

## The Ostrom-Wacquant Model Applied: Vietnamese Herbal Apprenticeship in Islamabad

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#### Abstract

Vietnamese herbal apprenticeship refers to an ancestry-based mode of knowledge transmission, in which, therapeutic practices are learned through direct mentorship, observation and long-term immersion within traditional healing environments rooted in Vietnamese ethnomedicine. Historically, such knowledge moved beyond Vietnam through diasporic mobility, transregional practitioner networks and integrative medicine exchanges, gradually entering Pakistan in the late 20<sup>th</sup> century via informal training circuits and complementary therapy clinics. This study addresses a core governance problem, namely the absence of regulatory clarity and institutional recognition for apprenticeship based foreign herbal systems within Pakistan's plural health structure. It raises two research questions, first how Vietnamese herbal apprenticeship is positioned within Pakistan's broader health governance framework, and second how such practices operate within the urban regulatory and socio-cultural environment of Islamabad. Empirical findings from semi structured interviews with experts (N=3) and their patients (N=20) indicate moderate socio-cultural acceptance driven by affordability, perceived efficacy and patient trust, alongside concerns regarding standardisation and legal ambiguity. Here, the Ostrom-Wacquant Model integrates polycentric governance with neoliberal structural analysis to conceptualise how multiple health authorities coexist under uneven regulatory conditions shaped by market expansion and state limitation. This study applies respective model to map authority distribution, regulatory gaps and legitimacy patterns within Vietnamese herbal practice. The findings demonstrate that Vietnamese herbal apprenticeship in Islamabad operates within a hybrid governance space marked by informal legitimacy, selective acceptance and structural regulatory exclusion.

## Introduction

Vietnamese herbal apprenticeship represents a historically grounded system of medical knowledge transmission rooted in familial lineage, master-disciple relations and experiential learning within local healing ecologies of Vietnam. This tradition evolved through centuries of interaction between indigenous Vietnamese practices and broader East Asian medical philosophies, particularly those influenced by Chinese materia medica and diagnostic frameworks. Knowledge transfer occurs through prolonged observation, repetitive practice and oral instruction rather than formal institutional certification. Apprentices internalise diagnostic reasoning, plant identification and preparation techniques within community-based settings. The system prioritises holistic healing, integrating physical, spiritual and environmental dimensions of health. During the colonial and postcolonial periods, Vietnamese herbal knowledge adapted to shifting socio political conditions while maintaining its apprenticeship core. Migration and regional exchange facilitated the outward movement of practitioners beyond Vietnam. As a result, Vietnamese herbal apprenticeship emerged as a transregional knowledge system embedded in informal yet resilient networks (Wilson, 2020).

The movement of Vietnamese herbal apprenticeship into Pakistan reflects broader patterns of medical mobility and cross-cultural exchange in late twentieth century Asia. This shift occurred through itinerant practitioners, integrative medicine initiatives and informal training relationships established in urban centres (Ahmed, 2023). Unlike institutionalised systems such as Unani or homeopathy, Vietnamese herbal practice entered Pakistan without formal regulatory endorsement. Its transmission relied on personalised mentorship and small-scale clinical engagement rather than state sanctioned curricula (Asim & Hussain, 2026). Early adoption was facilitated by patient demand for alternative therapies that were cost effective and perceived as natural. Over time, limited practitioner networks developed in select cities, creating micro level ecosystems of practice and learning. However, the absence of codified standards constrained its expansion within formal healthcare structures. This has positioned Vietnamese herbal apprenticeship at the margins of Pakistan's recognised medical systems while maintaining operational continuity (Hussain, 2026).

Within Pakistan's plural health landscape, Vietnamese herbal apprenticeship occupies a niche yet visible position shaped by socio cultural receptivity and economic considerations. Patients often engage with such practices as supplementary or alternative options when biomedical treatments are inaccessible or unsatisfactory. The perceived efficacy of herbal remedies and personalised care contributes to a degree of trust among specific population segments. At the same time, scepticism persists due to limited scientific validation and absence of institutional oversight. Regulatory bodies have not established clear frameworks to classify or monitor such foreign apprenticeship-based systems. This creates ambiguity regarding practitioner legitimacy, training standards and patient safety. Despite these constraints, informal acceptance continues to expand through word of mouth and practitioner reputation. The coexistence of acceptance and uncertainty reflects the broader dynamics of medical pluralism in Pakistan. This environment sustains Vietnamese herbal apprenticeship while simultaneously restricting its formal integration (Hussain, 2026).

In Islamabad, the practice of Vietnamese herbal apprenticeship exhibits a distinct urban configuration influenced by socio economic diversity and institutional proximity. The city's relatively educated population demonstrates openness to complementary and alternative medicine, particularly among middle and upper classes. Clinics operate in semi formal settings, often combining herbal treatments with

other integrative therapies. Patient engagement is shaped by considerations of cost, accessibility and perceived effectiveness. Regulatory oversight remains limited, with authorities largely focusing on biomedical and recognised traditional systems. This allows Vietnamese herbal practitioners to function within a loosely monitored environment. However, the lack of formal recognition constrains their ability to scale operations or collaborate with mainstream institutions. The urban context thus produces a controlled yet permissive space for practice. Islamabad therefore serves as a critical site for analysing governance gaps and adaptive strategies within medical pluralism (Hussain, 2026).

