Language Policy, Languages in Education and Physical Wellbeing

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Abstract

The paper uses capability approach to human development as an evaluative framework to analyze the differential impacts of languages learnt in private and government schools on the valued dimension of participants' health and physical wellbeing. The findings discussed, in the paper, are a part of a wider 3-year qualitative study in urban Pakistan. The data emerging from 16 cases (each case comprising a final year secondary school student and his/her 5-6 year older same-sex siblings) reveal that poorly learnt English, against the perspective of wide use of English in the field of health in Pakistan, constrained the government school participants' range of choices regarding their physical wellbeing. Insensitivity to the linguistic diversity in the domain of health services and lack of linguistic capital of English restricted their agency to access health related information; participate in their management of health and make effective choices. The paper argues for acknowledging the linguistic diversity of Pakistan and making room for local languages in the provision of health services, while expanding the opportunities for learning English in Pakistan.

***Keywords**: health, languages in education, language policy, capability approach*

Introduction

Language policies and the question of languages in education, in multilingual contexts, has been a subject of much debate because of the implications for resurrection of inequality (Pennycook, 1998; Rahman, 2006; Skutnab-Kangas, 1998; Tollefson, 1991). Languages are a subtle but potent tool of exclusion and discrimination (Bourdieu, 1991; Osama, 2012; Rahman, 2006; Tamim, 2013a; Tamim, 2013b). Robinson's (1996) study in African development perspective shows how ethnic and gender-based exclusion can result from the use of a certain language in development projects. A recent collection of sociolinguistic papers highlights the relationship of language choices and income poverty (Harbert, McConnell-Ginet, & Miller, 2008). However, there remains a gap for an integrated approach that conceptualizes languages in education and language policy in confluence with each other and explores it with reference to narrowly

defined poverty. Health, or physical wellbeing, is an important facet of multidimensional poverty that remains under-researched with reference to languages. Although studies in immigrant contexts in the West have highlighted the issue to some extent (Saal, 2011; Timmins, 2002; Wilson, 2005), the problem remains under-researched in home country context (Pakistan).

This paper contributes to the current literature by exploring the under-researched link between language policy, languages in education and relative poverty in the dimension of physical wellbeing in the multilingual context of Pakistan. The paper is based on some findings of a wider 3-year study, conducted in the urban Karachi (Sindh) and Lahore (Punjab). The question this paper explores is: How do languages learnt in private and government schools differentially affect participants' range of choices to achieve physical wellbeing? The paper uses the evaluative framework of Amartya Sen's capability approach to human development to conceptualize poverty as relative inequality in the range of choices or opportunities i.e. capabilities (Sen, 1990). The findings discussed in the paper are limited in the sense that these did not comprise the main area of inquiry but emerged as a significant theme during data analysis. Nevertheless, these findings highlight an important, but much ignored dimension of future research.

The paper is divided into six sections. The first provides the introduction. The following section gives an overview of literature. The third section discusses the theoretical framework and the fourth presents the context, followed by findings in the fifth section and discussion in the sixth. The paper concludes by summarizing the key points.

Literature Review

Language is a key semiotic mediational tool that facilitates communication. However, treatment of languages as a separate discipline, and its ubiquity in social interaction often leads to its invisibility in development-related discourse. Research on language and health is not only limited but also restricted to Western immigrant contexts. A systematic review of studies published in biomedical journals from 1990-2000, exploring language barriers in terms of access to health care, quality of care, and health status outcomes revealed a strong evidence that language acts as a barrier, adversely affecting access to care in 55% of the studies. In 86% of these studies there was an indication of "a significant detrimental effect of language barriers" on quality of care; while in two out of every three studies there was an indication of "language to be a risk factor for adverse outcomes" in terms of health, in one aspect or the other (p. 1). Timmins (2002) concluded that despite the presence of multilingual

communities, the health service system in California, United States was geared towards serving only the dominant language speakers. Yu, Nyman, Kogan, Huang, and Schwalberg *(*2005) in their study, using a bi-variant and multi-variant approach, analyzed the relationship between two key variables: level of English proficiency of the parents and access to health care that their children had. The study came to the conclusion that individuals who lacked knowledge of dominant language, remained poorly informed regarding health facilities provided by the state.

