriginal and Torres Strait Islander people in Australia.

Global Hearing Health: challenges and opportunities

Professor Andrew Smith

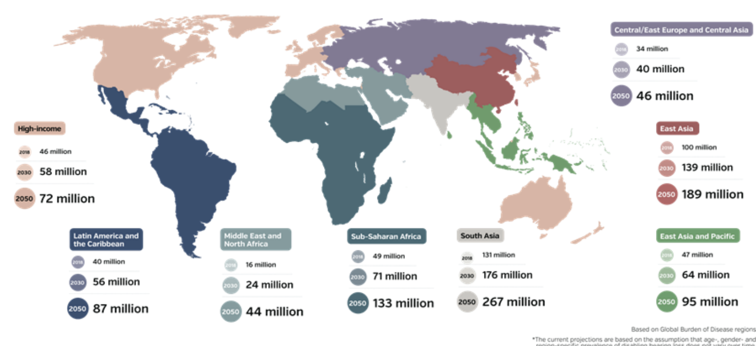
Introduction

I am very honoured to be asked to give the Libby Harricks Memorial Oration to open the symposium on Indigenous Hearing Health at Macquarie University.

Libby Harricks who experienced a profound hearing loss as a young adult overcame many obstacles to become a champion for Deaf people in Australia. I feel very inspired by her achievements for the Deaf Community.

My oration will focus on the challenges and the opportunities for Global Hearing Health. I will relate this to programs I have been involved with in low and middle income (LMI) countries. The challenges faced by the world are the numbers and location of hearing loss, the lack of information, and the lack of awareness. Opportunities do exist in the form of the public health approach to develop sustainable initiatives in low and middle income countries. I will address the important role of the World Health Organisation (WHO). I would like to relate the public health approach I use in LMI countries to address Indigenous Hearing Health in Australia.

Projected number of people with hearing loss in defferent world regions until 2050



The map shows the current and projected number of people with hearing loss in different regions. Projections show that the number of people with disabling hearing loss will increase in all regions.

Figure 1: WHO estimates of regional numbers with disabling hearing impairment 2018 – 2050. Slide Courtesy of WHO

Global Prevalence of Hearing Loss

On World Hearing Day (3rd March), 2018 the World Health Organization released some shocking figures. The main message was that by the year 2050 if nothing was done the global number of people with disabling hearing loss would reach 900 million - double what it is today. The WHO regional picture *(see Figure 1)* shows that the high income group which includes Australia, and other regions of the world, are showing an increase in the figures. The World Bank defined region with the highest figures is South Asia, comprising Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal Pakistan, and Sri Lanka. The historical look at the problem shows the figures have been increasing for more than the last 30 years. *Figure 2* shows the WHO estimates of the increases in the numbers of people with disabling hearing loss, (bilateral 'moderate or worse' hearing loss) since 1985.

The global numbers have increased progressively with most of the burden of hearing loss consistently in low and middle income countries. In 2018 WHO stated that 90% of the burden of hearing loss is in LMI countries and this percentage is continuing to increase.

What is driving this increase in hearing loss?

Surveyors are using improved measuring techniques for hearing loss and are therefore finding more people with hearing loss when they do surveys.

