Translating Foreign Ideas into Domestic Practices

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The views offered in this study are by an "outsider" who still has much to learn. Nevertheless, I have tried my best to create a picture that, at least in principle, can be recognised by those involved in international cooperation, be it in Laos, Vietnam or elsewhere. Concerning the political dimension of the analysis it is likely that my opinion as a political scientist differs from my informants and colleagues with medical and pharmaceutical backgrounds. Therefore, I would like to underline that my interviews have concerned the issue of the development and implementation of the National Drug Policies—the interpretation of the wider political context is mine. Further, I make no claims to tell "the whole story" of the events that have taken place. This is only one version among others, and all interpretations, and errors, are mine alone.

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Lund, 18 March, 2002

Kristina Jönsson

List of abbreviations

ADB	Asian Development Bank
ADPC	Area of Drug Policy and Control
ASEAN	Association of Southeast Asian Nations
CARE	Care International
CCL	Comite de Cooperation avec le Laos
CMS	Council of Medical Sciences
CPV	Communist Party of Vietnam
DAP	Drugs Actions Programme
DAV	Drug Administration of Vietnam
DMP	Drug Management and Policies
DQCI	Drug Quality Control Institute
DRF	Drug Revolving Fund
ED	Essential Drugs
EDL	Essential Drug List
EU	European Union
FAO	Food and Agriculture Organisation
FDA	Food and Drug Administration
FDB	Food and Drug Bulletin
FDD	Food and Drug Department
FDI	Foreign Direct Investment
FDQCC	Food and Drug Quality Control Centre
GATT	General Agreement on Tariff and Trade
GDZ	Deutsche Gesellschaft für Technische Zusammenarbeit
GMP	Good Manufacturing Practice
GPP	Good Pharmaceutical Practice
HSR	Health System Research
IEC	Information, Education and Communication
IHCAR	Division of International Health
IMF	International Monetary Fund
INRUD	International Network for the Rational Use of Drugs
IOCU	International Organisation for Consumers Union
JICA	Japan International Co-operation Agency
LFA	Logical Framework Approach
MNC	Multinational Corporations
MSF	Médecins sans Frontières
NDP	National Drug Policy

NGO	Non-Governmental Organisation
NIAS	Nordic Institute of Asian Studies
NIDQC	National Institute for Drug Quality Control
NIOPH	National Institute of Public Health
PAR	Public Administration Reform
PHC	Primary Health Care
RUD	Rational Use of Drugs
Sida	Swedish International Development Cooperation Agency
STG	Standard Treatment Guidlines
TRIP	Trade Related Aspects of Intellectual Property Rights
UN	United Nations
UNAIDS	United Nations AIDS Programme
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UXO	Unexploded ordnance
WHO	World Health Organisation
WTO	World Trade Organisation

Part I
Introduction

Chapter One

What is this study about?

The area of interest

We live in a world of increasing interconnectedness. It is easier to communicate, to travel and to gain information. At the same time it is getting harder to choose, and select, among the increasing amount of information flows. It is harder in the sense that there are more options to choose from and less time to consider the various options. This problem is accentuated in countries with limited resources. One can solve many problems by borrowing ideas from abroad, but at the same time it takes time and energy to adapt the new ideas to the national context. If the country is aid dependent new ideas and polices are presented on a regular basis as a part of aid packages.

The phenomenon I describe is not new *per se*. What is new is the pace and scope of ideational change. I have chosen to study two until recently relatively isolated countries, Laos and Vietnam, and how they deal with external ideas in reforming their health sectors. Both countries have experienced major changes in the last few years. In the 1980s reforms were initiated leading to far-reaching economic liberalisation. These reforms have had effects in all segments of society, including the health sector. The pharmaceutical sector, especially, was privatised and one could argue that the situation went out of control to a certain extent. As drugs became widely available, self-medication as well as fake and sub-standard drugs increased. This was the setting when the Lao and Vietnamese governments had to consider the development of a pharmaceutical policy, a National Drug Policy (NDP), as part of the aid programme to their health sectors. In 1993 a National Drug Policy was endorsed by the Prime Minister in Laos, and in 1996 the same thing was done in Vietnam.[1] Hence, the policy processes were initiated within the framework

1 Officially Lao People's Democratic Republic (Lao PDR), and the Socialist Republic of Vietnam.

of bilateral cooperation between donors and the two Ministries of Health. In other words, there had been a spread of external ideas, or policy diffusion. Later on these ideas and NDP had to be translated into and implemented in the national context.

The donor in question, the Swedish International Development Cooperation Agency (Sida),[2] obviously played an important role in the diffusion process, and recently the Swedish support to the NDP programme in Laos and the health sector in Vietnam was assessed (in 2000 and 2001 respectively). Interestingly enough, the Lao assessment appears more positive than the Vietnamese, despite the fact that the conditions for successful implementation at a first glance seem more favourable in Vietnam than in Laos insofar as Vietnam scores higher on a number of health indicators and in level of training and education. There are, of course, many reasons for this, but from my point of view, the way the new policies have been spread and translated into the new context has been decisive for the result.

Why do I use the health sector to illustrate current changes in society? The last few decades have involved large-scale reforms in a number of developing countries, mainly under the tutelage of the World Bank and other international organisations. This has several implications—the role of the state changes,[3] new actors enter the stage, policymakers face new problems, and policies are implemented at an increasing rate with varying degrees of success. Existing ideas and institutions grow obsolete, which in the end affects the people who are subject to the reforms. As indicated above, this wave of reforms also applies to health care systems that undergo rapid transformation all over the world.

So far, economic perspectives have guided the work in most sectors, including the field of health care, and deregulation, extensive liberalisation, privatisation of the public sector and cutbacks in public investment in health care have been encouraged. National and international demands for privatisation in the health care sector increase, but too much emphasis on economic rationality may jeopardise other values such as equity and the right to health. It may also neglect other aspects of the privatisation process such as

2 Previously Swedish International Development Authority (SIDA).

3 See e.g. Chapter 6 in "World Health Report 2000" where the role of the government is discussed in terms of stewardship. In the report stewardship is defined as a "function of government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry" (Saltman and Ferroussier quoted in WHO 2000:119).

societal control, governing, and the means for implementing the new polices. In most cases the government and its bureaucracy are in charge of the implementation of the reforms—they monitor, control, regulate and create institutions. The market economy system does not reduce the need for regulations, as workers and consumers need to be protected from the negative social effects of the market system. Furthermore, external forces such as multinational corporations (MNCs), supra-national organisations, non-governmental organisations (NGOs) and domestic pressure groups make the implementation of reforms a very complex mission. Besides, in aid dependent countries such as Laos and Vietnam, the government cannot act independently of their donors.

There is a tendency in public health to portray policy reform as a technocratic or economic process. However, policy reform is a profoundly political process where politics affects the origins, the formulation, and the implementation of public policies. Policy reform is also political because it seeks to change who gets valued goods in society (Reich 1995: 49; also see Walt and Gilson 1994). In this study the focus is on one specific part of the health sector, the pharmaceutical sector. The rationale behind the choice is that the pharmaceutical sector reflects a complex combination of medical, economic, social, ethical and political factors. Public health objectives confront commercial interests, and ideological and political considerations influence the view on how to proceed, as will be exemplified later on in the study. Another important factor is that the reform of pharmaceutical policy in developing countries represents one of the most important areas of health sector reforms, as well as one of the most contested.

Reich gives three reasons for investigating the pharmaceutical sector: pharmaceutical expenditures are high in developing countries; pharmaceutical policies usually involve both the private and the public sectors as well as domestic and international actors in various political patterns of cooperation, competition, and conflict; and pharmaceutical policies often provoke a debate about basic social values, including the roles of the market and the state, and the relative importance of efficiency and equity. Hence, a study of the pharmaceutical sector can yield important lessons for other areas of health sector reforms (Reich 1995: 59-60).

Using the example of the development of National Drug Policies in Laos and Vietnam may seem farfetched. However, they are illuminating examples of how ideas and policies travel. As it turns out the whole policy process, from

the initial planning to the realisation of the policies, can be studied through documents and interviews. Besides policy diffusion, the study focuses on the implementation of the policies, which makes it possible to relate the effects of the adoption of the policies to the origin of the policies. It will be shown that the diffusion of ideas does not end with the adoption of the policy. In fact, the success of the implementation is highly dependent on continued external support and on what donors regard as important to focus on. Consequently the flow of new ideas continues to enter the domestic arena. The way in which the NDPs are translated into a new context is another crucial factor for successful implementation.

It should be pointed out at the outset that the policy in question, the NDP, could be described as both a commitment to a goal and a guide for action. Basically the policy is a written document containing objectives, priorities and the main strategies and approaches for attaining the stated objectives. It provides a framework within which the activities of the pharmaceutical sector can be coordinated. The more general aim of an NDP is to achieve optimal availability and use of drugs, and in order to achieve this certain components or aspects—such as legislation and regulation, drug control and registration, supply of drugs, quality assurance and research—are emphasised.[4] Thus, the translation process includes the interpretation and adaptation of ideas and goals in a new setting as well as an understanding of how to act in order to achieve these ideas and goals.

Finally I argue that there is a new element in today's policymaking. I refer to what is vaguely called globalisation, or processes connected with so-called globalisation, and I believe that these processes have altered the prerequisites for international cooperation, especially for cooperation between "North" and "South." For example, aid negotiations are influenced by access to information in combination with the elite's willingness to reform. On the one hand the governments may have more to choose from as a result of the increased access to the rest of the world through information technology and the spread of ideas. On the other hand they may have too few resources to make the optimal decisions.

In authoritarian countries like Laos and Vietnam the lack of open debate is not facilitating the situation, and the decisions about reforms are actually made by a limited number of individuals at the top of the political hierarchy.

4 For a more detailed discussion see WHO 1988; WHO/DAP/95.9; WHO/DAP/98.7.

Nevertheless, today the governments have to listen to the people to a greater extent than before, because the people are increasingly acting as consumers in a new, economically liberalised society where health is only one of the commodities you can buy. Moreover, new technology and increased contact with the rest of the world lead to new solutions and interpretations of problems, and the regimes cannot expect uncritical acceptance of closed door decision-making. People compare not only with the situation in neighbouring countries, but also with other groups in their own society. In the wake of economic liberalisation inequalities increase together with corruption, at the same time as sectors like health lack resources. This in turn forces the governments to find new ways to legitimise their regimes in order to keep the people satisfied (see e.g. Jönsson K. 2002).

In this perspective the adoption of the NDPs can be interpreted in several ways. The most obvious, and most generous, is of course that they were signs of good intent from the governments to improve the situation in the health sector. A less benevolent interpretation is that the collaboration with the donor also generated money and prestige that benefited those involved in the development of the policy. I will return to this issue, but what is important to keep in mind is that policymaking can be less altruistic than one would like to think, even in sectors such as health.

Thus, similar policies may be found in different countries, such as the NDPs in Laos and Vietnam, and the question is why this happens. How can it be explained that the two communist states decided to change course in the health sector practically at the same time, and in the same direction? Often international organisations and commercial interests are seen as the main forces behind the reform processes, which also would explain the homogeneity of policies. However, an additional explanation might be that policymakers are interested in learning from other countries or organisations and actively seek new policies. The external influences must consequently be related to domestic factors in order for us to understand why policymakers choose the same kind of solution to their problems.

The first aim of the study is accordingly to analyse how foreign, or external, ideas are integrated and translated into a new context and how this import of ideas influences national policymaking, in this case public policymaking. The second aim concerns the effects of the diffusion, or the actual implementation of the policy, and how the policy is translated into action in a local context. I examine the problems connected with the implementation and translation

of a new policy and relate them to the origin of the policy in order to identify crucial dynamics in the process, in other words factors either facilitating or restraining the policy process.

To put it simply, the overall question concerns why certain policies are adopted while others are not, while the more detailed questions concern the analysis of two specific policies in Laos and Vietnam together with implementation difficulties of these policies. The policy process is studied from an international cooperation perspective, which means that domestic issues are related to international issues, both at the formulation and at the implementation phase. The intention is not to give specific policy recommendations, but rather to problematise the conditions of today's policymaking by bridging the national–international divide theoretically as well as empirically.

What is special about this study?

The political context in Laos and Vietnam complicates the study in the sense that the area of research to some extent is sensitive. Many think that health is a-political, but it is not, especially with regard to pharmaceuticals. External interference in domestic policymaking in Laos and Vietnam is a problematic issue, despite the fact that it is common knowledge that the countries are heavily aid dependent. External influences are definitely not always seen as something positive, which partly can be explained by the history of wars, colonialism and the effects of the Cold War (see e.g. Jönsson K. 2002).

Thus, I study policy processes in two countries that are not very open to studies of political science, a subject that tends to focus on power, interests and the workings of political systems—issues that are surrounded by much secrecy in Laos and Vietnam. Moreover, I study an issue area that to a large extent is neglected in the field of political science, namely the health sector, even if changes in international health have received growing interest in other fields.[5] The need for more studies has been acknowledged as the role of politics in the field of health is becoming more and more evident, although it is widely recognised that health has formed one of the cornerstones of international

5 For example the World Bank's World Development Report 1993 *Investing in Health*, and *Health Policy Reform, National Variations and Globalization* by Altenstetter and Björkman (1997).

cooperation for centuries.[6] For most of its history, international health policy has been referred to the realm of "low politics" because of its concern with highly technical and scientific subjects. However, the increased conflict and competition among different interest groups, institutions, and ideologies over health policy in recent decades has proved that health is a political issue (Siddiqi 1995; Walt and Gilson 1994). There is literature on world health and international relations, but it does not explore the political context within which policies are formulated and implemented. Moreover, very few books discuss the making of a NDP at all.[7]

My aim is modest in the sense that I have no intention to develop theory. Rather, I try to connect existing theoretical discussions and concepts in an eclectic way in order to capture the object of study. My empirical ambitions are also limited, insofar as I focus on process rather than on content. Thus, this study is a study *of* policies more than *for* policies. In other words, the research focuses on what policy is, the perception of policy, the communication and implementation of policy, rather than on the creation of products, technologies and approaches that can be used in health care (see e.g. Ham and Hill 1984: 4; Knutsson *et al.* 1997). Hopefully this approach leads to a greater understanding of the situation in Laos and Vietnam as well as of policymaking in a broader sense. At the same time it puts limits on how elaborate the analysis can be. Accordingly, this is not an area study or health study *per se*. This is a study about international cooperation with special emphasis on Laos and Vietnam and their pharmaceutical sectors, and I do not go into details about the overall situation in the countries or the health sector in general. My interest is rather how global processes are connected with local ones regarding policymaking.

However, being a student of international politics and international relations moving into policy studies in the so-called Third World, I found it disturbing that the theoretical tools at hand limited my research. For example, if you are interested in international cooperation in the field of policymaking in the developing world, you have to jump from the international relations

6 An exception is *International Cooperation in Response to Aids*, by Gordenker, Coate, Jönsson and Söderholm (1995), which contains a critical review of the limitations of orthodox international relations approaches for describing and explaining such international cooperation. Also see Walt (1994).

7 *The Politics of Essential Drugs, The makings of a successful health strategy: lessons from Bangladesh* by Chowdhury (1995) is an exception. Also see a special issues of *development dialogue* 1995:1 with the theme "Making National Drug Policies a Development Priority."

literature (highlighting international cooperation but neglecting some of the specific problems inherent in aid dependent countries) to policy studies (focusing on the policy process but primarily from a national perspective), and finally to area studies (which are useful for understanding the specifics of low-income countries in Asia but prevent theoretical generalisations applicable to phenomena common in the rest of the world).

Moreover, the literature of international relations, including literature about regimes and globalisation, puts emphasis on structures, while policy studies are biased towards agents. In order to understand the policy processes in Laos and Vietnam I have to take both structures and agents into account, even if the importance of the two varies during the process. For example, during the development leading to the adoption of the NDP in Laos, the agency, which included Lao as well as foreign actors, managed to overcome seemingly insurmountable structural obstacles such as lack of resources and bureaucratic inertia. However, later on in the process the same structural factors slowed down the implementation of the policy, although practically the same actors were involved in the process.

Furthermore, when dealing with aid dependent countries it is evident that policymaking is not a purely national business. The problem with the national–international divide is twofold. By limiting oneself to a national perspective, one omits important processes such as the connection between the policymaking of the donor country on the one hand and of the recipient country on the other. That is, the donors do not decide about development assistance isolated from the policymaking in their home countries. Moreover, today the access to information about how to reform a country is greater than previously. Hence, the recipient country may choose, or use arguments, from several sources when negotiating with the donor. Thus, the claims of dependency, and the claim that weak states cannot resist donors' requests, and so on, can to a certain degree be contested.

In the field of international relations, several studies have been published in the last few years discussing the impact of international norms on national policymaking, for example Audie Klotz (1995), Martha Finnemore (1996a, 1996b), Martha Finnemore and Kathryn Sikkink (1998), Jeffery T. Checkel (1997; 1998) and Richard Price (1998). These constructivist explorations look at the impact of causal beliefs via epistemic communities, or transnational networks of knowledge-based experts, and relate the roles these epistemic communities play in policymaking processes to the resolution of particular

policy problems (Ruggie 1998a: 19). This body of literature challenges the more realist approaches, where the states and their interests are in focus, by including other actors such as international organisations and their role as idea promoters in the policy process—actors that are highly relevant when studying policymaking in Laos and Vietnam.

Implementation research is part of the more general literature about policy analysis or public policy.[8] In policy analysis questions are asked concerning what governments do, why they do it and what difference it makes. Implementation theory, studying the output of political processes, can thus be considered a sub-field within state theory (Lundquist 1987: 28-29). Not much has happened within the field of implementation research during the last few years,[9] but I still find some of the analytical tools useful.

Nevertheless, in my study I question the notion of rationality common in the policy literature, in particular the goal-means rationality, as I believe that people behave according to different "rationality" depending on context and situation. Even if the most "logical" thing to do would be to achieve stated goals, as in policy documents, old structures and ways of doing things may in practice prevent changes. The Lao and Vietnamese societies are exposed to changes caused by globalisation and diffusion processes, and they have to deal with these changes. Thus, there is a tension in Laos and Vietnam between forces of change and forces resisting change.

The notion that implementation automatically follows policy formulation is also very often a utopia—maybe even more when new ideas are integrated in the policymaking through diffusion and have to be implemented in a new context. Still, the connection between international policy processes and implementation with the translation difficulties that may arise is rarely made. Policy diffusion, yet another sub-field of policy studies, is also coloured by assumptions about goal-means rationality, which is problematic when studying the policy process.

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8 In international politics or international relations one talks about compliance research (for an overview see Raustiala and Slaughter 2002). This research is comparable with what students of public policy call implementation research. However, the exchange of ideas between the two bodies of literature is limited.

9 Peters (1992: 102-103) blames the lack of a "implementation movement" on two issues, the theoretical content of the concept implementation and its mechanistic approach. Implementation merely alerts us to what most good managers have known all along, i.e. that things do not always turn out the way we want, which leads to a very pessimistic outlook on the policy process as it assumes that policymakers have very few options and that they easily give up their goals.

The result has been, as indicated above, an analysis with a mixture of theoretical approaches. However, instead of creating a comprehensive theoretical framework, I change perspective as the story moves on. The reason is primarily to avoid conceptual confusion, but also because I move from one level to another: from international or global norm diffusion between states and international organisations to policy formulation and implementation at the domestic level, and then back to the international level through the lessons learnt from the Lao and Vietnamese cases.

However, in order to have something to hang on to, I have decided to use a so-called *sensitising* concept, namely *translation*. Sensitising concepts can be characterised as analytical and organisational concepts derived from prior theory that interact with the empirical analysis and make it possible to elaborate on new theoretical ideas during the analysis (Layder 1998: 35-36; Aggestam 1999: 9-10).[10] In addition, translation works when discussing both international cooperation, including "North-South" cooperation, and policy implementation at the national level, from central to local level. My intention is thus to show how global is connected to local in a process of diffusion and translation by studying the policies from their origin to the implementation, highlighting the factors influencing the process.

Hence, I use literature from international relations as well as policy studies—including health policy—in order to connect norms, ideas and national policies. In this study norms can be defined as shared expectations about appropriate behaviour held by a community of actors with a given identity. Unlike ideas, which may be held privately, norms are shared and social; they are not just subjective but intersubjective. Ideas may or may not have behavioural implications; norms by definition concern behaviour. Norms can also be constitutive of actor identity and interests (also see Klotz 1995: 14; Finnemore 1996a: 22; Finnemore and Sikkink 1998: 891). There are norms for all levels of life—domestic, regional, and global (Shannon 2000: 294-295)—and they may vary considerably both in regard to time and place. Ideas are less comprehensive, and the way I use ideas primarily concerns ideas in relation to policymaking, for example ideas to develop a policy. Policy refers

10 The idea with sensitizing concepts is related to the use of adaptive theory, which basically is a recognition that theory and empirical data interplay and that in practice few studies are either deductive or inductive in approach. The adaptive part of the term suggests that the theory both adapts to, or is shaped by, incoming evidence at the same time as the empirical materials are filtered through and adapted to existing theories. See for example Alvesson and Sköldberg 1994: 41-42; Layder 1998: 37-38.

in this study to something very concrete stated in documents, while ideas can be more vague and inclusive.

I also use notions from the organisation literature and what has been labelled new institutionalism in order to capture and problematise differences in behaviour among the actors participating in the policy process (see March and Olsen 1989, 1996, 1998; Finnemore 1996b).[11] These aspects are relatively rare in international relations. An exception is the so-called English school[12] and more recently constructivism, as mentioned above. I am aware that some of the theoretical tools I use in my study are developed for other purposes than mine, but my hope is that the reader will keep an open mind to new interpretations.

From diffusion to translation

As mentioned earlier, translation is a key concept in this study. However, this concept is in a way an elaboration, or specification, of other concepts. My point of departure was originally the concept policy diffusion. The literature about policy diffusion can be seen as a branch of policy studies, and there is a rich tradition of diffusion research in anthropology, geography, history, sociology, and, more recently, political science.[13] An advantage with the concept of policy diffusion is that it manages to link with other worlds both within and beyond that of policy analysis, for example with implementation, policy networks, globalisation, and development theory (see Freeman and Tester 1996: 19). A combination of approaches makes it possible to find alternatives to the state-centric view, which is important as contacts and cooperation today reach across issue areas, hierarchies and power spheres as well as national borders.[14] Hence, by using the concept of policy diffusion it is possible to move beyond the actual decision-making process adding the origin of the policy to the analysis—in other words to connect international

11 Some use the labels new institutionalism, including March and Olsen themselves. Others prefer normative or sociological institutionalism, see e.g. Peters 1998: 121-122; Hall and Taylor 1996; Hedin 2001.

12 The English school was a forerunner to the constructivist approach, see Bull 1977; Dunne 1998.

13 At my own department a number of doctoral theses have used a diffusion perspective, e.g. Schmidt 1986, Kinnvall 1995 and Uhlin 1995. Also see Karvonen 1978, 1981a, 1981b, and Mörth 1996.

14 See Jönsson C. and Söderholm (1995) who analyse the pandemic of AIDS from an inter-organisational perspective.

policymaking with national policymaking. The influence of globalisation and changes in current developmental strategies can in this way be included in the policy analysis.

However, many of the traditional diffusion studies focus on reasons for a particular pattern of adoption rather than the reason for diffusion itself (Bennett 1991: 221). Who adopted first and who is a follower is not my interest here. I already know that Laos and Vietnam have adopted NDPs, that they were relatively late in doing it, and that Laos did it before Vietnam. What I am interested in is the dynamic behind the diffusion and the effects of the diffusion—something neglected in the traditional diffusion studies as well. One has to remember, though, that the major part of the diffusion literature was written before the vast literature of globalisation and that it served the purpose of putting the phenomenon of diffusion on the research agenda. Today the globalisation literature contributes substantially to our understanding of the spread or diffusion of ideas—partly because it helps to frame the policy process in a broader perspective, but also because it problematises the idea of global homogenisation (as a result of diffusion processes). The idea to connect diffusion and globalisation is not unique. Richard Common (2001), for example, analyses policy diffusion in Southeast Asia, using a framework based on policy transfer and globalisation. He also points out that it is important to include implementation in order to see whether the diffusion has had any effect in practice. In other words, adoption of a policy does not automatically mean that the policy is implemented as intended.

The concept diffusion has many meanings, and there are several alternative terms to be found in the current literature, although they are by no means identical or even refer to exactly the same processes, for example *policy borrowing* (Stoker and Mossberger 1994), *policy transfer* (Dolowitz and March 1996), *policy convergence* (Bennett 1991), and to some extent *policy change* (Bennett and Howlett 1992; Sabatier 1988) and *lesson-drawing* (Rose 1991).

Policy diffusion may be defined in several ways, for example as *the process by which an innovation is communicated through certain channels over time among members of a social system* (Rogers 1995: 11). The *innovation*, in turn, may be an idea, practice or an object.[15] The innovation only needs to be perceived as new, even though it might not be so objectively speaking, as it is the perceived

15 Leichter (1983) defines diffusion as "the process by which ideas, practices and material objects spread across specified units of analysis."

newness of the idea that will determine the reaction of the individuals. The actual *communication* process becomes important, because it is that process that will lead to convergence, or divergence, as individuals seek to transfer messages to each other in order to achieve certain effects. The *time* aspect involves dimensions such as the time laps between knowledge about an innovation and its adoption or rejection, the time between early and late adopters, and the rate of adoption within a system (Rogers 1995: 5-6, 20). *Members of a social system* refers to the range of diffusion, in other words if the diffusion is local, national, regional, or global—besides being a part of the context.

Another and, for political scientists, more interesting definition is *the borrowing of a policy from one political system for use in another* (Wolman 1992: 27). The emphasis on political system is important as it underlines the oft-forgotten political aspect within the health sector. This also includes ideology in the sense of promoting certain ideas, for example those associated with market-oriented policies. Regardless of which of the definitions one prefers, a "core definition" can be derived which captures the essence of the phenomenon policy diffusion. Something, an idea or policy, moves from one location to another. This "something" is perceived as new which implies a change, a break from what was before. Or, to put it differently, the adoption or implementation of the idea or policy in the new context will lead to certain consequences which can be defined as change. These changes are influenced by the social and political systems in which they are taking place.

David Dolowitz and David Marsh (2000:3) prefer policy transfer to lesson-drawing and policy diffusion, because lesson-drawing only covers volunteer transfer, and because policy diffusion originally neglected the content of policies and in effect also agency. However, in policy studies of later date this has changed to a certain degree. Another criticism concerns the connotations of the concept of diffusion. Several scholars think that policy diffusion leads the thought to the narrow definition evolved in the 1960s, which sought explanations of diffusion based on timing, geographic propinquity and resource similarities, and on that ground they prefer other definitions. Furthermore, diffusion emphasises the sender or source of diffusion at the expense of the adopter.

An advantage with policy transfer and lesson-drawing approaches is the focus on learning, and the idea that specific ideas and programmes often are underpinned by a deeper and prior process of learning (Dolowitz and Marsh 2000: 59). This is especially important as in practice policy processes often

involve a broad view of learning, which includes the learning of different concepts and approaches, rather than just specific policy designs (also see Wolman 1992: 41). Still I have decided to use diffusion rather than transfer because the diffusion concept facilitates the discussion on a more abstract level, for example when I discuss norm diffusion—which does not mean that I reject what the transfer concept entails.

The main point in the policy diffusion literature is thus the focus on the imitation process together with the adoption of policies. The adoption may be voluntary or coercive (some use the labels sought or imposed) depending on the situation. Voluntary adoption occurs as a result of free choices made by political actors, while coercive adoption can involve pressure by supra-national organisations, multinational corporations, or, as in our case, bilateral donors and other donor agencies. Dolowitz and Marsh (2000) describe policy adoption as a mixture of coercive and volunteer adoption that varies along a continuum. The idea of using a continuum when discussing the degree of volunteer or coercive diffusion is fruitful in the sense that it can be difficult to decide whether the studied policy diffusion is volunteer/coercive or not. For example, an international organisation may on the one hand require the adoption of a certain policy as part of an aid-package (coercive adoption), and on the other hand the same organisation may promote the idea of the policy through conferences or documents (volunteer diffusion). Thus, arguably the policy diffusion is voluntary but driven by perceived necessity (such as desire for international acceptance) (Dolowitz and Marsh 2000: 13). Moreover, the degree of voluntarism may change over time. What initially met resistance could over time be accepted and vice versa.

Policy diffusion may include several things, which means that the so-called object of diffusion may consist of different parts that can diffuse. The general definition of a policy is a programme or guidelines for certain actions (Premfors 1989: 9). It can take the form of a plan or a more general statement of approach. The kind of policy I am referring to here is a policy that is formally agreed upon by the appropriate legislative (or other) body (Barker 1996: 20). In other words, it is an official policy which is stated in official documents, like the Lao and Vietnamese NDPs. The diffusion may, however, refer to either intent, content or instruments of a policy. It is quite possible that, for example, the same goals are adopted but that different instruments are being used to achieve the goals (Bennett 1991: 218; Stoker and Mossberger 1994: 3). Another way to divide the policy is into one substantial and one instrumental

part (i.e. content and plan of action). When analysing the implementation of the NDPs in Laos and Vietnam, these distinctions become important in order to understand the success and failure of the policy processes in the two countries. Very often diffusion is thought of as the transfer of a policy as a whole, even though in reality not all parts diffuse while at the same time new concepts and approaches may be added during the implementation phase.

Scholars have complained that too little attention is paid to the communication processes and the agents of diffusion[16] (Karvonen 1981a: 36). This makes it even more fundamental to investigate how the ideas or policies spread (channels), and who spread them (agents of diffusion). The channels of diffusion refer to how and by what means the policy is spread and adopted. Agent includes individuals (policymakers, consultants, health workers, development workers, sales people etc.) and groups, organisations, or media participating in the diffusion process. In practice it is not always clear who is the source, the adopter or the link between the source and adopter. Very often the same person is both source and link, and the adopter may actively seek innovations as well. These actors have different functions and hence also different motives for their actions.

Dolowitz and March (1996: 345) mention six main categories involved in the diffusion process: elected officials, political parties, bureaucrats/civil servants, pressure groups, policy entrepreneurs/experts, and supranational institutions. Whereas these groups are all important at a global level, many developing countries lack elected officials, political parties and interest groups, and the bureaucracy and supranational institutions may be more influential than in many industrialised countries. Laos and Vietnam are one-party states, and even if the officials are elected in theory, the procedure that the communist parties selects the candidates makes the elections more or less pre-decided (see e.g. Fredriksson and Falk 1998; Bring *et al.* 1998; Jönsson K. 1998).

The channels of diffusion may take the form of interpersonal contacts but may also involve media (Stoker and Mossberger 1994: 3). The latter seem to be important in the dissemination of ideas and knowledge, whereas the former

16 Those spreading or diffusing the ideas and policies are named differently in the literature, for example agents of diffusion, brokers, facilitators, entrepreneurs or, in relation to the concept translation, editors (see Stone 2000). Although it may seem incoherent to mix concepts I have chosen to use translation, agent of diffusion, and sometimes also entrepreneurs when discussing norm diffusion.

appear important for the actual adoption of the idea (Rogers 1995: 18). Media play an important role as they reach almost everyone in the society. However, the role of the media in low-income countries is often quite different from the one in "Western" societies, and the scope of the media might be limited for a number of reasons. Nevertheless, in both Laos and Vietnam mass-mediated public drug education is a component of the national drug policy.

A variety of actors consequently play an important role in the diffusion of policies, in both facilitating and preventing the diffusion. They may serve as policy brokers (mediating between source and adopter) or gate-keepers (controlling the flow of messages) (Rogers 1995: 148). As already pointed out, the relationship among the actors is extremely important in this process. If the agents of diffusion cannot communicate with the adopter it will be difficult for diffusion to take place. Moreover, the agents of diffusion may use different methods or processes in the spread of policies, which naturally will have implications for the success of the diffusion. However, the existence of channels for ideas and policies does not automatically mean that the diffusion, or translation, is successful—and it does not say anything about the success or failure of the policy implementation, as will be shown later.

In the case of diffusion between societies with different cultural and social backgrounds, the term translation seems more adequate helping us understand why the policy developed the way it did. Moreover, diffusion suggests a physical process—something spreads—while translation may be associated with both movement and transformation, including both material and linguistic objects (Czarniawska and Sevón 1996). In a way I see diffusion as a prelude to the translation process, although the two are hard to separate in practice. One could argue that something has to diffuse before it can be translated. But by perceiving diffusion as a translation process, I can focus on how the idea, or policy, is integrated in the new context, how it is understood and later implemented instead of just identifying the diffusion process. Difficulties in the process may then be included in the analysis as well. Also, translation captures the problems connected with the spread of ideas and policies. Instead of just identifying agents and channels of diffusion, their communication and interaction can be problematised as well.

Moreover, translation avoids the notion of a one-way communication process where an agent of diffusion tries to transfer a message in order to achieve certain effects. In practice the policy diffusion is a process where individuals meet several times. Often it is hard to establish exactly when the

idea originally was discussed. Therefore it is more fruitful to look at the diffusion as a two-way communication process where the agents of diffusion share information with each other, which eventually will lead to change in one way or another (Rogers 1995: 7).