Singleton and Krause (2009) researched how culture and language could be taken into consideration for developing effective interaction patterns for health literacy. They found that the provision of health was intrinsically inter-connected with issues of communication in reaching out to a linguistically diverse population. According to their study, nurses played a crucial role in minimizing or maximizing the communication barrier in positive health outcomes. Another study, in South Africa concluded that when patients' home language was used to communicate health issues, their level of comprehension was much higher than when any other language was used (Saal, 2011; Wilson, 2005). Metzger, Phillips and Greenfield *(*2007) in their study analyzed the effects of language discordance of (i) level of health education and (ii) quality of interpersonal care that the patients receive with patients' satisfaction. The study led to the conclusion that language-based barriers between service providers and receivers in the health sector were associated with poor health education and low levels of patient satisfaction. The effect of the latter was not dispelled with the presence of a clinic interpreter. However, where concordance existed between patients and doctors, the patients were more satisfied with the consultation and displayed a greater understanding of their medical issue.

In another study, Wilson et al., (2005) conducted a telephonic survey of 1200 individuals in 11 languages, in California, United States. The survey aimed to study the link between English proficiency and medical comprehension through logistic regression. The findings revealed that limited English proficiency created difficulty in comprehension of medical information and exposed the patients to high risk of adverse medication effects. Respondents in this study indicated having problems in understanding their medical situations and trouble in grasping the medical terminology on the labels. These studies reveal significance of the relationship between language and health. However, being focused on culturally diverse immigrant communities in the West, they disclose little about the situation in Pakistani multilingual context.

Capability Approach: Agency, Choice, and Participation

Poverty, from a capability-based approach is essentially multidimensional. Hence it entails all physical, psychological and economic aspects of human life (Crocker, 2008). Correspondingly, the concept of wellbeing is also multifarious. The approach argues that rather than measuring equality in provision of resources, equality in social policies and institutions must be evaluated in the space of "capabilities" i.e. the range of freedom of choices and opportunities that these offer to individuals to achieve what they value (Sen, 1990). This is based on the realization that equality does not necessarily follow from the provision of the same resources because individuals, grounded in their own unique socio-cultural contexts, may require different resources to achieve the same valued goal. Hence, accounting for difference is the stepping stone towards an equitable society (Sen, 1983, 1990, 1999, 2000).

Freedom, incorporated in the concept of "capabilities" is based on a recognition of and respect for human agency (Sen, 1999, p. 69). Foregrounding human agency, allows the approach to conceptualize individuals as agents of change rather than passive recipients of aid (Sen, 1999). Agency is strongly connected to wellbeing but it is wider in meaning. While wellbeing is limited to one's own improved condition where the individual appears more of a beneficiary, agency is concerned with the totality of wellbeing goals of self as well as the capability to contribute to the wellbeing of others (Alkire, 2002). In this sense, it captures the contribution of the individual to the society. Participation crystallizes individual agency, ultimately leading to "collective agency" of people for "rational scrutiny of options," and positive social change (Crocker, 2008). Hence widening participation and inclusion lie at the core of social justice (Fraser, 2008) on which capability approach rests.

The act of choice and freedom to make a choice are of central concern to the capability approach. This is because making a choice is an act of agency and as such, intrinsically valuable to individuals. In addition, it is instrumentally significant for achievement of valued goals. Hence, mediated by agency, choice making is directly connected to individual wellbeing. The agency to make choices, however, is mediated by the sociocultural context, that may facilitate or inhibit its exercise (Ahearn, 2011). This explains the emphasis of capability approach on the choice making process and highlights two facets of capability: a) opportunity structure and b) development of skills. The first, we would argue, in the context of this paper, deals with the political economy of structures constructed by the language policy, while the second highlights the significance of education. Nussbaum (2000) focuses more on the first, while Sen (1990) on the other (Crocker, 2008), we argue for a conflation of

the two, as also suggested by Crocker. This is because choices can be meaningful only when there is congruence between the opportunity structure and individual skills of those involved. Hence, the necessity of considering the language policy and languages in education with reference to each other, in exploring language-based impacts in the domain of health.