WHO global estimates of disabling hearing impairment 1985 - 2018

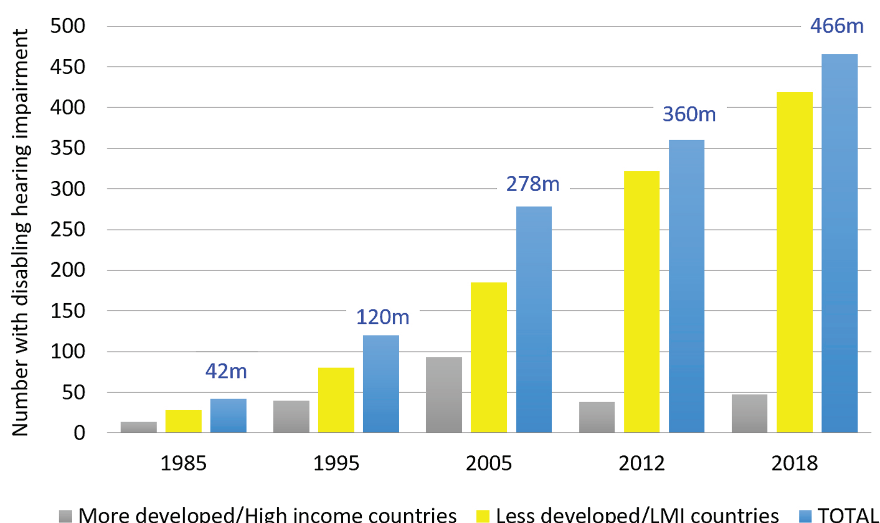


Figure 2: WHO estimates of global numbers with disabling hearing impairment 1985 – 2018.

The amount of noise induced hearing loss in the world is increasing everywhere. Occupational noise-induced hearing loss occurs globally, with higher rates in LMI countries where the controls and regulations on exposure are not available or not enforced.

There was a survey conducted in 2004 amongst remote Inuit Indigenous communities in northern Canada which showed very high levels of occupational noise-induced hearing loss. The surveyors commented that the rates of noise-induced hearing loss were similar to those found in LMI countries [Ayukawa 2004]. The noise induced hearing loss is often potentiated by chronic otitis media in childhood.

It was found that the Inuit People often do not wear hearing protection when they go hunting and sustain hearing damage from rifle fire. They use very noisy ice drills when they go fishing in the winter to break through thick ice. Some of the Inuit people use snowmobiles with the silencers removed. This technique enables them to travel faster for long distances over the ice to go hunting and visit neighboring communities.

Inuit artists do a lot of carving of soapstone and the grinders are used for long periods at very high noise levels, at 95 dBA, which is well above the maximum safe level of 85dBA.

The population of the world is increasing and the numbers of people with disabling hearing loss will also increase. People are living longer in all parts of the world including in LMI countries. The prevalence of hearing loss is much higher in the elderly group and this will massively increase the burden of hearing loss. Recent estimates published by WHO [World Health Organization, 2018] showed that the total global population is set to increase by about 11% between 2010 and 2020. The global population in the over 65 years age group is set to increase by about 37% during the same period.

There is an epidemic of noise-induced hearing loss caused by people world-wide wearing earphones and earbuds at high volume for long periods of time.

Severity of the Global Burden of Hearing Loss

The previous section looked at ***prevalence,*** which is concerned with measuring the numbers of people in the population with disabling hearing impairment.

A better measure of the burden of hearing loss would also take account of the ***severity*** of the condition. A study called the Global Burden of Disease [GBD 2017], is doing this for all health conditions including hearing loss. It measures the burden of disability that a particular disease causes to an individual, and then calculates the burden in the whole population. The measure used is called the disability-adjusted life year (DALY). It has two components; the first is *years of life lost* (YLL) due to premature death,

the gap between when you die from a disease and the average age of death in a population. However, deafness causes very little YLL.

The other component is ***years lived with disability*** (YLD). This is the component measured for hearing loss; years lived with the disability are multiplied by a factor less than 1, the level of which is set in proportion to the severity of the hearing loss. YLD are calculated for hearing loss in populations, and then summed for all countries and communities, in order to obtain a global figure which can be ranked in comparison with other health conditions. A recent Lancet paper [Wilson et al 2017] which used global burden of disease data showed that hearing loss was the 11th leading cause of years lived with disability in 2010, but by 2013 and 2015 it had risen to the fourth leading cause, suggesting that hearing loss has increased in burden. Vision loss, which most people thought was more important, is still ranked between 9th and 11th mainly because the programs against blindness, such as Vision 2020, have been very successful. Global Blindness has peaked whereas, as we have seen, deafness is continuing to increase. The latest figure for 2016 in the global burden of disease study shows hearing loss is now ranking at number three [GBD, 2017].

Lack of Information and Awareness

Another key challenge is the lack of information and lack of awareness about hearing loss. I was involved with 15 different prevalence surveys around the world using a WHO Survey Protocol. The most recent survey we did was in Ecuador, where adults were found to have a prevalence of 6.4% with disabling hearing loss, similar to the current global figure.