In bilateral projects, such as the projects in this study, the communication is two-way and includes bargaining and negotiations in addition to the spread of ideas. Those involved have to translate the ideas (as agents of diffusion). After the adoption the policy has to be translated from central level to local level, a process including difficulties that should not be neglected in poor and less developed countries—or in any country for that matter. In the case of Laos and Vietnam there is the additional problem of redirecting a communist framework to a Western, more liberal market-oriented, framework—which includes not only new ways of doing things but also new ways of thinking and approaching problems (see e.g. Nørlund, *et al.* 1995; Fford and deVylder 1996; Beckman *et al.* 1997; Fforde 1997; Chan *et al.* 1999; Ivarsson *et al.* 1995; Evans 1995). In short, the development and implementation of the Lao and Vietnamese NDPs include diffusion as well as translation, and take place within a complex communication process—not only from external to domestic actors, but also within the countries from policymakers to the people working at grass-root levels.

Both diffusion and translation thus serve as useful metaphors for the phenomenon I study. The essence of metaphors is to understand and to experience one kind of thing in terms of another (Lakoff and Johnson 1980: 5; also see Jönsson C. *et al.* 2000). "The use of metaphor implies *a way of thinking* and a *way of seeing* that pervade how we understand our world generally" (Morgan 1986). In other words, diffusion makes it possible to picture how ideas and policies literally spread across borders through certain channels by agents of diffusion. However, the concept is limited in the sense that it does not capture how policy can be understood and used in a new context. In this regard the term translation is useful. Translation leads the thought to communication, and the fact that information can be altered or distorted. At the same time as words and meanings may get lost in the translation process, new meanings may appear useful in the new context.

Even though the translation process in this study not only concerns language and communication but also behavioural aspects reflected in the formulation and implementation of specific policies, it hopefully leads the reader in the intended way. I want the reader to see the policy process as

constantly influenced by new translations and interpretations—not least during the implementation phase. The policy process is not straightforward and comprehensible to everyone involved. There are individuals involved as speakers, listeners, interpreters, translators, and censors, and they have to communicate within certain structures or rules (the language code in a broad sense). Some words do not even exist in a number of languages. The fact that the NDP in Laos is under revision makes the concept even more appropriate, as the revision opens up for new translations. In addition, it seems that my counterparts in Laos and Vietnam can relate to the concept translation when discussing the policy process, which in itself is a proof of usefulness.

Thus, the perspective I have chosen in this study has its focus on communication and understanding of policy. I could have used a development perspective, a power or negotiation perspective, or even a medical perspective as my main track. I chose not to, and this naturally has consequences for the study as I neglect processes others would have liked to emphasise. However, my choice hopefully will bring other, previously ignored, aspects into focus.[17]

Outline of the study

The book is divided into four parts and seven chapters. Some methodological issues are discussed below before proceeding to the analysis. First I briefly discuss my ontological standpoint, then I discuss the research process and problems connected to my field of research, material, and interviews.

Part II focuses on the spread of ideas in general and the origin of the NDPs in particular. The policy process as such is under scrutiny, both from a theoretical and empirical point of view. This discussion is related to international cooperation, aid cooperation in particular, and the impact of globalisation processes. Here a general framework is developed, which is then applied to the development of the NDPs in Laos and Vietnam. The pharmaceutical sector, the donor community, and the history of the NDP concept are included in the discussion.

17 Schön (1979) talks about generative metaphors which means that the metaphor give rise to a new view of the problem in question, or generates new perceptions, explanations and inventions—which is a step further than just understanding something in a different way. His example is to view social policy as problem setting and framing rather than problem solving. In a similar fashion I use translation to view policy diffusion as a communication process rather than just transfer of ideas, practices or material objects.

Part III focuses on the translation of external ideas into a national context by looking at the implementation of the NDPs. The implementation is analysed both from a top-down policy-centred perspective and from a bottom-up perspective where individuals and their behaviour are in focus. Special emphasis is given to the context in which the policies are implemented.

In Part IV the two previous parts are brought together. The general argument in this part is that the diffusion and translation process continues after the adoption of a new policy, especially in aid dependent countries like Laos and Vietnam, and that the difficulties related to the implementation of the new policies to a large extent can be explained by "insufficient translation" of the new ideas in combination with behavioural differences. In other words, it is not enough to agree on what to do; the involved parties must have similar understandings of what to do as well. Moreover, the translation difficulties that can be discerned during the policy formulation are arguably magnified during the implementation phase, as the new ideas have to be turned into practice. In policy research, it is often assumed that actors behave in a goal-oriented way—goals that mostly are stated in documents. Yet, other kinds of behaviour may compete with the "efficient" policymaker.

Moreover, policies are often treated as national projects. International politics is usually neglected in policy studies in the same way that domestic politics often is neglected in studies about international relations. This study intends to bridge this gap, which is needed in order to understand the on-going reform process in Laos as well as in Vietnam. Thus, in the following chapters I go back and forth between theoretical and empirical discussions, at the same time as I move between different phases of the policy process at global, national and local levels.

Chapter Two

Methodological Considerations

Worldview

In order to give an accurate picture of the study, I will make some clarifications with regard to ontological issues. The reason is that the literatures I use have different ontological points of departure. For example, most policy studies are based on the view that actors behave in a "rational" way aiming at utility maximisation and that the world is restricted by material objects, while several studies about norm diffusion regard the world as socially constructed. This, in turn, affects the analysis. To make it easy one could argue that my ontological standpoint coincides with some of the ideas found in the international relations literature written from the so-called constructivist perspective. However, constructivism covers a wide range of approaches and there is no clear consensus on what constructivism should entail.[18]

The approach I adhere to is mainly based on Emanuel Adler's (1997) ideas about a "middle ground." According to Adler, the constructivist approach argues that international reality is socially constructed by cognitive structures that give meaning to the material world. By middle ground he refers to the ground between rationalist approaches (whether realist or liberal) and interpretative approaches (mainly postmodernist, poststructuralist and critical approaches), because it integrates knowledge and power as part of an explanation of where interests come from. Constructivism, according to Adler, is the view that "the manner in which the material world shapes and is shaped by human action and interaction depends on dynamic normative and

18 Ruggie (1998b) divides constructivism into three groups 1) neo-classical constructivism with authors like himself, Ernst and Peter Haas, Emanuel Adler and Martha Finnemore, 2) postmodernist constructivism with writings by Michel Foucault, Jacques Derrida and Der Derian, and 3) naturalistic constructivism represented by Alexander Wendt among others (the last group is a mixture between the former two).

epistemic interpretations of the material world" (Adler 1997: 322, 337). According to this view international relations consist primarily of social facts based on human agreement only. At the same time, constructivists are "ontological realists." They believe in the existence of the material world, and that this material world offers resistance when we act upon it. Thus, the building blocks of international reality are ideational as well as material, and the ideational factors have normative as well as instrumental dimensions. In addition they express not only individual but also collective intentionality, and the meaning and significance of ideational factors are not independent of time and place. From an ontological point of view this makes it possible to problematise the identities and interests of states (Ruggie 1998a: 33).

In general, constructivism views international politics on the basis of a relational ontology, where ideational factors—including culture, norms, and ideas—influence the way in which actors define their identity and interests in the first place. Constructivists emphasise a process of interaction between agents and structures; the ontology is one of mutual constitution, where neither unit of analysis—agents or structures—is reduced to the other and made ontologically primitive (Finnemore 1996b: 24; also see Wendt 1987, 1991, 1994). A constructivist approach, therefore, can provide both theoretical and empirical explanations of social institutions and social change, with the help of the combined effect of agency and social structures (Adler 1997: 325).

In this study I blend impulses from international and national agency. In policymaking where donors are influential this is necessary. Individual international agents have an enormous impact in the policy process if they enjoy direct access to top-level policymakers, which is often the case in low-income countries. In the same manner a few domestic agents may have exclusive access to the international arena and serve as translators or agents of diffusion between international norms and ideas and national norms and ideas. The focus on communication processes brings forward the problematic nature of meaning and how different parties understand each other. Since actors hold different beliefs and have different frames, the reasoning and construction of meaning and understanding become highly contested processes. In this sense, constructivism is helpful in highlighting the importance of understanding situated actors and strategic games, which includes both material objectives and intersubjective understandings (Aggestam 1999: 34-35; also see Adler 1997).

Case studies

The focus of my analysis is the policy process, exemplified by the National Drug Policies in Laos and Vietnam. The policy process includes everything from the origin to the implementation of the policy—here perceived as a diffusion and translation process. There are several reasons for choosing these two specific policies. The policy processes take place in societies in transition that until recently were isolated, and consequently changes are visible. Also, there is a lack of transparency in these societies, and as a result not much is written about policy processes in general or these two policies in particular (besides project reports and a limited number of articles). Moreover, the countries have changed cooperation partners due to the collapse of the Soviet Union, which affects the ways of communication. This taken together makes it easier to identify changes and thus the translation process is more pronounced. In addition, the NDPs are included in on-going projects where Sweden plays an important role, the consultants are accessible for interviews, and the development of the policies is part of a World Health Organisation (WHO) NDP-strategy. Another reason to study the NDPs in Laos and Vietnam is that the countries fairly recently adopted their NDPs—in 1993 and 1996 respectively.

It is primarily the case-study method that is used when I analyse the two policy processes. Case studies are useful when investigating a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident, and when multiple sources of evidence are used (Yin 1984: 13, 23). Even though policies in both Vietnam and Laos are included in the study, the main focus is on Laos and the Lao NDP. The reason is practical: access to material and information, and time spent in the field. Moreover, the Lao adopted their policy three years earlier than the Vietnamese, and consequently, the effects of the policy are more visible. The Laotian NDP is currently under revision, which makes it easier to draw conclusions about what has worked so far and what has not.

Still, I find it useful to use two examples of diffusion and translation when identifying theoretically interesting points. Thus, Vietnam and the Vietnamese NDP are used in order to compare certain aspects of the policy process. Consequently, the study is not methodologically truly comparative in charac-

ter.[19] It should be pointed out though, that the choice of cases is based on the fact that both Laos and Vietnam adopted NDPs almost at the same time, not because the countries are neighbours or have similar background. The comparison is between policy processes, not countries as such. Another point is that to some extent the same international actors have been involved in the policy process.

The case-study method has been criticised for being unable to make generalisations. However, according to Robert K. Yin case studies can generalise theoretical propositions, but not empirical entities. Often case studies try to illuminate a decision or set of decisions: why they were taken, how they were implemented, and with what result (Yin 1984: 21-23), as in this study. Bent Flyvbjerg (1991: 148-149) talks about "the power of example." He means that formal generalisations based on a larger number of cases are overvalued as evidence of scientific development, while case studies, as good examples, are undervalued. In this respect, the policy processes in Laos and Vietnam serve as good examples of policy diffusion and how ideas are translated into a new context. Nevertheless, there are still problems of defining the case, for example where it starts and ends, due to variation in program definition or the perspective of different actors (see Yin 1984: 31). The analysis here is facilitated by the fact that it is possible to date the start of the policy process through interviews and documents as well as identifying the most important actors both directly and indirectly involved in the process. The NDPs were the first of their kind in Laos as well as in Vietnam, and my analysis ends by the year 2001.

There are important similarities as well as differences between Laos and Vietnam, which makes it interesting to analyse the NDPs in these countries. The most important similarities are, obviously, that both countries have experienced extensive reforms in the last decade aiming at more market-oriented policies. In the case of NDPs, as well as in general, Swedish support (Sida) has played a significant role. The two countries are a mix of market economies and communist regimes combined with dependence on extensive aid. Both countries are poor, and 60-80 percent of the population live in rural areas predominantly working in the agricultural sector.

19 The case study method and comparative method are closely connected, and certain types of case studies can implicitly be considered as parts of the comparative method when related to other studies. At the same time a truly comparative study should, according to Lijphart (1971, 1975), be designed similar to a statistical study. This study is a hybrid in the sense that my point of departure is the case-study method, even if I compare certain aspects of two policy processes.

A number of differences can be found as well. For example, Laos is a country with a population of five million, while Vietnam has nearly 80 million inhabitants. The population density differs from very low in Laos to very high in Vietnam. The health conditions in Laos are among the worst in Asia in combination with an under-financed and underdeveloped health system, and about 60 percent of the adults are illiterate. In Vietnam the achievements in health are relatively impressive, and the educational level is generally high. In Laos the total fertility rate is among the highest in the world, while in Vietnam the total fertility rate has fallen rapidly in the last two decades due to the promotion of a two-child policy. In addition, the infant mortality rate in Laos is three times higher than in Vietnam (Stenson 1995; Stenson and Höjer 1995; Paphassarang *et al.* 1995; Falkenberg and Tomson 1997; Lalvani *et al.* 1996; Phanouvong *et al.* 1996).

Moreover, the role of the multinational corporations (MNC) differs between the two countries. The involvement of the MNCs is more pronounced in Vietnam than in Laos, and Vietnam is considered to be one of the most promising markets for pharmaceuticals in the world. Thus, already on a very fundamental level the context for implementation of the policies differs. Later on other aspects influencing the policy process, such as historical legacy and political inertia, will also be discussed.

Research process

My research situation was special in many ways. Originally, the idea was that my Ph.D. project would be included in a larger project, which eventually was not the case. Nevertheless, the project was indirectly related to a larger bilateral project funded by Sida and with IHCAR (Division of International Health) at the Karolinska Institute, Stockholm, as institutional consultant. My co-supervisor was coordinating the project in Laos, and he had students at my contact institute in Vietnam.

My connections greatly facilitated the introduction to a completely new research environment. Many contacts were already established, and several related projects have been and are being conducted in the field. At the same time I was often regarded as a part of the larger project, with the same expectations but without really having the resources. My being a political scientist was also sometimes hard to relate to at the beginning, at least in Laos

where political scientists are not very common. I assume that initially many people saw me as being part of the political elite in my home country more than being a non-political social scientist.

Moreover, the cooperation included working closely with people trained in medicine and pharmacy and not social scientists, which turned out to be much harder than expected, but also very rewarding. One could argue that the project to some extent has been explorative both in terms of approach and multi-disciplinarity. Due to my close collaboration with medical professionals, the research project as a whole has partially been caught between two research traditions. In medical science a positivist approach to research is common with quantitative methods and measurements, indicators and causal relationships, while I am used to a more hermeneutic approach represented by my own qualitative research method.[20] Medicine is an applied science with clearly stated goals—to improve health and cure diseases—while social sciences often lack this quality. Although the result is a qualitative analysis, coming from a different research tradition has made the research difficult at times and caused some confusion on both sides.

I have retrospectively studied the formulation of the policy by so-called process tracing (see e.g. George and McKeown 1985: 34-41). Process tracing simply means that the researcher tries to reconstruct the decision process in relation to its outcome, which provides insights into which factors influence political behaviour and how they do so (Berman S. 2001: 244). The implementation process has been followed during my visits in Laos and Vietnam from 1998 to 2001. In 1999 I stayed in Laos for two months where I spent most of the time at the National Institute of Public Health (previously Council of Medical Sciences), an advisory body under the Ministry of Health. This was invaluable in order to understand the daily work of Lao health officials. The trips to the provinces and districts were very helpful in understanding the implementation constraints.

The time frame has not been unimportant. Besides studying what happened a few years back relying on people's memories, I also studied an on-going process without knowing the end of the story. Hence, during the years I studied the policy processes I had to deal with changes of perceptions and

20 My aim is primarily to increase the understanding of the problem area rather than trying to generalise in a scientific sense. Thus, the way I use the word explaining has not the same epistemological bearing as in the positivist approach (see e.g. Hollis and Smith 1990).

results of the implementation of the policies (see e.g. Thurén 1992). I should also add that my own perception changed somewhat during the research process due to increased understanding of the problem area. Upon my first arrival to Laos and Vietnam I had limited knowledge about the Lao and Vietnamese NDPs.

Material

Several sources are used in this study. Besides secondary material, such as various books and journals, a number of documents have been collected in Laos and Vietnam as well as in Geneva (WHO), Copenhagen (Nordic Institute of Asian Studies, NIAS), and Stockholm (Karolinska Institute). Due to the character of the project there have not been extensive field studies—even if fieldwork has been conducted every year of the project (all in all around five and a half months). A review of existing material has been the prime source of information together with interviews with policymakers, health officials and representatives from various donor agencies and international organisations. The documents are all kinds of health policy related documents, often so-called grey material, such as project reports, records of meetings and seminars. Official records such as the NDP have been studied.

Still there is a lack of written material, in particular about Laos and especially academic writings. Most of the policy documents are in English, but some are only in Lao or Vietnamese, which is problematic as I do not speak or read Lao and Vietnamese. At the same time I have had unique opportunities to follow the work related to the NDP, especially in Laos, participating in seminars and fieldtrips, which I hope compensates for the lack of language skills in the sense that I could experience the practical side of the policy process.

However, one of the most difficult parts of conducting research in countries like Vietnam and Laos is how to interpret information. As Dang Phong and Melanie Beresford put it "(i)t is a fact of life in Vietnam that the truth is often without hard evidence, but the hard evidence is also without truth" (Dang Phong and Beresford 1998: 7-8). Objectivity is equated with (political) correctness, and subjectivity is usually "wrong." In these terms ordinary people's points of view mean wrong points of view (Craig 1997: 78; also see Thurén 1992). The lack of accurate information is also influenced by the very absence of data, and that some of the existing data reflects political imperatives

among governmental departments and individual bureaucrats to demonstrate progress in achieving targets rather than showing reality (Rigg 1995: 150). Naturally the normative aspects in all material must be considered—including those produced by donors and international agencies.

As a result, documentation has admittedly been difficult. However, in research environments such as Laos and Vietnam, conventional methods of documentation often miss out on important aspects of reality. Accordingly, I have had to rely on "soft evidence" at times. However, although my sources separately should be treated with caution, I believe they collectively manage to reflect the situation in Laos as well as in Vietnam. Multiple sources of information have thus been of paramount importance in order to obtain a realistic picture of the research problem.

Interviews

Approximately 80 interviews were conducted between 1998 and 2001, most of them in Laos and Vietnam. The interviewees were primarily health officials at central level (many of those interviews were conducted in English), but also at provincial and district level (mostly interviewed through interpreters), all involved in the development and/or the implementation of the NDPs. Thus, I have interviewed pharmacists, doctors, university professors, heads of institutes and hospitals, vice health ministers, and many more. Interviews with representatives of the donor agencies and other expatriates working in Laos and Vietnam have also been important sources of information.

In the text, I mainly refer either to "health officials," which indicates that the person is either Lao or Vietnamese, or "expatriate," which implies that the interviewee is foreign—regardless of position. When I find it necessary for the analysis I further specify the category of the person interviewed. Although nobody has specifically asked for anonymity, I have chosen to keep my interviewees' identities anonymous in order to make sure that I have respected their integrity (see Uimonen 2001: 179). Moreover, in my case I do not think specific names would contribute to the analysis (see e.g. Lundberg 2001: 20). However, as I am trying to capture the communication process between foreign and domestic actors and how these actors perceive the situation—as well as to problematise their behaviour—I find it important to point out the background of these actors. When I refer to "personal communication" in the

text, it means that my inquires have not been within the framework of an interview. Instead, the purpose has been to get specific or complementary information about a subject matter.

Notes were taken during all interviews and transcribed directly afterwards. The interviews primarily served to increase my understanding of the problem area, to establish how the policies had been developed, and to investigate how the policy had been translated into practice. The interviews help to discover shades of meaning and can in that respect break through some of the barriers of secrecy (Stenelo 1984: 29). Moreover, interviews are probably the only way to find out what people know or what they think about certain issues (see e.g. Merriam 1988: 100).

The so-called snowball method was used in order to find key informants as well as material. In other words, every interview included questions concerning which other key actors to interview and where to find material. Access to so-called grey material was facilitated by this method. The types of questions asked concerned who was involved in the policymaking process, what type of collaboration took place between the actors, how information about policies was achieved, who had access to information, why certain components of a policy were adopted, what the main problems in developing and implementing the NDP were, and what the consequences of implementation of the NDP were. The interviews, which were semi-structured, were often combined with participant observation. For example, I had the opportunity to accompany colleagues in the field conducting research for another project funded by the Asian Development Bank (ADB). Even though I could conduct interviews, most of the time was spent observing. Combining interviews with observation is particularly valuable when studying a new problem area (see e.g. Merriam 1988: 88). I also participated in a number of seminars in Laos. In 2001 I was invited to participate in analysing a questionnaire distributed to around 90 policymakers in Laos, which has proved to be a useful source of information regarding knowledge and attitudes about the NDP in Laos.[21]

21 Questionnaire at the 5th National Drug Conference in Vientiane 27-28 February 2001. The questionnaire had several aims. First of all, it was a kind of base-line survey about knowledge and attitudes towards the NDP in general (the implementation of the NDP), and concerning the research component included in the NDP programme in particular. Moreover, it was a first attempt to relate research to policymaking. It was also an opportunity to find out what decision-makers consider to be the main problems in the sector and to get ideas about how to disseminate information about research results (and about the NDP in general). Finally, it was an evaluation of the conference itself. The response rate was quite high, 83 percent.

You often find scepticism towards cadre, health officials and the like among Western scholars conducting research in Vietnam and Laos. These politically trained officials tend to supervise those who are the subjects of the interviews. In my case this was not a severe problem, as my objects of research were these officials and how they perceived the policy process. At the same time I most probably influenced the interviews at times by asking leading questions. This was partly a result of using interpreters, which prevented a more open conversation. The use of interpreters also involves a risk of misinterpretations. Every now and then, albeit not often, I managed to ask "inappropriate questions," which meant that the interviewee chose not to answer my questions. However, due to the relatively large number of interviews, I believe that the interviews together have provided an accurate picture of the issue area. I was admittedly dependent on my counterparts and their contacts, but at the same time I would not have been able to conduct most of the interviews without their contacts.

Part II
Policy formulation

Chapter Three

How external ideas diffuse into national policymaking

In this chapter a theoretical framework will be developed. In each of the four sections I use ideas from different bodies of literature. First I discuss strong and weak points of policy studies in order create a structure for my analysis of the NDP processes. The next section introduces ideas from new institutionalism. The ideas I highlight concern the behaviour of actors and their way of reasoning, something I find decisive for the diffusion and translation of policies. Section three problematises policy diffusion by placing it in a wider perspective looking through the lenses of globalisation. Finally, ideas from the so-called constructivist school serve as the basis for identifying transmission dynamics. By scrutinising the connection between international actors, domestic structures and norms, it becomes possible to elaborate further on translation of policy and thus increase the understanding of the NDP processes. Hence, the aim with this chapter is to bridge the gap between foreign and domestic, policy diffusion and implementation, agent and structure, and policy, ideas and norms. The framework will later be applied on the Lao and Vietnamese NDPs.

The policy process

Traditionally, there has been a distinction between agenda setting, policy formulation, implementation and evaluation, but today it is acknowledged that these aspects of the policy process are strongly interconnected and difficult to separate. According to Gill Walt, there is little disagreement among policy analysts about the different stages of the policy process. The disagreement concerns how far policy follows a rational or logical process from agenda setting to policy evaluation. The linear process may give a false impression of policymaking in practice (Walt 1994: 45; see also Zwi and Mills 1995: 312).

Most people involved in policymaking are well aware that the process is often less rational than such models assume. Often it is a coincidence that a certain issue or policy is on the agenda, the outcome of decision-making might be a result of a power struggle between different groups, and the implementation may fail due to lack of resources or knowledge. If there is an evaluation, it could be biased or even neglected if the result is not satisfactory. Thus, the way the policy process is described is closer to an ideal model than reality. However, this does not mean that the model cannot be used as a guide for structuring an analysis.[22]

While aware that the policy process in practice rarely is linear, I use the categories "formulation" and "implementation" in order to highlight certain phases of the policy process and relate them to diffusion processes. Formulation includes the development and adoption of the policy, while implementation refers to the process after the adoption. Interestingly enough though, the linear description is fairly accurate in the Lao case. The reason is that there were no previous policies in the pharmaceutical area and the work had to start from scratch. In Vietnam there were several related policies even if no NDP, thus the work was influenced by previous policymaking in the area. This is yet another interesting difference between my two cases of policy processes.

"Agenda setting" and "evaluation" are only discussed indirectly. Arguably diffusion is a way to put an issue on the agenda, and in a way I include the agenda-setting process in what I call formulation.[23] In the case of evaluations I just want to make one point. Evaluations can be distinguished by type, where process evaluations in fact are similar to implementation studies (or formative evaluations) and outcome evaluations (also called summative evaluations or impact assessments) are designed to assess the effects of the policies or programmes on the broader society (Schneider and Ingram 1997: 33). The reason why I want to underline the different kinds of evaluations is that the evaluations I refer to in this study are not of the same kind. The evaluation conducted in Vietnam was formative, while the one in Laos was summative. My aim is, to repeat, primarily to highlight the diffusion and translation process and difficulties related to that process rather than trying to cover all aspects of the policy process.

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22 Models have been developed that are closer to reality than the strictly rational, prescriptive and normative ones, such as the more descriptive incrementalist models or mixed scanning, see Ham and Hill 1984; Walt 1994.

23 For agenda-setting see e.g. March and Olsen 1989; Kingdon 1995.

The kind of rationality posited in models of the policy process is based on assumptions derived from policymaking in the Western hemisphere rather than from the situation specific for countries like Laos and Vietnam. In other words, they do not sufficiently consider variations in context. The assumptions include some sort of democratic procedures in the policymaking that facilitate the search for the most efficient policy, and "rational" behaviour of the participating actors which means that they automatically try to make the "right" decisions and try to fulfil stated goals (see Walt 1994: 47; Mellander and Jönsson 1993).[24] Arguably, this cannot be the only existing "rationality," and consequently people may act in a number of different ways. Problems may arise when the involved parties act and understand the situation differently, for example if there are discrepancies in the perception of what is the most important issue at stake. Cooperation difficulties can in many cases be traced to communication problems.

Thus, my criticism against the rational model includes two aspects: one concerns the model as an analytical tool, which is less severe, and one is connected to the model's assumptions about the study of object, which I find more problematic. By extending the policy model to include the diffusion process these differences become more obvious.

At the same time the policy diffusion approach has its problems. Even though policy diffusion is widely applicable to most policy areas, it lacks a satisfactory account of the role of norms and ingrained practices in shaping policy and has failed to relate state theory to implementation studies (Hulme 1997: 409). This means that important information about the policy process is left out, concerning the rationale for adopting the policy in question and what the effects of the diffusion are. In addition, the policy-diffusion scholars make the same mistake as other scholars by assuming that policy decisions are carried through implementation with the results desired, as discussed earlier.

Furthermore, the diffusion process continues during the whole policy process, including during the implementation process which will be shown later, and arguably the diffusion process is even more complex in aid dependent countries due to the fact that donors as well have a say in what part of the policy is to be implemented. Moreover, new actors enter the policy

24 For a discussion about public administration, implementation and context see e.g. Ashour 1996; Common 2001; Cleaves 1980; Jain 1992; Haque 1996; Hydén 1997.

process during the implementation phase, domestic as well as international. NGOs, for example, can support parts of a policy through smaller projects. At the same time I do not want to characterise the policy process only as a dependency relationship because I think there is more to it than that. The recipient country has a possibility to choose its course, even if the choice sometimes is limited, and the outcome of this choice is to a certain extent dependent on what seems appropriate at the time. What is appropriate is decided by already existing domestic institutions and norms combined with global or international norms introduced through various forms of international collaboration.

Thus, by combining policy formulation and implementation with policy diffusion, the policy process can be stretched to include external as well as domestic factors. It is also possible to follow the policy from its origin to the effects of the adopted policy. However, in order to understand why certain polices are adopted and others not, and why those involved in the policy process behave in a certain way, we need to move beyond the "rational actor approach" and include norms, identity and structures.

Rationality versus norms and identity

Behaviour can be elaborated upon by using the two kinds of logic discussed in new institutionalism, a sub-field of organisation theory, namely the logic of consequentiality and the logic of appropriateness (see March and Olsen 1989; Hall and Taylor 1996). The logic of consequentiality is based on means-end rationality as described earlier, while the logic of appropriateness focuses on the role of norms and values, and culturally specific practices. The emphasis is on how to do the right thing in relation to informal rules and institutions based on identity and place in society. Action is related to interpretations, and institutions influence individual behaviour by providing cognitive foundations and structures of meaning (Jönsson and Tallberg 1999). In other words, actions are adapted to situations by their appropriateness within a conception of identity. From this perspective, the identities and capabilities of individuals cannot be seen as established apart from, or prior to, their membership and position in the community. The political community is based on a shared history, a shared definition of the common good, and a shared interpretation

and common understanding embodied in rules for appropriate behaviour (March and Olsen 1989: 160-161).

The logic of appropriateness gives great relevance to structures and their origins—how they are maintained and transformed (Olsen 2001a), while the logic of consequentiality is driven by agents and their preferences. When the logic of consequentiality prevails the questions asked are: What are my alternatives? What are my values? What are the consequences of my alternatives for my values? In other words, one should choose the alternative that has the best consequences, rather than doing what is most appropriate by asking questions such as: What kind of situation is this? Who am I? How appropriate are different actions for me in this situation? (March and Olsen 1989: 23).

James G. March and Johan P. Olsen (1989) see the logic of appropriateness as the fundamental logic of political action, and I agree with the notion that in reality people act more in accordance with the logic of appropriateness than of consequentiality. Moreover, in line with the constructivist reasoning the logic of appropriateness ought to be the basic logic, and accordingly the logic of consequentiality is just one kind of logic of appropriateness.[25] The "rational" behaviour is simply the most appropriate behaviour at the time, and how the involved parties perceive the situation is basically a social construction based on beliefs, norms and previous experiences. The behaviour can thus be related to the roles of the participating actors rather than to individuals as such.

Naturally the two kinds of logic can be difficult to separate in practice, but perceived as analytical categories, or ideal types, they facilitate the analysis considerably by distinguishing different kinds of behaviour. Relatively speaking, the donors and their consultants often, but not always, actually act more according to the logic of consequentiality, partly because they are trained in a certain way of reasoning and partly because their work in this context is primarily within the boundaries of time-limited programmes where goals and means are clearly stated. The Lao and Vietnamese counterparts relatively speaking act more according to the logic of appropriateness because they act in their home environment and have to consider issues beside the programmes in their daily work.

25 There are those disagreeing with March and Olson that there are only two kinds of logic and that the two are exclusive. Hedin (2001: 83), for example, suggests a third complementary logic, the logic of interpersonal trust. According to this logic agency is limited and enabled by social network structures and mechanisms. The questions asked are: Whom do I trust? What do they say? Can they help me with that? The imperative is to cooperate with trusted others.

What I try to capture is how the translation of policy is affected by conflicting behaviour as a result of different kinds of logical reasoning. For example, if an individual decides to accommodate the donors and their goals, and if this individual at the same time breaks informal rules, the consequences can be relatively severe (job replacement, lack of promotion etc.). My idea is that the two kinds of logic, used as analytical categories rather than meta-theoretical categories, can highlight aspects of policy diffusion that I find absent in the policy literature. Moreover, I want to see how much the analysis of the NDPs can be advanced by using the idea of logic of behaviour. For example, I can investigate whether the ways of adopting new ideas are "appropriate" or not and how this affects the implementation of the policy.

Claudio M. Radaelli (2000: 38) makes the same observation as myself, which is that the idea of policy transfer, or what I label policy diffusion, is based on a notion of rationality, and he also points at new institutionalism and the idea of appropriateness. He argues that the policy transfer literature is based on a view that political actors are rational decision-makers. New institutionalism, on the contrary, underlines the "taken-for-granted" aspects of political life, where actors follow rules, shared interpretations, symbols, and meanings. Policy transfer consequently assumes a rational process in which imitation, copying and adaptation are the consequences of rational decisions by policymakers.

Dolowitz and Marsh (2000) acknowledge some degree of bounded rationality, and other authors working on policy diffusion/transfer have challenged the logic of consequentiality by using a process perspective that goes beyond a mechanical transfer model (see e.g. Mörth 1997). Nevertheless, the fact remains that the majority of studies on policy diffusion/transfer downplay the logic of appropriateness and put emphasis on the logic of consequentiality (Radaelli 2000: 39). The focus on the agents (as in policy studies), and hence the neglect of structure, makes the behaviour of the Laotians and Vietnamese in some instances incomprehensible for an outsider. Personal networks and patron-client relations are significant institutions, and informal rules guide much of the behaviour. Colonial past and communist legacy colour the societies, and norms as well as material objects are often valued differently than in industrialised countries.

Related to this problem is that most policymaking models are designed for liberal democratic institutions with claims on some sort of transparency and accountability where elected officials make decisions and independent civil

servants implement those decisions (see e.g. Schneider and Ingram 1997: 15). This cannot be taken for granted in authoritarian one-party systems such as in Laos and Vietnam. The systems do not allow for critical assessment from independent organisations, parties and press—even if some internal criticism is allowed within the communist party. In addition there is no sharp distinction between policymaking and policy implementation, which means that central bureaucratic organs and local cadres have real opportunities to influence the direction of the policy (Porter 1993).

However, neither Laos nor Vietnam is insulated from foreign influences, and today's policymaking must be placed in a wider perspective in order to make sense. A globalisation perspective provides a way to do this.