Education is of crucial importance to capability approach for three main reasons: a) it has intrinsic value for individuals; b) it expands the range of effective opportunities for individuals; and c) it enables informed choice making. Hence, education mediates the achievement of valued goals through widening participation and access, while being intrinsically related to individual wellbeing. However, research puts forth evidence that such educational processes are not unproblematic (Unterhalter, 2005; Walker, 2007) and education can reproduce inequality, if inequitable (Bourdieu & Passeron, 1977). Hence, there is a need to evaluate educational outcomes in terms of equality.

The Context

Pakistan is a multilingual country with more than 25 languages. Of these, Punjabi is the mother tongue of 44.15%; Pashto, 15.42 %; Siraiki, 10.53 %; Urdu, 7.57 %; Sindhi, 4.10%; Baluchi, 3.57 % and others, 4.66 % (Census, 2001). Pakistan has a low literacy rate of 58% (Economic Survey Pakistan, 2012-13) with only 5 % in higher education (Economic Survey Pakistan, 2011).

In Pakistan, since its independence from the British in 1947, English has retained its status as the official language, although it was Urdu that was declared to be the national language. Despite constitutional commitment to Urdu (Constitution, 1973, Article 125), English remains the language of prestige, used by the elite, bureaucracy, military, higher judiciary, higher education and in all-important official discourse. Regional languages stay in the lowest position in the linguistic hierarchy and hardly any role is ascribed to them by the national language policy.

Languages, as medium of instruction have been an issue of much debate among educationists and politicians of Pakistan, and the controversy has been acknowledged even in the latest National Education Policy (2009). Such arguments have been three dimensional: emphasis on home language for better conceptual learning; promotion of Urdu for national identity and solidarity; promotion of English because of its growing global significance. However, it is Urdu vs. English as the medium of instruction that has formed the locus of the arguments.

Currently, a large majority of private schools, in urban areas, offer English as the medium of instruction and teach Urdu, English and Sindhi (the latter only in the case of some schools preparing students for provincial matriculation examination, in Sindh). Being "English-medium" is flaunted as a display of quality by these schools to attract parents in this context (Tamim, 2010). However, the teaching and learning of the languages in these schools often correspond with their fee structure, with those charging higher fees also offering better English. Hence, English is handed over differentially across classes (Rahman, 2006).

The mainstream government schools, until 2012, with the exception of the province of Sindh, have been offering education in Urdu, with regional languages ascribed little role, if any, beyond primary level. In Sindh, the option of secondary schooling in the medium of Sindhi also exists in some government schools. The latest National Education Policy (NEP, 2009) re-affirms the constitutional right of provinces to promote their languages and select languages for use in education but restricts its use to grade V, after which, it declares that English will be the medium of instruction for Science and Mathematics (p. 28).

The decision was taken to cater to the increasing demand of English-medium education in the country, notwithstanding the poor English proficiency of the teachers. A government policy paper, states "There seems to be an increasing demand for English as medium of instruction in government schools but the schools lack institutional capacity to offer education through English" (National Report of Pakistan, 2008-09, p. 11). Currently, the government, with the assistance of British Council, is launching English language teacher training program. However, teacher training is only one of the problems. Another major issue, largely ignored in the planning of commoditized re-distribution of English, is that the language is almost foreign to a large majority of the poor that form the major part of the student population in these government schools. The conceptual challenge of schooling for these cannot be hard to imagine. More recently, given these issues, the government of Punjab, has rolled back its decision of shifting the medium of instruction from Urdu to English, and left the choice to individual schools. However, oblivious of such problems in Punjab, other provinces, for example, Khyber Pakhtoonkhawan (KPK) press ahead with English-medium education. Hence, with little research and informed decision making the confusion around the medium of instruction is far from being resolved.