What is striking is the small number of prevalence surveys that have been done. This was noted in a meta-analysis by Stevens from the WHO [Stevens et al. 2011]. They assessed over 3000 studies, but only 42 were judged rigorous enough to be included. Their main conclusions were that the estimates of hearing impairment were uncertain because so few population-based surveys have been done. Therefore, we urgently need repeated cross-sectional population-based surveys in regions with the highest prevalences.

Another problem is the high cost of hearing loss - $750 billion - highlighted by the WHO in 2017 [World Health Organization 2017]. Several credible prestigious economic foundations have put together this figure. Hearing loss and poverty are linked. Hearing loss leads to poverty and poverty leads to hearing loss in a vicious cycle.

Why is it so difficult to mobilise resources against hearing loss? There are negative perceptions-- blindness tends to evoke sympathy but deafness evokes irritation. And there is a stigma associated with deafness. The idea of “deaf and dumb” is still pervasive - people don’t like to show that they are wearing hearing aids or they don’t want to wear them. There is a lot of ignorance around hearing loss in the general population.

What is hearing loss like?

That is one of the issues. We cannot clearly show the general public what it is like to have a hearing loss. There are attempts to do this with using videos published on websites to demonstrate what it’s like listening to music with different levels of hearing loss.

Young people are unaware that loud noise and listening to loud music will damage their hearing. Many people who go to rock concerts are totally unaware that it may cause a serious problem later in life.

This lack of awareness leads to a lack of political will generally and that leads to an inability to prioritize and a lack of programs and resources.

It is very important to raise awareness. Surveys themselves are a very good way of raising awareness. A survey generates a lot of publicity, and that gets people more interested and increases general understanding of some of the problems of hearing loss.

Opportunities

In order to address effectively the huge problem of hearing loss in the world, I believe it is essential to have a population-based public health approach as well as a one-to-one clinical approach.

Let us consider the example of a slum in Nairobi, Kenya, a lower-middle income country. Kibera is reputed to be the one of the largest slums in Africa. It lacks proper sewage facilities and the rivers and streams are highly polluted. The question is – how do we deal with hearing loss in situations like this?

Figure 3 shows the monthly ear care clinic in a remote part of Malawi, a low-income country in southern Africa. Local people have no other access to ear and hearing care. How do we deal with public health in situations like this?

The answer is we need to re-orientate our thinking towards the public health approach, particularly amongst clinicians in ENT and audiology, but also in health planners.

The epidemiologist and WHO Director, Dr Robert Beaglehole [2009] said.

"Public health is the art and science of preventing disease, promoting population health and extending life through organised local and global efforts."

This definition gives you an understanding of the breadth and reach of public health. It is useful to compare it with clinical medicine which centers on the health of individuals. In clinical medicine there is a consultation with the patient, but instead of dealing with the health of individuals, public health deals with the health of populations. Instead of having a consultation, you would do a survey in order to diagnose the health of the population, and then you would carry out a population intervention.

The intervention might be a prevention program; a very important aspect of the public health approach. It may be a clinical intervention such as providing hearing aids but doing it on a massive scale at a price that the majority of people can afford. It then becomes a public health intervention.

In order to follow up what you are doing, you do another survey. There are similarities between public health and clinical medicine and they overlap.

Figure 3: ENT outreach clinic, rural Malawi. Slide courtesy of Dr Piet Van Hasselt

When we look at which conditions should be targeted, *Figure 4* shows the frequency of causes of hearing loss, according to WHO. In red, are the most frequent causes. In the blue area the moderate frequency causes. The causes in red and blue should be targeted by the Public Health approach because they are relatively common.

The low-frequency causes in green can be dealt with on a one to one basis by clinicians

The route to a public health intervention is to target causes of hearing loss that have a *high prevalence* and at the same time have *an effective means of prevention or control.* The intervention used must also be *cost-effective.* A Government will be unlikely to implement an otherwise effective intervention if it costs too much.

What conditions should be targeted?