The impact of foreign ideas from a globalisation perspective

Policy studies mostly refer to national policymaking. However, the border between national and international policymaking is becoming increasingly blurred. In line with Walt (1994) I am interested in the question to what extent international policies influence national policymaking, which is related to the question why certain policies spread and others not. In aid dependent low-income countries the policies of bilateral donors and international agencies do influence national policymaking, and in an increasingly interdependent world decision-makers are not always sovereign. However, it is not only specific policies that influence the reform processes. As argued by several constructivist scholars more general norms can have an impact on how to view what is appropriate and what is not, in regard to policymaking, both among donors and recipient countries. Accordingly, the connection between norms, policy diffusion and national policymaking becomes significant. My intention is thus to show the importance of including policymaking at a global level when analysing policy processes in Laos and Vietnam.

One reason for looking at the global level is that there are some limitations of diffusion explanations in general. How do we know if diffusion has taken place at all? Could comparable policies arise as a result of similar problems in the countries? The proponents of this view would argue that problems of social, economic and technological character can only be solved in a certain number of ways (Stoker and Mossberger 1994: 1). I do not deny that this kind

of tendency exists, yet consider it unlikely that societies of today develop independently of each other. The communication across the world is extensive and exchanges of ideas occur constantly, entailing varying degrees of diffusion. Richard Rose (1991: 22), for example, distinguishes between copying, emulation, hybridisation, synthesis, and inspiration, where copying means using a programme as it is, emulation means adoption of a policy with adjustment, hybridisation the use of elements from two programmes, and synthesis the use of components from three or more places. Inspiration implies intellectual stimuli from programmes elsewhere for developing a complete new programme. In practice it may be difficult to place a policy in a single category. However, the categorisation illustrates that the diffusion processes can vary in character depending on the policy in question.

Introducing globalisation

The literature on globalisation can be helpful in order to frame the issue of diffusion in a broader perspective. However, the literature is very diverse, both in regard to specific approaches adopted and conclusions reached. Globalisation can be seen as the diffusion of neo-liberal values and market principles. It can also be viewed as a higher level of internationalisation or regionalisation, alternatively as something completely unprecedented in the sense that there is no longer a clear distinction between foreign and domestic affairs (McGrew *et al.* 1998).

Included in the notion of globalisation is so-called time and space compression, where the development of transport and communication plays a decisive role. The processes of economic integration and developments in communication technology are by many thought to give rise to increasing cultural interconnectedness and homogenisation worldwide (Randall and Theobald 1998). The exact impact of these processes is hard to estimate, but it is indisputable that people (at least in the urban areas) are exposed to forces beyond national borders through the growth of the global economy, the information technology revolution, and the diffusion of political and cultural ideas—although globalisation is not necessarily linear or uni-directional. From a development perspective globalisation is indeed very uneven, as many parts in the rural areas never, or only to very limited degrees, become affected by so-called global forces. Parts of rural Vietnam and Laos are good examples of this phenomenon, at the same time as the urban areas are good examples

of how quickly societies may change once open to global forces—which in the end affects policymaking and implementation of new ideas.

Thus, the literature on globalisation is heterogeneous in the sense that there are many opinions about what globalisation really means and what the consequences of globalisation are.[26] Here I use globalisation more as a point of departure for my research problem than as the main focus of the research itself. In other words, this is not a study about globalisation *per se*, but a study about the spread of ideas and policies from a global perspective and the changing conditions for policymaking in a "globalising world." Another way to put it is that by trying to understand the timing and adoption of policies new insights about contemporary politics and local-global linkages can be generated (see e.g. True and Mintrom 2001).

According to David Armstrong (1998), globalisation includes seven broad forces: issues, actors, markets, communication, culture, legitimacy, and postmodernity. These forces can all be related to this study. Many issues, including health and pharmaceuticals, can no longer be contained within national borders. Moreover, non-state actors operate on a global scale as agents of diffusion. There are networks connecting transnational companies (including pharmaceuticals), and on another level individuals act in the capacity of international bureaucrats, or consultants in low-income countries. The global market makes it impossible for governments to act on their own, as seen in connection with the Asian financial crisis, and the governments have less and less ability to influence and control information within their borders. Transnational corporations and institutions are exercising more influence and power, and the capacity of national policymakers to frame their own agendas is diminishing. Public policy takes place in a world system as well as in national political systems (Parson in Dolowitz and Marsh 2000: 6).

However, at the same time as globalisation is seen as a force of homogenisation, it also opens up for fragmentation when subnational groupings assert their right to a separate identity. Multi-cultural Laos and also Vietnam have for a long time tried to unite their people through a Marxist-Leninist version of nationalism. However, today the young seem more interested in catching up with the neighbouring countries than in revolutionary ideals. The old enemies are gone and the legitimacy of the communist regimes is thus threatened.

26 For an elaborated discussion about globalisation in general and in Asia in particular see Kinnvall and Jönsson 2002.

The last category, postmodernism, has more to do with undermining the dominant discourse of modernity and its links to positivist approaches to knowledge—with all its dichotomies such as domestic/foreign, East/West, North/South, realism/idealism, order/anarchy, security/insecurity—and with the power relationships that underlie and emerge from such representation of reality. States are embedded in an international social fabric that extends from the local to the transnational. Local events experienced by particular individuals can have transnational effects, such as environmental disasters, at the same time as transnational politics and the structure of system-level actors can have localising effects. An example of this could be the World Bank targeting small farmers in rural developments projects (Finnemore 1996a: 145).

The argument that globalisation threatens the sovereignty of the state is one of the core elements in the literature about globalisation. However, some scholars challenge the view that globalisation leads to the erosion of the state. They agree that control is lost, but not as much as sometimes perceived. The reason for this perception can be found in the lag between new challenges and the states' ability to address them through policy (Lord 1998). An example of this problem is the privatisation of the pharmaceutical sector in Laos and in Vietnam, where the relative lack of regulations created chaos with extensive self-medication, among other things, as a result. This precarious situation eventually forced the governments to adopt national drug policies in order to create order in the pharmaceutical sector.

Globalisation in low-income countries

The impact of globalisation in the developing world is another issue of debate. From my standpoint, it is natural to ask questions about the role of globalisation forces in Laos and Vietnam, even if we talk about two low-income countries with limited access to the world economy. The regimes are authoritarian and inherently sceptical to external influences at the same time as their populations watch cross-border television and use the Internet[27] — even if it is also true that the societies are largely agrarian and many people live in remote areas cut off from technical innovations and international commu-

27 See Uimonen (2001) for an interesting account of the use of the Internet in Laos and Botha and Larsson (2001) for the use of Internet in Vietnam.

nication. Hence, at least in the long run it will be difficult to resist global forces. At the same time there is a lack of civil society that could provide transnational connections, with the result that globalisation has limited (political) effect in societies like Laos and Vietnam. Most new (political) ideas filter through the "top," or the elite, and in fact only a small number of people can actively influence the policymaking.

Nevertheless, even though the effects of global forces are uneven, I would argue that the development in technology and communication has an impact even in poor countries with effects on public policymaking, not least because the policymakers get access to new ideas through their increased contact with the rest of the world. Globalisation promotes the expansion of new norms and ideas and creates new opportunities for norm entrepreneurs and agents of diffusion.

Moreover, pharmaceuticals is an inherently globalised issue area, and it is possible to see a spread of neo-liberal values and market principles in the area—and in Laos and Vietnam. Since the beginning of the 1980s most developing countries have moved toward market-oriented reforms. There has been a major shift from inward-oriented import substitution toward export promotion, trade liberalisation and privatisation. Behind these policies a new set of ideas can be discerned. The novelty of the liberalisation discourse is the idea that the main obstacles to development are to be found within the developing countries themselves, as opposed to the dependency discourse which blames development problems on "developed" countries' exploitation of developing countries (Biersteker 1995: 177).

Quite often free market ideology has been transferred to the developing world in line with structural programmes orchestrated by the World Bank and the IMF. Reduced health budgets, often as a part of structural adjustment programmes, and lack of convertible currency created drug shortages in most countries (Kanji 1992: 68). Cost-recovery has been seen as one way out of the problem. For example, the Bamako Initiative, originally introduced by UNICEF in 1987, has been duplicated in many places including in Laos and Vietnam. The Bamako Initiative basically means that charges should be made for drugs and services in order to contribute to the health workers' salaries or other aspects of building up primary health services (Walt and Harnmeijer 1992: 41).

An additional effect of reduced health budgets is that many health ministries have become weaker and do not have the strength to coordinate all national (private and public) and international agencies, development banks, international organisations, non-governmental organisations, bilateral cooperation and so forth (Antezana and Velasquez 1996). The trend toward globalisation and homogenisation of the world market strengthens some international actors at the expense of the national ones. This is noticeable in the pharmaceutical sector as well as in such areas as intellectual property rights and control over drug prices (Hamrell and Nordberg 1995: 8-9).

The GATT agreement, the creation of WTO and Trade Related Aspects of Intellectual Property Rights (TRIPs) are contributing to this trend. The impact of the section on patents of the Final Act of the Uruguay Round on global production and trade in goods and services has consequences for the drug sector (Correa 1997). According to a WHO official, globalisation, in relation to the access to drugs and TRIPs, is the most pressing issue today. However, it is still an unexplored and emerging issue, and countries are not aware of the effects yet (interview in Geneva 10 December, 1998). The effects on Laos and Vietnam may not have been substantial so far, but as the countries become more integrated into the global economy, this kind of agreement will leave an imprint on the Lao and Vietnamese pharmaceutical sectors as well.

Even though it cannot be established how, or to what degree, globalisation affects the policymaking in Laos and Vietnam, it is clear that policy diffusion is a part of the globalisation trend. Global economic forces exert pressure towards policy diffusion, but also the rapid growth in communications of all types makes exchanges of ideas and knowledge much easier. International organisations often advocate, and at times enforce, similar policies across diverse countries, exemplified by the WHO advocacy of NDPs. By subjecting countries to similar pressures and expanding the amount of available information, policymakers increasingly look to other political systems for knowledge and ideas about institutions, programmes and policies and about how they work in other jurisdictions (Dolowitz and Marsh 2000: 7).

Sweden has, for example, received quite a number of delegations from Vietnam in particular, but also from Laos, in the past few years. The role of consultants increases as well. International organisations spread ideas, programmes and institutions around the globe, not only through their policies and loan conditions, but also indirectly through the information and

policies disseminated via their conferences and reports. Thus, what we see is a mix of coercive and voluntary diffusion of ideas and policies (ibid: 11).

Previous waves of diffusion

Diffusion as such is nothing new in Laos and Vietnam, however. The Vietnamese are influenced by a millennium of Chinese rule and Confucianist ideals, while Laos has been Buddhist and Indian in cultural orientation (Ljunggren 1992: 33). Both Laos and Vietnam were part of French Indochina, which also included Cambodia, until the 1950s (although Vietnam was proclaimed an independent state in 1945, the French rule did not end until 1954). After independence the influx of ideas was of Marxist-Leninist orientation, and today the countries are exposed to liberalism and influences from the Western world.

Stein Tønnesson (2000) describes the present Vietnamese state as a result of a number of historical layers that in different ways and to various degrees influence the state capacity, which can be related to diffusion of external ideas. These are: the Confucian layer, the colonial layer, the Viet Minh layer, the South Vietnamese layer, the centralised layer, and the market oriented layer. The first layer, the Confucian one, left values such as social harmony and the importance of education. The colonial layer contributed with a French modelled educational system and nationalism. The Viet Minh layer represents the national liberation state emphasising the international outlook, revolutionary ideology, a tightly knit party comradeship that binds the elderly elite, and a system of voluntary organisations. The South Vietnamese layer reflects the division of Vietnam from 1946-1975 and the anti-communist networks outside Vietnam that today have renewed their ties with relatives in order to pursue their business interests. The centralised planning layer was based on incorporated structures, codes of behaviour and values from the previous layers together with a militarised, subsidised, centralised planning state nominally constructed on the Soviet model. The party and the state became heavily bureaucratised during this period. Finally, the market oriented layer originated in conjunction with *doi moi*.

In Laos the French influence was never as pronounced as in Vietnam, because it had less significance for the French administration. Yet French colonial administrative practices were adopted. The country was declared

independent in 1953, but shortly afterwards a civil war broke out, which lasted from 1954 to 1973. Two years later the communists came into power. During those two decades American influence was present through training and educational opportunities, employment in US agencies, and massive aid (primarily military). The country also suffered during the Vietnam War due to the bombing by US war-planes of the extension of the Ho Chi Minh Trail—although this was kept secret for the rest of the world for a long time. The influence from Vietnam has been substantial as well. Besides long-time military mentors from Hanoi, some 50,000 Vietnamese troops were stationed in Laos for 14 years after the war—together with thousands of Vietnamese and Soviet advisors, doctors, teachers and experts (Thalemann 1997; also see Rigg 1995; Zasloff 1991).[28] These foreigners filled some of the vacuum caused by the many, mostly high educated, persons who fled after the communist take-over.

However, according to Grant Evans (1995, 1998) socialism has both come and gone. The socialist institutions in Laos only lasted for a very brief period of time with few strong interests attached to them, as has been the case in Vietnam. Hardly a generation was socialised in school, and many of the old institutions in the villages, along with religion, remained intact. According to Andrea Thalemann (1997), there was a significant lack of dogmatism from the top, and Buddhist-style pragmatism outweighed ideological orthodoxy.

Still, the contacts with Vietnam and China remain important, even if the major influence in Laos today comes from Thailand. Consequently the biggest fear of some of the leaders is "Thai-fication" of Lao culture. Besides extensive trade and personal contacts, Thai soap operas and music are extremely popular in Laos. Also, Thai television is considered to be more reliable than the Lao, especially concerning political and world news (Uimonen 2001: 205). Naturally the similarities between the Thai and Lao languages and culture in general contribute to the diffusion of ideas and impressions. Historically the ties between Laos and Thailand have been strong. Before the communist takeover 80 percent of the Lao official trade passed through or into Thailand, and the majority of all ethnic Lao actually live in the North-Eastern region of Thailand (Rigg 1995; also see Evans 1999).

28 See Stuart-Fox (1997) for a detailed historical account from the time of Kingdom of Lan Xang to present Lao PDR.

The novelty of today's diffusion compared to previous ones is the speed of change and the multitude of actors trying to spread their ideas. The effects of the economic reforms are increasingly visible, and even I could see the change from my first visit to Laos and Vietnam in 1998 compared to my latest in 2001.[29] A few years ago, Sweden and a few other donors were the only ones operating in Laos and Vietnam, and the rate of foreign direct investment (FDI) was low. Today many donors compete with each other, including NGOs, and the Lao and Vietnamese governments do their best in trying to attract foreign capital. The impact of tourism is substantial as well. Consequently the countries are continuously exposed to the diffusion of ideas at all levels of society.

Transmission dynamics

So far the discussion has dealt with the diffusion process in more general terms—how international policymaking influences national policymaking and how globalising forces affect the policy process. In addition behavioural aspects have been highlighted by including communication and translation as well as the two kinds of behavioural logics. However, it is still not entirely clear what makes some policies spread and others not. The factors deciding which ideas, norms or policies will succeed in being spread and adopted are, in fact, understudied. For example, the idea to develop NDPs in Laos and Vietnam can be viewed as a result of external ideas, originally from WHO, channelled through bilateral cooperation between the Swedish government and the governments in Laos and Vietnam respectively. However, this kind of process is often portrayed in a simplified way emphasising imposition through aid dependency. As I will show, the processes were much more complex than that, warranting more thorough analysis.

International norms and policy

The interplay of norms and policies is a neglected, albeit important aspect of policy diffusion. Policy diffusion often describes something very concrete,

29 See Templer (1998) for a well-informed discussion about modern Vietnam and Evans (1998) for modern Laos.

while norm diffusion is more abstract in character. A policy is connected with both a substantial and an instrumental part (e.g. content and action plan) while norms are more connected with values and identity (e.g. the direction of foreign policy and other security related issues). Agents of diffusion aim at changes in specific policies, while norm entrepreneurs are described as influencing more ideational changes. Still, there is a connection between norms and policies, as indicated. In order for a policy to be implemented, there must be some kind of resonance with the norms on which the policy is based and prevalent norms in the society where the policy is supposed to be implemented.

Klotz (1995: 27-28) looks for transmission dynamics that link norm and policy choice. According to her, discourse and institutions guide us to the motivational dimension of norms, linking identity and interests, on the one hand, and policy and behaviour, on the other. Through international and domestic decision-making processes, various avenues exist for norms, as embodied in individuals' beliefs or embedded in social discourse, to influence the determination of national interests and political goals. Among these transmission alternatives are multilateral institutional memberships, bilateral persuasion or learning, elite changes, domestic coalition building, and more dramatic domestic social transformation. These international and domestic policymaking institutions may remain insulated from new norms, hence variation across decision-making institutions must be investigated individually (ibid: 32).

Exemplifying Klotz's discussion one can say that a mixture of transmission dynamics was at work in Laos and Vietnam—which ones depends on whether one looks at norms or actual policies. For example, the introduction of market-oriented reforms certainly had social effects on a broader scale paving the way for reforms in the health sector, while the actual policies were primarily a result of bilateral persuasion and learning. Elite changes, domestic coalition building, and more dramatic domestic social transformation were never an issue in Laos and Vietnam. However, in Bangladesh as well as in the Philippines, the introduction of the NDPs was related to domestic political turmoil and elite changes. Political conditions outside the countries played a decisive role in developing a pharmaceutical policy as well. In Bangladesh General Hussain Muhammad Ershad had just seized power, and in the Philippines Corazon Aquino was the new leader; in both cases the change of political leadership opened up an opportunity to introduce new ideas. Dedicated individuals in the Ministry of Health, who pushed for the policies,

and the support of international agencies facilitated the adoption of the NDPs when the reforms were questioned. The NDP in Bangladesh was met with heavy resistance from multinational corporations as well as from foreign governments, but Ershad managed to maintain the pressure[30] (Reich 1994 and 1995; Lee 1994; Chowdury 1995).

The redefinition of interests is thus not always the result of external threats or demands from domestic groups. Rather it is shaped by internationally shared norms and values that structure and give meaning to international political life (Finnemore 1996a: 3). This indicates an inverse causal relationship where for example international organisations can be the point of departure instead of states. In aid dependent countries like Laos and Vietnam this is a highly valid argument, especially in a globalising world where the state has to compete with other actors in the realm of policymaking. Not only do bilateral donors try to influence, but large international organisations and agencies may directly or indirectly diffuse ideas and policies as well, which helps to shape the interests of states and eventually their policymaking. In the health sector, for example, WHO is one of the main actors in promoting ideas and norms, such as reforms in the health sector and the development of NDPs.

Profession is another category of powerful and pervasive agents working to internalise norms among their members. Professional training does more than simply transfer technical knowledge; it actively socialises people to value certain things above others—often through a specific scientific language. For example, doctors are trained to value life above all else, with the result that the medical profession operates in a similar way in many countries. Systems of medical education, exchange of academic and professional views through academic journals, and the reliance on medical technology, are remarkably similar across the globe—even if the situation in many poor countries differs from this general view (see e.g. Zwi and Mills 1995). Also, as state bureaucracies and international organisations have become more and more professionalised during the twentieth century, we should expect to see policy increasingly reflecting the normative biases of the professions that staff these decision-making agencies (Finnemore and Sikkink 1998: 905).

30 Within hours of the announcement of the NDP, the US ambassador called for an appointment with Ershad in order to persuade him not to implement the policy as it was unacceptable to the USA and its commercial interests. The British, German and Dutch ambassadors also expressed their dismay over the policy. Several MNCs started to actively lobby against the NDP, see Chowdury 1995; Reich 1994, 1995.

Agents and their networks

The point of departure in this study is that not only states' interests rule the policymaking in the world, but that international organisations and other actors also influence by promoting certain norms, ideas and policies through various networks. The UN system, for example, provides an important channel through meetings, committees and reports, and so on, for dialogue on many different issues (see e.g. Walt 1994). Some call these networks epistemic communities,[31] while others call them advocacy coalitions or groups, issue networks, or policy networks. An epistemic community can be described as "a knowledge based network of individuals with a claim to policy-relevant knowledge based upon common professional beliefs and standards of judgement, and common policy concerns." These communities may operate on both the national and the international level, and its members may share concepts and methods, but they do not always agree about policies (Rose 1991: 15-17).

What these communities, groups or networks have in common is that they all consist of policy specialists who congregate to discuss specific issues and serve as brokers for admitting new ideas into decision-making circles of bureaucrats and (elected) officials. The networks can be seen as the channels (of diffusion) through which new ideas circulate from society to governments as well as from country to country. The members of the networks function as gatekeepers governing the entry of new ideas into institutions (Haas 1992: 27). They may diffuse their policy advice transnationally through communication with their colleagues in scientific bodies and other international organisations, during conferences, and via publications and other methods of exchanging lessons and information. The diffusion of intellectual innovations can help government to redefine their expectations, to reach common understandings, and to coordinate their behaviour accordingly (Adler and Haas 1992).

31 According to Adler (1997: 43), the study of epistemic communities does not make much sense unless it follows the constructivist approach. Epistemic communities are not a new kind of actors on the international scene or an interest group for that matter. Rather, they are a vehicle of collective theoretical premises, interpretations and meanings; in some cases they help construct the social realities of international relations by intersubjective knowledge.

If there are no existing policies and decision makers are unfamiliar with an issue not having treated it in the past, or if decision makers have no strong preconceived views and beliefs about an issue area in which regulation is to be undertaken for the first time, the members of the network can frame the issue and help define the decision makers' interests. They can have an impact in shaping the policymakers' interpretations and actions and establish patterns of behaviour that they can follow in subsequent cases regarding the issue area. If there are no institutions yet in which responses to a given problem can be pursued internationally, the community can also provide a new institutional framework for dealing with the problem (Adler and Haas 1992; Cortell and Davis 2000: 75). This line of argument corresponds with the situation in Laos in particular, as will be discussed later.

The framing of the issue area or problem is important as it may create a climate favourable to the further acceptance and diffusion of certain beliefs or ideas (Adler and Haas 1992). One could talk about a learning process whereby actors change not only how they deal with particular policy problems but also their very concept of problem solving—resulting from the recognition that they and other actors face similar conditions, have mutual interests, and share aspirations (Ruggie 1998a: 20). International contacts are in this respect important for Laos as well as for Vietnam, as the inflow of external ideas previously has been limited. To the extent that the advice of an expert network justifies a particular policy pursued by the state, it also legitimates the power that the state exercises in moving toward that policy (Adler and Haas 1992: 389).

The expert groups participating in the networks work with communication. The diffusion from nation to nation of meanings, concepts and norms involves a process where the players must bargain their way to an outcome, where they must find ways of communicating their intentions (Adler 1997: 346). This process is evident when negotiating development assistance. For instance, by using a special scientific language it is possible to push for policy change. The scientific tone increases the legitimacy of the new ideas. However, the translation of these ideas into practice can be quite complicated, as we will see later. People working in the field must relate to the new concepts and ideas, which may be a time-consuming process.[32] Using the WHO as an example,

32 See Bäckstrand (2001) for a discussion about the role of scientific language, discursive changes and epistemic communities in the field of environment. Also see Keeley and Scoones (1999).

the homogeneity of staff is more pronounced than in many other organisations as most have medical background. The language in WHO documents is full of medical terminology as well.

WHO has access to a network of experts that can be consulted when needed. Yet one should not over-emphasise the common outlook associated with the concept epistemic communities. This is especially true today when many problems require expertise from many disciplines and groups to be solved. Consequently I find the more inclusive term network to be more useful, as it avoids the assumptions of homogeneity associated with epistemic communities. Finally, the importance of interpersonal networks should not be underestimated. These networks help in coping with the uncertainties of new ideas and also help with persuading the person or organisation to adopt new innovations (Rogers 1995: 281).

Agents and domestic context

Agents and their networks may explain why policies diffuse. However, without including domestic factors they cannot help us understanding why some countries adopt specific policies and others do not. Moreover, the effects of the policy adoption are related to domestic structures.

According to Checkel (1999: 88) there are basically two different diffusion dynamics empowering norms domestically: one is a bottom-up process, while the other is top-down. In the first case, non-state actors and policy networks are united in their support for international norms. In the second case, social learning, not political pressure, leads agents—typically elite decision makers—to adopt prescriptions embodied in international norms. Through learning the agents acquire new values and interests from norms; their behaviour, in turn, comes to be governed by a new logic of appropriateness. Arguably social learning is more likely in particular types of polities—like Laos and Vietnam—where the friction and tumult of politics are reduced (ibid: 90-91).

However, this elite-learning approach does not consider the obstacles at grass-root level, neither does it acknowledge that the elite as well may be included in policy networks. In societies where a civil society separated from the state does not exist, transnational networks most probably include members of the elite. Moreover, evidence also indicates that a number of elites are not learning, primarily because their preferences are shaped by historically

constructed and institutionalised domestic norms (Checkel 1999: 106). The conservative wings in the communist parties both in Laos and in Vietnam are good examples of this. They still reject certain reforms in the name of the revolution with reference to the fight against imperialism and capitalism.

Domestic norms, thus, shape the preferences of agents and predict the degree to which international norms resonate and have constitutive effect. The degree of (cultural) match between global norms and domestic practices will be crucial in determining the pattern and degree of diffusion, and therefore the adopter's experience, norms, values and intentions become important when studying diffusion. In other words, the domestic actors' motivation to accept new normative prescriptions becomes decisive. Hence, the preferences of domestic agents, in the presence of diffusing global norms, are shaped in important ways by countering domestic norms (Checkel 1999: 86-98).

However, Checkel (ibid.) goes one step beyond agency by incorporating domestic structures as well as norms. The domestic structures determine which kind of diffusion will prevail and identify key agents. These structures, not least political ones, are important because they condition access to policymaking fora and privilege certain actors in policy debates. Routines, decision-making rules and processes are incorporated in law and custom, as well as the values and norms prescribing appropriate behaviour embedded in the political culture. The domestic political institutions provide the rules of the game for citizens and state officials, establish rights and obligations, identify what is legitimate and what is not, and, in the process, help national actors define their interests domestically and internationally (Cortell and Davis 2000: 66, 79; see also Risse-Kappen 1994).

Similarly, Thomas Risse-Kappen (1994: 187) argues that the ability of transnational actors to promote norms and influence state policy is dependent on domestic structures understood in terms of political institutions and state-society relations. For example, in the former Soviet Union with its state-controlled structure, the transnational actors needed to gain access to the very top of the decision-making hierarchy to have an impact.

The structure plays an important role because identity and interests depend on socio-historical context, and behaviour takes on different meanings depending on the context. Community standards define how far behaviour can diverge from norms, and the norms by which behaviour is judged set the boundaries of political conflict and cooperation (Klotz 1995: 28-31). Klotz

shows that considering a global constitutive norm such as anti-apartheid even weak states and non-state actors have power, a power that is ignored by analyses that focus on military coercion and market incentives alone (ibid: 165).

Naturally it is important which issue we study. For example, actions against landmines are accepted in most mined countries, while the opposite accounts for Human Rights activities which is a much more sensitive issue (see e.g. Price 1998), not the least in Laos and Vietnam. One could assume that NDP is a relatively uncontested issue area considering the health gains, but as indicated in the introduction and discussed more in detail later, this is not always the case.

Thus, the recognition of an international norm is not necessarily frictionless. It might be likened to cultural imperialism or colonialism and cause domestic resistance or rejection. This appears in many parts of Asia, where ruling elites reject international calls for policies reflecting the Western conception of human rights and political pluralism with appeals to the primacy of Asian values. Also, even if the elite embraces the norm it may meet resistance from the population (Cortell and Davis 2000: 74).[33]

Policy change

Ideas do not float freely. Decision-makers are always exposed to several and often contradictory policy concepts, not least in aid dependent countries. However, to influence policies, transnational actors need channels into the political system of the target-state and domestic partners with the ability to form winning coalitions. Ideas promoted by transnational actors or policy networks do not matter much unless those two conditions are met. In other words, we have to look at the links between transnational networks, domestic context and policy change (see e.g. Risse-Kappen 1994).

Furthermore, which norms, and whose norms, come to constitute the base of action? How and why do certain collective expressions of human understanding, become firmly established within social and political systems,

33 For a discussion about Asian values and human rights in Vietnam see Jacobsen and Bruun (2000), also see Jönsson, K. (1998).

spread around the world and become reified or taken for granted? Adler (1991, 1997) has found a solution in what he calls cognitive evolution. Cognitive evolution includes a process of innovation, domestic and international diffusion, political selection of effective institutionalisation that creates intersubjective understandings on which the interests, practices and behaviour of governments are based. As the innovations are created and introduced to the political system, policymakers can develop new interpretations of reality.

However, the capacity of institutions in different countries to learn and to generate similar interests will depend on the acquisition of new information in combination with the political selection of similar epistemic and normative premises. The new ideas must have authority and legitimacy and must evoke trust, hence the importance of the framing. New ideas are more likely to become established when agents of diffusion manage to frame reality around authoritative meanings (scientific or not) and/or gain control of the social support networks of politics. In this way it will be too difficult and costly for opponents to deconstruct institutionalised intersubjective ideas. The new ideas can emerge both from socialisation processes that involve the diffusion of meanings from country to country and from political and diplomatic processes that include negotiation, persuasion and coercion (Adler 1997: 339-341). Another aspect is point of time. The ability of the network of expertise to nudge decision-makers into new patterns of behaviour by policy selection is dependent on timing.

Control over knowledge and information is an important dimension of power because the diffusion of new ideas and information can lead to new patterns of behaviour. What is perceived as appropriate in specific issue-areas of policymaking is influenced by how the problems are understood by the policymakers or their advisors. Moreover, various political groups and institutions may learn different lessons or interpret reality differently. Consequently it is crucial to know who learns what, whose learning gets translated into policy and why (Haas 1992; Adler and Haas 1992). However, arguably knowledge is constructed twice—first by members of various networks and later by individuals and institutions interacting in domestic and international political systems (Adler 1997: 344). The construction of knowledge is intimately related to translation. In order for new knowledge to diffuse, the "innovation" must be understood.

One could object to the way I mix ideas from foreign policy and public policy. However, I would argue that the underlying dynamics are very much

the same. Besides, there is the tendency to treat public policy as a national business neglecting the influences from abroad, at the same time as norm diffusion studies seem to avoid the issue of connecting norms and policy. The role of agents of diffusion in relation to domestic structures is yet another area that needs to be addressed further. Policy is not made in a vacuum. There are changes in society leading to a change in norms that eventually are expressed in various policies. The international world is full of norms, ideas and concrete policies, some of them have been around for a long time, and resisted ideas may be accepted eventually.

Summary

The purpose of this chapter has been to discuss how external ideas diffuse into national policymaking. First the policy process was problematised by questioning implicit assumptions about rationality and context. Policy diffusion was discussed in the same manner highlighting the lack of connection to prevailing norms, ingrained practices and implementation. By merging policy diffusion with implementation the policy process was extended to include the national as well as the international sphere.

However, the lack of tools for analysing the contextual differences remained. By introducing the logic of consequentiality and the logic of appropriateness, the notion of rationality could be further problematised. The two logics highlight the issue of behaviour in relation to context. While in the logic of consequentiality behaviour is based on means-end rationality, in the logic of appropriateness behaviour can be derived from norms and contextual factors. I use the two kinds of logic to understand the diffusion and translation of policy primarily at the individual level.

Nonetheless, as the aim is to connect international with national policymaking, a discussion about globalisation was added. By framing policy diffusion in a globalisation perspective it is possible to increase the understanding as to why specific policies are adopted or not. We live in a changing world where notions such as national/international, domestic/foreign, and East/West/South/North are increasingly undermined—which affects the prerequisites for policymaking. Globalisation opens up the world for norm and policy diffusion at the same time as its effects are uneven—which is particularly noticeable in low-income countries.

Finally, in order to identify factors either facilitating or restraining policy diffusion a discussion about transmission dynamics was included. Agents and their networks are indisputably important for policy diffusion. The agents are the carriers and translators of new ideas, norms and policies, and they serve as brokers and gatekeepers and have in that respect considerable influence over the policy process. However, domestic structures and norms are equally important. The structures decide who have access to the policymaking, while norms shape the preferences of the actors. The domestic actors' motivation to adopt new ideas and policies is consequently important—together with how well the policy fits into the new context.

By including ideas from different theoretical traditions, a framework has been created that will guide the following analysis of the Lao and the Vietnamese NDPs. Chapter 4 focuses on the development of the policies, while Chapter 5 and 6 analyse how the policies are translated into practice. In Chapter 7 I elaborate on the empirical findings in relation to the theoretical framework.

Chapter Four

The Lao and Vietnamese National Drug Policies

Below, the first part of the policy process is in focus—in other words the formulation phase. The discussion concerns the policy process until the adoption of the policies, which includes how the ideas to develop the NDPs entered Laos and Vietnam. First a brief description about how the policies came about will be presented. Then the two policy processes are compared in relation to how the polices spread and translation difficulties connected to the diffusion process. Finally I relate the two policies to their origin. In other words, I discuss how NDPs as a solution to the problems in the pharmaceutical sector have evolved over time. Special attention is given to two major stakeholders: the pharmaceutical industry and the donor community. The reason is that they represent interests not only in Laos and Vietnam but also on a global scale and consequently take an active part in the spread of norms globally as well as in promoting certain policies. Special characteristics of the pharmaceutical sector affecting the policy process are included in the discussion.