Methodology

The study used a qualitative methodology and a multiple case study design. The 16 cases were pairs of siblings, educated from 3 public

and 4 private schools in Karachi (Sindh) and Lahore (Punjab) in Pakistan. Each case comprised final-year secondary school student and his/her 5-6 year older sibling of the same sex. This allowed studying of time-related processes, with reference to schooling choices, and language-based practices within schools and outside. Though, the case study design restricted the generalizability of its findings, it allowed an in-depth exploration of the issue, otherwise not possible (Pring, 2000).

The methods of data collection included: a) semi-structured, individual, ethnographic style interviews; b) participant observation; and c) documentary analysis. The three principles guiding data collection were: a) using of multiple sources of evidence; b) creating of a case study database; and c) maintaining a chain of evidence (Yin, 1984). It was the issues highlighted by the participants in the interview data that largely informed the collection of other data. The dimension of human development suggested by Alkire (2002) provided a flexible structure to the interviews (see Appendix A). The interview began with broad questions related to a specific domain, and the participants were encouraged to provide real life examples to validate their statements. A new domain was only introduced, if the participants had not commented on it earlier. This was only to remind if the participants wished to add something to their responses. The participants were not obliged to comment on each dimension. At the end of each individual interview, the researcher revisited the key responses with participant, listing them under each domain, to arrive at a mutually agreed interpretation.

The data analysis was guided by the constant comparative method of Strauss and Corbin (1998). Each interview was fully transcribed and line-by-line coding was done. This mainly comprised the terms used by the participants. The data was then revisited to merge initial codes into broader categories. This was followed by "axial coding," to access more abstract categories, under each dimension of human development, identified by Alkire (2002). Finally, data across the cases was revisited and several detailed matrices were made. This led to the cyclical process of collapsing and emerging of earlier categories, until a coherent interpretation and explanation of the phenomena could be constructed. This was validated with evidence from other sources. Hence, the whole process of analysis though described here in a linear fashion was very much cyclical, leading to increased depth of interpretation, at the completion of each cycle.

Findings

Profile of the Participants

The private school participants (PSPs) had English-medium schooling and belonged to relatively stronger economic background than the government school participants (GSPs). The PSPs also had educated parents, who were supportive of their education. In contrast, all the government school participants (GSPs) reported low parental education. Four of the eight GSP cases, which formed the lowest income group, reported disruptive schooling journeys, as their parents attached little value to their education. The others with relatively higher income, however, did share with PSPs, a parental commitment to their education. Research has highlighted how these differences advantage the middle class children in terms of cognitive and verbal development (Bernstein, 1970; Lawton, 1968). Even if not seen in deterministic terms, it can hardly be denied that this social positioning placed the lowest income group of GSPs most disadvantageously. At the time of the data collection all the younger siblings were in the final year of secondary school. All the PSP elder siblings were in higher education. The low-income group of GSPs was in low-paid jobs (except one female who had started a small- scale business), while those with comparatively higher incomes, among GSPs, were in higher education.

At the end of secondary school, the participants' self-reported learning of English corresponded to their socioeconomic background. All of the PSPs claimed having learnt English to a considerable extent, though only seven of them felt highly confident of their English skills. In contrast, the GSPs described their English skills as only minimal. The PSPs, invariably reported their Urdu as "poor," while a majority of the GSPs reported learning Urdu. With the exception of one, none reported learning Sindhi from school. Significantly, those with the lowest income backgrounds benefited the least from schooling in terms of language learning. The findings, reported in this paper, are in the form of themes arising across the cases of two groups of government and private school participants, in relation to freedom of choices to achieve valued physical wellbeing and health. A discussion of intra-group and gender differences lie beyond the scope of this paper.