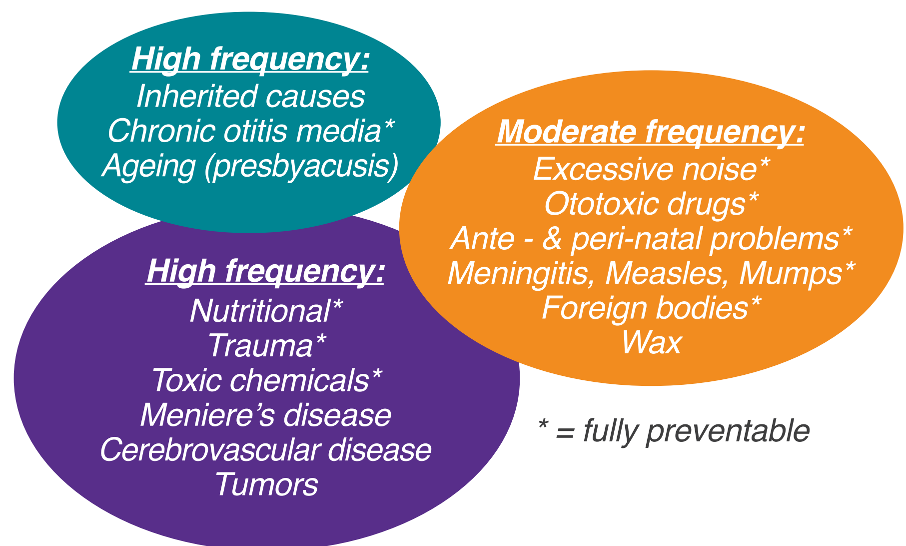


Figure 4: Causes of hearing loss by frequency.

Public Health Programs which are likely to be cost-effective:

- *primary ear and hearing care, providing affordable hearing aids on a massive scale,*
- *setting up national programs*
- *training for program planning,*
- *health education and advocacy*

All these need to be assessed for their cost effectiveness in comparison with other health programmes.

It is important to do cost effectiveness studies of key interventions, since such studies are greatly lacking in this field. Cost-effectiveness studies require good epidemiological data. This means that more prevalence surveys of hearing loss will need to be conducted in order to provide such data.

In 2017, WHO stated that a number of interventions in hearing healthcare were cost-effective [World Health Organization 2017].

The box lists public hearing health programmes that are likely to be cost-effective, but for which cost-effectiveness data is currently lacking.

I would like to present examples of two LMI countries that recently developed a national strategy or plan for ear and hearing care, looking at some of the challenges they faced, and how they overcame them.

Kenya:
Example of a lower-middle income country

The Republic of Kenya

Capital
Nairobi

Population
48.5 million

Area
582,646 sq km
(224,961 sq miles)

Major languages
Swahili, English

Major religion
Christianity

Life expectancy
63 years (men),
69 years (women)

GNI per capita (2017)
between US$996 and
$3,895

Kenya is in the lower middle income group (Gross National Income, GNI per capita between US$996 and $3,895). They have recently developed and started implementing their national strategy for ear and hearing care.

The key challenges to the provision of ear and hearing care in the country were lack of a national program, uncoordinated service provision, inadequately trained human resources, inadequate financial resources, lack of infrastructure and supplies, and lack of data on burden of disease. They have fairly good numbers of personnel compared with most African countries: ENT surgeons (85), audiologists (7), clinical officers (200), audiology officers/technicians (12) and speech language therapists (16). Almost all are in major urban areas except for Clinical Officers of which only 50% are in rural areas. There is a mismatch between the need and the location of staff.

Professor Isaac Macharia and colleagues first attempted in 2008 to set up a national strategy. A middle level officer in the Ministry of Health represented what they were doing within government and was tasked with taking the draft plan to the Minister. It didn't work – the Minister wasn't really interested and the stakeholders lost interest and the committee died.

Fast forward to 2013, there was more interest, this time starting from the top with a Minister of Health who showed possible interest in ear and hearing health. They needed a push because of other competing priorities. Professor Macharia invited Dr Shelly Chadha, the WHO Technical Officer in charge of the global programme for prevention of hearing loss to meet the Minister of Health and give a convincing exposition of what needed to be done.

This transformed the situation. The Minister convened a National Committee which he chaired. WHO planning tools, available on the WHO website [1] were used for developing the national strategy. The committee carried out a situation analysis, and SWOT analysis, devised the vision, mission and guiding principles. They set up goals and SMART objectives – Specific, Measurable, Achievable, Reliable, and Time-bound. The plan was done rigorously and clearly set out roles and responsibilities.