How the policies spread

The development of a Lao NDP

Encouragement from Sida and their consultant agency IHCAR at the Karolinska Institute in Stockholm was crucial in initiating the development of the Lao NDP. Sida provided financial support (Boupha and Dalaloy 1997: 11; Paphassarang *et al.* 1995), while IHCAR assisted with technical support as institutional consultant. The work to develop an NDP can be dated back to 1990-1991. Sida sent a number of missions for fact finding and problem

identification, in response to a Lao request for a drug quality control laboratory. After a visit in March 1992 by a consultant team consisting of Swedish, Thai and Lao participants led by IHCAR, it was concluded that in order to improve the drug situation in Laos, an NDP was needed. The Ministry of Health's request to Sida changed from being a laboratory for drug control (Food and Drug Quality Control Center), to a more comprehensive pharmaceutical sector development. This would include problem identification, projects on availability, use and knowledge about pharmaceuticals. Thus, Sida, through its consultants, widened the scope of the original proposal, so that more emphasis was put on awareness of the complexity of the area of drug politics among the Lao.

During that time, the Food and Drug Administration Commission (FDA, previously the Department of Pharmacy) with representatives from several ministries, was created in order to facilitate the cooperation between different sectors involved in the pharmaceutical field. A one-day Round Table Discussion on the development of an NDP in Laos was organised by the Department of Pharmacy and Sida in May 1992. Some 30 Lao professionals met together with the IHCAR team and representatives from WHO and the World Bank. At this meeting, a national seminar with around 100 participants and background papers was commissioned (it eventually took place in November, see below), together with Lao multidisciplinary working groups for each element of the suggested NDP. It was also decided that five smaller field studies would be conducted, which turned out to be an important source for learning and understanding of the problems in the sector. It should be pointed out that these studies were the responsibility of the Lao who could learn from first hand experience.

About the same time a review mission report[34] was submitted to Sida by the consultant team. In the report, the need for a national drug policy was strongly underlined. In addition, a Lao delegation went to Stockholm to discuss the development of an NDP and to negotiate funding (Kiatying-Angsulee *et al.* 1992). In June, a workshop was held in Colombo, Sri Lanka, arranged by the International Organisation for Consumer Unions (IOCU),[35] to which the Lao Vice Minister of Health was invited on IHCAR's suggestion. This proved useful in making the leadership in Laos understand the needs for and the possibilities of an NDP at an early stage.

34 Towards a National Drug Policy, Review mission of the essential drug sector in Laos (1993).

35 Today Consumers International.

In November, the fourth national drug seminar "Towards a National Drug Policy of Laos" was held in Vientiane, supported by Sida and other international organisations[36] (Towards a National Drug Policy 1993). Most of the participants were Lao, representing various ministries, health offices and the industry. The international representatives came from Sida/IHCAR, the Thailand Health Research Institute and the Food and Drug Administration in Thailand (acting as consultants to IHCAR), DAP/WHO,[37] WHO Manila and Laos, the Australian Embassy, La Trobe University of Australia, UNICEF, and Médecins Sans Frontières (MSF) Belgium (Towards a National Drug Policy 1993). In addition to the papers prepared by Lao delegates, presentations were made by some of the foreign participants, and experiences from Thailand, Australia and Sweden were shared with the Lao audience. Afterwards, a report was produced as a component of the institutional collaboration between the Lao Ministry of Health and IHCAR. This report was for a long time the main document in English on the Lao NDP.[38]

In effect, the NDP had already been approved at the time of the seminar, and no real changes were made in the documents. The Lao made all the preparations, and the draft that was passed was based on background papers prepared by the Drafting Committee, which consisted of members of the team from the Department of Pharmacy and representatives from different departments within the Ministry of Health, appointed by the Minister of Health. It has been stressed that the Lao counterparts formulated the policy themselves, as they knew what was best for their country. Hence, national policymakers made the decisions on design and content of the policy without the participation of foreign advisers. In March 1993 the Prime Minister adopted the National Drug Policy[39] (Paphassarang *et al.* 1995). All in all, the actual preparatory process did not take more than a year.

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36 The three previous seminars, sponsored by WHO, had only focused on the Essential Drug List. The first Essential Drug List was prepared in 1978 but not implemented until 1991 (Kiatying-Angsulee *et al.* 1992).

37 Drugs Action Programme (DAP) or Action Programme on Essential Drugs was a unit within WHO created to implement WHO's approach to drugs policy. Today DAP and Division of Drug Management and Policies (DMP) have merged to form the Essential Drugs and Other Medicines Department.

38 As late as May 2000 there was still no written or published comprehensive NDP or health legislation (Syhakhang 2000).

39 The content of the Lao NDP booklet is: foreword, the article from the Essential Drug Monotor "Why countries in the world need national drug policies", The essential drug and vaccine programme of WHO, The decree of the Prime Minister, Directives for implementation of the NDP, The two main goals of the NDP—to make drugs available and the Rational Use of Drugs—and the thirteen components. The components of the Lao NDP are: (This note continues on the next page).

The WHO guidelines[40] on NDPs was one of the most important sources of information on how to develop the NDP in practice. A specific issue of *The Essential Drug Monitor* (No. 12 1991), published by DAP/WHO, played a significant role. The editorial "Why countries need a national drug policy" was translated and included in the introductory pages of the Lao NDP booklet, and information about the Malawi and Nigerian NDPs—which eventually served as models for the Lao—was used. The NDP model for Asian-Pacific countries and other material and ideas collected at the conference in Colombo also served as sources of inspiration for goals and structure, which means that primarily the headlines of the NDP model were really copied (twelve components), while the content was developed by the Lao themselves. The drafting committee appointed by the Ministry of Health added a thirteenth component, traditional medicine. Multi-disciplinary working groups were responsible for developing the different policy components, and various experts (including Thai) were engaged to conduct surveys and collect material in order to adapt the policy to specific country conditions (Jönsson *et al.* 1999).

The development of the Vietnamese NDP

Similarly to Laos, the diffusion of ideas in Vietnam primarily took place at the initial stage of the policy formulation. Information about NDPs came from Sida and WHO, and then the Ministry of Health took the initiative actually

(continued) Drug legislation and regulation, Drug selection, Drug nomenclature, Drug registration and licensing, Drug procurement, Financial resources, Drug distribution and storage, Quality assurance of drug substance and pharmaceutical products; Rational drug use; Drug advertising and promotion, International technical cooperation, Traditional medicine, Drug monotoring and evaluation. The Lao NDP document is not translated into English. Instead, the report from the fourth seminar on NDP "Towards a National Drug Policy" is provided to foreigners who are interested in the NDP.

40 The guidelines have evolved over time since its introduction in 1988, but according to the 1995-update ten components should be taken into account in an NDP: legislation, regulation and guidelines; selection of drugs; supply; pharmaceutical quality assurance; rational use of drugs; economic strategies of drugs; monitoring and evaluation of national drug policies; research; human resources development; and technical cooperation among countries (WHO/DAP/95.9). As Laos developed its NDP prior to 1995 the 1988 guidelines (WHO 1988) had to be used. The structure of the 1988-version differs from the later version, although the content to a large extent is the same, which could explain the differences between the Lao and the Vietnamese NDPs. The 1988-guidelines is divided into ten chapters: Components of a drug policy (including legislation and regulation, cost and price, supply, traditional medicine, quality assurance and manpower aspects etc.); Specific legal issues; Information and promotion; Appropriate use of drugs; Self-medication; Health education; Monitoring and evaluation; Financial resources; Research and development; and Technical cooperation between countries.

to develop the NDP (interview with health official 1998). Guidance from an international consultative group with experts from Sweden, Australia, Thailand and the United States and leverage from the Word Bank was important as well (Craig 1997: 301). Besides being involved in the development of the Lao NDP, Sida already supported the pharmaceutical sector in Vietnam through the Area of Drug Policy and Control Project (ADPC) and WHO. The ADPC was the main institution to develop the NDP, which is currently implemented by InDevelop, a Swedish consulting firm. In the action plan of the ADPC there was an item to develop an NDP, so the need for a policy was recognised. In 1993 it was suggested that a special committee should elaborate on a new national drug policy, and in December 1995 a National Drug Policy seminar was held with around 100 participants, primarily from drug control (Department of Pharmacy/Ministry of Health), the pharmaceutical industry (state and private), university, health services, the WHO, Sida, UNICEF, other international agencies and NGOs (Ministry of Health/WHO/SIDA 1996). The seminar was followed by a small number of additional seminars (including one larger in Ho Chi Minh City in January 1996), leading to the adoption of the policy in 1996.[41] The draft of the NDP was prepared by nine working groups from an NDP Commission meeting on a regular basis in the period from February to October (interview with health official 1998) together with suggestions from the two larger seminars and from local and international organisations as well as from individuals, and was later forwarded to the office of the Prime Minister (Ministry of Health/WHO/ SIDA 1996).

The WHO guidelines on NDPs seem to have been the most important source of information on how to develop the NDP in practice, as in Laos. Vietnam primarily used NDPs in other ASEAN countries as models (Philippines, Thailand, Laos etc.), rather than African ones. However, the models had to be adopted to country-specific conditions. For example, similarly to Laos, a section on traditional medicine was added to the NDP. The working

41 The Vietnamese policy document consists of: The Government Resolution No 37/CP, Strategic Orientation for People's Health Care and Protection from now to the years 2000 and 2020, Vietnam's National Drug Policy (and the components), and Strategy for people's health care and protection from now to the year 2000 (presentation of the Minister of Health). The specific items of the Vietnamese NDP are: Essential drugs—rational and safe use of drugs; Drug quality assurance; Manufacture, supply, import and export of drugs; Traditional medicine; Training pharmaceutical personnel; Drug information; Strengthening of drug management; Scientific research, domestic and international cooperation in pharmaceutical field. The Vietnamese NDP-document is translated into English.

groups met every week, and they were responsible for developing the different policy components. Various experts and others were engaged to conduct surveys and collect material to be used as base for the policy. This process took little more than a year. However, surveys were continuously conducted even after the adoption (interview with health official 1998).[42]

In my interviews the importance of foreign advisors was mentioned, but it was also said that these advisors did not participate in the actual making of the NDP. It was pointed out that the Vietnamese themselves should make the policies, and the actual policymaking of the NDP, the decisions on design and content of the policy, was done by national policymakers. Vietnam has a strong political tradition of independence in policymaking and resistance to what is perceived as impositions by outsiders. Sida has responded by offering international study tours that have helped to bring about an understanding that Swedish support in policy matters is non-aligned. This means that Sida has shown that the intention is not to market a particular model, even though it should be noted that Sida strongly supports the very idea of policy development instead of supporting other kinds of activities in their development assistance. Interviews conducted by evaluators of the Sida health-sector programme support the idea that this contributes to the credibility of information and advice given from Sweden (Jerve *et al.* 2001: 39).

Similarities and differences between the Lao and the Vietnamese NDPs

There are several similarities as well as differences between the policy processes in Laos and Vietnam respectively. As already mentioned, the most obvious similarity is that the development of the NDPs was a result of bilateral cooperation between the Ministry of Health in question and Sida/Sweden. Also, the agents of diffusion were to a large extent the same in both diffusion processes, even if they worked in different capacities. For example, in Laos IHCAR coordinated the Sida programme, while in Vietnam members of the IHCAR team merely served as advisors (informal as well as formal). Nevertheless, the consultants in Laos and Vietnam were members of the same

42 For example, surveys on drug distribution network, pharmaceutical manpower, rational and safe use of drugs in Vietnam, herbal plant resources, the situation of drug production, supply and distribution, traditional medicine resources (Final Report 1999).

network, serving as channels of diffusion with the possibility to give input into the process.

Sida plays a bigger role in Laos than in Vietnam in relation to the NDP, and consequently the influence differs. For instance, in Vietnam ideas about NDPs did not only come from Sida. Moreover, Sida had to push more for the policy in Vietnam than in Laos. In Laos the process was smoother, and the leaders could see the advantages of the NDP as it could help to improve the situation in the country. The medical profession volunteered information about the situation and actively asked for help. Ironically, the result was that policy development was to a larger extent internally driven in Laos and externally driven in Vietnam. The medical profession and the pharmaceutical industry are stronger in Vietnam than in Laos. There are more vested interests in Vietnam which made reforms more complicated, while the stakeholders in Laos were to a large extent "taken by surprise" and found no reason to question the policy. Moreover, in Laos both pharmacists and the medical profession were, and still are, involved in the policy process, whereas in Vietnam the NDP work is dominated by pharmacists (which is common in other countries).

As shown above, the line between voluntary or coercive diffusion is difficult to draw. At first it may seem that the Lao NDP was a result of coercive measures, but once the concept was understood it was welcomed. Moreover, in Vietnam the development of an NDP had been on the bilateral cooperation agenda for a long time. The official version is that the Vietnamese chose to develop the NDP, while in reality the support to some degree can be questioned. As will be shown later, this affects the implementation of the policy. Also, in my interviews complaints were made that the process was too hasty in both countries, and that there was not enough time for thinking and discussing properly.

The fact remains, however, that both countries faced a problem in the pharmaceutical sector that sooner or later had to be solved, and the governments actively sought help and ideas from abroad. The policymakers could not solely draw on domestic experiences, but had to rely on external ideas. In Laos there was no previous policy to rely on, while in Vietnam a range of drug policies and regulations already existed but lacked cohesion (Ministry of Health 1996: 21). The main work was thus to harmonise these policies and to collect them in one document, rather than developing a completely new policy as in Laos. At the same time, the same kind of background material was used for guidance in Vietnam as in Laos. The degree of imitation from the

other models is difficult to measure, but it is clear that none of them have been copied as they are. Using Rose's terminology (1991), the most suitable term would be emulation, which means adoption of a policy with adjustment.

The Lao and Vietnamese NDPs are very similar in content but not in wording and structure. Hence, the Vietnamese NDP is not an exact copy of the Lao NDP. The aim of the NDPs differed slightly as well. In Laos, the development was pushed more out of concern about the uncontrolled use of pharmaceuticals, while in Vietnam the development was pushed to meet two demands: the present situation in the pharmaceutical sector, and the global integration in a long perspective (interview with health official 1998). The wish to meet the challenges of global integration in the Vietnamese case indicates the difference between levels of ambition between Laos and Vietnam, in the sense that the pharmaceutical industry plays a larger role in Vietnam than in Laos.

The situation in the Vietnamese pharmaceutical sector could be characterised as an uncontrolled growth of private pharmacies selling substandard and fake drugs in combination with self-medication. The changes in the health sector in Vietnam date back to 1986 and the initiation of *doi moi*, when the patients had to start to pay for their drugs and the sector started to privatise (Valdelin *et al.* 1992:53). The ambition to provide free health care for all after the unification in 1975 became too big a burden for the government, and drugs were lacking in the public sector (Witter 1996:160-161). The withdrawal of support from the Soviet Union added to the difficulties (Wolffers 1995:1327). Another factor was the collapse of the cooperatives which meant that the financial basis of the commune health system was removed (see Jerve 2001; Kerkvliet and Porter 1995; Kerkvliet 1998). As there were no resources to keep up with the aim of free health service for all, private pharmacies were allowed, and the number of pharmacies rose quickly—partly because the previous scarcity of drugs created a strong urge to buy drugs when incomes rose (see Chuc and Tomson 1999). However, the consequences of the privatisation in the health care sector were to a large extent unanticipated, and adequate legislation and regulation were lacking to control the new situation.

The situation in Laos was similar with a lack of drugs in the public sector as a result of the end of Soviet aid, which was followed by economic liberalisation and mushrooming private pharmacies (see e.g. Syhakhang 2000). However, the Lao health system is even more underdeveloped and underfinanced than the Vietnamese. As in Vietnam, some of these problems

can be traced back to the colonial times. In other words, in order to understand the current health system one has to look at past health systems.

Anthony Zwi and Anne Mills (1995) divide health systems into five categories: traditional health systems, colonial health systems, health systems and health policy in the post-colonial period, health policy in transforming states, and finally health policy in newly industrialising states. While most societies have had traditional health systems, not all have been colonialised. Organised health services were a component of British, French, German and Belgian colonial services. Initially this health care was only designated to the military, civil service and settler community, but it became apparent that in order to protect the health of expatriates it was necessary to address the health needs of those subjected to colonialisation—especially in relation to communicable diseases such as typhoid and tuberculosis.

In the case of Laos health care did not reach much further than to the French expatriates, as the French only invested in a few hospitals with the result that the country was left with a limited health sector and the neglect of traditional medicine, which was not favoured by the French. The situation was similar in Vietnam where traditional medicine was removed from the governmental health system. When the communists came into power, one of the aims was health for all—although the quality was low—and traditional medicine became important again. The long periods of war contributed to the popularity of traditional medicine, as modern medicine was hard to provide (interviews with expatriates in 1998 and 2000).

In the period after World War II a large number of countries became independent, and many of the regimes consolidated their power by delivering gains in the form of social services such as education and health care. In several countries, like Laos and Vietnam, these services were provided free of charge to the user, a policy which has more recently proved difficult to sustain. A large number of people were medically trained, but often the training was ineffective, and people would not use the health facilities. In addition, many of the educated fled the countries when the communists seized power (Zwi and Mills 1995: 302; Holland *et al.* 1995: 22; interviews with expatriates in Hanoi 1998 and Laos 2000; also see Boupha and Dalaloy 1997 for the health transition in Laos from 1965 to present times).

In conjunction with the economic liberalisation in the 1980s Laos started to be exposed to Thailand through trade and personal contacts, and it was obvious that the low standard in health was unacceptable. Donors started to

arrive at the same time. Today the better off prefer to go to Thailand to get treatment. Although around 100 people are being trained to become physicians every year, the quality is still a major problem. Books and manuals are lacking as well as practical training (interview with expatriate 1999). Thus, some of the problems in today's health sectors in Laos, as well as in Vietnam, are the results of years of mismanagement.

Why the policies spread

Why did diffusion occur in Laos and Vietnam? As indicated in Chapter 3, there is no simple answer. Personal interaction pushed the diffusion and influenced when the diffusion took place and what was diffused. National as well as international actors played crucial roles in this process. While the foreign consultants often came with suggestions and ideas about how to proceed, the Lao and Vietnamese counterparts had to adapt and develop the proposals in order to get them accepted by the national decision-makers. At this stage the NDP was not very controversial. In the transformation from a centrally planned economy to a more market oriented system the NDPs are useful in meeting new demands, especially since the policy-concept is developed in the context of the global pharmaceutical market—as will be shown later. The policies also give practical advice on how to approach the sector by pointing out crucial issues which have to be dealt with in order to make a difference. However, some of the details were hard to agree on. In Laos as well as in Vietnam it was not entirely clear who should be responsible for the NDP, and consequently some of the disagreements concerned organisational matters rather than the content of the policy.

It is important to make a distinction between donors and consultants, on the one hand, and counterparts and national decision-makers, on the other hand. It was the foreign consultants and their Lao and Vietnamese counterparts who acted as agents of diffusion, that is they were the mediators between the donor and the leadership. The local counterparts worked at the Ministry of Health and related institutions, and had in that capacity a close relationship with the political leaders, even if they themselves had no decision-making power. However, as prime communicators they still had a great influence on the outcome.

Another important aspect is the fact that the foreign consultants *could* play an active role in the development of the NDP. This was especially pronounced in Laos, where there was little previous knowledge about NDPs. Personal contacts, including regular meetings, between the consultants and their Lao counterparts facilitated the process. Cooperation within the health care sector was already established between Sida and the Lao government through UNICEF; hence, channels of communication were already in place through an existing network. Moreover, the number of actors directly involved in the process was limited—primarily IHCAR consultants and a few members of the team from the Department of Pharmacy—which probably contributed to the rapid process. In addition, these individuals were experts within the pharmaceutical field (and also experts on health systems and public health), well aware of the problems in the area.

The introduction of new foreign experts around 1992 was an important turning point in the cooperation on the NDP leading to intensified work. The fact that there were strong links between the consultants and DAP/WHO through personal networks facilitated the access of information about NDPs. Furthermore, in February 1993 IHCAR invited DAP to assist in the implementation of the Lao NDP. The Thai advisors were also recruited through IHCAR. The well-established network of experts, in combination with committed officials in the Ministry of Health, was clearly a crucial factor in the process (Jönsson K. *et al.* 1999).[43]

In Vietnam the collaboration looked somewhat different. Sweden had supported the pharmaceutical sector since the mid-1980s through a project about provision of drugs (including regulatory control, drug production and drug procurement). In 1991 new directions came from Sweden, and Sida decided to support the Area of Drug Policy and Control Project (ADPC), which eventually lead to the development of the NDP (Lalvani 1996: 30-31). Thus, the collaboration in the sector was already established.

What kind of process can we see in the development of the Lao NDP? In terms of the previous discussion, some kind of elite learning took place over a relatively short period of time. There were regular meetings and seminars pushing the development forward. In addition, the support from the highest

43 Not only in Laos, but also in the United Kingdom in 1968, Bangladesh in 1982, the Philippines in 1988, Guinea in 1992, and Uganda in 1993, the development of an NDP was supported by individuals and institutions who were convinced that an NDP was needed (MSH and WHO 1997: 66).

political level speeded up the process. The issue quickly rose to a high level, although some leaders were hesitant originally. The policymakers in Laos wanted something tangible, such as a laboratory for drug control, while the donor (Sida) preferred a wider approach, such as a policy. Yet eventually a compromise could be reached. Even if only a few Lao carried a heavy burden to convince government bodies on all levels, they managed to persuade the leadership to adopt the policy.

There was also the element of donor persuasion. The fact that the cooperation on the NDP was connected to other projects naturally influenced the outcome. The success of the persuasion was facilitated by the precarious situation in the pharmaceutical sector, in combination with the problem identification through existing health system research projects. The Lao government needed assistance from abroad, and there was a donor's request, which included the development of an NDP. Hence, both push and pull factors were at work. The conditions for the introduction of a new policy were in that respect favourable.

In Vietnam the process as such looked similar with regular meetings and so forth. However, the Vietnamese NDP looks slightly different compared to the Lao. The resolution in which it is published, Strategic Orientation for People's Health Care and Protection in the Period of 1996-2000 and Vietnam's National Drug Policy, consists of two parts, one drafted by medical professionals and one by pharmacists. The two parts demonstrate that the NDP is to be implemented in the context of the national health policy, something that is lacking in Laos.

On closer look, however, one can discern a difference between the two parts, which can be explained by a lack of experience on the part of the pharmacists. For them it was the first time they had to develop such a policy, while the medical side had previous experience (interview with health official 2000). The two groups initially had problems agreeing on areas of responsibility, which probably added to the discrepancy. One could argue that there is incoherence between goals and means, as there are more goals than means to achieve the goals. In addition most of the strategies support the first goal concerning the supply rather than the rational use of drugs. In other words, the policy is defined from a market rather than from a medical perspective.

According to David Craig (1997: 305) uneven treatment of the consumers and rational use of drugs (RUD) in the document and accompanying

masterplan of implementation[44] is a reflection of bureaucratic and funding agendas on the part of the implementing institutions. While the second overall goal is about RUD, there is no mention of it in the specific objectives. Consumer education is not mentioned at all, although drug information is one of the issues in the document.

This issue is related to a more general problem. The capacity to investigate and to write policy documents in an analytical way is limited. The texts are often very descriptive and full of details as opposed to proceeding from a specific problem. According to an interviewee this is a result of fear to implicitly criticise the regime. (Socialist) rhetoric is colouring the texts as well. Consequently, problems arise during the implementation of the policy because the implementers do not know how to translate the policy into practice.

In both the Lao and the Vietnamese case Sida played a significant role. However, the fact that there was a WHO strategy to develop NDPs and that a large number of countries already had adopted an NDP certainly increased the legitimacy of the policies. The set up was similar in both cases; meetings with representatives from foreign agencies and organisations, participation in fact-finding missions and conferences, working groups and seminars and so on. To some degree the same people were involved as policy diffusion agents, which undoubtedly influenced the outcome.

There was one difference, however. In Laos the participating consultants had short-term appointments within the framework of institutional collaboration (a team consisting of members of an academic institution), while in Vietnam there were also long-term consultants involved (from a consultancy firm). Which is to be preferred is much disputed, as became obvious during my interviews. Some would argue that it is impossible to make any difference if only visiting a few days or weeks at the time, while others would argue that it is a waste of time to spend long periods in the country in question. Besides, it is better if the majority of the work is left to the local counterparts. Others claim that the Lao and Vietnamese do not learn so much because the consultants do the job for them. Yet others perceive some of the consultants

44 A masterplan is an overall plan which contains detailed analysis of the pharmaceutical sector problems, and the objectives, strategies and activities that are likely to solve the identified problems during a given period. The masterplan is based on the NDP, which is often perceived as a theoretical and abstract tool (WHO/DAP/93.9).

as too eager to become involved in issues they should not. In other words, they do not act in accordance with their presumed role. Naturally this is a question of finances as well, and of finding a person willing to stay for a longer period of time. Nevertheless, the fact that there were already well-established contacts between Sweden and Laos and Vietnam certainly facilitated the process.

Another aspect is the role of expert groups. In the medical field these groups are more homogeneous than in many others due to the many medical professionals participating. Moreover, to a large extent it is the same people working in different projects, either for the WHO or the World Bank or in bilateral cooperation (as consultants). In the case of work in low-income countries, this group is even more limited, something I experienced during my research. In addition, many of the people working in this issue area go to the same conferences, and quite a substantial network has developed over the years. Even if these individuals may disagree on how to solve certain issues or which means to use, they still have a similar background that unites them.

Bilateral cooperation naturally facilitates this process as it provides channels or entry points for these networks. In the cases described here, one could argue that both problems and solutions came from outside—there was a policy problem, or lack thereof, and the solution would be a policy in line with the WHO guidelines. The work was basically top-down, as is often the case in bilateral cooperation—and policymaking in authoritarian societies for that matter.

Nevertheless, there were some bottom-up influences through NGOs such as Médecins Sans Frontières (MSF), at least in Laos. Not only did MSF participate in the national seminars/conferences, but it was also active in developing treatment guidelines to be used by medical personnel at grass-root level. In other words, MSF had already initiated work that later was integrated in the policy. Foreigners working for NGOs in Laos and Vietnam have in general good access to the Ministry of Health and can thus influence the policymakers more directly.

Societal pressure is not pronounced in Laos and Vietnam, as there are few channels for feedback for ordinary people. There are (political) meetings at all levels, but there seem to be few chances of giving feedback to the policymakers at the central level. There is no standard reporting system covering all health activities in the countries either—even if health information systems have been initiated. Or people are simply not accustomed to give feedback (this will be elaborated upon further, when discussing the implementation of the NDPs).

As discussed earlier, transmission of ideas and norms can, for example, take place through multilateral institutional membership, bilateral persuasion and learning, elite changes, domestic coalition building, and more dramatic domestic social transformation (see Klotz 1995). Besides being members of the UN family, membership of ASEAN has played a role due to the need for integration with the neighbouring countries. In 1995 Vietnam joined ASEAN and in 1997 Laos followed.[45] Membership of ASEAN leads to more cooperation and more harmonisation of laws and regulations, including in the pharmaceutical sector. This may be truer for Vietnam than Laos because of its higher ambitions to integrate and compete in the regional economy.

Bilateral persuasion was present during the formulation phase, but the learning process should not be under-emphasised. The leaderships in both Laos and Vietnam are eager to learn from other countries, and Sweden has for a long time been one of the countries they have been interested in learning from—partly because of its mixed economy where the state by tradition has played a major role in providing, for example, health care and education.

There have not been any real elite changes in Laos and Vietnam since the communists came into power. Individual leaders change, but theses changes are all sanctioned by the communist parties. The principle of collective leadership avoids making the succession of leaders disruptive (see e.g. Porter 1993: 104). In Vietnam some kind of balance of power between more reform friendly and less reform friendly factions is reflected in the appointments of the highest leaders. For example, if the party secretary general is conservative the president and the prime minister may be more liberal or vice versa (see e.g. Brunnstrom 2001).

It is true however, that if a health minister (or vice-minister) is strong enough this person can make a difference by promoting a certain policy. For example, the present health minister in Laos supports the work with the NDP even though it constitutes a relatively small part of the health sector, which greatly increases the chances of successful implementation (interview with expatriate 2001).

Domestic coalition building with strong interest groups urging NDPs was not important in the formulation phase either. In Laos and Vietnam the

45 For a discussion about Vietnam's foreign policy from 1995 and onwards see Thayer and Amer (1999). For a discussion about Laos' foreign policy see e.g. Thayer (2000).

communist party is still setting up the guidelines, and without the approval of the party there will be little reform, regardless of the interest of other groups. Most organisations cannot work independently of the state, which prevents lobbying of the kind we see in many democratic societies. At the same time many members of the government have interests in pharmaceutical companies, for example, which may influence the decision-making process. And most members of the government are also party members, even if today it is possible to make a career without party membership. Even though Laos and Vietnam are societies in transition, the changes have not been as dramatic as those described in for example Bangladesh and the Philippines.

The political structure in Laos and Vietnam leaves little room for anything but top-down policymaking, at least in regard to public policymaking and NDP,[46] hence the transmission dynamics are related to the elite in the countries. However, domestic norms shape the preferences of key agents and predict the resonance of what is diffused and if the diffused "object" is going to have constitutive effects in the country in question. The policy depends on a blend of novel ideas and domestic context (what is needed, what is acceptable, what is suitable, what is possible etc.). In a way the NDPs were unproblematic in the sense that they were easily copied and adapted, there were guidelines to follow and so forth. The framing was also relatively unproblematic with obvious health gains to win, and the scientific medical language increased the legitimacy of the issue. There were no threats, external or domestic, in the picture, and the NDP belongs comparably speaking (and traditionally) more to low-politics than high politics. The fact that there was no previous experience in Laos made the network more influential in defining the interests of the decision-makers.

The timing was important as well. The problems in the pharmaceutical sector could easily be identified, and very timely a solution was offered that was acceptable to the Lao and the Vietnamese. However, even if the NDPs were adopted rather quickly it did not happen without difficulties. After all, neither Laos nor Vietnam had an NDP previously, and a number of new concepts and ideas had to be translated into a new context.

46 This is in a way a simplified picture of the policy process. It we look at more broader policies and reforms, such as *doi moi*, most scholars of Vietnam would characterise the change as a bottom-up process, so-called fence breaking. *Doi moi* was in fact an official recognition to changed that to a large extent already had taken place (see e.g. Fforde and deVylder 1996; Ljunggren 1992).

Without going too far ahead of the discussion, I would like to point out a few issues that may have been crucial for the problems arising at a later stage. Though there may be a change of attitudes and norms eventually, and for sure many fully support the policy, there are other issues at stake as well. For example, material gains certainly play a role. Not only do the departments in question get funds for implementing the policies, but individuals gain through participation in study tours, conferences and workshops. In the best of worlds these tours and conferences would aim at increasing knowledge that would help to develop the countries in need, which of course happens as well.

However, these activities are also included in a reward system, which means that the most suitable are not always selected to go. Often the most high-ranking official must be offered to go before more low ranking officials, even if the low ranking official would gain more from the trip. The per diem is relatively generous, following international standards, and therefore makes trips abroad very profitable for the participants. The per diem is often seen as something to bring home rather than to cover expenses, with the result that people skip meals they have to pay for themselves. Considering the low salaries in both Laos and Vietnam this does not come as a surprise. Naturally the issue of prestige is important as well, not only material gains. The point is however, that the incentives, or motivation, to adopt a policy can affect the policy process at later stages, especially when there may be hidden agendas involved (also see Jerve *et al.* 2001: 23, 95).

To summarise, arguably the most important transmission dynamic in the case of the development of NDPs in Laos and Vietnam is what can be called multilateral institutional membership and bilateral persuasion and learning. International contacts through various networks were conducive to policy diffusion. A mix of coercive and voluntary measures pushed the development. Moreover, it is possible to adopt a policy without complete coherence with existing norms, especially where there are coercive measures involved as in aid negotiations. The policies were a product of top-down policymaking in centralised and state/party-dominated structures, and the top echelon of the decision-making structure agreed to the policy before adopting it. However, agreement does not mean that everything will run smoothly afterwards. As will be discussed later, the donor agencies are not always happy with the way things develop during the implementation phase—although they may agree with how the policy was developed.

Translation of foreign ideas

Although the formulation processes in Laos and Vietnam only took about a year and were relatively smooth, there were still some obstacles to deal with. In Laos a major complication was the language, in the different senses described earlier. First of all, a completely new concept was introduced, an NDP. Initially a one-page document with five components was presented to Sida; thus, according to the Lao counterparts, there was already a national policy, and they could not see the point in developing a new one. However, an NDP implied something completely different to the Swedish counterparts, who did not perceive the document to be a national drug policy. A policy should be comprehensive and relate to the implementation phase including both substantial and instrumental parts. Once the meaning of policy was made clear, the interest in an NDP increased however. The lack of tools for implementation added to the interest on the Lao side in obtaining external help. Still, when the NDP proposal was circulated to the seventeen provinces and some fifty departments throughout the country, only ten responded. The reasons were a lack of time in combination with problems for the recipients to comprehend the document (interview with health official 1998; also see Jönsson K. *et al.* 1999).

An additional problem in the Lao case was the fact that communication during the diffusion phase was primarily in English. The Thai experts facilitated the communication, since Thai and Lao are very similar, but the most important actors, the so-called key actors, had to communicate in English or through interpreters. Even though many Laotians speak English, there are still many who do not. Especially in introducing new ideas, the lack of a common language can be a serious problem. The meaning of words and concepts easily gets lost or distorted in the communication process. It should not be forgotten that all documents had to be translated as well, which can be a time consuming process.

