Submission to the Standing Committee on Aboriginal and Torres Strait Islander Affairs **Inquiry into language learning in Indigenous Communities.**

The gap between the health of indigenous and non-indigenous Australians is particularly wide in the Northern Territory where a high percentage of the Indigenous population do not have English as a first language. Reasons for this are multiple. From the perspective of a clinician working in the Northern Territory, one of the major contributing factors is the divergence between "Western" and Indigenous understanding and construction of illness and health.

Aboriginal knowledge comes out of the routine practices of life and makes those practices possible. It is not naturally commodified like laboratory knowledge which forms the basis of the biomedical health construct on which the medical model relies. The specialisation of health work into clearly defined areas (i.e. surgery, cardiology, pharmacy, nutrition, social work etc), frustrates Indigenous practices of addressing health issues holistically (Christie, 2006).

Assumptions underlie both the biomedical and Indigenous discourses of health, disease, treatment of illness etc. Without the benefit of Indigenous knowledge which underpins Indigenous health constructs, attempts to apply the medical model of health (and illness) care are often ineffective. Language plays an integral role in shaping cultural constructs of health and disease and is crucial to identity, health and relations. It is especially important as a link to spirituality which is an essential component of Indigenous health and wellbeing (King *et al*., 2009).

There is a direct relationship between first language capacity and the capacity to learn another language. Indigenous language programs in the NT are not currently highly valued sending a concurrent message that Indigenous culture is also of little value. If Indigenous language speakers are not given the opportunity to maximise their first language capacity, then their capacity to proficiently learn English is compromised. This means that they operate ineffectively between the dominant culture which is providing their health care services and their own culture with resulting poor health outcomes. Interpreting services (which are currently used very inefficiently in the public health system) are vital to beginning to establish some

common understanding between a "white" medical system and its Indigenous patients, but words and word use alone do not equate to understanding, especially where those providing the information (i.e. health care professionals and interpreters) may not fully comprehend the information themselves or the implications of that information.

The communication of health prevention, promotion and maintenance messages must take place in a meaningful manner. This can only occur when all stakeholders have some common understanding. The teaching and associated validation of Indigenous languages and culture, both in Indigenous and non-Indigenous communities and including in early childhood education can only strengthen Indigenous identity as well as promote stronger cross-cultural understanding (Greenwood 2005). Better cultural understanding between health care providers and health care users results in better health care and health outcomes. Indigenous language teaching and revitalisation contributes to this and can thus a health promotion strategy.

References

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