Physical Wellbeing, Languages and Choices

In the two urban areas of Karachi and Lahore, there was hardly any evidence of official use of regional language in the domain of health. Information collected at different private and public hospitals, revealed that English was the main medium of almost all documentation. The patient consent forms and other legal documents were also in English. In

privately run hospitals, the sign posting was mainly in English, only occasionally accompanied by Urdu. However, in government hospitals, more Urdu than English was used for the same purpose. In pamphlets for public health awareness, in these hospitals, though both English and Urdu was used, the information provided in English was often different from that given in Urdu. The English information was more detailed, while the information in Urdu was very basic. Despite limited collection of data, it was clear that English was the main language used in health related documentation, followed by Urdu. There was, however, hardly any use of regional languages.

The participants did not attribute any role to regional languages in their physical wellbeing. However, they felt the use of regional language, at times, generated a sense of bonding between the doctor and patient, when they belonged to the same ethnic background. In contrast, they ascribed a pivotal role to Urdu in maintaining their health. Both the groups felt that they received and understood most of the health-related information, through media and in Urdu. In addition, the doctor-patient communication also mainly took place in Urdu. Participants, with a mother tongue different from Urdu, especially appreciated the role Urdu, learnt from school, played in allowing them to facilitate the medical treatment of their parents, who could not speak the language. However, the subtle discrimination at work because of not knowing English did not go unnoticed by the participants.

All the participants felt that not knowing English constrained the agency of the government school participants (GSPs) to make informed choices, while expanding the range of choices available to the already privileged private school participants (PSPs). Rizwana (PSP) described how her English skills enabled her to make healthy choices related to her “diet,” “medication” and “cosmetics.” She pointed out, that the large variety of “off the shelf products available in the market” were mostly imported, and hardly ever, carried information in Urdu. She emphasized, “I can read through information and decide what suits me to avoid any adverse effect [or] to gain maximum benefit.” Tehmina (PSP) reported how her brother consulted a number of health magazines for his physical fitness regimes. She argued “these are available only in English,” and “only someone who knows English can access these magazines … although they are quite cheaply available [in second-hand book stores].”

The government school participants emphasized that the major bulk of health related information was in English, and the information in Urdu was only selective translation of the English text. Hence, they were denied the primary choice of what to know and what was important regarding their health. “Even a disposable syringe has English on it,”

commented Khalid (GSP), as he explained how not knowing English restricted his agency to make informed choices. Sameen (PSP) also related an incident of someone in her family, who suffered from the adverse effect from the intake of a medication, since she could not read the English literature accompanying the syrup.

Language and Access to Health-Related Information

Although GSPs considered Urdu as a major medium of their information regarding diseases like HIV, AIDS, Tuberculosis and Hepatitis C etc., several of them expressed a sense of vulnerability because they could not "fully understand what was going on [since] so much English is used," commented Khalil. Adil (GSP) emphasized that even in Urdu programs televised on health, so many English terms are used that it is difficult to understand "we called them [the television station] and told them of our problem but they do not get it."

Almost all of the GSPs had access to Internet cafes, which they frequented. "There is so much information [health-related] on the internet," explained Asim but "we cannot understand English." In contrast, PSPs related how their English enabled them to retrieve health-related information on the Internet. Farhan (PSP) felt his English empowered him to manage his father's illness by exploring his illness-related information on the Internet. This enabled him to ask the doctor specific questions that facilitated managing of his health problems. "If I had not read about his illness on the Internet, the doctor would not have discussed things in half the detail he did." Anyone, he believed, with poor English language skills, could never do the same. Where the participants reported low English proficiency, they also reported constantly switching between Urdu and English to process information. Misbah said, "There are so many things I cannot understand in Urdu then I read in English to understand like expiry dates." This suggested poor language learning, while indicating that health related information if only in one language could be difficult to access.