Another aspect is the context in which the translation takes place. Arguably Laos was less prepared to develop a new policy than many other countries, in the sense that it had not had time to adjust to the new conditions caused by the recent opening of the country. The country obviously had problems handling the effects of economic liberalisation in the pharmaceutical sector.

For example, laws and regulations (which are now being developed) were lacking in response to the growing private sector, and policymaking had to be done within a weak judicial structure, which severely hampered the work, as it caused confusion as to what was legally correct to do and what was not. There was no previous NDP—not even a health policy (which is not uncommon in developing countries). In addition, the change of economic system and cooperation partners, which includes a change in working style, put a heavy strain on the government and on the administration—coupled with all the socio-economic problems any poor country has to deal with, such as lack of trained manpower, fear of donor withdrawal and so forth.

In Vietnam the situation differed. To start with, there were already several policies in the area, so the idea of an NDP was not too much of a novelty. During the last 50 years a number of policies (and documentation) related to drugs have been promulgated by the government (Ministry of Health 1995 in Craig 1997: 301). Moreover, the Vietnamese had more experience to draw on, including the development of the Lao NDP. However, it seems that the Vietnamese were more reluctant to listen to their foreign counterparts than the Lao. This could be explained by the stronger Vietnamese feeling of proving their capabilities. But there is also another side to it. Here the idea of logic of appropriateness can be helpful in understanding the policy process.

According to Checkel (1999), some elites do not learn because their preferences are shaped by historically constructed and institutionalised domestic norms. In the case of Vietnam, and to a lesser extent in Laos, people are very proud and they do not like to have ideas imposed on them. This can partly be explained by the history of foreign intervention; the Americans, the French, and before that the Chinese. The urge to prove independent is strong, despite the long history of aid dependence (earlier from the Soviet Union and now from a wide range of bilateral and multilateral donors). Hence, it becomes important that it appears to be the Vietnamese who come up with the ideas and decide over events—regardless of the real case.

Similarly it is important that the seniors in the hierarchy are not "threatened" by more junior colleagues. Everything has to be approved from the top, and initiatives from below are not encouraged unless sanctioned from the top. Thus, for a suggestion from outside to be successful, it has to enter the policy process in an appropriate way through the appropriate channels. If someone (influential) feels neglected in the process, this person may lobby against the

suggestion—or even stop it from coming on the agenda or being adopted. At the same time the converse may happen. If the "conditions" are right, new ideas may be approved very fast.

Thus, if the representatives of the donors primarily act according to the logic of consequentiality (choose what has the best consequences according the programme) and the representatives in Laos or Vietnam act according to the logic of appropriateness (choose what is most appropriate in the situation based on position in society), there will sooner or later be cooperation difficulties. For example, if the donor suggests a certain person to attend a meeting or conference because the person in question is the most suitable candidate and would benefit from it in their work, the donor may in fact make two "mistakes:" the suggestion in itself, and to suggest an "inappropriate" person. The result may be a refusal to participate, which may be hard to understand from the donor's point of view as this kind of problems are not discussed in the open.

This kind of "misunderstandings" can of course be applied to other situations as well, such as how to use material resources. Both in Laos and Vietnam tangible or material benefits are still very important—it is something to show to others—which makes it difficult to push for more abstract things like a policy or human resource development. Also, even though advisors are often viewed as competent and effective professionals, they are also perceived to lack in understanding of the political work in a ministry (Jerve *et al.* 2001: 39-40).[47]

This leads to yet another issue. How and under what conditions do the different kinds of logic constitute (individual) agent identity (see Checkel 1997), and why do certain ideas and concepts acquire epistemic, discursive and institutional authority (Adler 1997)? After all, there are changes in Laos and Vietnam, both with regard to policy and cooperation. And even if I use the two kinds of logic to make my points more obvious, many of the involved parties are in practice aware of the collaboration difficulties and why they arise. There is also a process of learning where the involved parties learn form their mistakes and adapt their behaviour to improve the collaboration.

When Adler (1991) talks about cognitive evolution, he describes a process

47 See Walt and Gilson (1994: 358) for a discussion about the problem with gaps in knowledge about how bureaucracies work and how policymakers respond to pressure, and how these gaps make it unclear how far implementation of reforms are influenced by domestic policy processes.

of innovation, domestic and international diffusion, political selection of effective institutionalisation that creates intersubjective understandings on which interests, practices and behaviour of governments are based. Laos and Vietnam are interesting in the sense that they are societies in transition where identity and also interests are questioned at the moment. Although socialist on paper, both countries have liberalised their economies and many policies are not at all Marxist-Leninist in orientation. Free health and education for all, two of the cornerstones of the old ideology, cannot be taken for granted and user fees are getting more and more prevalent. The gap between rich and poor is increasing, and the revolutionary ideals are fading away. People want to increase their living standards, and do what they can to achieve that—even if it sometimes means breaking rules of appropriate behaviour. The more people start to act in a certain way, the more it becomes accepted.

What I am trying to say is that even if old structures prevent rapid change, these structures are not immune to changes. If there are ideas that spread and become accepted, they will eventually have an impact. Why certain ideas have a greater impact than others could be explained by matching domestic norms with nice packaging—in other words the right framing (which most probably also includes personal gains). At the moment it is difficult to see where Laos and Vietnam are heading, as there are strong forces working to preserve an old system at the same time as the two societies are exposed to strong forces of change through, among other things, the diffusion of ideas.

Returning to the translation process, one can argue that knowledge and understanding of the new policy are constructed twice, first by members of expert networks and later by domestic actors. The experts are important not only because they possess valuable expertise, but also because they frame the issue in question and influence the choice of means to deal with it, for example, what regulations may be needed. If the decision-makers have no strong preconceived views and beliefs about an issue area it is easier for the experts to exert influence, as in Laos where the consultants have had, and still have, great influence in the field of drugs and policymaking (see Haas 1992; Cortell and Davies 2000). The experts can in other words influence the way political leaders think about science and this has consequences for policymaking (Adler 1997).

Good examples are the concepts evidence-based medicine and evidence-based policymaking, which have gained currency during the last few years (e.g. evidence-based NDP implementation in Laos). Evidence-based medicine

means that one should only apply treatments that are known to be effective, and evidence-based policies means that new policies, too, should be rigorously tested and evaluated before applying across the board (Zwi and Mills 1995: 315). The answers to the questionnaire distributed among health officials during a national health conference in Laos show that the concept evidence-based policy has a strong impact and that the participants looked favourably upon it—although it also became clear that not all participants knew what research really means. However, policy is only in small part driven by data. Priority-setting and decision-making systems are also important. Not only health effects but also perceptions, attitudes, processes, systems and institutions must be considered (ibid: 321).

Hence, when it comes to translation of the new policies many obstacles have to be overcome. The translation includes not only words and concepts but also behaviour. In the translation process different ways to perceive things are confronted, which might distort the translation. People may communicate, but they do not necessarily understand each other.

Global and local interests in the field of pharmaceuticals

There are a number of actors who influence health policy. So far the focus has been on the agents of diffusion, or translators, and their role in the policy process. However, besides these specific actors directly involved in the policy process, there are other interests, or actors, who have an indirect impact on the two specific policy processes. Accordingly, the role of the pharmaceutical industry and the donor community will be discussed below in relation to the development of NDPs in general and to the development of the Lao and Vietnamese NDPs in particular, with view to the global–local connections in relation to public policymaking.

Pharmaceuticals

From the period of the initiation of a pharmaceutical policy by the WHO in the 1970s until now there have been difficulties; the policy, especially of the

essential drug concept,[48] has met with strong resistance, and there have been numerous controversies. One aspect of pharmaceuticals is that the area covers thousands of products, life-saving as well as dangerous. Another aspect is the amount of money involved. Even though the essential drugs policy is accepted today, it initially received negative reactions from the pharmaceutical industry. The industry eventually accepted the fact that the developing countries wanted essential drug polices, but it still tried to limit its applicability whenever possible. For example, the United States and the industry wanted the list to cover only the public sector in poor countries, not the private sector (Hardon 1992: 62). Moreover, many multinational pharmaceutical companies carry out research for the development of new raw materials in their parent industries. This means that the drug that is termed essential drug in one country may not be of importance in the home country of the MNC, since each of these countries have their own essential-drugs list. Consequently, MNCs which manufacture drugs that are not on the list will experience a major loss of production if so-called non-essential drugs are stopped (Adikwu and Osondu 1991).

Nevertheless, international companies are still commonly referred to as opposed to NDPs, and their influence in the pharmaceutical sector must be taken into account when discussing the development of NDPs. It is often pointed out that a handful of countries control almost three-quarters of world drug production, and that these countries also contribute half of the WHO budget. Companies do not want to see markets in Third World countries erode because, although relatively small, their consumption accounts for twenty percent of world spending on pharmaceuticals (Phillips 1990: 265). If the country in addition is heavily dependent on aid and loans for financing the drug costs, the pharmaceutical policy is open to manipulation by international influences (Kanji 1992: 89). Pharmaceuticals represent a profitable business sector, and health considerations often collide with commercial interests. Moreover, governments' regulatory goals may conflict with market processes when health policy has to compete with public-expenditure goals, especially if the government is the industry's major customer (Hancher 1990: 2). However, three-quarters of all medicines are still sold in industrialised countries (Ballance *et al.* 1992).

48 The aim of the essential drug concept is to avoid fake and harmful drugs and limit the number of recommended drugs to the most essential.

The most recent example of double standards is the case of HIV/AIDS-medicine in South Africa. At first USA was opposed to the use of cheap drugs because it violated the WTO patent rules, but when anthrax medicine was needed in the wake of the World Trade Center-attack at the 11 of September 2001, USA did not hesitate to break the patent-rules to promote their own interests. A compromise was eventually reached which allows states to protect the public health of their people when needed. This means that they can produce cheap medicine for diseases such as HIV/AIDS, tuberculosis and malaria—at least in theory (Olsson 2001a and b).

There was hardly any opposition to the development of the NDPs in Laos and Vietnam, either from professional groups or from non-governmental organisations. The political situation in Laos, as well as in Vietnam, is in that sense stable and has been so for many years. Laos and Vietnam are one-party states governed by Marxist-Leninist ideology, where health for all has been one of the goals—at least in theory. Consequently, the governmental reforms could basically stand unchallenged. Moreover, there was little resistance from the pharmaceutical industry, which often is cited as an opponent of NDPs, despite the fact that the NDP was directed towards the private sector as well.[49]

However, the situation in Vietnam differs from the one in Laos in some aspects. The involvement of the MNCs is relatively open, and Vietnam is considered to be one of the most promising markets for pharmaceuticals in the world, while Laos with its five million population is not as attractive to the big MNCs. Moreover, the state-owned pharmaceutical companies and factories in Vietnam leave the government with conflicting interests—public health issues versus profit—which in part can explain the slow NDP implementation. Thus, although the sector for now is relatively uncontroversial it does not mean it will stay in that way in the future. The lack of disputes can be explained by the political system, which at least until now, has left little room for open conflicts with the government.

In Laos, there are not many multinational corporations compared to Bangladesh and the Philippines, for example, where the MNCs control 70-75 percent of the total market (see Reich 1995: 75-76). There are around 30 licensed pharmaceutical companies (Syhakhang 2001b), many of them Thai. The Lao government actively promotes the national pharmaceutical industry

49 For the governments' effort to regulate the private pharmaceutical sector in Laos see Stenson *et al.* 1997, 1999, 2001a and 2001b.

by lower taxes on raw material import and priority to buy local drugs in the government budget (Boupha and Dalaloy 1997), premised on the notion that too much is spent on foreign medicine. The domestic production covers 30-40 percent of the market, which is a relatively high proportion (the production is only for domestic needs).

There are six main pharmaceutical factories in Laos, two of which are state-owned. These two factories produce about 90 percent of the drugs manufactured in the country, measured by value (Holland *et al.* 1995: 42). Four of the six factories are in the capital Vientiane: the government-owned Factory No. 2 and No. 3, one privately owned and one joint-venture with Chinese counterparts. There is one joint-venture with Vietnam in the south and one fully Chinese-owned in the north. Still there are problems with smuggled drugs from primarily Vietnam, China, and Thailand (interview with health official 2001). There are also pressures to use foreign drugs, not only from the few MNCs, but from physicians and patients as well, as foreign drugs are perceived to be the most efficient ones.[50]

The government in Vietnam also actively promotes the national pharmaceutical industry—even if the production is relatively modest and of low quality (World Health Organisation 1996). Export of pharmaceuticals is increasing however, and there is a plan to build two new pharmaceutical manufacturing plants in Hanoi and Ho Chi Minh City (interview with health official 1998). The Vietnamese NDP is actually very protective of the domestic production. Thus, as already mentioned there is an obvious conflict of interests. The Ministry of Health is the major owner of pharmaceutical and import-export companies at the same time as it is the regulatory authority (World Health Organisation 1996).

In 1996 there were 17 central pharmaceutical enterprises, 118 local pharmaceutical companies and factories and 18 licensed pharmaceutical investment projects and joint-ventures in Vietnam—all 153 governmental. In addition, there were 170 private pharmaceutical enterprises. This makes a total of 323 units. France had the first joint venture in early the 1990s. After

50 Smuggling is not only common, but also a serious problem, insofar as many of these drugs are either fake or substandard. Studies show that 33 percent of drugs sampled through inspections in five provinces were substandard (Stenson *et al.* 1997). Another problem concerns the insufficient attention to the quality of production, so-called Good Manufacturing Practice (GMP). A study made in the province of Savannaketh in Laos shows that half of the samples collected would not be approved according to international standards (Stenson *et al.* 1999).

that Thai, Korean and Japanese joint ventures were added (Ministry of Health 1996). However, the out-dated Vietnamese companies have difficulty in competing with the foreign companies as only 10 percent use 1990s technology. There are around 120 foreign companies operating in the country,[51] which cover around 70 percent of the market, with local products covering around 20 percent of the domestic market. It should be pointed out, however, that before 1993-94 everything was Vietnamese.

Vietnam has to import most of the material to be used in the pharmaceutical industry (aid from Sweden covered some of it earlier). As early as in 1990 Sida wanted to encourage the pharmaceutical industry to adjust to market economy, but the tradition of state-owned enterprises supported by the government regardless of profit seems to be hard to break. As for private pharmacies there has been a dramatic change since the economic liberalisation and privatisation started. In 1998 Vietnam had 21,900 private pharmacies *(Vietnam News Agency* July 23, 1999), which is a rapid increase in a few years. Recent surveys show that the value of drugs distributed through the private sector is around 80 percent of the total in Vietnam (see Cederlöf and Tomson 1995; Falkenberg and Tomson 1997). As mentioned previously, the explosion of private pharmacies where drugs were, and still are, sold in an uncontrolled manner was a major reason for the development of the NDPs in both Laos and Vietnam.

A problem in the pharmaceutical sector compared to other sectors is the relative lack of consensus about what is a dangerous or an unsafe pharmaceutical product. Thousands of products are covered, many of them with tremendous life saving capacity. Others are relatively harmless, like vitamins, but heavy promotion of these may lead to misallocation of national and personal health budgets that may be more detrimental to health than the more occasional but shocking deaths caused by dangerous drugs. The export and marketing of potentially dangerous drugs has been on the UN agenda since 1978, when the World Health Assembly gave WHO a mandate to develop a code of marketing practices under the Action Program on Essential Drugs (DAP). However, consumer groups and international organisations officials stress the adoption of health policies at the national level and such programmes as the WHO/DAP rather than development of a code of conduct for

51 From France, Singapore, USA, Hong Kong, Thailand, Switzerland, South Korea, Japan, Holland, Germany, Austria, India, and Hungary (*Vietnam Economic News* May 21, 1998).

pharmaceutical marketing (Sikkink 1986: 837-838).[52] According to Sikkink, it is possible that the drug industry and the US government, the major contributor to the WHO budget, may have threatened to withdraw support for current programmes, should WHO move on proposals for a pharmaceutical code of conduct. Issue linkages may be at work, causing an international organisation to limit progress on a pharmaceutical code in order to protect other crucial programmes (ibid: 839).

Similarly to Laos, the Vietnamese government thinks that too much is spent on imported medicine. For example, about 80 percent of the total medicine bill is spent on foreign drugs. This is a burden for the national health insurance and for the poor, as foreign drugs are more expensive than those locally produced *(Vietnam News Agency* March 14, 1998). Earlier, Vietnamese living in other countries sent drugs home so that their families could sell them and earn some extra money. Also, the advisors working in Vietnam, from the Soviet Union in particular, brought drugs that could be sold (interview with health official 1998).

After the liberalisation of pharmaceutical production both domestic production and imports increased manifold, and the per capita drug consumption (which also included drugs bought unofficially by traders and overseas Vietnamese) was estimated to have risen from 0.3 to 3.2 US Dollars (Nguyen Than Do *et al.* 1998). However, today it is primarily drugs from Western countries that are perceived as good. As a result, domestically produced drugs with labels in English have been sold as foreign at a higher price (interview with health official 1998). When it comes to Western drugs in developing countries, they may be used in ways not originally intended; they may even become "fetishised," or "charged with desire and connotation of modernity, like other 'outside' (imported, foreign) products…" (Finer 1999:14).

The tendency over the last few years has thus meant a move towards commodification of health, which means that health, in particular pharmaceuticals, is treated like other consumer goods. In parallel with the commodification of the healthcare sector, a new consumption norm has emerged. As incomes rise, due to economic development, people buy more

52 The International Federation of Pharmaceutical Manufacturers Associations has discussed a code of marketing of pharmaceutical products, but with little result. This can be compared with the code of infant food marketing, which was a formal agreement between Nestle and its non-governmental critics by which the corporation guaranteed to abide by a voluntary code of conduct worked out in an international organisation (WHO/UNICEF).

drugs. This naturally contributes to the complicated situation in the pharmaceutical field, as it is difficult to regulate and control the behaviour of individuals. Dealing with pharmaceuticals is profitable, both for the industry and for the individuals selling and prescribing the drugs. The availability of pharmaceuticals in combination with domestic demands have resulted in a situation where private pharmacies increasingly are taking over and where profits from drug sales lead to the temptation of over-prescribing drugs. Furthermore, up to 80-90 percent of all illnesses are self-treated with modern pharmaceuticals in many low-income countries, but the people seldom have the knowledge to buy and use the appropriate drug in the correct way (Cederlöf and Tomson 1995). Participants are lost in a market place where the information "noise" is made up of state propaganda, pharmaceutical marketing hype and interpersonal misinformation (Finer 1999).

There is a shift in health seeking behaviour, moving towards not only self-medication but also private medical treatment. Informal financing systems spur inequalities in health, which favours groups benefiting from the economic growth and leave the marginal and poor further behind (Jerve 2000: 15). A new poverty trap has emerged caused by poor the borrowing money, often at high interest rates, to buy drugs (interviews with expatriates 2000, 2001). Thus, health transactions between providers and consumers have evolved from bureaucratic management and subsidised health care to free and virtually unregulated market exchanges (Chalker 1995; also see Nguyen Than Do *et al.* 1998: 49). At the same time low salaries and rigid structures threaten the motivation for health workers to do a good job, that is, acting in accordance with the NDP.

The donor community

The last few years have involved a change in donor support in general and in the field of health care in particular. A shift in balance between WHO and the World Bank can be discerned in relation to health policy formulation. WHO is a policy agency with limited funds, while the World Bank has resources (Walt 1994: 129), and today the World Bank is the major financial contributor to health sector activities in developing countries. Hence, there is a shift from grants to loans, and from technical assistance and administrative costs, to direct support of public sector projects (Walt 1994: 128; Zwi and Mills 1995: 312-314). In general, both Laos and Vietnam belong to the main

borrowers in the region from the World Bank (World Bank 1998 in Common 2001: 110). However, in spite of being a large lender, the World Bank's technical competence is very limited in regard to NDPs (Falkenberg and Tomson 2000).

A the same, WHO's role and function has been criticised. Part of the criticism concerns the feeling that WHO is slow to adapt to global health scenarios and thereby jeopardises its role as lead agency in international health policy development and coordination. Another part concerns WHO's increasing politicisation (Stenson and Sterky 1994; Walt 1993). Some criticism relates to the organisational structure. WHO is seen as being too top-heavy. Appointments are often made on the basis of nationality and patronage rather than merit. The country representatives have inadequate power and resources at their disposal; and the precise role of the organisation is ill-defined relative to other organisations operating in the field. Thus, in the absence of leadership and adequate response from WHO, the World Bank has filled the policy vacuum. However, the last few years WHO has recovered much of its leading role in the health sector—especially since the World Bank more and more prioritises poverty reduction. Another criticism concerns the fact that WHO has had little influence over the growing private market (Hamrell and Nordberg 1995: 2).

However, WHO has access to an immense network of technical skills and capacity through linkages with academic institutions and individuals worldwide (Zwi and Mills 1995), and the organization has around 2000 experts from all over the world. In the pharmaceutical field both WHO and UNICEF have specialised in "software," such as development of NDPs and rational use of drugs (RUD),[53] information activities and capacity building, while the World Bank has focused on "hardware" (drugs etc.). At the same time the World Bank attracts "co-financing" from international and bilateral agencies together with funds from recipient countries, which increases its importance as a player in the health field (Falkenberg and Tomson 2000).

Bilateral donors have their own battles with budget cuts and domestic opinions to take into account, which affects the level of aid. Especially

53 Rational use of drugs (RUD) prescribing involves a decision whether to use a drug or not, and if so selection of a suitable drug. It also involves consideration of compatibility between the drug and patient or any other drugs given, appropriate information to the patient, and follow-up activities (Tomson 1990: 12. Also see Tomson 1990 for a discussion for various aspects of drug utilization).

programmes with long lead times, for example those involved in institution building, may have problems getting support (Berman P. 1995:3). A substantial amount of funds are also channelled through NGOs. Some of the reasons for doing this are their presumed flexibility, their close relationship with local communities and their greater promotion of equity and gender awareness. The drawbacks are problems that may emerge when NGOs are not as representative or accountable as assumed, when they resist coordination and compete with one another, and when little attention is given to promoting sustainable interventions based on building and entrenching local capacity and policymaking (Zwi and Mills 1995: 319; also see Walt 1994: 115-120; Burnell 1997: 175-186).

In Laos particularly Japan, Australia, Sweden, and France, have been offering aid for some time, and today Germany, Belgium, Canada, China, Cuba, United Kingdom, Luxembourg, New Zealand, Norway, Thailand, USA and the European Union (EU) contribute as well. Various United Nation agencies, such as FAO, UNICEF, UNDP, UNFPA, UNAIDS and WHO, are also present in Laos together with some 65 NGOs (Ministry of Health 2000a; also see Stuart-Fox 1998: 78; Zasloff and Unger 1991: 8.). The amount of money spent on health projects in Laos has increased dramatically with new players like the Asian Development Bank (ADB), and the World Bank. These new partners are naturally of great interest for the under-financed Ministry of Health. One has to remember that aid dependent countries always face a risk of donor withdrawal, and the search for new partners is of great importance. WHO has primarily supported the drug sector via short-term consultants, equipment and the Essential Drug project, and UNICEF has supported the rational use of drugs through its maternal and childcare programmes.

In the pharmaceutical sector in Laos, Sida is the largest donor working with the policy. ADB primarily provides drugs but works also with RUD. ADB has its own projects but follows indirectly the guidelines of the Ministry of Health. There are a number of international NGOs as well, like the Swiss Red Cross and the MSF. The main activity of the NGOs is to organise drug revolving funds (Syhakhang *et al.* 1998: 6). According to a health official the NGOs are fine to work with, but at the same time they sometimes "do what they like." The authorities then try to make them comply with the guidelines (interview 2001). Within the Ministry of Health the NDP-programme is only medium sized compared to immunisation and mother and child health care

programmes, for example. The present support by Sida for the implementation of the Lao NDP is granted until the year 2002.

The special relationship between Sweden and Vietnam started as far back as in the mid-1960s with the medical supplies and equipment as part of the humanitarian aid managed by Swedish NGOs during the Vietnam War (Jerve *et al.* 2001: 15). Sida has been active in the health sector since the mid-1970s with family planning, hospital construction and rural health projects (the support to the children's hospital in Hanoi and the hospital in Uong Bi did not phase out until 1999,[54] see Jerve 2001 and interview with health official 2000).

However, the situation in Vietnam at the beginning of the 1990s was not very positive with large differences between central and district level. At first Vietnam was presented as a role model in line with the Alma Ata conference in 1978 and the idea of primary health care for all. However, much turned out to be rhetoric and the emphasis was in fact more on quantity than quality. Many were trained as doctors or para-medics, but the standard of education was low and there was a constant lack of equipment and drugs.

Another problem was that the donors, including Sida, did not know the real situation, which made some programmes unrealistic. Thus, there were problems already from the start. For example, the hospital in Uong Bi (in the mining district in North-East Vietnam) was over-dimensioned from the beginning. Instead it was suggested that two hospitals would be built, one in Uong Bi and the other one in Hanoi. Besides, the hospital in Uong Bi was supposed to belong to the Ministry of Mining,[55] but when the authorities realised how big the hospital would be the Ministry of Health took over. Still, the Vietnamese found the hospital too big for their needs. The hospital was a direct copy of a Swedish one, not taking into account that it was a built in a country with great poverty right after a war. For example, a Swedish-style canteen was built but nobody could afford eating there. Even today it remains unused for its original purpose—instead it is used to receive visitors. The hospital is working well at present; the support from Sweden has ceased, but

54 Sida arranged a study tour for Lao health officials to visit Uong Bi, which was highly valued by the Lao (interview with health official 1998).

55 In general health policymaking belongs to the Ministry of Health, the Ministry of Finance and National Committees for Family Planning and the protection for Children, but a large number of sectoral ministries, such as mining, heavy industry and the army, also run health services for their employees (Güldner 1995).

the director says that they feel isolated being the only hospital in that area following good procedures (interview 2000).

In an evaluation from 1992, one can learn how the Swedish side, both in Stockholm and its consultants in Vietnam, lived with a homemade picture of how the centrally planned economy of Vietnam functioned. The Swedish view in regard to pharmaceuticals is described as being limited to the domains of the Ministry of Health, although the pharmaceutical sector is much bigger. Not until in the beginning of the 1990s was the scope of analysis widened beyond the Ministry of Health (Valdelin *et al.* 1992: 52).

Sida and WHO were practically the only external donors in the Vietnamese pharmaceutical sector earlier, but now there is a growing number of donors, such as the UNICEF, the World Bank, the French government, and several NGOs including Save the Children Fund/UK, the International Federation of Red Cross, and—although a relatively new player in the pharmaceutical field—the EU. Sida's involvement in the pharmaceutical sector started in 1983 through the project "provision of drugs" (with the sub-projects drug regulatory control, drug production and drug procurement). Most of the support was directed towards procurement of raw materials for drug production and upgrading of facilities. New directions came in 1991 when Sida decided to support the Area of Drug Policy and Control project (ADPC). Through ADPC considerable resources have been, and are being, invested by Sida in equipment and training (20-30 million US dollars over the past decade in the field of pharmaceuticals) (Lalvani 1996: 30-31).

From being the only donor in Vietnam, Sweden is now relatively small, although still well regarded among the older generation. The largest donor is Japan, followed by France, Denmark, Great Britain and Australia. Most countries have an office in Vietnam today, including small countries like Luxembourg. The World Bank and IMF have agreements with Vietnam, and most of the funds are loans to be spent on infrastructure. Only 20 percent is aid (Sweden spends 20 percent on loans and 80 percent on aid). Poverty reduction is the main target and has been for a while (see e.g. UN 1995). During the 1990s this work has been successful and praised by the international community, even though poverty remains widespread and deep (see e.g. Attacking Poverty 1999). However, the strategies presented to the donors are not always exactly the same as the government actually pursues. Some of the government's plans are political and coincide with control over ethnic groups (interview with expatriate 2001).

There are also large problems with corruption, and the relative abundance of funds does not make the situation any easier. Often many levels in a ministry or organisation need bribing, which means that large sums need to be paid in the end (Murray 1997: 52-54; also see Kerkvliet 1995: 20-28). Revisions are made and irregularities are found, but much money disappears without a trace. A recent audit of government agencies made by the Ministry of Finance found that close to 30 percent of the state assets have been excluded from the official records (Quan Xuan Dinh 2000: 373). Wasteful spending on large office buildings and too many cars within the state apparatus are additional problems, according to Prime Minister Phan Van Khai (BBC January 1, 2002).

The number of international actors should be related to the management capacity within the Ministry of Health, especially in Laos. Structural problems prevent efficient leadership in coordinating the Lao health system, and the various departments work virtually independently of each other. When the international agencies arrive, they command resources that the Ministry does not possess. They have their own policy agenda and priorities, and with the lack of an overall strategy and an urge to grasp any opportunity to obtain desperately needed funds, the result is not always optimal. Often the programmes end up being single-purpose, top-down products with unrealistic goals. More serious still, with already small resources, the capacity to develop a comprehensive national health strategy is in this way prevented (Renault 1997). Worries about the lack of programme coordination have been expressed by the international donors and Lao officials alike, and steps have been taken to arrange regular donor meetings. At the same time there is resistance to coordination, as this may lead to less funding for particular projects. Another reason may be the fear of loosing control over the decision-making power.

The situation is similar in Vietnam concerning resistance to donor coordination. The donors pressed for meetings every three months with bilateral and multilateral donors together with representatives from the government. However, when the number of participants rose, the Vietnamese suggested that the meeting should be held every six months instead. Regardless, the donors hold informal meetings and some sort of coordination is taking place anyway (interview with expatriate 2001). The capacity in Vietnam is hard to measure. Relatively speaking it is better than in Laos. People are in general better educated in Vietnam, Vietnam is involved in more cooperation and so

on. At the same time there are limitations, as many donor representatives have pointed out during my interviews. Structural problems in combination with a lack of resources are hampering the development, just as in Laos.

Evolving National Drug Policies

The interests of the donors are reflected in their conditions for aid or loans. Sweden's warm support of the development of the Lao and Vietnamese NDPs can be explained by the long-standing support of DAP/WHO. The Scandinavian countries have, on the whole, been keener than other donor countries in supporting the development of an NDP.

Twenty years ago only a few countries had an NDP as compared to 88 in 1998, and three out of four countries in the world (141) have an essential drug list (WHO/DAP/98; also see Finer 1999). WHO has played a major role in this process from the outset. As far back as 1948 the organisation already had an explicit mandate to work in the area of pharmaceuticals, but until the early 1970s its effort was to harmonise drug standards in international commerce. In other words, the focus was on technical matters concerning efficacy and standards in drug control.

In the mid-1970s a more comprehensive strategy was adopted as part of a change in health policy in the broadest sense. The WHO director-general at the time, Halfdan Mahler, introduced a policy aimed at improving basic health service and coverage, especially in neglected rural and peri-urban populations. The idea of Health for All by Year 2000 was to be achieved through the Primary Health Care (PHC) approach. At the PHC conference in Alma-Ata in 1978 the role of pharmaceuticals was recognised, and essential drugs became one of the components of the PHC strategy. This change of policy was in line with the general shift of polices in the developing world. Until then, development theories had emphasised modernisation through investments in industry, roads, dams and so forth. Now attention was drawn to neglected social issues and inequality between groups, with health as one area of concern (Mamdani 1992:12-13).

Hence, from 1975 onwards WHO became actively involved in helping countries to develop their own national pharmaceutical policies, with the essential drugs concept launched in 1977 as a milestone. The Action Programme on Essential Drugs (DAP) was created in order to implement the

new approach to drugs policy.[56] In 1985 *The Essential Drug Monitor* was established for dissemination and promotion of the essential drug list, and it has played a significant role in the development of NDPs—as we have seen in the case of the Lao NDP.

From a relatively modest start with an essential drugs list and the focus on distribution and supply, the action programme embraced all aspects of a national drug policy in its document Guidelines of Developing NDP in 1988. Since then the guidelines have been updated in order to meet the new demands in the sector and to fit different situations in the countries that want to develop an NDP. In addition a number of related documents have been produced as a result of expert meetings.[57] The rapid expansion of the DAP's programmes has been facilitated by the support of professional consumer and non-governmental organisations[58] as well as some donor agencies in Europe, in particular the Scandinavian countries. Their aid has been a cornerstone in the policy implementation, which has made it possible for national governments to resist substantial pressure from the industry (Walt and Harnmeijer 1992: 45).

Very few were in fact involved in the development of the NDP concept. In 1976 a group of three met and wrote a draft that was later developed. However, the budget was limited which, in combination with resistance from the industry, slowed down the work. According to Margaretha Helling-Borda (interview 30 January 2000), who was involved in the development of the NDP from the beginning, the work was difficult and sensitive, and without the commitment of a few individuals the result would have been quite different. At the same time, the small size of the group together with good networks made the work very efficient. Still, only in 1987 did the first working group meet; the following year the guidelines were accepted. At first it was difficult for the countries to know where to start. WHO focused on African countries at the beginning of the 1990s (Nigeria 1990 and Malawi 1991, for example). However, in Asia the work started earlier, much thanks to the regional WHO-advisor (e.g. Thailand adopted an NDP in 1981, Indonesia

56 For a comprehensive description on the development of the organisation structure of the drug programme see Walt and Harnmeijer 1992. Also see WHO/DAP/95.9.

57 For example "Guide for the Formulation and Implementation of a National Drug Policy and a National Pharmaceutical Masterplan" (WHO/DAP/93.9, 93.11, 93.12).