The National strategy provides a framework for the coordination and mobilisation of resources. It addresses advocacy at all levels, human resource capacity building, access to services and assistive devices and data collection. The strategy is an excellent plan with a clear goal and good strategic objectives.

The plan was published by the Government and because the Minister of Health was involved, he took ownership of the plan. The Minister launched it at a national workshop, awareness was raised and the plan was implemented.

The plan had a rocky start but a successful outcome. What next though? There must be *sustainability in setting up a national plan.* The Kenyan Ministry of Health want to cascade the plan out to county level, identify resources, and plan regional meetings. Resource allocation has been devolved to county level. The counties will be expected to allocate money in their own budgets to implement this plan.

Professor Macharia stated that what was most needed to succeed was *leadership, determination, patience and endurance.* I believe this is the route to sustainability.

[1] https://tinyurl.com/yxqm8su7
https://tinyurl.com/y5bxgnmc

Malawi:
Example of a low income country

The Republic of Malawi

Capital
Lilongwe

Population
18 million

Area
118,484 sq km
(45,747 sq miles)

Major languages
English, Chichewa
(both official)

Major religions
Christianity, Islam

Life expectancy
60 years (men),
65 years (women)

GNI per capita (2017)
US$995 or less

Figure 5: Clinical Officer trainees for ENT. Photo courtesy of Dr Wakisa Mulwafu.

Malawi is a small country in southern Africa, along the shores of Lake Malawi. 80% of people are rural, 23% have no education and 55% live below the poverty line. Until recently they had only one ENT surgeon for 18 million people, now there are two. There is a low investment in health. They have one clinical officer in ENT and are training 15 more ENT clinical officers. There are challenges on all fronts. There is no focal person for ear and hearing health at the Ministry of Health, although they do have a national committee on Ear and Hearing Health.

Dr Wakisa Mulwafu is the first ENT surgeon; he is very dynamic and active and has achieved a lot. A national plan has been developed in 2016 instigated by Dr Mulwafu. It is more theoretical than the Kenyan plan because there hasn't yet been an opportunity to implement it. The key outputs cover training, infrastructure & equipment, procurement of supplies, reduction/prevention of ENT diseases, research, monitoring & evaluation, management and supervision. These outputs are fine and resources are needed to implement them.

External bodies are helping with facilities and training. An audiology clinic has been set up by an Australian charity and local audiologists are being trained. A UK charity has provided a converted vehicle to do outreach otology and audiology clinics.

Hearing aids are being provided by a US Hearing Aids company foundation.

Capacity building is an essential component of the plan. *Figure 5* shows the first group of 15 clinical officers who are being trained by Dr Mulwafu. There are plans to train more ENT surgeons and set up centres of excellence. A lot is being achieved on the basis of very limited resources.

These are two examples from a lower middle income country and a low income country in the developing world. There are some lessons from Kenya and Malawi in terms of developing programmes for the hearing health of Indigenous people in Australia.

Role of the World Health Organisation

The World Health Assembly Resolution on Prevention of Deafness and Hearing Loss passed in 2017 has really set the scene for moving forward. The resolution sets out the key actions that Member States and also WHO need to do in developing a programme of ear and hearing health. Since it was ratified unanimously, all countries have an obligation to start to address these actions.

Current activities at WHO to address hearing loss, under the capable leadership of Dr Shelly Chadha are increasing. The new World Hearing Forum is bringing stakeholders together, the first World Hearing Report is being developed, the Primary Ear and Hearing Care Training Resource and the WHO Survey Protocol are being re-vamped. A survey method is being developed for Rapid Assessment of Hearing Loss(RAHL), which will make it a lot easier and faster to carry out prevalence surveys once this has been validated.

For World Hearing Day 2019 the theme was “Check your Hearing”. WHO has just released an app HearWHO and anyone is able to check their hearing on their own. *(https://www.who.int/deafness/hearWHO/en/).*

What can you do ?

“Think globally, act locally.”

This slogan, from Dr Lee, a former WHO Director general, emphasizes the need to think at the global level but implement most activities in a local setting.