Halima (PSP) described how she developed a "deeper understanding" of "dengue fever," from a seminar at a medical college rather than just "fragmentary information" on the media. However, the use of English in these "free for al" seminars, subtly excluded from its participatory benefits, those who did not know English. Hence, from the opportunity to take control of their health, make informed choices and achieve physical wellbeing.

Partnership in Health Management: Doctor-Patient Communication

All the participants regarded Urdu as highly important in doctor-

patient communication. A few also suggested that the use of Sindhi created a sense of bonding between the doctor and the patient, if they shared the same ethno-linguistic background. Nevertheless, the PSPs, more confident of their English skills argued that if they discussed health issues with the doctors, in English, the latter responded in more detail and trusted them of being capable of handling in-depth information. Faraz (PSP) recalled taking his grandmother to a doctor with his father. He described the effect of his using English on the doctor. "I talked to him in English and the doctor would then just look at me and explain everything to me, although my father was also there."

"The doctors also feel more comfortable in communicating in English because the medium of their education has been English, so it is easier for them to convey the information in the same," explained Hira (PSP), a final year medical college graduate. Nevertheless, Hira emphasized the down side of the lack of regional language knowledge among the doctors. She reported that "the majority of the medical students and doctors at our hospital cannot speak Punjabi or understand it."Referring to the common mode of borrowings from English into Urdu, she commented:

> We only think we know Urdu but we don't ... try it yourself and it is such an issue … every word of English we speak is simply lost on them [patients from rural backgrounds] ... any word of English that slips through you is not there … for them as good as never spoken. (Source: Interview PSP Lahore, 2008)

Samia (PSP), another final year medical student, in Sindh, explained that not knowing the regional language led to serious issues regarding diagnosis and management of the diseases when rural population turned to hospitals in urban areas for treatment. She explained, with reference to the government hospital where she worked: "We are just running about to find someone who can understand what they are saying … or making wild guesses," In such cases, patient compliance and trust important for effective diagnosis and health management could hardly have been achieved.

Discussion

The findings highlight the relationship between languages learnt within formal education and the agency to make informed choices participate in social processes and contribute to the wellbeing of self and others. English language skills emerged as an important factor in determining both the range of choices available to participants, for physical wellbeing, and exercise of individual agency to decrease health-related vulnerability. However, use of English can be clearly seen as only

one aspect of the issue. Another emerging aspect was that of health professionals' lack of familiarity with regional languages, and their failure to connect effectively with the poorest, and the most vulnerable section of the population. This is an issue that remains unaddressed in the National Education Policy (NEP, 2008-09), and in other policy documents. Even if all the school going population acquires English, the issue of disconnect between the educated and the existing, large, illiterate, rural population in Pakistan, that may not have access to any of the dominant languages, will not be resolved. Alkire (2002) with reference to the "informed consent" of the patients, sought by doctors, argues that:

> A patient is not a victim but a person with many activities, needs and values of which health is one. And the medical professional is not an expert in all things, but has a delimited area of knowledge and resources in relation to human health. (p. 147)

This means that the doctor and patient have to forge a partnership to manage the targeted illness, based on a relationship of trust. Even the concept of "informed consent" is based on the idea of balancing out the power equation between doctor and patient, and allowing the patient to understand, weigh options and make choices. This is hardly possible if the doctors and patients barely understand each other. Here, the pivotal mediational role of language becomes apparent. Language emerges as "a part of what constitutes these contexts rather than a separate and independent set of structures" (Pavlenko, 2002, p. 298). It can be seen, subtly resurrecting inequality, as the agency of the GSPs to make informed choices is restricted, while being extended to others.

Significantly, the results of this study are congruent with the findings of similar studies in the West. Timmin's (2002) study in the context of USA revealed that the multilingual context stands ignored in the domain of health and the languages used in the field of health are primarily dominant. He also found that the choice of language affected different dimensions of health care. This was true in the current study in Pakistani context as well. In Pakistan, Urdu and English were the dominant languages in health sector. At times there was more use of English than Urdu. This was in strong contrast to the linguistic reality of the context, where English is an elite capital and its access to a majority of the population is limited in Pakistan. The findings also reveal issues of communication between doctors and patients, as indicated by other studies (Saal, 2011; Singleton & Krause, 2009; Yu et al., 2005); and limited access to health information, if English proficiency was low, as revealed by Wilson's study (2005).