The Ostrom-Wacquant Model provides the analytical framework through which this study evaluates the governance dynamics surrounding Vietnamese herbal apprenticeship. This model integrates Elinor Ostrom's concept of polycentric governance with Loïc Wacquant's analysis of neoliberal restructuring. It conceptualises health systems as arenas where multiple authorities operate simultaneously under uneven regulatory conditions. Polycentric governance explains the coexistence of state, private and informal actors without assuming centralised control. Neoliberal structural analysis highlights how market expansion and limited state capacity shape service provision and inequality. By combining these perspectives, the model captures both institutional plurality and power asymmetry within healthcare systems. In this study, it is applied to examine authority distribution, regulatory absence and socio-cultural legitimacy. The framework enables systematic evaluation of how Vietnamese herbal apprenticeship functions within Pakistan's hybrid governance structure. It also supports empirical linkage between theoretical constructs and observed practices<sup>1</sup>.

The research questions guiding this study are operationalised into specific investigative components addressed through interviews with experts and patients. The first question examines how Vietnamese herbal apprenticeship is positioned within Pakistan's health governance framework, which is further divided into analysis of regulatory recognition, institutional exclusion and interaction with existing medical systems. It also investigates perceptions of legitimacy among practitioners and policymakers. The second question focuses on Islamabad and is broken into assessment of urban acceptance, patient trust and accessibility of services. It further explores how socio-economic class influences engagement with Vietnamese herbal practice. Additional components include evaluation of perceived efficacy, cost considerations and continuity of care. Interviews with experts provide institutional and practitioner perspectives on governance and legitimacy. Patient interviews capture experiential dimensions of trust, satisfaction and cultural alignment. This structured breakdown ensures comprehensive empirical coverage aligned with the study's theoretical framework.

## Research Methodology

This study adopts a qualitative dominant research design grounded in critical governance analysis and interpretive medical anthropology to examine Vietnamese herbal apprenticeship within Pakistan's plural health system. The methodological orientation is theory driven and empirically anchored, enabling structured evaluation of governance dynamics through the Ostrom-Wacquant Model. The research design aligns with the complexity of the subject under investigation, where multiple health authorities operate simultaneously and where institutional legitimacy is socially constructed rather than formally codified. A purely quantitative approach would not capture the layered realities of informal practice, patient

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<sup>1</sup> (Ostrom, *Governing the Commons*, 1990) (Ostrom, *Understanding Institutional Diversity*, 2005) (Ostrom, *Beyond Markets and States: Polycentric Governance of Complex Economic Systems*, 2010)

perception and regulatory ambiguity. Therefore, this study prioritises in depth qualitative inquiry supported by targeted sampling and systematic analytical procedures. The methodological framework ensures coherence between theoretical constructs and empirical investigation. It allows precise mapping of governance structures and their operational implications. This approach maintains analytical rigour while preserving contextual sensitivity.

### **1) Theoretical Operationalisation of the Ostrom–Wacquant Model**

The Ostrom-Wacquant Model functions as the central analytical instrument for this study. It integrates the polycentric governance framework of Elinor Ostrom with the neoliberal structural analysis developed by Loïc Wacquant (Ali & Hussain, 2026). This integration allows the study to examine how multiple centres of authority coexist alongside market driven inequalities within Pakistan’s health system. The model is operationalised across three analytical dimensions, authority distribution, regulatory capacity and socio-cultural legitimacy. Authority distribution refers to the presence of overlapping actors including state institutions, private clinics and informal herbal practitioners. Regulatory capacity examines the extent and effectiveness of formal oversight mechanisms governing practice standards. Socio cultural legitimacy assesses how patients and communities recognise and validate Vietnamese herbal apprenticeship despite limited institutional endorsement. These dimensions directly correspond to the research questions and their sub components. The model ensures that empirical observations are systematically categorised and interpreted within a coherent theoretical structure.

### **2) Research Design and Sampling Strategy**

The empirical component of this study is based on purposive sampling to capture informed perspectives from both practitioners and patients. A total of three experts were selected based on their direct involvement in Vietnamese herbal practice within Islamabad. These experts represent the practitioner level authority within the polycentric framework and provide institutional as well as experiential knowledge. In addition, twenty patients were selected to reflect diversity in socio economic background, gender and treatment experience. The inclusion of patients ensures that the study captures demand side dynamics, particularly perceptions of trust, efficacy and accessibility. Sampling prioritised variation rather than statistical representation to enhance analytical depth. This approach aligns with qualitative research standards where insight generation takes precedence over numerical generalisation. The selected sample size is sufficient to identify recurring patterns while allowing detailed examination of individual narratives. The sampling strategy supports triangulation between practitioner and patient perspectives.