58 For example, during the 1990s the International Network for Rational Use of Drugs (INRUD) was working to improve the RUD (see e.g. Syhakhang 2000).

in 1983, the Philippines in 1987, and Cambodia in 1995). Similarities with the WHO guidelines are, not surprisingly, obvious.

Although the WHO has promoted the use of essential drugs and NDPs since the 1970s, relatively few studies are available. In addition the results are inconclusive, as they focus on different aspects. Many countries have adopted EDLs or NDPs, but that does not say much about what is happening at the grass-root level. Nevertheless, the essential drug programme in Yemen seems to have had an impact on drug availability and use at the time (Hogerzeil *et al.* 1989), and Burkina Faso seems to have had success not only in performance but also in acceptability and utilisation by the population (Krause *et al.* 1998).

In Nigeria the awareness of the EDL was 100 percent, but still the acceptability, or use, of the EDL was very low. The low acceptability could be explained by the fact that the majority of respondents in this particular survey had heard about the EDL only through the media, and only a third had a list on their own. Moreover, the activities relating to the EDL took place at the central levels of the Ministry of Health and thus not at all levels of health care providers (Adikwu and Osondu 1991).

In Laos a recent survey among policymakers shows that there is a very high acceptance rate of the Lao EDL. According to surveys in Vietnam, the knowledge about ED at commune level is very low, although the first ED list came in 1985. Obviously there is little teaching about NDPs at the universities, and many doctors prescribe drugs that are not on the ED list (interview with university representative 2000). Also among private pharmacies the knowledge about RUD is low (Chuc and Tomson 1999).

Naturally the power of international actors should not be over-emphasised in the development of an NDP, but the discussion above shows that there is a connection between the goals of DAP/WHO and the development of an NDP in Laos and Vietnam. Moreover, there is a connection between the goals of the Swedish government and Sida and the development of the NDPs. In order to understand the diffusion of an NDP, it is important to keep this in mind. The development of the NDPs did not occur in isolation, but was part of international policymaking—including the development strategies of Sweden/Sida.

Summary

The Lao and Vietnamese cases have shown how external ideas enter the domestic arena through bilateral projects, international meetings and personal contacts. Information is also acquired through written material. The specific timing and the adoption of policies in these two countries were to a large extent determined by the agents of diffusion and their personal negotiation skills. To put it differently, the need for an NDP was identified by the consultants, and it was possible to reach mutual understanding among the involved parties relatively fast. Moreover, the attitudes of the key actors facilitated the process in the sense that they were positive to the development of the NDP.

The diffusion can be characterised as an elite learning process, insofar as a relatively limited number of individuals, primarily in the ministries, were involved in the process. This process included both push and pull factors, such as the precarious situation in the health sector and the need for aid versus the donor's inclusion of an NDP in the aid programme. Thus, one could argue that the lack of strong interests working against the development of the NDP greatly facilitated the process. In addition, the speed of the process may have contributed to the lack of conflict, as there was little time to mobilise any major objections. In other words, the diffusion was both sought and imposed in a stream of demands from both sides.

However, when we widen the scope the picture becomes more complicated. The pharmaceutical sector is a mixture of domestic and local interests, commercial and health considerations, individual behaviour and governmental laws and regulations, legal and illegal transactions. In this mix the idea of NDPs has evolved and later been developed and implemented in a number of countries, including Laos and Vietnam. The formulation of the NDP is thus a result of a number of interests and problems existing side by side in the pharmaceutical sector.

Part III
Policy Implementation

Chapter Five

How policies are translated into practice

This chapter is devoted to the theoretical aspects of policy implementation. The discussion about the policy process initiated in Chapter 3 is developed by elaborating on implementation in relation to policy diffusion, and by specifying the top-down and bottom-up perspectives. The top-down perspective focuses on the policy and goal-attainment, while the bottom-up perspective is directed to the implementers and their behaviour. The implementation framework is applied to the Lao and Vietnamese NDPs in Chapter 6. Although the broad definition of translation permeates the implementations analysis, as presented in this chapter as well as previously, the more narrow definition focusing on language and communication will be highlighted at the end of Chapter 6 due to its immediate relevance to the understanding of the NDPs in Laos and Vietnam.

Implementation perspectives

As mentioned earlier, most diffusion studies stop at the adoption stage, while neglecting, or taking for granted, implementation. According to Rob Hulme (1997: 411) "(s)uccessful formulation and implementation of policy often depends on the effective transfer of policy goals between a series of networks in both policy formulation and implementation." However, from my point of view transfer/diffusion is not enough, as it does not say anything about how the policy is understood. Thus, the investigation ought to be directed to how the policy is translated through the different networks.

Implementation can be defined as those activities that occur after the issuing of authoritative public policy directives. This includes both the administra-

tion and the impacts of the policy. Consequently, the behaviour of the administrative body responsible for the policy is central as well as the compliance of the target groups. However, political, economic, and social forces that directly or indirectly influence the behaviour of all those involved are also part of the implementation process (Mazmanian and Sabatier 1983: 4).

Although the final impact of the policy, or the outcome, is important, that is not my main focus here. Instead, the policy process as such is under scrutiny. When I talk about the consequences of adopting a certain policy, I think more in terms of consequences for the policymaking process than for health care as such. Nonetheless, the impact on the work and behaviour of people directly or indirectly involved in the implementation of the NDP is of course highly relevant, even if I do not discuss them all in detail in this study. I am thinking of the working conditions for doctors, pharmaceutical personnel, drug-sellers and to a limited degree the people buying and using the drugs. But again, this study says nothing about improved health as a result of the NDP.

As much as there is a lack of discussion in the implementation literature about implementation in relation to policy diffusion, there is also a lack of discussion, as to how foreign ideas and policies are translated into a national context. For example, problems in the implementation phase may result from the many donors working in a country, each of them with its own ideas of what to do and how to go about it. Foreign aid supported projects often result in demands on the recipient country for separate accounting systems, evaluations, visits by missions, tying up policymakers' time with duplicatory efforts that may impede actual implementation. Moreover, competition and bureaucratic demands on donors can lead to poor thinking through of the potential complexities of project implementation (Walt 1994: 158). In some countries there may be several sources of financing for health programmes at the local level, and the ministry of health may not be in control of health policy. Implementation is therefore dependent on the extent to which the centre can expect the lower-level authorities to follow its guidelines (ibid: 161).

Why implementation is a forgotten aspect in diffusion research can partly be explained by the pro-innovation bias in the research, which means that innovation, in this case the policy, is often automatically perceived as something good. As a result some agents of diffusion pay little attention to the consequences of the diffusion. The neglect concerns, for example, the distribution of socio-economic benefits of the policy within a social system.

This has in particular been noted in developing countries, and the health sectors in Laos and Vietnam are no exceptions. It should be pointed out though, that the development of the NDPs was an attempt to lessen the effects of the uncontrolled privatisation process in the pharmaceutical sectors.

The consequences of a new policy can be of various kinds, for example, desirable or undesirable, direct or indirect, and anticipated or unanticipated. This is often related to people's perception of the new policy—in this case their attitudes to pharmaceuticals and health care. Normally innovations are introduced with the expectation that the effects will be desirable, direct and anticipated. Too often the results come out differently, for example with unanticipated undesirable effects, which partly can be traced to the fact that it is difficult to predict people's perception of the innovation (Rogers 1995: 30-31, 125, 405). Imported models may coexist with traditional cultures and polities, and incongruities may occur in habits and behaviours. Sometimes donors under-emphasise the practical consequences of adopting particular policies (Walt 1994: 3, 137). The underlying norms of the policy in relation to political system and institutional and structural setting, and level of economic development, must therefore be considered.

Hence, the ability to understand the viability of the implementation designs is a crucial part in the adoption of a policy (May 1992). Still, many programmes, all around the world, are based on centrally made decisions prepared by highly trained policymakers who might not be completely familiar with conditions in remote areas (see e.g. Mellander and Jönsson 1993). Or, as March and Olsen (1995: 210) put it: any political actor with specialised or new experience is likely to lack the capabilities to translate that experience into action.

One could say that there are two complementary perspectives in the implementation literature, the top-down and the bottom-up approaches, each of them emphasising different features of the implementation process (see e.g. Sabatier 1986). However, the classical hierarchical top-down model, which focuses on the policy and its goals, has more and more been complemented with bottom-up approaches emphasising the implementers and their

59 Lipsky's study in 1980 was important in portraying the street-level bureaucrats as the real policymakers. A street-level bureaucrat can be defined as public officials who in their work interact directly with members of the target groups and who often enjoy considerable discretionary power.

behaviour.[59] Today a study like Pressman and Wildavsky's famous work in 1973 about the implementation failure of a large job-creation scheme in Oakland would not raise any eyebrows as it did at the time of its publication. Most people involved in policymaking are aware that implementation is difficult and that policies have to be adjusted over and over again. However, from a reading of policy documents, including evaluations, it transpires that there are still relatively few discussions about the implementers and their situation.

The top-down approach is policy centred and can be said to represent the policymakers' perspective. In its more "rational" versions this model treats organisations as value-maximising units and views implementation as an ordered, goal directed activity. Control is hierarchical and responsibility lies at the top management. Implementation consists of defining a detailed set of objectives that accurately reflect the intent of a given policy (see e.g. Elmore 1978). As directions and control emanate from the top, formal steering and management plans are in focus. Formal steering issues include funding formulas, organisation structures, authority relationships among administrative units, regulations, and administrative controls, such as planning and evaluation (Elmore 1979: 605; Lundquist 1987: 26).

Organisational structure, planning and evaluation are thus important, and implementation failure is often explained by a lack of planning, specification and control (including sanction possibilities). This approach represents a view where predictability is fundamental in combination with clarity of intended goals. The model is underpinned by two values in particular. The first value implies a liberal-democratic view that policy should be made by the elected representatives of the people and implemented in a subordinated manner by public officials. The second value is represented by the view that rationality in public policy involves goal setting followed by activities in pursuit of those goals which may be systematically monitored (Ham and Hill 1984: 108).

The bottom-up approach has its starting-point in the society. The focus is on individuals and their behaviour. Policy goals and factors influencing policy goal attainment are not the main topics of this implementation research. Implementation is primarily viewed as a decision-making process with many actors involved, each with his or her own intentions and goals. This implies that bargaining, negotiation and conflicts are being taken into account in the analysis. Moreover, roles, expectations, norms, needs and motivation are examined (Younis and Davidson 1990: 8; Yanow 1990: 215).

According to this approach, routine and discretion might cause implementation failure along with ineffective behaviour, poor interpersonal skills and lack of motivation (ibid.). An underlying assumption is that delivery of services shapes policy outcome more than the design of the policy, and consequently the behaviour of the actors involved in the implementation process must be understood in the context of the political, organisational, social and economic setting (Palumbo and Calista 1990; Younis and Davidson 1990). The reason is simple. The implementers find themselves in situations where they lack organisational and personal resources to perform their jobs, and they have to find strategies to cope with the immediate pressures of their work. Informal routines may develop which could distort the aims of the policymakers. Strategies could, for example, be limiting information about services, making access difficult, concentrating on a limited number of selected clients, down-grading programme objectives, as well as routinisation and choice of "the easiest" types of programmes and solutions. As a result, higher priority is given to easy routine cases and cases where clients demand a decision rather than cases involving preventive action and follow-up activities (Elmore 1978, 1979; Winter 1990).

Those who prescribe a bottom-up approach tend to stress the importance of decentralisation of control instead of centralisation, as opposed to those favouring a top-down approach. The focus is on factors that only indirectly are influential on the policy, such as problem-solving ability at lower administrative levels, incentive structures, and bargaining relationships among actors at various levels of the implementation process. The relations between and among groups are examined, together with power, influence, interests, coalition building and negotiation (Elmore 1979; Yanow 1990). Success can only be defined in relation to the goals of one party in the bargaining process, and to the actor's ability at one implementation level to influence the behaviour of actors at other levels. It is not the policymaker who solves the problem but the one close to the sources of the problem (Elmore 1979). Thus, instead of the rationality described in the top-down model, every situation is unique depending on the specific actors involved and the context in which the process takes place.

Regardless of the merits and weaknesses of the two models, both perspectives need to be taken into account in an analysis of the implementation of a policy, as they highlight different aspects. Quite obviously the bottom-up approach is a response to the top-down perspective. The criticism of the top-

down model includes its neglect of policy distortion by the implementers and the assumed control over the implementation process. It is also assumed that all priorities are known and that they can be ranked. The bottom-up approach is criticised for its rejection of policymakers' authority and thus the foundation for democratic politics, and because it does not provide any thoughts on how to improve the policy at the street-level. Moreover, the bargaining perspective can explain how organisations operate but is not very helpful from a policy perspective, as implementation is seen as a relative notion with no standards to measure success and failure (see Younis and Davidson 1990; Palumbo and Calista 1990; Ferman 1990; Elmore 1979; Palumbo 1987). Finally, it has been demonstrated that people with very little education and poor social background are less likely to benefit from social services than more educated and wealthier people. This is the case even when these social services are targeted primarily at the former category. Thus, there is a process of self-selection to consider as well, which is related to equity issues (Winter 1990: 32).

In the analysis of the implementation of the NDPs in Laos and Vietnam respectively, the top-down perspective will serve as a base, or background, to the following more bottom-up oriented, or behaviourally focused, discussion. The policy perspective offers an opportunity to introduce the content of the NDPs, and although the content is not my primary concern it still constitutes a part of the policy-diffusion process. In other words, plans and formal steering issues will be discussed in order to set the frame for the implementation of the NDP, while the behavioural aspects will enhance the analysis by widening the scope of the policy process. In the analysis not only so-called street-level bureaucrats, but also health officials at the central level are included. The reason is simple: in societies like Laos and Vietnam the differentiation between policymakers and those who implement the policies is often hard to make.

Translating policy

By thinking in terms of the concepts logic of consequentiality and logic of appropriateness I hope to be able to advance the analysis beyond looking at the traditional perspectives in the implementation literature. The bottom-up perspective covers parts of the behavioural side of policymaking. However, the

perspective focuses on the domestic implementers and not on their foreign counterparts and the communication processes between the involved parties. Due to the close relationship between the implementation of the NDPs and development assistance from Sida/Sweden, an analysis of the behaviour of both sides is necessary in order to understand the policy process.

The main characteristics of the logic of consequentiality is, to repeat, some kind of goal-means rationality where the actor choose the option with the best consequences (in this case the best consequence for the policy), while the logic of appropriateness puts emphasis on how to do the right thing in relation to informal rules and institutions based on identity and place in society. As indicated earlier, foreign development assistance officials are more coloured by the logic of consequentiality since their work to a large extent is centres on specific programmes with explicit goals, while domestic actors have to act within domestic structures considering other agendas as well.

The interesting point in relation to policy diffusion and the translation of policy into practice is the meeting between the two ways of reasoning and behaving and what consequences the possible differences between the two may have on the policy process, not to judge whether one way is more preferable to the other. The two kinds of logic are social constructs and should be treated as such. In other words, what I am trying to investigate is whether there is any difference in practice, and I do that by applying the two kinds of logic. The different kinds of behaviour are connected to the roles of those involved in the policy process rather than to the individuals. I am also interested in how those involved can learn from their interaction and thus change behaviour in the long run. This, in turn has consequences for policy diffusion within the national borders, how health officials at central level translate the policy to the their colleagues at provincial and local level.

The logics of consequentiality and appropriateness in relation to the translation problem are instrumental in understanding why actors behave the way they do, and why cooperation can be so complicated. Problems can arise when goals and means (ways to implement the stated goals) are translated into a new context. Not only may the meaning get distorted, but misunderstandings may arise due to different ways of reasoning as reflected in the two kinds of logic presented above. An additional aspect is that the intentions, understanding and resources of the parties involved may change over time, during the reform process, especially when bilateral agreement and donor persuasion are present (Olsen 2001b; Lundquist 1987).

One could object to the statement that the donors are more goal-oriented than their Lao and Vietnamese counterparts. Communist systems are well-known for their plans with targets and goals to fulfil. However, these goals are not always achieved in practice. Another aspect to consider in low-income countries is the in many cases large gaps between top and lower level bureaucrats, between nurses and doctors, between policy elites and managers. Moreover, power rests not only on internal relationships but on external relationships with foreign advisors and experts, donors and financial institutions as well (Walt and Gilson 1994: 366).

In the next section I will look more closely at the implementation of the NDP and how the NDP has been translated into practice in a Laotian and Vietnamese context, together with the problems related to this process. It should be underlined that the implementation in fact has only started to accelerate the last few years in both Laos and Vietnam, and that things may change. Nevertheless, one may still ask why the implementation has been so slow.

Summary

Implementation is a neglected aspect in diffusion research. This can partly be explained by the notion that the diffused innovation often is perceived as something good. However, in reality the consequences of a new policy can be undesirable as well as desirable. The reasons for this can be found in the neglect of practical consequences of the new policy together with incongruities in behaviour. There are different ways of approaching implementation. One can apply a policy centred perspective or a perspective highlighting the implementers and their behaviour. Both perspectives suffer from advantages as well as from disadvantages, hence, a combination of the two is preferable.

The translation concept facilitates a perspective combining the two approaches. In this way, not only formal steering issues become important when studying the policy implementation, but also behavioural aspects are underlined. In cases where actors with very different backgrounds and interests interact, the meeting between diverging ways of behaviour warrants special attention in order to understand how policy is translated into practice. By including the communication process between the actors involved in the

policy process we consequently achieve a fuller picture. The top-down perspective serves its purpose by giving the frame for the policy implementation. The bottom-up perspective widens the scope by including constraints beyond the official policy.

Chapter Six

Implementing the Policies

In this chapter I focus on the implementation of the Lao and Vietnamese NDPs. Instead of discussing the policies in parallel as in previous chapters, the policies will be analysed separately starting with the Lao NDP followed by the Vietnamese NDP. First the implementation of the policies will be scrutinised from a top-down perspective, taken into account of the political context in which the policies are implemented. As pointed out previously, the domestic structure is decisive for the diffusion and implementation of policy. After that I elaborate on possible reasons as to why the implementers act the way they do when they translate policy into practice. In order enhance the understanding of the slow start of the policy implementation, the focus is rather on implementation obstacles than on enabling factors. The chapter concludes with a discussion about translation in relation to language barriers and the introduction of new concepts. Finally, I briefly analyse the role of the media as diffusion agents and thus also integrated parts of the translation process. Hence, in this chapter, translation from central to local level is in focus together with a more narrow definition of translation, namely the linguistic one. Translation between different kinds of behavioural logics will be discussed more in detail in Chapter 7.

Implementing the Lao National Drug Policy

The policy perspective

In order to investigate strong and weak points of the policy implementation from a formal perspective, steering issues such as planning, organisation, legislation and funding will be discussed. The analysis will cover to what extent the goals and objectives have been attained, to what degree the actions of the implementing officials have been consistent with the goals, to what extent

different means of steering have affected the policy process, and whether the policy has been reformulated over time (see Sabatier 1986: 22-23). The investigation is based on policy documents, including Sida programme documents, and the views of various official and donor representatives.

Planning and goal attainment. The overall goals of the Lao NDP are to make essential drugs available and to promote rational use of drugs. This entails promoting good quality and distribution of drugs. At the revision of the Lao NDP in 2001 a third goal was added: promotion of traditional medicine.[60] Within the policy there are thirteen technical and administrative components, which aim at fulfilling the overall goals: drug legislation and regulation; drug selection; drug nomenclature; drug registration and licensing; drug procurement; financial resources; drug distribution and storage; quality assurance of drug substance and pharmaceutical products; rational use of drugs; drug advertising and promotion; international technical cooperation; traditional medicine; drug monitoring and evaluation. Thus, there is a clear set of objectives outlining what to accomplish and which areas to prioritise.

In order to achieve these goals, the Ministry of Health has implemented a number of measures with the assistance of Sida and its consultants. The NDP programme has run since the initiation of the NDP process during three phases, 1992-1995, 1996-2000, and 2001-2002, and the programme has covered most of the components in the policy. There were five projects within the programme originally: 1) quality of drugs, 2) rational use of drugs, 3) traditional medicine, 4) managing drug supply, and 5) strengthening the institutional framework for the NDP. Project management was later added as project 0. The phase III programme consists of three "new" projects: management of the quality assurance system; health system research; and programme administration, along with two of the previous projects—quality of drugs and rational use of drugs (Ministry of Health 2000b).

The policy has primarily been implemented at central level and in five pilot provinces. These pilot provinces represent the most populated areas in Laos: Vientiane municipality, Vientiane province, Luang Phrabang, Savannaketh and Champassack. The provinces are also easily accessible.

60 Traditional medicine has always been more or less important in the Lao society. While most other countries abandoned this kind of medicine in favour of modern medicine, Laos kept the tradition alive during the years in war. First of all modern medicine was not accessible, and secondly, traditional medicine was, and still is, much cheaper (personal communication with health official 1998).

Areas of progress are the establishment of a quality assurance system including the drug law, a Food and Drug Quality Control Centre (FDQCC), and an inspectorate of private and public pharmacies. The rational use of drugs has been improved through information, education and communication (IEC) to lay people both in rural and urban areas, as well as to professionals in the public and private sector. Development of drug therapeutic committees at hospitals and standard treatment guidelines has lead to improved quality of care at provincial and district hospitals. The foundation for a more appropriate use of traditional medicine has been laid, and drug management and monitoring components have been improved (Tomson and Wahlström 2001). However, these last two areas have not been included in Phase III of the Sida programme, as Sida is not considered to be the most suitable agent to support these activities (interview with Sida representative 2000).

Already here it becomes obvious that Sida's support has been crucial for the policy implementation. It is an aid-funded project and it has been prolonged several times already. An evaluation was conducted in 2000, seven years after the adoption of the policy. The evaluation was conducted relatively late, and even if the largely positive evaluation led to continued support for another two years, Sida had already indicated that a prolongation of the programme could not be taken for granted. The continued support is much dependent on how the overall development assistance to Laos will be distributed among all sectors, including road construction and forestry (UD98/1447/ASO; personal communication with donor representative 2002). The estimated time of the NDP implementation is approximately ten years.

Several progress reports have been produced over the years, including annual reviews and financial reporting, but still it appeared as a surprise to Sida that the programme was considered as successful as it was by the evaluators—even by international standards (interview with Sida representative 2001). It should be pointed out though, that the evaluation takes its point of departure in the programme plans, which means goal achievements and written contracts. From that point of view the results are positive. However, from a larger perspective there are issues that can be questioned, such as administrative capacity, management and financial steering—especially compared to other sectors (interview with Sida representative 2000). According to the evaluation, the reports produced contained too much detail and too little by

way of broad overview (Helling-Borda and Andersson 2000), which could explain the misconception.[61]

The evaluation team concluded that the policy was relevant to the situation in Laos when it was adopted in 1993. According to the evaluators, around 70 percent of the NDP had been implemented at the time of the assessment, and the five initial projects had largely contributed to that. There were relatively few resources devoted to improvement of the overall management work at the Food and Drug Department (FDD), which has been criticised. This was partially solved by the addition of the sixth project called 0. As this project was not included in the original contract, it cannot be said to be an implementation failure—it was rather a planning failure. The Laotian capacity was overestimated, which contributed to the slow start of the implementation. As I was told during an interview: "it is difficult to know where to start, to identify what the Lao can do" (interview with expatriate 1998).

Only in about 1998 did the implementation process start to accelerate. During the first phase, 1992-1995, the main effort concerned training of inspectors in good pharmacy practice, the rational use of drugs and the establishment of the drug quality control centre. However, during the interim period 1995-1996 late settlements of the negotiations between Sida and the Ministry of Health caused delays in the implementation. Too little time for technical assistance hampered the implementation as well (Tomson and Wahlström 2001). During the second phase, 1996-2000, a drug law and concomitant regulations were developed together with standard treatment guidelines (how to prescribe drugs etc.), drug information and management for drug supply. But at the end of 1997 constraints and delays in the implementation created a situation where the NDP management and the IHCAR consultants decided that a new approach was necessary in order to achieve the goals of the programme.

The new approach aimed at strengthening the research capacity within the Ministry of Health as well as other authorities and health facilities involved in the implementation of the NDP. The emphasis would be on how to promote change through the implementation of the NDP rather than studying the content of the policy. Through operational research training, so-called Health

61 One could argue that it should be the responsibility of the Ministry of Health to conduct an evaluation. However, as the evaluation is related to how the money has been spent and as the implementation of the NDP is donor funded, it is natural that Sida is more eager to evaluate the programme.

System Research (HSR), both theoretical and practical aspects would be covered—in addition, valuable information about the situation in the pharmaceutical sector would be gathered (NIOPH *et al.* 2000; also see Syhakhang 2000).[62] A similar approach had been used during the development of the NDP, when five smaller fieldworks were conducted. The success of the HSR-project is reflected in the third phase of the Sida programme, where the component has become one of the main items, and is now also a priority of the Ministry of Health. Thus, this was an unanticipated consequence of the collaboration that evolved over time.

The third phase was delayed due to difficulties in negotiations over short-term consultancies and in appointing a long-term consultant (Wahlström and Tomson 2001). The cooperation with IHCAR is institutional, and over the years close to twenty different consultants have worked with different project in Laos.[63] Some of these have only worked short periods of time, while others have been going back and forth between Sweden and Laos for nearly ten years. Two long-term consultants have been involved as well. Thus, many of the consultants are well known by the Lao health officials both at central, regional and, in some cases, also district levels, which facilitates the cooperation. The institutional collaboration makes it possible to benefit from the total competence of a whole institution at the same time as it is easier for the participating consultants to stay updated when they are not on missions.

At the same time many of the officials working with the NDP at the Ministry of Health have changed over the years, which arguably has slowed down some of the work, insofar as the newcomers have had to learn the issue area. In other words, very few of those initially working with the NDP

62 The five research projects are: 1) Can health messages reduce irrational use of antibiotics? A study on self-medication and media use in two provinces in Lao PDR; 2) Use of traditional medicine in the Champassack province; Knowledge, attitudes and perceptions about the quality of drugs in Lao PDR. Explorations among community members, customers, drug sellers, and drug regulatory authorities in the Savannakhet province; 4) Effectiveness of "feedback" for improving quality of treatment based standard treatment guidelines—a randomized controlled trial at provincial hospitals in Lao PDR; 5) Toward an effective National Drug Policy implementation in Lao PDR—comparing the effectiveness of the NDP programme, sponsored by Sida, in one pilot and one non-pilot province. An additional five HSR projects was approved in 2001: 6) Use of antibiotics as self-medication for Reproductive Tract Infections and testing pamphlet for intervention among the adult population in Lao PDR; 7) Improving performance of drug therapeutic committees in Lao PDR; 8) Improving pharmacy practice in private pharmacies in rural areas of the Vientiane province; 9) Accessibility of essential drugs in remote areas in Lao PDR; and 10) Developing tools for information on drug use among the general population in Lao PDR.

63 Due to new Sida rules of competitive bidding IHCAR was not entitled to assist during a short period in 1995 (Falkenberg and Tomson 1997).

participate in the implementation today. An advantage, though, is that the ministry is relatively small and it seems that most of the employees working there know each other on a personal basis.

The results of the Sida-funded health system research projects provide a preliminary picture of what has been working and what has not been working in the implementation process. Research shows that knowledge about the objectives of the NDP in the pilot provinces is higher than in the non-pilot provinces, and hence implementation is more successful and comprehensive in those provinces—even if there are variations among the pilot provinces.[64]

The comparison of two provinces in the study (the pilot province Luang Phrabang and the non-pilot province Sayabury) shows that the availability of essential drugs in the private sector is more or less the same in both places. In the public health sector, however, differences in availability can be noted. Possible explanations for this situation could be that the budget is too limited, or that the supply system is not well functioning in the non-pilot province. Some districts have difficulties in obtaining drugs from Vientiane for logistical reasons, while the private sector can obtain them from "across the river," which means Thailand. As for quality of drugs, the pilot province shows better results in several areas (e.g. registered drugs, complete bill of purchase). Essential drug lists are more common in the pilot province, while lists of banned drugs are more common in the non-pilot province. One explanation could be that the non-pilot province focuses on banned drugs because some banned drugs are still in use in Thailand and smuggled into Laos. Finally, the number of educated pharmacists is higher and the rational use of drugs better in the pilot province. To summarise, the differences between the provinces are not overwhelming, but regarding knowledge about the policy, the quality of drugs and the rational use of drugs, the results are better in the pilot province. This indicates that the extra efforts devoted to the area have made an impact (Paphassarang *et al.* forthcoming).

64 According to the results of the questionnaire distributed to health officials at the national drug conference in 2001, most respondents knew about the Essential Drug List (92 percent), and the majority of those considered the list to be adequate for the country (83 percent). The knowledge about Good Pharmacy Practice (GPP) was high, 70 percent. However, when the respondents were asked to explain what GPP was, only 50 percent gave an explanation (if they actually did not know or if they just chose not answer is hard to tell). There was a slight difference in knowledge about the GPP in favour of pilot provinces (14 percent higher in pilot provinces). The difference in knowledge between pharmacists and medical doctors were higher however (83 percent and 57 percent respectively).

In Savannaketh, a pilot province in the south, several research projects—which are not part of the NDP programme—have been conducted in relation to public and private pharmacies. According to the results, the performance between public and private pharmacies does not differ substantially, even if the public ones perform better in general. However, both sectors perform sub-optimally with respect to good pharmacy practice (GPP) and rational use of drugs (i.e. lack of essential drugs, material, and information about drug use together with inadequate drug labelling lead to so-called irrational use of drugs) (Syhakhang 2000; Stenson *et al.* 2001b). The results can be interpreted in different ways. Either knowledge is still lacking, or change of behaviour is lagging behind information and knowledge.

The questionnaire distributed to health officials from all provinces in Laos during the latest national drug conference in Vientiane in 2001 also sheds some light on the major problems in regard to implementation of the NDP. The most pressing issues specified in the responses concern regulation, rational use of drugs and quality assurance control. The questionnaire indicates that there is a problem with the enforcement of the regulation. The lack of training is another issue of concern. For example, when asked about the main problem in private pharmacies, most respondents stated "non-pharmacists as drug seller." Licensed pharmacies are divided into three classes depending on the qualifications of the licence. Class I is allowed to dispense the largest number of drugs, and class III the least. To obtain a class I licence you must be a pharmacist with a university degree, for class II it is enough to be an assistant pharmacist or technician pharmacist. In class III pharmacies, where the largest number of drugs is dispensed (95 percent), the personnel do not have to be pharmacists—even if they may have received some training in drug management. Instead other health workers such as nurses and retired medical doctors work there (Stenson *et al.* 1997, 2001b). The "non-pharmacists as drug seller" category was in fact responsible for many of the other problems such as "order of the pharmacy" (order of pharmacy means correct labelling etc.) and "dispensing of low quality drugs." Consequently, respondents saw the lack of training among drug sellers as the major problem.

Although it is difficult to draw any firm conclusions from the studies above, they indicate that the efforts made in the pilot provinces have made an impact, and that the major problems concern the lack of regulation and training—which of course includes a lack of resources. Even if the staff are becoming familiar with work and the knowledge of management is increasing, the

foreign consultants are still needed. The difficulties concern financial management, reporting and implementation of technical management (interview with health official 2001).

The health-official questionnaire also revealed dissatisfaction over the lack of opportunity to share experiences from the various provinces, especially from the pilot provinces. This indicates the need for a functioning feedback and information system. But at the same time it shows that health officials are willing and interested to share experiences and to learn more about the NDP. It should be pointed out, though, that often parts of the policy are being implemented without the health officials knowing it. Thus, some individuals do not always recognise the NDP described as a policy, although they know parts of its content or the instruments used for implementation. This phenomenon is confirmed in many of my interviews—especially at district level.

Organisation and administration. The health administration in Laos is hierarchical consisting of four levels: central, provincial, district and subdistrict (or village) level (the army and the police have their own health systems). At the central level there are six departments: the Department of Hygiene and Prevention; the Curative Department; the Department of Food and Drugs; the Department of Organisation and Human Resources for Health; the Office of Scientific and Technical Council; and the Cabinet of the Ministry of Health. There are also institutes, centres, health schools and hospitals. Provincial and district health services together with health centres at district and village level are responsible for public health. The Food and Drug Department (FDD) is in charge of the implementation of the NDP. There should be at least one person responsible for FDD matters at provincial and district level. The FDD is, for example, responsible for licensing the private pharmacies.

It should be pointed out, however, that the administrative and political areas of the Ministry of Health are not separated, and that the minister and vice ministers are acting both in an administrative and a political leadership role. In addition, while many ministries are involved there are relatively few individuals directly engaged in NDP work. Moreover, there appears to be problems with the flow of information and coordination of planning and programme activities across the ministry. As a consequence, the coordination of donor activities, for instance, is actually often achieved through control of visas and approval of individual projects rather than by a comprehensive health strategy. Inadequate managerial functions and overlaps between differ-

ent levels of management have been reported as one of the fundamental imbalances of the health system, contributing to the low quality of services. The authority relationship among administrative units, in other words, is not clear (see Stenson *et al.* 1997; Syhakhang 2000; Boupha and Dalaloy 1997; Holland *et al.* 1995; Dukes 1999).