Acting Locally:

- The first thing is to develop a coherent and rigorous plan using the planning cycle *(Figure 6).*
- Determine the size, location and causes of the problem.
- Use the public health approach together with the clinical approach.
- Self-empowerment is important.
- Focus on primary health care, with training at all levels starting with the primary level.
- Use the WHO materials and guides.
- Set up links with Indigenous groups in other countries for research and development.

Figure 6 shows a simplified version of the planning cycle. Decide where are you now, where you want to be, how you will get there and how you will know when you arrive. This is set out in detail in the WHO planning manuals mentioned previously. Monitoring and evaluation is important to track progress and know whether you have achieved what you set out to achieve.

The Planning Cycle

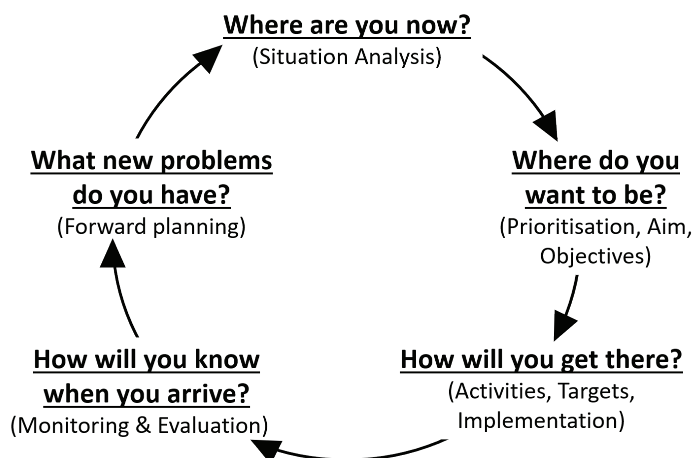


Figure 6: The Planning Cycle.

Health By The People: A Way Forward

This section is further to the hearing health survey carried out in 2004 amongst Inuit People in Nunavik, in northern Canada, that I mentioned previously. The communities are very isolated and scattered around the edge of the Ungava Peninsula bordering Hudson's Bay. Since there are no roads the survey team had to go by ship, (a Canadian icebreaker, in which they installed a sound-proof booth). They found high levels of middle ear infection and hearing loss and disability, comparable to levels found in LMI countries.

Inuit men were found to suffer from three times more hearing loss than women due to noise induced hearing loss from the causes that I mentioned earlier. The team wanted to do more to prevent hearing loss. They obtained a selection of ear protectors for the hunters but allowed them to test and make the choice themselves as to which sound protectors they wanted. The hunters were concerned that the sound protectors would make it difficult for them hear the animals when they were hunting. This is not done for sport but to feed the community they live in. They were able to select a protector which did not reduce their ability to hear the animals. The model chosen was then stocked in the local shops at an affordable price.

Self-empowerment is very important. Kenneth Newell, formerly Director of the WHO Division of Strengthening of Health Services brought out a revolutionary WHO report in 1975 called 'Health by the People'. He collected many examples of how different local communities through self-empowerment made their own choices of the type of health care and health workers they wanted. Village health workers were selected from the villages themselves. These ideas led to the development of primary health care (PHC), one of the biggest achievements of the WHO since its foundation. Last year was the 40th anniversary of the Alma Ata Declaration which launched PHC, which is still relevant today. WHO developed the Primary Ear and Hearing Care Training Resource based on and linking with PHC.

Community-based rehabilitation (CBR) is also important, and CBR workers also come from the community.
We should also remember that the people with hearing disability are part of the wider disability movement, which includes the rights of people with disabilities enshrined in the UN Convention on the Rights of Persons with Disabilities (CRPD).

A Plan For Future Action

My idea is to link up researchers and programme developers in Indigenous groups from different parts of the world. This has already been done in the polar regions with the Circumpolar Health Research Network and the Circumpolar Health Observatory which gathers data and records information.

The research network brings together researchers including Indigenous People from around the Arctic Circle including Alaska, northern Canada, Greenland, Scandinavia, Finland and Russia. There is an International Journal of Circum-Polar Health [2].