### **3) Data Collection Techniques**

Data collection was conducted through semi structured interviews designed to align with the research questions and their analytical breakdown. Interview protocols were developed to capture responses across the three dimensions of the Ostrom-Wacquant Model. For experts, questions focused on regulatory experience, training processes, interaction with state institutions and perception of legitimacy. For patients, questions addressed treatment outcomes, trust in practitioners, affordability and comparative evaluation with other medical systems. Semi structured interviews were selected to balance consistency with flexibility. This technique ensures that all key themes are covered while allowing respondents to elaborate on context specific experiences. Interviews were conducted in a controlled environment to minimise external influence and ensure data reliability. Each interview was recorded and transcribed for systematic

analysis. The use of verbatim transcription preserves linguistic nuance and supports discourse-based interpretation. This method strengthens the validity of qualitative findings.

#### **4) Analytical Framework and Coding Strategy**

The analysis follows a structured coding process informed by the Ostrom-Wacquant Model. Transcribed interviews were subjected to thematic coding to identify recurring patterns and conceptual categories. Coding categories were developed inductively and then aligned with the model's analytical dimensions. Authority related codes capture references to institutional roles, practitioner autonomy and interaction with formal health systems. Regulatory codes identify perceptions of oversight, legal ambiguity and standardisation challenges. Legitimacy codes focus on trust, cultural acceptance and perceived efficacy. This multi-layer coding approach ensures comprehensive coverage of empirical data. Analytical consistency is maintained through iterative comparison of codes across expert and patient responses. The process allows identification of convergence and divergence in perspectives. This enhances the robustness of findings and supports theoretical interpretation.

#### **5) Application of the Model to Research Questions**

- The first research question examines how Vietnamese herbal apprenticeship is positioned within Pakistan's health governance framework. The Ostrom-Wacquant Model assists in evaluating this by mapping the distribution of authority among state institutions, private actors and informal practitioners. Expert interviews provide data on institutional interaction and regulatory absence, which are analysed under the authority and regulatory dimensions<sup>2</sup>. Patient responses contribute to understanding how these governance structures influence healthcare choices. The model enables systematic linkage between institutional arrangements and lived experiences. It identifies gaps between formal regulation and practical operation. This structured evaluation provides a clear answer to the first research question.
- The second research question focuses on the operational context within Islamabad. The model evaluates this by analysing how urban conditions shape legitimacy and accessibility. Patient interviews provide direct evidence on trust, affordability and treatment outcomes. Expert responses offer insight into practice conditions, clinic operations and engagement with urban institutions. The socio-cultural legitimacy dimension of the model captures how acceptance is constructed within the city's diverse population. Regulatory analysis highlights the extent of oversight within the urban governance framework. This dual perspective ensures comprehensive assessment of the second research question. The model integrates both supply side and demand side factors into a unified analytical process.

#### **6) Triangulation and Validity Assurance**

Triangulation is employed to enhance the credibility and reliability of findings. Data from expert interviews are cross analysed with patient narratives to identify consistent patterns. This approach reduces bias associated with single source data. The use of multiple respondent categories strengthens the internal validity of the study. Methodological transparency is maintained through clear documentation of data collection and analysis procedures. Consistency

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<sup>2</sup> (Berman, 2016)

in interview protocols ensures comparability across responses. Reflexive evaluation is applied to account for researcher interpretation and minimise subjective distortion. These measures collectively ensure that the findings are analytically sound and empirically grounded.

#### **7) Ethical Considerations**

Ethical compliance is maintained throughout the research process. Participants were informed about the purpose of the study and their voluntary participation was ensured. Confidentiality of responses was strictly maintained to protect participant identity. Data storage and handling followed standard research ethics protocols. Informed consent was obtained prior to conducting interviews. The study avoids any form of coercion or misrepresentation. Ethical integrity strengthens the credibility of the research and supports responsible knowledge production.

#### **8) Methodological Justification**

The chosen methodology is justified by the nature of the research problem and the theoretical framework employed. The Ostrom-Wacquant Model requires detailed empirical data to evaluate governance dynamics across multiple dimensions. Qualitative interviews provide the necessary depth to capture institutional complexity and social perception. The combination of expert and patient perspectives ensures holistic analysis. The structured application of the model enables systematic interpretation of data. This methodology ensures alignment between theory, data and research objectives. It provides a robust foundation for answering the research questions with precision and clarity.

## **Part I**

### **Positioning of Vietnamese Herbal Apprenticeship within Pakistan's Health Governance Framework**

Vietnamese herbal apprenticeship occupies a marginal yet operational space within the health governance structure of Pakistan. Its positioning is shaped by the absence of formal regulatory classification and limited institutional engagement. The system functions through informal authority structures grounded in practitioner expertise and patient trust. This creates a parallel layer of healthcare delivery outside codified governance frameworks. The following sections examine its institutional location through regulatory, structural and perceptual dimensions.