Legislation and regulation. The lack of adequate legislation was one of the major problems that triggered the development of an NDP. During the 1975-1982 period there was no regulation at all on drugs (Falkenberg and Tomson 1997).[65] Although the development of laws and regulations has been a priority, there still remains much to do in the field. A drug law has recently been passed (April 2000) and a hygiene law will be adopted shortly (*Vientiane Times* 3-5 April 2001). The Hygiene Law is considered to be a first step towards a comprehensive health policy (personal communication with health official 2001). Regulations on import and export, manufacturing and private pharmacies have been updated, and new regulations on traditional medicine, drug donations, prescribing, and narcotics/psychotropics are being developed (Wahlström and Tomson 2001; Sayamongkhonh 1996).

One also has to remember that there is limited experience of legislation in Laos, both how to make it and how to use it. For example, in a centrally planned economy one ministry could be given authority to regulate a factory, whereas in a competitive economy several ministries become involved in regulation such as industry, commerce, labour, finance, and so on. The need for private-law institutions is not fully recognised either. Other notions that are not completely comprehended are that there is no need for detailed instructions, if basic principles and institutions are established by law, and that legislation must try to foresee future problems (e.g. internationalisation of the market and MNCs) (see Dukes 1999).

Dissemination of laws and regulations is the next issue of concern. For example, even though the drug law was endorsed in April 2000, it has not yet been distributed to relevant authorities. The reason is a system of negotiation between different divisions within the FDD regarding the contents of what is supposed to be distributed. Another issue of concern has been whether a prime ministerial decree is required for implementation. Once there is a plan

65 For a more comprehensive discussion on pharmaceutical regulation see Stenson *et al.* 1997, 1999, 2001a, 2001b.

it must normally be accepted by the Minister of Health and then sent to the Ministry of Justice for comments. Thereafter it must return to the Ministry of Health before being issued as an official decree by the Prime Minister's office. Only then can the drug law be implemented. However, in this case the Minister of Health has indicated that the decree is not needed, and after publication of the law in 2002 it may progressively be brought into effect (Wahlström and Tomson 2001; Dukes 2002).

Finally, there is a problem with the enforcement of existing regulations. For instance, inspections of pharmacies are difficult due to the lack of resources (transportation, money to buy samples etc.). Even if the inspectors report embezzlements, the authorities seldom take any action against the perpetrators and very few fines have been imposed so far (interviews with health officials 1998-2001). However, several studies indicate that despite these difficulties the NDP and associated regulations have made a difference. For example, a study in one of the pilot provinces, Savannaketh, shows that the percentage of substandard drugs decreased substantially between 1997 and 1999 (Syhakhang 2001b).

Funding and donor coordination. Financing is another area of concern for the Lao government. The health system is under-financed and dependent on donors' support for its activities. In 1995 about half of the expenditure in public health system was financed by aid (Holland *et al.* 1995; Sida 1998). In 1997/98 national health expenditure was 3.2 percent of the GDP, or 11.50 USD per capita, which is low compared to other low-income countries. Of these the government sources accounted for 1.30 USD, donors for 3.50 USD per capita and households spent 6.70 USD per capita. Lately, the household out-of-pocket spending has increased (Ministry of Health 2000a).

In addition, the financial system is complicated. For example, the budget of the Ministry of Health is located at the Ministry of Finance, and every time the Ministry of Health needs funding it has to go through the Ministry of Finance. Furthermore, the budget has suffered severely from inflation, especially during the late 1990s. In 1998 inflation reached 100 percent. This has been a problem with the Sida-funded NDP programme, too, as the level of aid did not follow inflation.[66] Another problem with funding is connected

66 A driving force in the inflationary process is the high import dependence and the exchange rate depreciation of the Lao Kip against Thai Baht and US Dollar. Baht and Dollar are being used side by side with the Kip (see e.g. Thayer 2000).

to logistical matters. It may take a long time for drugs to arrive at provincial and district levels, and when inflation is high the result is that there is not enough money to pay the bill (interview with health official 1999). Hence, instead of free drugs for all, the pharmaceutical sector is today financed by international assistance and fees—in addition to the national budget (Boupha and Dalaloy 1997: 14). At the same time, the health sector is receiving little investment.

Although Sida is the major donor promoting the NDP, several other international agencies and NGOs are active in the sector albeit on a smaller scale, for instance with drug revolving funds.[67] The Rational Use of Drugs guidelines were developed by Médecins Sans Frontières (although the Red Cross started the project). Other actors in the field are Santé Sud (a Swiss organisation), the Swiss Red Cross, Consortium (American NGO in contact with the Lao woman union), a Japanese foundation (JICA), EU, CARE (trained drug sellers), World Vision, and CCL (French NGO) (Syhakhang *et al.* 1998; Helling-Borda and Andersson 2000).

Obtaining a complete picture of all the funding is difficult, however. A comprehensive report about donor participation in the health sector was written a few years back, but it was never published. Nevertheless, the involvement of the organisations mentioned above indicates that there is not only policy diffusion from central level, but also a diffusion of ideas from external actors during the implementation process. Another aspect is that these organisations and their projects, at least at times, compete with public projects in areas with scarce resources in regard to manpower and human resources (I will return to this issue later). This situation can to some extent be explained by the administrative structure in Laos. Since 1975 the vertically managed health programmes, funded by multilateral and bilateral donors and NGOs, have expanded, usually with relatively small contributions from the Lao government. Most programmes are managed from the central level, but some bypass the formal administrative structures (Holland *et al.* 1995). Consequently coordination of donor projects is difficult.

To summarise, the goals and objectives have to a large extent been attained, or at least they are on their way to being attained. Noteworthy though, is that

67 Drug revolving funds existed before the adoption of the NDP (UNICEF introduced them in 1990), but the NDP has facilitated the implementation.

the framework to measure success was related to the Sida programme and pre-established criteria for a summative evaluation. In other words, the evaluation only focuses on how the NDP goals have been achieved in relation to the Sida NDP programme.

The implementing officials have in general acted consistently with the goals. People seem to have worked according to their ability both at central level and in the pilot provinces. Considering the lack of training and regulation the achievements are relatively impressive. Other factors affecting the policy process concern financing, aid dependency and lack of coordination. The policy has been revised to fit the situation in Laos better, and the major obstacle to continued progress is whether or not the Lao government will manage to sustain the work if Sida ceases its assistance. Another challenge is to implement the policy in all provinces, and not only in the five pilot provinces—especially as many of the provinces can be considered remote and hard to access.

The advantage of the policy perspective applied thus far is that it focuses on formal steering issues, which tell us something about the formal rules at play in the sector. The drawback is that it says little about the implementers and their behaviour, and how these influence the implementation. But first a few words about the context in which the policy is implemented. As previously argued, domestic structures determine what kind of diffusion will take place and who the key agents are. Domestic political institutions provide the rules of the game for state officials as well as for ordinary citizens.

Political and administrative structure

With an under-financed and underdeveloped health system, the health conditions in Laos are among the worst in Asia. Today maybe 40 percent of the poor have access to quality drugs. However, the implementation suffers not only from distrust and dissatisfaction with public health facilities, lack of drugs and equipment, the physical inaccessibility of hospitals and health posts, but also cultural and linguistic inaccessibility of public services to ethnic minorities. This is obviously a problem as the country is ethnically diverse with close to 70 ethnic groups (Holland *et al.* 1995: 48). In other words, urban areas are favoured at the expense of rural. According to Stephen Holland *et al.* (ibid: 84), the organisational structure in Laos is relatively inflexible, reflecting the political system and the Lao culture in general. Respect for authority is high,

there is a reluctance to confront differences, and there is a preference for the individual rather than collective work.

The political system is thus important in order to understand the policy process. Laos has a National Assembly, a Council of Ministers and a number of ministries. The country is divided into 17 provinces and one special zone, 133 districts and some 12,000 villages. The highest level of administration at central level is the Political Bureau of the Lao People's Revolutionary Party and the Central Committee of the Party. These two determine the policy of the country. The legislative power is represented by the National Assembly, and administrative powers rest with the president and a governmental board headed by the prime minister that implement the policy and guidelines (Boupha and Dalaloy 1997).

The judicial branch comprises people's prosecution, a people's court, army, and police. In each province there are governors, district chiefs, commune chiefs, and chiefs of village together with mass organisations, such as the Lao People's Revolutionary Youth, the Federation of Lao Trade Unions, the Lao Women union, the Lao Buddhist Union and the Lao Front for National Construction. The leaders at central and provincial levels are selected every five years following the resolutions of each party congress. The National Assembly appoints the governmental board, while deputy ministers and the majority of administrators at each level are appointed by the prime minister (ibid.). Nevertheless, Laos is relatively decentralised, despite the image of centralisation, and many of the provinces have strong leaders that to a certain extent are able to work independently from the central authorities (see e.g. Uimonen 2001: 187).

The party structure is intimately linked to the government structure. All the important decisions have to be approved by the party, and even during the implementation party cadres play an important role. In Laos the leadership uses political seminars to spread the message of the party to their employees, for example how to deal with corruption. The seminars are also used for talking about what is happening around the world. The political seminars often come on short notice, which makes it difficult to plan ahead. This is accordingly a source of conflict in the collaboration with the donor community (personal communication with health officials and expatriates 1999-2001). Further, the party is consulted before the approval of a new law. The Ministry of Health prepares the first draft, which is submitted to the Ministry of Justice, then to the Cabinet of the Prime Minister and finally to the government. The government consults the Party Central Committee before

the draft is submitted to the National Assembly (see Dukes 1999: 9). The parallel structures in combination with a lack of transparency naturally make the policy process opaque to an outsider.

If one looks at the legal system in Laos, it can be expected that there are complaints about the lack of regulations. First of all, Laos did not get its first constitution after the communists came into power in 1975 until 1991. The legal system, inherited from the French, was abandoned in 1975, and Laos became a state with little or no legal basis at all. Accordingly, is takes time to rebuild the legal system (Stenson *et al.* 1997).[68] The ideal situation is to promulgate a law first and then develop a policy. In the case of the NDP it was the opposite: the policy in the form of a decree came several years before the law. Rule by decree is the common way to implement new policies, together with regulation and control. Information and economic means are hardly used at all. This approach is a remnant from the previous command economy (ibid.). Thus, if regulations are the base for an NDP and if regulations are lacking, there will automatically be problems.

If domestic political institutions provide the rules of the game—which includes who has access to the policy process—domestic norms shape the preference of the involved and predict the degree of diffusion. Accordingly, it is important to keep in mind that people have different roles depending on position, family, party structure, patron-client relationships and so forth—all directly or indirectly affecting the health officials in their daily work. According to Joseph Zasloff (1991:4-5), many attributes of the old system remained after the king was dethroned in 1975. New families and clans, with privileged access to the communist roots of power have emerged acting as patrons for clients of lower status. Even some of the old families who had links to the new revolutionary elite managed to survive and wield significant influence. Thus, traditional political behaviour remains although organised as a "communist people's democracy." The economic liberalisation seems to have strengthened these groups and their practices, and today the wealthy families share their privileged position with members of the administration (Uimonen 2001: 189).

68 The legal hierarchy in Laos is: the constitution is the supreme law of the state, laws or acts are enacted by the National Assembly, decrees are signed by the president or the prime minister, orders, ministerial decisions, and instructions and notices are signed by respective minister or his deputy for their respective sector. The 1991-constitution aims to make the exercise of power by the party less arbitrary and more predictable, while retaining absolute control. However, these aims are ambiguous, which also is reflected in the contradictions in the social field (Stenson *et al.* 1997).

When people negotiate in their daily work these different roles influence what is appropriate or not. For example, the power of the central government over the other regions is still tenuous. It must rely upon bargains with local chieftains to secure loyalty of their peoples (Zasloff 1991). In addition, historical and cultural aspects shape the identity of the Lao. "War-thinking" is still prevalent, contributing to the focus on material things and scepticism towards foreigners. The communist legacy of thinking more in terms of quantity than quality, presenting reports with plan and goals but neglecting how to implement them is also still present. For example, texts may be phrased like "(s)ince the war period, manpower development policy has been focused on nationalism, fitness and great sacrifice, meaning that the highest ideological commitment was regarded as a priority together with the quantitative development of nurses and assistant physicians in response to the crucial demand during the war period…" (Boupha and Dalaloy 1997: 26).

The implementers' perspective

In this section the implementers are in focus rather than the policy itself. The roles, expectations, needs and motivation of those involved in the policy process are discussed and analysed. Health officials at district, provincial and central level are included in the analysis as the prime implementers of the NDP. The working conditions of these actors are highlighted instead of the goal attainment in order to elaborate on why the implementers behave in the way they do. What kinds of issues influence their performance in relation to the implementation of the NDP? What factors restrain the policy process? The situation of those selling and prescribing drugs is only indirectly discussed, as my aim is to investigate the policy process rather than the outcome of the policy. The analysis is to a large extent based on interviews and observations in provinces and districts in combination with written materials discussing the situation in Laos from a more general perspective.

Obstacles at provincial and district levels. As indicated above, health officials in the provinces and districts find it difficult to implement the NDP and its components. Either they do not know what to do or they feel they do not have enough resources. However, even if they do have the knowledge and the resources, there are other factors beyond their control that influence their work. For example, communication and travel are difficult in many areas, and numerous villages are more than a half a day's journey from the nearest health

facility and more than a day's journey from emergency services (Ministry of Health 2000b). Several areas are inaccessible during the rainy season, except by foot or boat. This means, in turn, that these health facilities are far away from the provincial or district health offices. Consequently health officials, including inspectors, cannot visit remote areas on a regular basis.

During a visit to the non-pilot province Xieng Khuang in northeast Laos I experienced the problems with poor infrastructure. In one district we could barely reach two out of nine health posts—and the rainy season had not yet started.[69] In another district the health post seemed abandoned. Many drugs had expired and the facility had not been cleaned in a long time. At the same time I was impressed by some of the other health posts, which were clean and had a good stock of drugs—despite their remoteness. This indicates that the person in charge of the health post in question also makes a difference.

Another issue concerns the use of resources. For example, there may be a vehicle to use for inspection. The car, most likely an aid donation, is at times perceived as the property of the highest ranking official, which means that the director uses the car as his (her) private property and the inspectors are left without means of transportation. With a tradition of not criticising the superior, the situation is not likely to change. The reluctance to criticise is related to the lack of taking individual initiatives. Initiatives are seldom rewarded, and there may be dangers connected with moving in your own direction. The definition of what constitutes a crime against socialist morality, or against the party or the state, is not always evident (Zasloff 1991: 23).

Other complicating factors are caused by poverty. Although public pharmacies are obliged to provide the most efficient drugs, they cannot always do that for a number of reasons. For instance, the lack of electricity means there is no refrigerator to store drugs that need to be kept cold. As a result, the policy guidelines cannot always be followed. The same accounts for drug revolving funds. Sometimes there are not enough customers to sustain a drug revolving fund because people buy from private drug sellers, or people are too poor to buy any drugs at all, which makes the system unsustainable. The very poorest

69 The fact that the area still suffers from un-exploded bombs, so-called UXO, is another concern when travelling around. Large numbers of Laotians are still killed or injured every year, many of them children. I was told by health officials at the provincial health office in Xieng Khuang that more than 70 injured people had visited their hospital since 1996. They did not know how many got killed by UXOs as deaths are not reported.

can get drugs for without payment, but the system for granting free drugs seems vague (interviews with health officials 1999).

Also, the awareness among drug sellers is very low. This adds to the difficult situation of the inspectors—partly because they lack resources and partly because they have few means of sanctions. The drug sellers may buy from wrong, often unauthorised sources (Syhakhang *et al.* 2001b). They mix the drugs and the original labels are often absent. Sometimes the labels are written in English or French, but the drug sellers can seldom read foreign languages. Also, customers are likely to buy less than the prescribed amount of drugs (Syhakhang *et al.* 2001a). During one fieldtrip I saw medical doctors selling drugs in their practices. Although this is not allowed, it did not seem to worry them at all, despite the presence of representatives from the Ministry of Health. Thus, even if the drug sellers know they are doing wrong, they also know that they probably will get away with it (personal communication with health official 1999).

There are other problems related to the lack of enforcement and sanctions. For example, there are conflicts between licensed sellers who pay a fee for their licence, and unlicensed sellers who are not fined when they sell banned drugs. That obviously weakens the incentives of the licensed pharmacists to uphold the quality of drugs when others sell cheap drugs from other countries. In small villages it may also be difficult to enforce regulations when everybody knows one another. Moreover, drug sellers sometimes bribe the inspectors (interview with health official 1999). Further, in the pharmaceutical sector there is a trade-off between the two aims of the right to access for everyone and quality of care. The quality is the major aspect being regulated. However, if the regulation is too strict people may complain, as access to drugs would drastically decrease (Stenson *et al.* 1997). This obviously leaves the health officials in a precarious situation.

Studies show that many of the drug sellers and consumers do not worry and/or are not aware about the quality of drugs. Customers trust the drug sellers, who in turn trust the drug companies to provide good quality drugs (Syhakhang *et al.* 2001c). Thus, ignorance is a major obstacle to good health. The low standard of knowledge of drug sellers is linked to more general problems in society with low levels of education and management skills. These factors influence the implementation, but the problem is that ignorance cannot be removed purely by means of sanctions, regulations and occasional

training. Thus, focus on NDP alone will not solve all the problems in the pharmaceutical sector (Stenson *et al.* 1997).

Moreover, even if information about the policy has been spread, it is not certain that the policy has been understood and translated into practice. Information for planning is in general scarce and often unreliable, with the result that health officials are not accustomed to implement a policy such as the NDP. Even if knowledge about the *objectives* of the NDP is good among the health officials, at least at provincial level, only a relatively limited number of individuals have participated in training, conferences or seminars. In the districts training is not always available at all. On occasions, manuals and other material have been distributed, but according to my experience they have often ended up in someone's drawer not being used in daily work.

The lack of policy coordination amongst donors also causes problems and confusion—especially when the donors promote different practices at the grass-root level (training, guidelines etc.). Some projects only last for a short period of time, creating expectations that cannot be fulfilled, and sometimes the "wrong" drugs are donated (personal communication with health official 1998). In addition, donor-produced manuals for health worker training are often translations of foreign manuals. Especially the coordination between English and French speaking donors has been poor.

Furthermore, the projects, including the NDP programme, are spread unevenly across the country favouring the easily accessible areas. The problems in the health posts in Xieng Khuang province described above are connected to the fact that the Lao government has selected only five pilot provinces, which implies that in the rest of the provinces a comprehensive approach to the NDP is still absent. However, Xieng Khuang province is part of an Asian Development Bank sponsored project. During my visit, I was told that the lack of a comprehensive approach made the work difficult. ADB only supports the provision of drugs and not the treatment-side (training on how to provide and treat). The project is fairly small, and the first evaluation took place in 1999 when I was there. For the private sector the project only includes inspection and training of inspectors, and for the public sector ADB sponsors the procurement of drug kits at health centres and district hospitals. Despite suggestions that the programme should support the whole cycle in line with the NDP, ADB has chosen to focus on the provision of drugs alone. It was explained to me that the ADB and the World Bank do not have the technology, but they have the money. As a result, they adopt ideas developed

by others and conduct their own projects. However, it turned out that information about the NDP had been sent out to the province (through *the Food and Drug Bulletin*), but the people we spoke to had not read it. Thus, the diffusion of the NDP from central to local level is very uneven for various reasons.

Hence, the motivation for the health officials at provincial and district levels to implement the NDP can be expected to be limited considering the many practical obstacles and difficult working conditions. The incentives are not overwhelming either. Low salaries and rigid structures threaten the motivation of health officials to do a good job. Health workers need to moonlight in order to support their families, and sometimes they attend to their public duties for no more than three to four hours a day (Holland *et al.* 1995: 26-27). The pay for volunteers working in health posts is extremely low, if any at all. Often health workers cannot even choose where to work. Devoted people may spend a few years in remote areas before they get a job where they want, but there are also people quitting the health sector in order to live and work where they wish (personal communication with health official 1999).

Sustainability and aid-dependency. Motivation is not only a problem at the regional and district levels. The officials working at the central level have difficulties to face as well. One concern that has been pointed out every year I have visited Laos is the fear of donor withdrawal. The NDP programme is dependent on Sida funding, and the question is what will happen when the programme is eventually phased out. The officials in charge of the NDP programme at the Ministry of Health have voiced concern about the sustainability of the programme. However, according to my interviewee, they will try to find support from other sources than Sida after the phase out. In fact they have already discussed the matter with other organisations. There is a wish to continue the collaboration with IHCAR, but the shortage of funds is a source of worry. Hence, the programme will continue after Sida—but with less funding (interview 2001). It is interesting to note, though, that the first option is to find other donors willing to sponsor the programme rather than turning to the government. In general, the people I have talked to seem positive about the NDP, but the programme does not seem to be high priority when it comes to distributing governmental funding.

The shortages of funds are most likely related to the view of material objects. For example, it seems to be more popular to build new than to take care of the old. After numerous visits to hospitals during my travels in Laos, it became

quite obvious that there are no or very few funds for cleaning or repairing old buildings, but at the same time it may be possible to add new buildings. Another experience is that foreign aid is increasingly important and abundant. Apparently, the more money you can raise the better, and neither public health officials nor donors can take their privileges for granted. I have seen a health official from the central level upset because a local health official who prioritised a meeting with a foreign NGO neglected him/her. At the same time I have experienced the harsh reality of being involved in a project with little funding—the risk of being neglected is always there. In other words, the more money you bring, the more attention you get.

This leads me to a related issue. The donors bring large sums of money, which naturally is interesting for the under-financed Ministry of Health, and today the Lao have a greater chance of choosing collaboration partners than previously. At the same time the Lao see the wealth the donors bring and how much the foreigners earn, which is a lot compared to Lao standards. Thus, if you are not familiar with the donor-country's system, it seems as though the consultants' fees, which include taxation in the donor country, take up a disproportionate share of the project budget. This might upset individuals at the Lao side on occasion—which in turn may affect the collaboration.

Education. A brief comment on education of health officials and staff will end the discussion about the implementers' situation. The most difficult part in implementing the policy is ostensibly manpower, and that there are not enough qualified people to do the necessary work (interview with health official 2001). This is a big problem not only for the Ministry of Health but for the whole country. Even though people are formally qualified, many have taken their degrees in Laos where the curriculum is often inadequate (e.g. the School of Pharmacy only provides training based on the colonial French system). Others have received their degrees in the former socialist countries and the Soviet Union. The variations in curriculum actually have made the situation in Laos quite confusing at times (Stenson *et al.* 1997). Often the training is theoretical and not adapted to local situations, which further reduces the low standard of services.

To given an example, internship for graduating doctors is rare, even if graduates working for the government are posted straight to the field—often to remote positions without supervision and support. There is a lack of medical textbooks available to medical students, and although there are books

in other languages, most students only know Lao (interview with expatriate 1999). According to Lamphone Syhakhang (2000), the role of the pharmacists has been neglected and is not very well defined in Laos. Consequently there are comparatively few pharmacists, and those who do exist are relatively unknown predominantly working in the public sector. Considering that many of the health officials are trained in medicine and pharmaceuticals rather than in management and administrative skills, it not surprising that there are implementation difficulties.

To summarise, on looking beyond the actual policy it becomes evident that there are many factors influencing the implementation. First of all, the practical obstacles are many. Infrastructure might be lacking, and resources may be scarce or used in unintended ways. Health officials may not feel motivated to do a good job due to low salaries, or simply because they do not know what to do in the first place.

Secondly, the prevailing structures do not facilitate the situation. A new way of thinking and working has to be integrated in old structures. The legal system does not yet match the requirements of the NDP, and the political system does not favour openness and critical discussions. Remains of socialist ideology confront market forces in a country where people try to make a living through selling drugs (among other things). The same individual may have to act according to several roles: as health official, party member, family provider, parent, relative, neighbour, and so on. Thus, many different agendas are at stake at the same time. In addition, the sustainability of the NDP programme has been questioned.

In other words, even though the idea of the NDP meets little resistance, in practice the situation is more complicated—partly due to socio-economic factors and partly because of embedded norms and behaviour. Accordingly, it takes time for new ideas to get accepted and to be understood. Thus, even if information about the NDP is distributed and explained, there are other factors interfering with the implementation, and the personnel who are expected to perform certain tasks might have a hard time fulfilling them. The NDP may be high priority in Vientiane but is not always so outside the capital. Hence, the awareness of the problems might be there, but changes come slowly. Nevertheless, the differences between pilot and non-pilot provinces indicate that it is possible to make a difference despite all the difficulties.

Implementing the Vietnamese National Drug Policy

The policy perspective

In this section formal steering issues will once again be in focus in order to investigate strong and weak points of the policy implementation. Policy documents and the views of various official and donor representatives serve as the basis for the analysis.

Planning and goal attainment. The overall goals of the Vietnamese NDP are "Ensuring a sufficient supply of good quality drugs to the people" and "Ensuring a rational, safe and efficacious use of drugs." In order to achieve these goals a number of specific issue areas have been identified: essential drugs; drug quality assurance; manufacture, supply, import and export of drugs; traditional medicine; training pharmaceutical personnel; drug information; strengthening of drug management; scientific research; domestic and international cooperation in pharmaceutical field (Ministry of Health 1996). The nine specific areas reflect the mainstream NDP concerns, but also a socialist commitment to equity of access. National self-sufficiency, human resources, market streamlining, traditional medicine and drug safety are in various ways written into the text (Ministry of Health 1996; also see Craig 1997: 304). The policy is to be implemented by 2010, according to the official documents.

As in Laos the policy is a part of the Swedish development assistance. In order to understand why certain parts of the NDPs have been implemented and others not, it is important to look at the objectives of the development assistance as the two issues are intimately related. At first, the programme aimed at increasing the capacity of the Department of Pharmacy and associated institutions in relation to the control of supply, quality and marketing of drugs, the rational prescription and use of drugs, and the training of pharmacists and other health workers. Later the objectives were to include the development of an NDP with associated legislation (Jerve *et al.* 2001).

The policy was adopted in 1996, three years later than the Lao NDP, and a masterplan was developed in 1997 and piloted in seven provinces out of 42 thereafter. Today there are ten pilot provinces. In these pilot provinces efforts have been focused on improving competence in management skills, inter-sector coordination in control activities, training of pharmacy assistants, and increased involvement of the provincial People's Committee (Jerve *et al.* 2001: 64).

The NDP is supposed to be implemented in three phases: 1996-2000, 2001-2005 and 2006-2010 (Ministry of Health 1996). The overall aim of the programme is to increase capacity amongst relevant institutions dealing with drug control, rational use of drugs and health workers training (Jerve *et al.* 2001: 61). Besides the NDP, other activities to reach this aim are: to upgrade the National Institute for Drug Quality Control (NIDQC); to strengthen pharmaceutical inspection systems; to develop a method of financing the purchase of drugs; to develop a drug monitoring system at the ministry of health; and to increase the knowledge of drugs among the public (ibid: 62).

The Area of Drug Policy and Control (ADPC) is a unit established within the Ministry of Health/Drug Administration of Vietnam (DAV). The ADPC's task is to transfer and monitor Sida's support to the appropriate key institutions and implementers. It is described as a think-tank and initiator, which promotes and supports the development of drug legislation, pharmaceutical services and rational use of drugs in Vietnam within the Vietnam-Swedish health cooperation. It is thus aiming at developing and implementing the NDP. The time frame for the implementation of the ADPC component was 1994-1999 with an extension of at least two years. The present contract ends 31 May 2002 (personal communication with consultant representative 2002).

A so-called formative evaluation, or process evaluation, was conducted in 2001. In other words, it was not summative, or outcome oriented, as the evaluation of the Lao NDP. Also, the evaluation covered the whole Vietnam-Sweden health cooperation between 1994 and 2000, with the NDP-project as one part. Similarly to the Lao assessment, this evaluation did not cover issues besides the actual policy, such as corruption and equity issues. For example, today it happens that poor people have to borrow money at high interest rates in order to afford drugs. This makes drugs up to 30-40 percent more expensive than originally and leads to a new kind of poverty trap (interview with expatriate 2001).

Many of the activities stated in the project document have been initiated, while some have not because of the direction of government policy, or because of reordered priorities by ADPC/DAV. The Drug Quality Control Institutes have been developed institutionally in a technical sense, but there is no evidence that there have been any significant changes in the style of operation or the role or purpose of the institutes, with the result that relatively few drugs are being analysed—despite the changing environment (Jerve *et al.* 2001: 65). Also in the seven pilot provinces many components have not been imple-

mented, partly due to low management competence among health officials at all levels (Project Document 1999). According to Alf Morten Jerve *et al.* (2001), much remains to be done before any impact will be seen in the sector.

Issues that are not implemented are related to methods of financing drugs, methods of procurement of drugs and coordination of training of health workers and pharmacists at all levels relating to the guidelines (Jerve *et al.* 2001: 63). Treatment guidelines are developed and promoted by many different institutions, organisations and health projects, but there is no consensus and very little coordination among them. The result is conflicting information about the guidelines, which in turn discourages doctors from using them (Project Document 1999).

Nevertheless, a number of elements have been implemented so far—in full or in part. Specialist groups have been created for studying the pharmaceutical sector in Vietnam and in other countries in order to define policies and propose legislation; the essential drug list has been defined and updated; guidelines for rational prescription of drugs have been developed; facilities and procedures at the National Institute for Drug Quality Control (NIDQC) have been improved; facilities have increased, systems have been strengthened and staff skills relating to monitoring the use of drugs have increased; an inspection system to control import, distribution and sales has been established; information programmes and education for the public on the appropriate use of drugs have been initiated and coordinated (Jerve *et al.* 2001). Other things that have changed are: the Department of Pharmacy has been reorganised, some ASEAN standards have been achieved (but not all manufacturers meet General Manufacturing Practice, or GMP, standards), and a number of committees for drug and treatment in the hospitals have been created.

Thus, the implementation has not really reached the grass-root level yet, and much of the work is still at the discussion and planning stage. According to one of my interviewees (2000), the focus is more on the central level, more on administrative aspects than on how to serve the people. A reason for implementation difficulties could thus be that the NDP is not very easy to understand and accordingly to translate into practice. A related problem is that there is a tendency not to draw on previous experience such as documents from other activities—with the result that new pages are turned every day (interview with expatriate 2000). Pham Huy Dung (1996, 1997) explains the low value for implementation with the separation between the party and the Ministry of Health. The party is more concerned with policy orientation that

is based on political issues related to social welfare and with regulation than with the health provider. At the Ministry of Health the public providers carry more weight because the ministry is concerned with both administration and provision of care. Implicitly this implies that without the full support of the party, implementation will be hard.

The main reason given for implementation difficulties is the lack of resources, not only for capital investment but also for human resource development. However, even if parts of the NDP have not been implemented, surveys have been conducted that will serve as a basis for the implementation (interview with health official 1998). As in Laos, Sweden supports health research. In Vietnam the research covers the area of drug policy, rational and safe use of drugs, and in the field of good pharmaceutical practice (Sida 1999; Project Document 1999). Swedish institutions, IHCAR being among them, have a Health System Research and training programme in collaboration with Vietnamese institutions (see e.g. Johansson 1998). However, these studies have a medical focus and are primarily made by medically trained people, and do not highlight issues related to policy issues in a broader sense.

However, research can be very sensitive, and not all data are allowed to be published. In addition, there is a problem concerning the lack of accurate information, such as statistics (personal communication with expatriates 2002). Besides lacking systems for obtaining information the use of information is changing—or needs to be changed. In the earlier (health) system, planning was based on norms and quantitative targets set at central level rather than on what realistically could be achieved considering the situation at grassroot level—such as disease patterns and basic needs for the population. As the lower levels of health administration were held accountable for providing health information and thus also expected to demonstrate that targets had been met, the information reported often reflected what was expected and not what was the real case.

Some question marks may also be raised in conjunction with the measurement of the NDP implementation. According to an interviewee, surveys underpinning the decisions regarding the NDP are done in selected areas, and different aspects are measured in the different pilot provinces. In addition, statistics from the state sector are used even if the private sector is larger—which provides a distorted picture of the situation. Finally, many do not go to the hospitals when they are ill, which also makes the statistics unreliable (interview with expatriate 2000).

Organisation and administration. In Vietnam, as well as in Laos, there has been reorganisation in order to meet the new demands in the health sector. In 1996 the Department of Pharmacy became the Drug Administration of Vietnam (DAV) and the staff was increased from 13 to over 50. The activities of the ADPC would be coordinated by, but not take place within, DAV. As a result, the ADPC was given separate offices and staff from the DAV—even if the head was the same. However, DAV has become an isolated specialist department rather than an integral part of the health ministry and health care—probably because it is not involved in patient care, or in the supply and use of drugs by individuals. As drug therapy is an integral part of treatment, it would for instance have been desirable to have somewhat closer collaboration with the department of therapy, according to the recent evaluation (see Jerve *et al.* 2001: 62-65). However, there is nothing equivalent to DAV at regional and district level, only some bureaus. The system of inspections, for example, is run by another governmental system (interview with health official 2000). In other words, several units of the Ministry of Health deal with drug issues. However, changes occur continually, and consequently it is difficult to get a clear overview of the administrative structure. As ADPC is aiming at implementing the NDP, many of its activities have taken place outside the DAV.

Two long-term consultants have been working with ADPC/DAV, one focusing on rational use of drugs and one working with laws, guidelines, control, and administration. There is a tradition of using long-term consultants in the Vietnam-Sweden health collaboration, which among other things means that the possibility of building trust between the counterparts is increasing. Spending long periods of time in one country also facilitates the process of identifying where to direct assistance. At most there were 30 consultants as opposed to one or two in the past few years (Jerve 2001: 28).