It would be an excellent idea for Indigenous People and others who research and work in these fields in Australia to come together with others in different parts of the world to share knowledge, ideas and experience.

Advocacy for Public Hearing Health: The Way Forward

I would like to mention that a biography I read about Libby Harricks said that as the first president of the Deafness Forum she actively lobbied on behalf of Deaf and hearing-impaired people at the highest levels. She was the archetype of a successful Deaf achiever despite her profound hearing loss.

Libby Harricks' actions reminded me of Helen Keller, a famous Deaf achiever born in the 19th century. Helen Keller was blind and deaf.

She said, "I am just as deaf as I am blind. The problems of deafness are deeper and more complex, if not more important than those of blindness. Deafness is a much worse misfortune, for it means the loss of the most vital stimulus, the sound of the voice that brings language, sets thoughts astir, and keeps us in the intellectual company of man. Blindness separates us from things but deafness separates us from people." [3]

I was recently at a conference in Bali and the organisers invited young Deaf Achievers from Indonesia to the conference dinner.

These young deaf achievers are working in fashion, computing, management, and many other areas. They were awarded prizes at the conference to recognize their achievements.

There should be advocacy for public hearing health at every level of society. I think it would be a good idea to involve Indigenous Deaf Achievers in the planning and implementation of a programme for sustainable Indigenous Public Hearing Health.

Leadership, determination, patience and endurance are the keys to success.

[2] https://www.tandfonline.com/toc/zich20/current
[3] From a letter by Helen Keller to Dr John Kerr Love in 1910

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Libby Harricks Memorial Oration Series:

Since 1999, Orations have been presented annually throughout Australia by a series of outstanding Orators. To achieve wider and more permanent coverage, the Oration Series is published by Deafness Forum of Australia at www.deafnessforum.org.au
In order, the Orations to date are:

1999: 'Hearing Access Now!'
Emeritus Professor Di Yerbury AM
(Sydney)

2000: 'Recent Advances in the Understanding of Meniere's Disease and Tinnitus'
Professor William Gibson AM
(International Federation of Hard of Hearing Conference, Sydney)

2001: 'The Politics of Deafness'
Senator Margaret Reid
(National Press Club, Canberra)

2002: 'The Prevalence, Risk Factors and Impacts of Hearing Impairment in an Older Australian Community: The Blue Mountains Study'
Professor Paul Mitchell
(XXVI International Conference of Audiology, Melbourne)

2003: 'Disability Law and People with Hearing Loss: We've come a long way (but we're not there yet)'
Ms Donna Sorkin MCP BA (Hons)
(Macquarie University, Sydney)

2004: 'A Sorry Business: Lack of Progress in Aboriginal Hearing Health'
Dr Peter Carter
(3rd National Deafness Summit, Brisbane)

2005: 'Deafness and Disability Transformed: An Empowering Personal Context'
Alex Jones (Blue Mountains NSW)
(This Oration was presented in Auslan)

2006: 'Hearing Loss: The Silent Epidemic: Who, why, and what can we do about it?'
Professor Harvey Dillon
(4th National Deafness Summit, Perth)

2007: 'Hearing and Communication – A Primary Concern in Aged Care'
Richard Osborn
(9th Rural Health Conference, Albury)

2008: 'Access, Equity and Hearing Loss in Australia in 2008'
Professor Robert Cowan
(5th National Deafness Sector Summit, Canberra)

2009: 'The Bionic Ear: From an Idea to Reality'
Professor Graeme Clark AC
(GP Continuing Education, Sydney)

2010: 'Early Identification of Hearing Loss in Australia: Well Begun is not All Done'
Professor Greg Leigh
(6th National Deafness Summit, Sydney)

2011: 'Molecules,Managers or Mentors: How Can We Minimize Noise Damage in the Worksite?'
Dr Robert Patuzzi (11th National Rural Health Conference, Perth)

2012: 'A Report Card on the Social Well-being of Deaf and Hearing Impaired People in Australia'
Dr Anthony Hogan (7th National Deafness Summit, Melbourne)

2013: 'The Consequences of Being Born Deaf in the 21st Century'
Dr Laurie Eisenberg
(Australian Hearing Hub Inaugural Conference, Macquarie University Sydney)