#### **1) Regulatory Recognition and Legal Status**

The regulatory recognition of Vietnamese herbal apprenticeship in Pakistan remains structurally undefined within existing health governance laws. The state has established formal councils and regulatory bodies for biomedical, Unani and homeopathic systems, yet no parallel mechanism exists for apprenticeship based foreign herbal traditions. This absence creates a legal vacuum where practitioners operate without explicit authorisation or prohibition. As a result, Vietnamese herbal practice falls into an ambiguous category of tolerated but unregulated activity. Regulatory silence reduces accountability mechanisms related to training standards, treatment protocols and patient safety. It also limits the capacity of practitioners to seek formal certification or institutional affiliation. Interviews with experts indicate that this ambiguity constrains professional legitimacy and restricts expansion into formal healthcare markets. Patients remain largely unaware of the legal status, relying instead on experiential validation and social recommendation. The absence of codification also prevents integration into public health initiatives. This condition reflects a

broader governance limitation in accommodating transnational medical practices (Alhamd & Hussain, 2026) (Hussain, 2026).

## **2) Institutional Exclusion and Policy Gaps**

Vietnamese herbal apprenticeship experiences systematic exclusion from Pakistan's formal health policy architecture. National health policies prioritise recognised systems while neglecting emerging or transregional practices that lack historical institutionalisation within the country. This exclusion is not an active rejection but rather a passive omission from policy discourse. As a result, no structured pathways exist for inclusion, evaluation or regulation of such practices. Experts highlight that policy frameworks are designed around established categories, leaving no adaptive mechanism for new entrants. This creates a rigid governance environment that fails to respond to evolving medical pluralism. Institutional exclusion also affects access to funding, research platforms and professional networks. Practitioners remain isolated from mainstream medical discourse and policy consultation processes. Patients engaging with Vietnamese herbal treatment therefore operate outside formal healthcare coverage. The gap between practice and policy demonstrates a structural disconnect within governance planning. This disconnect reinforces the marginal status of apprenticeship-based systems despite their operational presence (Alhamd & Hussain, 2026) (Hussain, 2026).

## **3) Interaction with Biomedical and Traditional Medical Systems**

The interaction between Vietnamese herbal apprenticeship and existing medical systems in Pakistan is characterised by coexistence rather than integration. Biomedical institutions dominate the formal sector and maintain regulatory authority over recognised medical practice. Traditional systems such as Unani and homeopathy operate within regulated frameworks with established educational and licensing structures. Vietnamese herbal practitioners function outside these systems and maintain independent clinical practices. Experts report limited collaboration with biomedical professionals due to differences in epistemology and absence of formal recognition. Patients often utilise Vietnamese herbal treatment as a complementary option rather than a substitute for biomedical care. This creates a pattern of sequential or parallel healthcare utilisation. There is minimal institutional dialogue between Vietnamese herbal practitioners and other traditional systems. The absence of integration mechanisms prevents knowledge exchange and coordinated care. This fragmented interaction reflects the polycentric yet disconnected nature of Pakistan's health system. It also highlights the lack of governance structures to facilitate inter system collaboration (Alhamd & Hussain, 2026) (Hussain, 2026).

## **4) Practitioner Perceptions of Legitimacy and Authority**

Practitioners of Vietnamese herbal apprenticeship derive legitimacy primarily from experiential knowledge, patient outcomes and lineage-based training. In the absence of formal certification, authority is constructed through demonstrated efficacy and sustained patient relationships. Experts indicate that legitimacy is reinforced through word of mouth and repeat consultations rather than institutional endorsement. This form of authority aligns with informal governance structures where social validation replaces legal recognition. Practitioners perceive themselves as operating within a parallel legitimacy framework independent of state approval. However, they acknowledge limitations in gaining wider acceptance without regulatory backing. The absence of formal status affects their ability to expand practice or engage with official healthcare institutions. Despite these constraints, practitioners maintain confidence in their methods based on accumulated experience. Patient feedback plays a central role in sustaining practitioner

credibility. This dynamic illustrates how legitimacy is socially produced within medical pluralism. It also demonstrates the resilience of informal authority systems in constrained regulatory environments (Alhamd & Hussain, 2026) (Hussain, 2026).

### **5) Policy Level Interpretation and Governance Constraints**

At the policy level, Vietnamese herbal apprenticeship is largely absent from formal governance discourse in Pakistan. Policymakers prioritise systems that are historically embedded and institutionally organised within the national framework. This results in limited awareness and engagement with transregional apprenticeship-based practices. Experts suggest that governance structures lack adaptive capacity to incorporate non-conventional medical systems. The absence of data and formal research further restricts policy attention. Regulatory bodies operate within predefined categories that exclude emerging forms of practice. This creates a structural constraint in recognising and managing medical diversity. Policy interpretation remains narrowly focused on standardised and codified systems. Consequently, Vietnamese herbal apprenticeship remains outside strategic health planning. This exclusion limits opportunities for regulation, quality control and integration. The governance constraint reflects a broader institutional rigidity in responding to evolving healthcare realities (Alhamd & Hussain, 2026) (Hussain, 2026).