The results of the study showed that the concurrent processes of: a) unequal opportunity to learn English; b) de-valuation of the language (Urdu) that the GSPs had learnt and which was almost the lingua franca in the country; c) lack of emphasis on the learning of regional languages in education; and d) dismissal of regional languages in the domain of health, excluded and marginalized the already disadvantaged GSPs, and by extension others with disadvantaged backgrounds, while enhancing the agency of the privileged. Language played a crucial role in limiting the participation of the GSPs in processes that could lead them towards better health management. This was evident in their subtle exclusion from health seminar conducted in English, their limited access to Internet and their inability to read medical literature accompanying medicines. Such instances of exclusion curtailed their informational base and limited the range of health-related choices GSPs could make. The power of English in the given context, also limited their agency to take control of their health, with the help of doctors, and likewise the agency of the doctors to contribute to the wellbeing of the poorest and most vulnerable population.

The findings support the claim that "agencies are always co-constructed," and can only be realized "if the environment allows for such agency" (Pavlenko, 2002, p. 293). In ascribing a diminished role to Urdu and regional languages, in favor of English, the language policy perpetuates marginalization. It is significant, that while the studies cited in this paper, were in immigrant contexts of the West, the findings of the current research relate to a vast majority of the population, in home country context of Pakistan. Hence, the current language policy and languages in education policy fail to restore full citizenship rights to all, in terms of accessing, processing and utilizing health-related information, for achieving the valued goals of physical wellbeing. In marginalizing the role of Urdu, and regional languages, the national language policy and the languages in education policy fail to address the issues of inequality and instead force a large population into marginalization in the crucial domain of health.

Conclusion

The aim of the paper was to explore the relationship between languages in education, language policy and physical wellbeing, which is an important aspect of relative poverty. Equality, in the paper, was conceptualized in the space of "capabilities" i.e. the range of freedom of choices offered by social institutions and social policies, as suggested by Sen (1990). The findings revealed that the government school graduates remained marginalized in terms of their agency to fully participate, access information, and make informed choices to achieve their physical

wellbeing, despite completing secondary education. This resulted from poor learning of English, in contrast to the wide use of the language, in the domain of health. Hence, opportunity structures are shaped that subtly exclude not only the GSPs but by extension, also a large section of rural population, seeking health care in Urban areas, with little access to dominant languages. The redistribution of English, fails to address the problem in is entirety. Achieving equality requires acknowledging and accepting the multilingual diversity of the context. This means incorporating regional languages in education and moving towards a more inclusive language policy that ensures representation of regional languages in health services, for enhancing the agency of individuals to achieve their physical wellbeing. While the study may be limited in its findings, it puts forth an important area of future investigation in Pakistan.

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Appendix A

Dimensions of Human Development

Knowledge: Capability to use languages, access knowledge in formal and informal settings, and life-long learning. This includes accessing, participating, and pursuing in valued educational activities including use of technology.

Life (*Health, Economic and Psychological Security*): Capability to survive and being healthy, employability and capability to financially support self and family, being able to live with dignity and respect, and feeling secure and free of threat or humiliation.

Relationships: Capability to build relationships based on mutual respect, affiliation and collaboration; social networking.

Excellence in Work: Being able to participate, enjoy and experience creativity; compete for promotions and recognition in work.

Control over Environment: Capability to control day to day issues; gain understanding and independence in matters confronted.

Participation: Capability of being aware of political circumstances and making informed decisions; having a voice and being heard.

Religion/Spirituality*:* Capability to access multiple sources of religious information, and practicing religion.

Inner Peace: Being satisfied and contented (Many participants affiliated it with religion and psychological security).

Adapted from Alkire (2002)