2014: 'Making Connections'
Professor Susan Brumby
(8th National Deafness Summit/XXXII World Audiology Congress, Brisbane)

2015: 'Towards a new model for the Deaf Inclusion of Leadership in early hearing detection and intervention services'
Dr Christine Yoshinago-Itano
(8th Australasian Newborn Hearing Screening Conference, Sydney)

2016: 'The 2016 Libby Harricks Memorial Oration'
Hon John Howard OM AC, 25th Prime Minister of Australia (9th National Deafness Sector Summit, Sydney)

2017: 'Hearing and Mind: What should we do about hearing loss to promote cognitive well-being in older age'
Dr Piers Dawes (17th Alzheimer's Australia Biennial National Dementia Conference, Melbourne)

2018: 'Sisters are doin' it for themselves'
Dr Graeme Innes AM
(23rd Audiology Australia National Conference, Sydney)

2019: 'Global hearing health: Challenges and opportunities'
Professor Andrew Smith
(Indigenous Hearing Health Symposium, Hearing Hub, Sydney)

Libby's story:

Libby Harricks

Libby's story is one of courage and triumph over adversity by utilising the knowledge of her own severe hearing loss to help others.

Libby started to lose her hearing following a bad dose of flu in 1969 and she began to find difficulty in understanding conversation and instructions, particularly on the telephone which was very important in her profession of pharmacy.

In spite of advice to the contrary, Libby tried hearing aids and found they helped. Had she heeded the negative advice, Libby believed she might never have embarked on the road to self help, which so enriched her own life and that of many others. She thought her two boys quickly learnt to sleep through the night and her friends remarked they had loud voices, which was the boys' mechanism for coping with a deaf mother!

The more the doctors said nothing could be done to help, the more Libby looked towards self help and so she learnt to lip read, a tool she relied on heavily in her quest to help others. Libby's will to win led her, with the help of others, to get involved with the setting up of a support group, which became SHHH – Self Help for Hard of Hearing people. The American founder, Rocky Stone, was invited to Australia in 1982 and did a lecture tour entitled "The Hurt That Does Not Show" which cemented the bonds between the US and Australian groups and helped the local SHHH develop.

Libby, with others, then began SHHH News, a quarterly publication, and with Bill Taylor set up the first Hearing Information and Resource Centre at "Hillview", Turramurra with support from Hornsby/Kuringai Hospital. This centre provided reliable information on, and demonstrated, assistive listening devices for hearing impaired people. Through this interest, Libby became an enthusiastic user of technology and with her handbag full of electronic aids was enabled to join in a full social life with family and public.

Libby became President of SHHH (renamed Hearing Matters Australia in 2019) in 1986 and began to develop her role as an advocate for hearing impaired people generally.

She became involved in ACCESS 2000, under the Australian Deafness Council, and a member of the Disability Council of NSW. Her horizons broadened further as Vice President of the Australian Deafness Council and then as the first, and two terms, President of the newly formed national peak body in deafness, the Deafness Forum of Australia. In this latter role Libby made a huge contribution to bring together all the different organisations into a central body, and actively lobbied on behalf of Deaf and hearing impaired at the highest level – the archetype of a successful achiever despite her profound hearing loss.

For her work on behalf of hearing impaired people Libby was made a Member of the Order of Australia in 1990. Later she was appointed by the Government to the Board of Australian Hearing Services and was asked to represent the needs of hearing impaired on the Olympic Access Committee.

Libby faced another hurdle when she was diagnosed with breast cancer in 1995. Following surgery, she continued her family and volunteer work with undiminished vigour. She would wickedly show off her wig at public functions after her chemotherapy, and talked openly of her "mean disease". She died peacefully on 1 August 1998 and was honoured by hundreds who attended her Thanksgiving Service on 6 August.

In her own words, Libby related her outlook:

"I look back over these years since I became hearing impaired and realise that any efforts that I have made have been returned to me threefold. I have found talents I never knew I had, I have gained so much from the many people I have met and worked with to improve life for people with disabilities and through self help I have turned the potential negative of a profound hearing loss into a positive sense of purpose and direction in my life".

Libby Harricks Memorial Oration number 21

deafness forum of australia