## **Part II**

### **Urban Operational Dynamics of Vietnamese Herbal Apprenticeship in Islamabad**

Vietnamese herbal apprenticeship in Islamabad operates within a distinct urban environment shaped by socio economic diversity and institutional proximity. The city provides a semi formal space where alternative medical practices can function without strict regulatory intervention. Urban dynamics influence how patients perceive, access and engage with such treatments. The interaction between practitioner networks and patient demand determines the operational stability of these practices. The following sections analyse key dimensions of urban functioning through empirical evidence derived from expert and patient interviews.

#### **1) Patterns of Urban Acceptance**

Urban acceptance of Vietnamese herbal apprenticeship in Islamabad reflects a selective yet expanding pattern across different social groups. Acceptance is not uniform and varies according to education level, exposure to alternative medicine and personal health experiences. Middle-and upper-income groups demonstrate greater openness due to awareness of global integrative health practices. Experts indicate that acceptance is often initiated through personal referrals rather than institutional endorsement. Patients tend to approach these services after dissatisfaction with conventional treatments. Cultural adaptability of herbal remedies contributes to their gradual acceptance. However, scepticism persists among individuals who prioritise biomedical validation. Religious and cultural compatibility does not pose a major barrier, allowing smoother integration into patient routines. Acceptance is therefore driven by pragmatic considerations rather than ideological commitment. This pattern highlights a demand driven expansion within an unregulated urban framework (Alhamd & Hussain, 2026) (Hussain, 2026).

#### **2) Patient Trust and Perceived Efficacy**

Patient trust in Vietnamese herbal apprenticeship is constructed through direct experience and observable treatment outcomes. Trust develops incrementally as patients report improvement in

chronic or unresolved health conditions. Experts emphasise that personalised consultation enhances patient confidence in the treatment process. The absence of standardised certification does not significantly deter trust when positive results are achieved. Patients often compare outcomes with previous biomedical interventions to assess efficacy. Perceived natural composition of herbal remedies contributes to a sense of safety. Trust is reinforced through consistent follow up and practitioner accessibility. However, some patients express concern regarding lack of clinical testing and formal validation. This creates a dual perception where trust coexists with uncertainty. Overall, efficacy-based validation remains the primary driver of sustained patient engagement (Alhamd & Hussain, 2026) (Hussain, 2026).

### **3) Accessibility and Service Distribution**

Accessibility of Vietnamese herbal services in Islamabad is shaped by geographic concentration and informal practitioner networks. Clinics are typically located in accessible urban sectors, allowing patients from diverse areas to seek treatment. However, distribution remains limited due to the small number of practitioners operating within the city. Experts report that service reach is constrained by lack of institutional expansion and regulatory support. Patients often rely on digital communication or referrals to locate practitioners. The absence of formal directories or listings restricts visibility within the broader healthcare system. Despite these limitations, accessibility is enhanced through flexible appointment structures and personalised service delivery. Travel distance is not a major barrier for patients who perceive treatment value. Service distribution therefore reflects a concentrated yet functional network. This pattern aligns with the informal nature of apprenticeship-based practice (Alhamd & Hussain, 2026) (Hussain, 2026).

### **4) Socio-Economic Class-Based Engagement**

Engagement with Vietnamese herbal apprenticeship varies significantly across socio economic classes in Islamabad. Middle class patients form the primary user base due to their balance of affordability concerns and openness to alternative treatments. Upper class individuals engage selectively, often viewing such services as complementary rather than primary healthcare options. Lower income groups show limited participation due to lack of awareness and preference for public healthcare facilities. Experts indicate that educational background strongly influences engagement patterns. Patients with higher education levels demonstrate greater willingness to experiment with non-conventional therapies. Socio economic status also affects frequency of visits and continuity of treatment. Cultural capital plays a role in shaping acceptance and trust. This class-based variation highlights structural inequalities in access to alternative healthcare options. It also reflects broader patterns within urban medical pluralism (Alhamd & Hussain, 2026) (Hussain, 2026).

### **5) Cost Structures and Affordability Analysis**

Cost structures of Vietnamese herbal apprenticeship in Islamabad are relatively flexible and patient specific. Pricing is determined by consultation time, type of herbal preparation and duration of treatment. Experts report that costs are generally lower than specialised biomedical treatments but higher than public healthcare services. Patients perceive the cost as reasonable when balanced against treatment effectiveness. Affordability is a key factor influencing initial engagement and continued utilisation. Some practitioners adjust fees based on patient financial capacity, reflecting an informal pricing mechanism. The absence of regulatory oversight allows flexibility but also creates inconsistency in pricing standards. Patients from middle income groups find the services accessible without significant financial strain. However, long term treatment may

increase cumulative costs. Inclusively, affordability supports moderate expansion within urban settings (Alhamd & Hussain, 2026) (Hussain, 2026).

#### **6) Continuity of Care and Patient Retention**

Continuity of care in Vietnamese herbal apprenticeship is sustained through personalised treatment plans and ongoing practitioner patient relationships. Patients who experience positive outcomes are likely to continue treatment over extended periods. Experts highlight that follow up consultations are essential for monitoring progress and adjusting remedies. This continuity strengthens patient retention and reinforces trust in the system. Retention is also influenced by the practitioner's communication style and accessibility. Patients value consistent engagement and responsiveness to their concerns. However, lack of formal medical records and documentation may affect long term continuity. Some patients discontinue treatment due to time constraints or shifting preferences. Despite these challenges, retention rates remain stable among satisfied patients. This pattern indicates that relational dynamics are central to sustaining practice within an informal healthcare environment (Alhamd & Hussain, 2026) (Hussain, 2026).

### **Part III**

#### **Comparative Analysis between Expert and Patient Narratives**

This section undertakes a structured comparison between expert perspectives and patient experiences within the operational context of Islamabad. The objective is to identify areas of alignment and divergence in relation to governance, legitimacy and healthcare outcomes. Expert narratives reflect institutional positioning and practitioner level constraints, while patient narratives capture lived experience and service evaluation. The comparison enables a multi-dimensional understanding of Vietnamese herbal apprenticeship within a plural health system. The following analysis is organised across three core dimensions derived from the research framework.

##### **1) Convergence in Governance Perceptions**

Both experts and patients demonstrate a notable convergence in their perception of weak governance structures surrounding Vietnamese herbal apprenticeship. Experts consistently highlight the absence of formal regulatory frameworks and institutional oversight. Patients, although less familiar with policy structures, indirectly recognise this absence through their reliance on informal networks for accessing services. Both groups acknowledge that the practice operates outside codified health governance systems. There is shared awareness that no licensing or certification authority currently governs such practices in Pakistan. Experts interpret this as a structural governance gap, while patients perceive it as an accepted operational norm. Both perspectives identify limited state engagement as a defining feature of the system. This convergence reinforces the classification of Vietnamese herbal practice within a polycentric yet weakly regulated environment. It also indicates that governance absence is not contested but rather normalised across stakeholders. The alignment in perception strengthens the empirical validity of the governance analysis (Alhamd & Hussain, 2026) (Hussain, 2026).

##### **2) Divergence in Legitimacy and Trust**

A clear divergence emerges between experts and patients in relation to legitimacy and trust. Experts frame legitimacy in terms of institutional recognition, professional standards and regulatory validation. They express concern that the absence of formal certification undermines

long term credibility and limits professional integration. In contrast, patients construct legitimacy through personal experience, treatment outcomes and social recommendation. Trust among patients is primarily outcome driven and does not depend on institutional endorsement. Experts view this reliance on experiential validation as insufficient for ensuring standardisation and accountability. Patients, however, prioritise perceived efficacy and practitioner accessibility over formal qualifications. This divergence highlights two parallel systems of legitimacy, one institutional and one experiential. The gap between these perspectives reflects broader tensions within medical pluralism. It also demonstrates how different actors evaluate healthcare systems through distinct criteria. This divergence is central to understanding the persistence of informal medical practices (Alhamd & Hussain, 2026) (Hussain, 2026).

### **3) Institutional Versus Experiential Interpretations**

The distinction between institutional and experiential interpretations provides critical insight into how Vietnamese herbal apprenticeship is understood within Islamabad. Experts approach the system from an institutional perspective, focusing on governance structures, policy gaps and professional recognition. Their analysis is shaped by awareness of regulatory frameworks and comparative medical systems. Patients interpret the system through direct engagement with treatment processes and outcomes. Their evaluation is grounded in personal health improvement, affordability and interaction with practitioners. Experts emphasise structural limitations such as lack of standardisation and absence of formal integration. Patients, in contrast, emphasise functional effectiveness and relational aspects of care. This creates a dual narrative where institutional critique coexists with experiential validation. The divergence does not result in conflict but rather in parallel acceptance of different evaluative frameworks. This duality reflects the hybrid nature of health governance in Pakistan. It also confirms that informal medical systems sustain themselves through experiential legitimacy despite institutional exclusion (Alhamd & Hussain, 2026) (Hussain, 2026).

## **Part IV**

### **Application of the Ostrom-Wacquant Model to Empirical Findings**

This section applies the Ostrom-Wacquant Model to interpret empirical findings derived from expert and patient interviews in Islamabad. The model provides a structured framework to analyse governance complexity within a plural health system. It integrates polycentric authority mapping with a critical assessment of neoliberal influences on healthcare provision. Empirical data are organised across key analytical dimensions to ensure coherence between theory and observation. The following subsections operationalise the model to evaluate authority distribution, regulatory limitations, market dynamics and socio-cultural legitimacy.

#### **1) Mapping Polycentric Authority Structures**

The empirical findings confirm the existence of a polycentric authority structure governing Vietnamese herbal apprenticeship in Pakistan. Multiple actors operate simultaneously, including state health institutions, private biomedical providers and informal herbal practitioners. Experts identify that Vietnamese herbal practitioners' function outside formal regulatory hierarchies yet maintain operational autonomy. This reflects a decentralised governance arrangement consistent with polycentric theory. Patients interact with these practitioners independently of state

mediated referral systems. Authority is therefore dispersed rather than centralised within a single institutional framework. The absence of direct coordination among these actors results in parallel service delivery structures. Experts note that this fragmentation limits opportunities for collaborative healthcare provision. Patients navigate between systems based on accessibility and perceived effectiveness. This multi layered authority structure illustrates the coexistence of formal and informal governance mechanisms. The findings validate the relevance of polycentric governance in explaining Pakistan's health system configuration (Alhamd & Hussain, 2026) (Hussain, 2026).

## **2) Identification of Regulatory Gaps**

The application of the model reveals significant regulatory gaps within the governance of Vietnamese herbal apprenticeship. Experts consistently report the absence of licensing frameworks, accreditation systems and monitoring mechanisms. This lack of regulation creates uncertainty regarding practitioner qualifications and treatment standards. Patients indirectly recognise these gaps through reliance on personal judgement and social networks for selecting practitioners. Regulatory absence also limits the state's ability to enforce accountability and ensure patient safety. Experts highlight that existing health laws do not accommodate apprenticeship based foreign medical systems. This results in a governance vacuum where practices operate without formal oversight. Patients remain largely unaffected in the short term but face potential risks due to lack of standardisation. The model identifies this condition as a consequence of uneven regulatory capacity under neoliberal restructuring. These gaps demonstrate the limitations of current health governance frameworks in addressing emerging medical practices (Alhamd & Hussain, 2026) (Hussain, 2026).

## **3) Analysis of Market Driven Health Practices**

Market dynamics play a central role in shaping the operation of Vietnamese herbal apprenticeship within Islamabad. Experts indicate that practitioners rely on patient demand and service differentiation to sustain their practice. The absence of state support necessitates market-based survival strategies. Patients evaluate services based on cost, accessibility and perceived effectiveness. This creates a competitive environment where informal practitioners position themselves against biomedical and traditional systems. Pricing flexibility reflects adaptation to market conditions rather than regulatory control. Experts note that neoliberal policies have expanded private sector dominance, indirectly enabling such informal practices to flourish. Patients benefit from increased choice but face variability in service quality. The model interprets this as a manifestation of market driven healthcare provision under weak state regulation. This dynamic reinforces inequalities while simultaneously expanding access. The findings demonstrate how economic forces shape healthcare delivery within a plural system (Alhamd & Hussain, 2026) (Hussain, 2026).

## **4) Socio-Cultural Legitimacy within Hybrid Governance**

Socio cultural legitimacy emerges as a critical factor sustaining Vietnamese herbal apprenticeship despite institutional exclusion. Patients confer legitimacy based on treatment outcomes, practitioner behaviour and cultural compatibility. Experts acknowledge that this form of legitimacy operates independently of formal recognition. The model captures this as an essential component of hybrid governance where social validation complements regulatory absence. Patients demonstrate trust in practitioners who provide personalised care and consistent engagement. Cultural openness within Islamabad facilitates acceptance of foreign herbal

practices. Experts observe that legitimacy is reinforced through community networks and patient testimonials. This process creates a self-sustaining cycle of acceptance and utilisation. However, the lack of formal endorsement limits broader institutional integration. The coexistence of social legitimacy and regulatory exclusion defines the hybrid governance environment. The findings confirm that socio cultural factors play a decisive role in shaping healthcare choices within plural systems (Alhamd & Hussain, 2026) (Hussain, 2026).

## Part V

### Synthesis of Findings and Theoretical Implications

This section consolidates empirical findings within the analytical structure of the Ostrom–Wacquant Model. It aligns interview evidence with the study’s core research questions on governance positioning in Pakistan and operational dynamics in Islamabad. The synthesis advances a structured interpretation of how informal systems persist within regulated environments. It establishes linkages between observed practices and broader theoretical constructs of governance and medical pluralism. The following subsections present validated conclusions with direct relevance to policy and institutional design.

#### 1) Validation of Hybrid Governance Thesis

The findings provide strong empirical support for the hybrid governance thesis articulated through the Ostrom-Wacquant framework. Vietnamese herbal apprenticeship operates within a system where formal regulation and informal practice coexist without direct integration. Experts confirm that state institutions neither fully recognise nor actively suppress these practices. This creates a governance space characterised by partial tolerance and indirect oversight. Patients reinforce this structure through continued utilisation based on trust and perceived effectiveness. The absence of enforcement mechanisms allows informal actors to sustain operational continuity. Experts identify this arrangement as a pragmatic adaptation to regulatory limitations within Pakistan’s health sector. Patients do not perceive this hybridity as problematic unless adverse outcomes arise. The coexistence of formal exclusion and social acceptance defines the operational environment. This validates the model’s assertion that governance systems can function through layered authority rather than centralised control. The thesis is therefore empirically grounded within the Islamabad context (Alhamd & Hussain, 2026) (Hussain, 2026).

#### 2) Evaluation of Medical Pluralism Outcomes

This study confirms that medical pluralism generates both functional benefits and systemic risks within the healthcare environment of Islamabad. Patients benefit from expanded access to diverse treatment options, particularly where conventional services are perceived as costly or ineffective. Vietnamese herbal practitioners fill service gaps by providing affordable and accessible care. Experts acknowledge that such pluralism enhances patient choice and service flexibility. However, the absence of standardisation introduces variability in treatment quality and safety. Patients rely heavily on informal verification methods such as referrals and personal experience. Experts raise concerns regarding inconsistent training standards within apprenticeship-based systems. This creates challenges for integrating such practices into formal healthcare structures. The plural system operates efficiently at the level of access but lacks coherence at the level of regulation. The outcomes reflect a trade-off between inclusivity and

institutional control. This evaluation demonstrates that medical pluralism remains operationally viable yet structurally uneven (Alhamd & Hussain, 2026) (Hussain, 2026).

### **3) Implications for Health Policy and Regulation**

The findings indicate a clear requirement for adaptive policy frameworks to address the governance of foreign apprenticeship based medical systems in Pakistan. Experts recommend the development of minimal regulatory protocols rather than full institutional absorption. Such protocols may include practitioner registration, basic competency assessment and monitoring of treatment practices. Patients would benefit from increased transparency without compromising accessibility. The model suggests that rigid regulatory imposition may disrupt existing service networks. A calibrated approach would align with the polycentric nature of the health system. Experts emphasise the need for policy instruments that recognise informal legitimacy while ensuring safety standards. This includes engagement with practitioners through consultative mechanisms rather than enforcement driven strategies. The Islamabad case demonstrates that regulatory absence does not eliminate practice but shifts it into informal domains. Strategic policy design must therefore prioritise integration without suppression. The implications extend to broader health governance reform within plural medical systems (Alhamd & Hussain, 2026) (Hussain, 2026).

## **Conclusion and Strategic Policy Recommendations**

This section consolidates the analytical and empirical outcomes of the study into a structured conclusion. It aligns the findings with the two central research questions concerning governance positioning in Pakistan and operational dynamics in Islamabad. The analysis confirms that Vietnamese herbal apprenticeship functions within a hybrid governance environment shaped by informal legitimacy and regulatory exclusion. It further establishes that socio cultural acceptance compensates for institutional absence but does not eliminate systemic risk. The following recommendations present actionable pathways for governance reform, system integration and regulatory standardisation within a plural healthcare framework.

### **1) Governance Reform Pathways**

The study identifies a requirement for calibrated governance reform that acknowledges the operational reality of informal medical systems. Existing frameworks in Pakistan do not adequately address apprenticeship based foreign therapeutic practices. A phased reform strategy should be implemented to introduce controlled recognition without immediate full-scale institutionalisation. Experts indicate that regulatory engagement must begin with mapping active practitioners and service locations. This will establish a baseline for administrative oversight. A decentralised governance approach aligned with polycentric principles is appropriate for such reform. Provincial and municipal health bodies should be authorised to initiate pilot regulatory mechanisms. These mechanisms may include voluntary registration and periodic compliance reviews. Patients will benefit from increased transparency and accountability within service provision. Reform pathways must avoid excessive bureaucratic burden to prevent displacement into deeper informality. Strategic governance adjustment will enhance system coherence while maintaining service accessibility.

### **2) Integration Strategies for Apprenticeship Based Systems**

The integration of Vietnamese herbal apprenticeship into the broader health system requires a structured yet flexible approach. Immediate formal absorption is neither feasible nor operationally efficient given current institutional constraints. Experts recommend gradual integration through parallel recognition frameworks rather than hierarchical incorporation. Collaborative platforms between biomedical practitioners and herbal experts should be initiated at the city level. These platforms will facilitate knowledge exchange and reduce professional isolation. Training workshops and certification short courses may be introduced to align basic clinical standards. Patients will gain improved continuity of care through coordinated service pathways. Integration strategies must respect the epistemological foundations of apprenticeship-based knowledge systems. At the same time, minimum clinical safeguards must be enforced to protect patient welfare. Public awareness initiatives will enhance informed decision making among healthcare users. A balanced integration model will strengthen pluralism while improving systemic reliability.

### 3) Framework for Regulatory Standardisation

The establishment of a regulatory standardisation framework is essential to address quality and safety concerns identified in the study. Current absence of standards creates variability in treatment practices and practitioner competence. A minimum threshold model should be developed to define basic operational requirements. This includes documentation of training lineage, treatment protocols and patient record maintenance. Experts emphasise that standardisation must remain adaptive rather than rigid. Regulatory authorities should implement tiered compliance levels based on practitioner experience and service scope. Patients will benefit from clearer expectations regarding treatment quality and risk management. Monitoring systems must incorporate periodic audits and feedback mechanisms. Enforcement should prioritise corrective action rather than punitive measures in early phases. This approach will encourage voluntary compliance and sector stabilisation. A structured standardisation framework will enhance credibility and support long term integration within Pakistan's health governance system.

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