Legislation and regulation. One reason for the implementation delay is the lack of legal framework. Until the drug law is in force, the legal basis for much of the work will be absent. At the moment a steering committee and a number of working groups work on developing the drug law. However, little progress has been made despite optimistic predictions and numerous drafts based on national-wide consultations (see Jerve *et al.* 2001; interview with expatriate 2000 and 2001). Consequently more money is needed from the Sida programme. However, with the system in Vietnam, where drafts often are sent back and forth numerous times, this is not completely surprising. In the recent

Sida evaluation, it was pointed out that the initial budget stimulated expenditure-driven rather than needs-based planning (Jerve *et al.* 2001). This could explain the reluctance to complete projects such as drafting a drug law. During my visit in 2000 there was optimism among the expatriates that the law would be completed relatively quickly. However, a year later the optimism had turned into pessimism. Often a law is redrafted 20-30 times, and the drug law does not seem to be an exception (interviews with expatriates 2000 and 2001).

Funding and donor coordination. Steering difficulties can also partly be explained by the financing system. For example, health budgets are administered at provincial level and not by the Ministry of Health. This means that the Ministry of Health has little control over budgets and cannot use them as an instrument of steering (interview with health official 2000).

At the same time, the implementation is highly dependent on foreign resources. For example, the health sector received relatively little aid from foreign donors before *doi moi*. Today the donors play a considerable role in health sector development. In 1992 between one quarter and one third of the health budget was contributed by external aid. According to Sophie Witter (1996:166-168), donors focus on preventive health while the government spends most resources on curative health. Experimental drug revolving funds (such as UNICEF's Bamako initiative) and insurance schemes are being implemented with donor support. There appears to be resistance from within the Ministry against too much coordination and what is perceived as centralisation of powers dealing with donors (Jerve *et al.* 2001)—probably for the same reasons as in Laos, namely that it limits the room of manoeuvre to obtain funding.

Other donors in the field of pharmaceuticals include WHO, which provides technical support in the field of good manufacturing practice. WHO also promotes essential drugs and Standard Treatment Guidelines (STG). The TGA of Australia and Aus Aid provide some training, UNESCO has mainly focused on research, and the World Bank focuses on the supply of essential drugs to fifteen provinces and drugs to the national health programmes on malaria, tuberculosis, and so on (Project Document 1999). Also in Vietnam drug revolving funds were established prior to the NDP. Sida already funded drug revolving funds in Quang Ninh province in 1992. Médecins sans Frontières and the EU have also supported DRF in the province. In the past, each programme was operating from different guidelines depending on donor. However, since 1995 unified guidelines are in place (Törnquist *et al.* 2000).

The capacity for aid management and coordination within the Ministry is relatively weak and consequently the absorption capacity is low. During the period 1990-1997 only 70 percent of the donors' contributions were used. However, while the Ministry of Health has raised concerns about uneven distribution of projects in the country and responsibilities between the departments within the ministry, the donors are more concerned over the lack of transparency and over-lap of donor activities (Embassy of Sweden 2002). Thus, interests may be diverging.

Sida prefers a policy as the main instrument to improve the situation, but there are those claiming that top-down steering has little effect in practice. Instead people "develop" or "invent" their own policy and act accordingly. In addition, there is a lack of information, which makes it hard for the implementers to know what to do. Thus, although there is a formal agreement between the Vietnamese and the Swedes, the implementation does not always work as intended. People have their own incentives, including money, and they do not always follow the official line. This would validate the comment that the policy process is more connected with individuals than with issues or ideology (interview with expatriate 2000, 2001).

To summarise, the goal attainment appears lower in Vietnam than in Laos, as many issues are still at the planning stage. The consistency of the implementing officials' actions compared with the goals can be questioned, due to the fact that the implementation has not been initiated at all in some cases. However, the policy was adopted three years later than the Lao NDP, and parts of the policy have been implemented—especially at the central level. However, the organisational structure differs from that in Laos in some important aspects. Although the organisation at the central level appears more impressive in Vietnam, the ADPC seems to be somewhat disconnected from the rest of the Ministry of Health, and the question is to what extent the long-term advisors are allowed to become integrated in the regular work of the ministry considering the sceptical attitude towards foreigners in general. Another crucial difference is that a drug law is adopted in Laos but not in Vietnam.

However, the lack of transparency, unreliable statistics and ambiguous organisational structure make it hard to truly grasp the impact of the policy process. The diverging concerns of the Ministry of Health and Sida illustrate the situation. While the Ministry of Health worries about distribution of projects and areas of responsibility, Sida's concern comprises the lack of

transparency and overlap of donor activities. Yet other factors affecting the policy process are similar to those in Laos, for example, lack of human resources and legislation. However, as shown in the Lao case, the policy alone and formal steering issues do not provide a comprehensive picture of the situation.

Because the implementation in Vietnam has not proceeded as far as the implementation of the Lao NDP, the following discussion will differ slightly from the analysis of the Lao implementation perspective. Less time will be spent on the situation of the implementers in the health sector and more time will spent on discussing general problems associated with policymaking and implementation in Vietnam. The analysis aims at understanding why the implementation of the NDP appears more cumbersome in Vietnam than in Laos.

Political and administrative structure

At the outset, one should remember that even if the health indicators are higher in Vietnam than in Laos, Vietnam also belongs to the group of low-income countries.[70] In addition, the quality of the health facilities has deteriorated in the remote areas in recent years. This is noteworthy as only 5 percent of the health budget is allocated to the commune health centres, which serve the absolute majority of the population (Quan Xuan Dinh 2000: 363).

The administrative structure of Vietnam, which is similar to that in Laos, is divided between the Communist Party of Vietnam (CPV), the State of Vietnam and the Fatherland Front. The CPV consists of the politburo, the central committee, the secretariat and party committees at different levels. The state consists of the National Assembly, the standing committee of the National Assembly, the president, the government and the prime minister, the ministries and state committees, the supreme people's courts and the supreme people's procuracy. The Fatherland Front, which is an umbrella organisation for all mass organisations, consists of a Women's Association, Ho Chi Minh league, Peasant's Association, labour unions and other mass organisations (see e.g. Bergling *et al.* 1998).

70 For an overview of health and other living standard indicators at household level see Haughton *et al.* 1999.

The constitution, which was amended in 1992, aims at providing clearer separation between the state and the party (see e.g. Ljunggren 1992; Tønnesson 1993). All institutions are supposed to operate within the framework of the constitution and the laws. However, the party is present at all levels of the administration to ensure that the leadership and consistency with central policies are maintained. As in Laos, the Vietnamese administrative system has four tiers: central ministries, provinces, districts and communes. Each level of local administration has an executive arm in the form of a People's Committee and a legislative arm in the form of the People's Council. Although the bodies are separated, their memberships overlap. The Fatherland and Motherland Fronts, the political arms of the communist parties, usually nominate the members of the People's councils. The members of the People's Committees are selected by the People's Councils, elected by the party congresses, and must be approved by provinces and appointed by the prime minister (see Rondinelli and Le Ngoc Hung 1997: 517-18).

One can describe the political system in Vietnam as a bureaucratic polity. This means that the major decisions are made within the bureaucracy rather than by forces in the society, such as parties, interest groups or mass movements. As the bureaucratic organs and local cadre influence the direction of policy, there is no sharp distinction between policymaking and implementation, a distinction that is assumed in most policymaking models based on democratic political systems. The Vietnamese system is guided by the Leninist principle of *democratic centralism*. Democratic centralism requires unconditional implementation of the decisions of higher organs by the lower organs, even though party members can voice their dissenting opinions within the confines of party regulations (Porter 1993: 101-102; also see Peter Nguyen Van Hai 1994).

The Vietnamese leadership has used two not mutually exclusive kinds of implementation models. One can be described as a mobilisation campaign model. Examples include the collectivisation of agriculture, where the fulfilling of targets has been important. The other model is more incremental, based on experiments with different methods of implementation by different localities, leaving room for adjustment of the policy itself. The incremental model is the most common model of the two, and it involves a long and complex interaction process among various levels of the party and state bureaucracies (Porter 1993: 118-120).

Hence, there is a system of trial and error where a new policy is implemented

in a number of test sites before being finalised. The results from these test sites can be used in different ways. For example, the proponents of change use the positive results, while the opponents highlight the negative consequences (Porter 1993: 123). Also, there is room for different interpretations of resolutions and policies at different levels. Sometimes the provinces, districts and localities resist policies if they mean encroachment on their power and interests (ibid: 127). This system applies to the pharmaceutical sector as well. For example, if the Ministry of Health wants a committee on drug treatment, it assigns a number of people who will work with the proposal. Then a pilot study is conducted in a district or province before any conclusions are drawn (interview with health official 1998).

An additional problem is the overlapping jurisdiction in Vietnam. Individual departments and different levels of government regularly issue legislation that may contradict other directives.[71] For example, it is officially admitted that too many legal documents have been promulgated. Some are outdated and people do not know whether they are still enforced or not. Others cannot be enforced due to weak enforcement structures (Ministry of Health 1996 in Craig 1997: 303). The constitution tells which laws to follow, but it does not specify which of the old laws are no longer valid. As laws are rapidly drafted and enacted, there is a risk of inconsistency in the legal system and that new laws may never be used in practice. Some of the laws are very general, and without detailed regulations or explanations, they will not be properly implemented. This inevitably leads to uncertainty in rural areas as to how to behave (see e.g. Berling *et al.* 1998).

For example, when a thorough analysis of Hai Phong City's normative legal documents was carried out by the People's Council and Committee, the Department of Justice discovered that one third of all the regulations were not compatible with those given by the central authorities. However, the reason given for this inconsistency was a lack of knowledge and an inefficient legislative system rather than a struggle between the central and provincial governments. Despite centralisation local authorities in fact do enact a lot of detailed regulation, since the laws and ordinances are often too vague to be applied. At the same time the state authorities cannot control all the regulations made by local authorities. After all, the real power still seems to rest

71 A comprehensive overview of the Vietnamese legal system has been made within the framework of the Swedish-Vietnamese cooperation in the legal area, see Bergling *et al.* 1998.

with the executive branch, the Government and the People's committees (Bergling *et al.* 1998: 37-39). Nevertheless, since *doi moi* there has been a shift towards more rule of the law and legal thinking (see e.g. Ljunggren 1992: 196).

Vietnam has a reputation of being one of the most bureaucratic countries in Asia. As in Laos, the bureaucratic style puts heavy emphasis on political training and procedures rather than management and implementation skills. There is little training in methods or problem solving with the result that officials have difficulties transforming resolutions into action. Traditionally, socialist systems focus heavily on input norms rather than information about outcomes. However, to start by defining problems may be interpreted as criticising the government, at least implicitly (interview with expatriate 2001). The situation has improved slightly under *doi moi* (see Witter 1996), but the problem remains despite current aid programmes focusing on public administrative reforms (PAR) (see e.g. Quan Xuan Dinh 2000: 372).

According to Dennis Rondinelli and Le Ngoc Hung (1997), the inequalities between regions and provinces, urban and rural areas, are exacerbated by the lack of formal channels other than the politically dominated People's Councils, through which local needs can be reflected in central government decision-making. The deterioration in health, education and social services in general can partly be attributed to an administrative structure that is inconsistent with the need for (economic) transformation. Although formal structures exist for local fiscal and administrative participation by mass organisations and the People's councils, they have weak mechanisms for obtaining popular participation and commitment to improving service coverage.

As discussed previously, the historical legacy has an impact on politics as well. The local independence with roots from pre-colonial times confronts the centrally planned society today, even if it is moving towards more decentralisation. There is a saying that the emperor's rule stops at the village gate, which indicates that the control from the central level is not always effective, and that a great deal of autonomy exists. However, this autonomy, reinforced during the war, has also resulted in inefficiency and corruption among local cadres (Peter Nguyen Van Hai 1994), which in turn has led to open discontent among the population lately.

Reasons for the slow implementation can thus be found the political structure and administrative procedures. Although there are attempts to

separate the state and the party, the party is still the dominating force in society with a double structure of command as a result. The incremental way of implementing new policies is a time consuming process, but it also offers possibilities to control the development by conducting small size experiments before implementing on a larger scale. Moreover, even if legal thinking is changing, the jurisdiction is still over-lapping with confusion of what is to be used or not as a result. The emphasis on political training rather than management and implementation skills makes implementation difficult, and the absence of feedback mechanisms others than the political organs do not encourage popular participation. In other words, new ideas cannot be adopted and implemented without thorough consideration and subsequent approval of the party.

While the domestic political structure set the boundaries of action for the policymakers and implementers, norms shape the preferences and predict the degree of diffusion. Below I will continue to elaborate on issues affecting the policy process highlighting the implementers' situation and what may influence their behaviour.

The implementers' perspective

The implementers' perspective focuses on individuals and their behaviour, in this case health officials at all levels. Due to my limited number of visits to provincial and district health offices, I am unable to give concrete examples of the working conditions of the NDP implementers. However, I will still try to create a picture of the difficulties health officials are facing in their daily work in general and at the central level in particular—and relate the situation to the implementation of the NDP. The description is coloured by personal views presented to me during interviews conducted at the central level and should be treated as such. Again, material covering other aspects than the NDP is used in the discussion.

Vietnam is similar to Laos in many respects considering the implementation difficulties, such as lack of funding and training. But there are also a few differences. The population of Vietnam is greater, and the private sector is larger as is the pharmaceutical industry. Consequently there is more money around, and also more vested interests. The most critical voices say the Vietnamese show little interest in implementing the NDP. This statement should be compared with what one Vietnamese observer pointed out, namely

that Vietnamese-Swedish health cooperation is developing in terms of ideas and policies that rest on one fundamental assumption; that it is in the interest of the people in the system to follow them. In other words, Vietnam is not the only country facing problems in linking the rationality guiding the planning process to the often very different rationality of day-to-day life of public institutions (Jerve *et al.* 2001: 23). One interviewee described the situation as two policy processes. The official policy is the one originating from Sida and WHO. The unofficial, or the real, policy can be discerned if one looks at where interventions have taken place.

Divided loyalties. Another problem concerns the discrepancy between decisions made at central level and implementation at local level. A system that is highly centralised in ideological and political terms but decentralised in management leads to confusion and fragmentation of service delivery, if there is no clear framework as to how guide the practical work (Güldner 1995). In a similar vein, Craig (1997: 27) argues that official policy can be something to play against in local politics where networks of patrons, relatives and friends are alternative sources of power.

At the same time there is little scope for expertise at local and provincial levels to contribute to national debates, as innovations travel slowly to the central level. Directives from the central level to the lower bureaucratic levels travel fast, however. Consequently local and provincial officials tend to focus on implementing the decisions from the central level, rather than taking initiatives on their own that may contradict central authorities (Craig 1997: 302). Within this system the degree of flexibility and discretion for provincial, district and communal decision-making and administration of service is limited—although there may be exceptions in practice as seen above.

Moreover, the role of the officials differs. Some see themselves as agents of the government, while others see themselves more as representatives of their localities. The former seem to accept the norms given by the central authorities, while the latter seek to negotiate with higher levels of administration for budget resources, and so on (Rondinelli and Le Ngoc Hung 1997: 519). According to Peter Nguyen Van Hai (1994) the public servants can be divided into two categories: the political public servants and the career public servants. The former are recommended by the party and act in a leadership role with functions of political control. The latter undertake the professional work. The recruitment is still very restricted, however, and public service has not yet incorporated the principle of political neutrality and bonus systems common

in other bureaucratic systems. Party members tend to be tried within the party rather than in open courts. In addition, there is a brain drain of skilled professionals into the private sector or employment with foreign companies.

If one considers the grass root-level, the implementers are in general just as much ordinary community members as representatives of the authorities. According to Tine Gammeltoft (1999: 64), who has studied family planning in a rural community, it makes sense to see policy in the light of double ethics. People may feel a serious commitment to state norms, seeing the national policy as good and necessary, while at the same time their everyday actions are more concrete and based on a kind of relational ethics. The family's needs must come first, and the policy is accepted only as far as the specific conditions of one's family allow. Thus, people do not uncritically absorb state propaganda. They may accept state norms as overall guidelines, but these guidelines can also be adjusted to fit a specific situation.

Profit versus health. Another accusation is that profit comes before public health considerations. The pharmaceutical sector suffers from structural problems favouring corruption, and a lot of money is indeed at stake. Moreover, in countries such as Vietnam, where health workers' salaries are very low, the boundary between public and private sectors has been blurred by the private practice of government health workers (Zwi and Mills 1995). There is money to earn in the private sector, and public health workers offer services for a fee after official working hours. Consequently the public health service suffers when members of staff prioritise their own business (Moghadam 2000). The private sector's wages are estimated to be between two and four times those the public sector (Peter Nguyen Van Hai 1994: 136).

A further trend seems to be that high-ranking health officials start to work in the private sector after retirement. Many of them have good contacts through their previous employments, and they know well which rules exist and what laws in the pipeline could affect their business in the future (interview with health official 2000). There is also a reward system, particularly noticeable at ministry level, which means that it is the same individuals rotating to different posts. The incentives are to obtain a senior position with all its benefits, to go trips abroad and to be given human resource development (interview with expatriate 2000).

Also, health is starting to become a class issue favouring rich people. It is possible to pay extra at public hospitals in order to get better treatment. Although officially 5 dollars per capita are spent on drugs, the unofficial figure

is several times higher—especially in urban areas. One problem is that the doctors receive commission on drugs sold, and that there is no real discussion about the problem (Güldner 1995). An attempt has been made to introduce a health insurance system (Ensor 1995), but according to my interviews, it is not working very well due to lack of funding. The formal sector is too small, and consequently people continue to pay out of pocket.

Knowledge—or lack thereof. There is another side as well, however. Some ideas are adopted, even if it takes some time. In other cases ideas are adapted and used for other purposes than initially planned. It is important to show who is in charge, and it is not wise to suggest that Vietnam is dependent on foreigners. Although it would be possible to learn from Laos in relation to NDP issues this is also a sensitive issue. Many Vietnamese perceive themselves as more advanced than the Lao and would be loath to take their advice. They also seem more reluctant to take advice from foreigners in general than the Lao. Some Vietnamese seem almost to view expert aid (consultants) with distrust and as a waste of money. At the same time, there are those embracing the Western way of doing things.

Similarly to Laos, many civil service staff are university graduates (40 percent in Vietnam), but very few have expertise in administration, human resources, training or management. Instead they have a background in engineering, agriculture, languages and so on. This is naturally a constraint for implementation of new reforms and policies (Quan Xuan Dinh 2000: 376). An additional problem related to education is that the doctors know too little about essential drugs, which affects the possibility of implementing the NDP. There is little teaching about NDP at the university (interview with university representative 2000), and this is undermining efforts to change behaviour—including the rational use of drugs. And even if there are committees at the hospitals, many do not know how they are supposed to work and what for (interview with health official 2000). Lack of knowledge is not the only problem. For example, studies among private pharmacies in Hanoi show that there is a significant difference between knowledge of how to treat and prescribe drugs and practice among drug sellers (Chalker *et al.* 2000; Chuc *et al.* 2001). Thus, behavioural changes may take time.

To summarise, the lack of implementation progress can partly be explained by the fairly recent adoption of the NDP in combination with socio-economic factors. However, looking closely at the political structure together with historical and cultural legacy, the slow diffusion of new ideas does not come

as a surprise. It seems that the diffusion from central to local level cannot be taken for granted, partly due to old patterns of local governance but also because of divided loyalties and different roles of the health officials. At the same time the limited degree of flexibility and discretion does not encourage initiatives from below. Adding the scepticism towards foreigners and foreign ideas, the implementation difficulties are to be expected.

Besides, the money at stake in the sector in combination with low salaries does not facilitate the situation. Health is increasingly becoming a class issue favouring those with money. Adding the lack of appropriate knowledge among health officials as well as medical personnel, the slow pace of implementation can be further understood. Arguably, the context in which the implementation is taking place ought to be considered when assessing the implementation as well as when introducing a new policy.

Before summarising this chapter, the translation process will once again be highlighted. Even though implementation as such implies a translation process (translation into practice), there are other aspects included in the concept to be considered.

Translation and means of communication

Translation includes several aspects. There is the purely linguistic translation of words from one language to another. Then ideas and concepts need to be translated from one setting to another. Finally, behavioural aspects are included in the translation process. Below I will elaborate on the two former aspects of the implementation process. The last category, translation of behaviour in a broader sense, will be discussed in Chapter 7. Thus, instead of discussing Laos and Vietnam individually, I will now let the concept translation govern the discussion. Albeit not the most important aspect of diffusion, language as a tool of communication can be decisive for the spread and implementation of new ideas—at least in the short run. At last I briefly discuss the role of the media as additional agents of diffusion in the pharmaceutical sector. Media may not be crucial for adoption of a new policy. Nevertheless, media are powerful in dissemination of ideas and knowledge and have been used in relation to the implementation of the NDPs in Laos as well as in Vietnam.

Language barriers. In general, there is a crucial lack of capable manpower to

deal with reforms upon the opening of a country, in this case Laos and Vietnam, which had little contact with countries outside the socialist bloc prior to the 1980s. The language barrier is one problem. English is needed to communicate or learn from external experiences. Laos and Vietnam are still in much need of external assistance, and the price for this is to allow foreign experts—often from institutions such as the IMF, the World Bank and the ADB—to monitor and suggest reforms, even if the Lao and Vietnamese in practice do not always follow their advice. Many key documents are consequently often written in "economist English" (Ivarsson *et al.* 1995: 30).

In Laos, there is a translation problem from English into Lao. More words are needed for the Lao to express the same thing as English speakers. Also, many words do not exist in the Lao vocabulary and have to be invented. For example, there is only one word for benefit and profit. At the same time two words can be used in relation to research, which easily can be mixed up. Many of the concepts used in the pharmaceutical field and in the NDP have been—and still are—difficult for many Laotians to understand. One of the studies conducted recently had problems with the interpretation of prescription, since that word also means doctor's advice. As all health staff at different levels are called doctors by lay people, prescribed by the doctor may in fact mean advised by a drug seller—and not a medical professional (Syhakhang *et al.* 2001c).

Recently more and more of the documents in English are translated into Lao, which of course is important if the message is to be spread to the provinces and districts. Many of the officials working at the Ministry of Health at central level speak English, partly due to the Sida-sponsored language training, but the further away from the centre you get, the less people speak English. A story may illustrate the difficulties "to do the right thing" in a changing world. A few years ago a new wing was built at the main public hospital Mahasot in Vientiane to receive emergency cases. Very conveniently the sign at the entrance was in English. The thing was, however, that it said Urgency Room instead of Emergency Room.

In Vietnam communication has remained a bottleneck throughout the cooperation around the NDP programme. The problem concerns language and the cost of translation, as well as a clash of different institutional cultures. According to Jerve *et al.* (2001), the responsibility for alleviating such problems remains primarily with the Vietnamese side, since foreigners come and go.

Included in the notion of translation is style of language, which in turn is related to the political system. In both Laos and Vietnam political correctness is paramount, which is reflected in the political language in documents. For example, a Health Sector Review carried out by the Vietnamese Ministry of Health and the World Bank (funded by Sida) took a long time to approve because of discontent over wording (personal communication with donor representative 2002). Another example can be found in the project document for phase III of the NDP-programme in Laos where the expected development in the sector is described: "Strengthening the ability of Health Service Staff in socialist idealism, appropriate attitude, medical ethics and technical skills to ensure high quality service to the population" (Ministry of Health 2000b). The presence of the party is thus obvious in many of the policy documents, which are often coloured by Marxist–Leninist rhetoric. The (Marxist-Leninist) language can be explained by the political situation at large. To remove the rhetoric completely would be to question the rationale for the revolution and thus also the legitimacy of the present regimes (see e.g. Jönsson K. 2002).

Translation of new concepts. All in all, the NDP has been well received in Laos, where no serious criticism has been raised. However, in retrospect it is obvious that the initial plans were over optimistic—not only with regard to some of the goals of the policy in relation to resources and human capacity, but also in relation to difficulties in introducing new ways of thinking and doing things. In other words, at the time of the initial adoption of the policy, the understanding of the viability of the implementation design was not sufficient. Possibly the major problem of implementing the NDP in Laos is that policy is a very abstract phenomenon, and that the concept policy was hard to grasp initially. The NDP was adopted almost ten years ago, and only now is the understanding of the policy spreading to a larger group of people in Laos. Officials are more used to decrees and regulations, and they do not always know how to respond to the NDP and to translate the policy into practice. It is interesting to note that there has been a significant change in vocabulary in recent health documents in Laos. Words such as human rights are being used, although only in relation to health care (see Ministry of Health 2000b). This is another result of the Lao-Swedish cooperation.

The lack of trained personnel gives the government no other option than to rely on foreign advice. The problem is, however, that many foreign experts have a mainly theoretical approach to reality. They do not really know the

country, the people, their culture and their ways. The cultural distance between the donor-influenced central administration and the people affected by the development projects in the provinces may be considerable (Ivarsson *et al.* 1995: 30). For example, when the new Hygiene Law was discussed at the Lao National Assembly, delegates from the provinces did not understand all the wording and concepts despite previous workshops and fact-finding missions to the provinces (personal communication with health official 2001). Besides, the Lao are not a reading people (see e.g. Uimonen 2001: 188). Books are rare and I often heard the comment "it is so much to read" even with reference to shorter reports.

Hence, for those working in remote areas, daily life constraints may overshadow instructions from the central authorities. At the same time officials at the central level have their hands full with work, which leaves little time for dealing with problems outside the capital—even though they visit the provinces and districts at regular intervals. There are occasions for feedback, but these occasions seem to be erratic and not followed-up at central level. As a result, some districts do things in their own way (interview with health official 2000).

The Swedish support in Vietnam includes health policy work and capacity building work, but "to get this somewhat abstract ambition translated into concrete and realistic plans turned out to be more difficult than anticipated" (Jerve 2001: 28). Thus, the translation problem has been noted, and the introduction of many new concepts is blamed for some of the problems (ibid: 32). Due to the lengthy isolation of Vietnam there are still linguistic and conceptual gaps between the donors and the Vietnamese. In addition, the donors' plans are often based on generalised international experience, which does not necessarily have any bearing on Vietnam today. In other words, it is important to be aware that there may be a gap between theory and practice (Güldner 1995; Witter 1996), and that this affects policymaking concerning priority setting and budgetary constraints, among other things. Consequently it also affects the translation of ideas into a new context, as the ideas are based on certain assumptions and/or norms.

Media. As mentioned initially, not only individuals are important in the policy process, but media, too, can play a role in the diffusion process and the translation of new ideas. In Laos as well as in Vietnam public health messages are spread through radio and television. However, in health communication and behavioural change top-down approaches to information are in general

disappointing. Even if this may be well-known, practice lags behind research. Policymaking, including implementation, is still often influenced by simplified notions of a seamless relationship between information and behavioural change according to a crude knowledge-attitude-practice or sender-receiver model (Finer and Tomson 1995). Naturally information is important, especially to increase knowledge—which is a first step towards change in behaviour. Media can contribute by keeping issues alive and by improving the general "drug literacy." However, as we have seen, drugs may be "fetishised" and "rational" health-seeking behaviour may not be the first option (see Finer 1999).

In Laos mass media are not well developed, and media as well as information in general are tightly controlled. This in combination with poor infrastructure, linguistic and ethnic diversity, and low literacy makes the reach of the media limited. Some groups do not have a written language and some do not speak Lao. Television covers only 35 percent of the country, and many prefer the better produced Thai television, which also has superior coverage, instead of Lao television. Regular health education programmes are produced, but only for 15-20 minutes every week. Radio has limited coverage as well (50-60 percent). Publications have extremely low circulation, except for political material. The reluctance to read can partially be explained by the kind of available literature. Marxist writings are displayed together with approved material such as reports published by international development agencies and government bodies (see e.g. Uimonen 2001: 188). Language skills are poor among journalists, and consequently reporters are not able to obtain news stories from foreign sources and rewrite them. Moreover, journalist training does not exist in Laos—neither do specialised health reporters. Reporters are subsequently sent abroad for training, previously to East Europe and the Soviet Union and now more commonly to Vietnam and Australia. A proposed way to make health messages more popular is to use dramas or soap operas (Finer and Warsame 1997). Thus, at the moment the main channel for mediated drug information in Laos is *The Food and Drug Bulletin*, which has been published quarterly since the beginning of 1996 and sold mostly to health centres and pharmacists.

In Vietnam mass media are a sensitive issue, and domestic as well as foreign media are firmly controlled. Radio has been important, not least foreign broadcasters, such as the BBC, but has had to give way to the more popular television. Newspapers and magazines experienced a face-lift in the early

1990s, much thanks to the Swedish-financed Bai Bang pulp and paper mill.[72] At the same time journalists started to access a variety of foreign news sources, rather than depending entirely on the Vietnam News Agency. However, in remote and poor areas the radio still is important, especially as few read newspapers and many cannot afford to buy a television set (see Marr 1998). Consumption of mass-mediated drug information seems to be high, print media being the major source. However, the government has been criticised for being too passive in letting commercial sources provide most of the information. The result is that people are lost in a marketplace with a mix of state propaganda, pharmaceutical marketing hype and interpersonal misinformation. According to David Finer (1999), health is used to uphold traditional values through propaganda in both medical and political terms, and he argues for a stronger media role in health communication and critical health reporting.

Hence, the media do not play the role they could play in diffusing health messages, either in Laos or in Vietnam. In Laos they are rather underdeveloped, while in Vietnam they are too commercialised focusing on selling drugs. State media are politically laden, which also influences the health messages. In addition, in the areas where health messages are perhaps the most needed, people do not have access to the media.

Summary

To some extent it is difficult to make a comparison between the two policy processes because the implementation of the NDPs has progressed further in Laos than in Vietnam. Nevertheless, many similarities as well as differences can be noted. For example, socio-economic factors and the political and administrative structure are not that different, and the lack of resources, including human resources, and training are important impediments to successful implementation.

72 Bai Bang was the most costly, one of the longest lasting (almost 30 years) and also most controversial aid-projects Sweden has ever undertaken. See Jerve *et al.* (1999) for a discussion about the change of aid paradigms over time, the role of foreign policy in development in cooperation, cultural obstacles, and recipient responsibility versus donor led development in relation to the project. Reading the evaluation is it quite clear that the communications skills on both sides have improved substantially over the years.

However, the obstacles for implementation in Vietnam seem larger than in Laos from a policy diffusion perspective. First of all, the structures in Vietnam appear less penetrable than in Laos. The Vietnamese seem more prone to ignore the advice of foreigners and do things their own way. This in combination with factors such as the organisation of the NDP programme, where the programme seems more integrated into the regular administrative structure in Laos than in Vietnam, could be a partial explanation to why the NDP process in Laos emerges as less complicated than in Vietnam. Despite a number of disadvantage Laos has succeeded to make a big change in a relatively short period of time, whereas Vietnam, from a resource perspective, ought to have progressed further. In addition, the Lao have already reformulated their policy based on their own experiences.

Also, the motives of people involved with pharmaceuticals are crucial for the policy process, and as long these motives contradict each other and/or the aim of the NDP there will be implementation difficulties. As a consequence of the administrative and political systems health officials at lower levels may chose to ignore a new policy they do not entirely comprehend rather than doing something wrong. It may also be decisive that the cost of *not* implementing the NDP programme differs between the two countries. In Laos there are not yet as many donors as in Vietnam and consequently the Ministry of Health are dependent on good relations with Sida. In other words, it is less "crowded" in Laos in regard to donors.

It is evident that the policy-centred perspective fails to give a comprehensive picture of the policy implementation as it leaves out factors outside the direct scope of the policy and its immediate environment. Adding the notion of translation—in a narrow as well as in a broader sense—to the more traditional ways of approaching implementation, we obtain a more fine-grained picture of the difficulties of diffusing the NDPs in Laos and Vietnam. Not only material aspects determine whether the implementation will succeed or not, but also language, identity, norms, political structure, historical and cultural legacy influence how the policy process is perceived and thus dealt with. If these perceptions differ among those involved in the policy process, and these differences are not communicated, understood and translated cooperation will be beset by problems.

Thus, a limited scope of policymaking in theory affects implementation in practice. Even though the planning seems appropriate, the result does not always turn out as expected because factors indirectly affecting the programme

are not considered when planning the activities. Donors are far from united regarding best strategy, which makes this situation difficult in practice as a number of strategies are competing for limited resources.

The discussion in this chapter illustrates further the argument that it is necessary to take a wide approach to policymaking and to contextualise the policy process. At the same time one should not conclude that successful translation equals successful implementation or vice versa. Translation is one part of the implementation, while material resources and steering issues are other important parts. The aim has not been to measure success and failure, but to problematise the policy process. The point made in this chapter is hence that one must consider both ideational and material aspects when studying the policy process.

Part IV
Conclusion

Chapter Seven

From external ideas to domestic practices

In this chapter the analysis moves from the specifics of the Lao and Vietnamese NDP processes to a more general discussion by returning to the research questions posed in the introduction. The overall aim of the study, to analyse how foreign ideas diffuse and are integrated and translated into a new context, will be discussed in relation to the theoretical framework as well as to the empirical findings. As stated in the introduction, the purpose of this study is thus to provide an alternative way to look at the situation in Laos and Vietnam with regard to policymaking in health care and pharmaceuticals compared to the more medically oriented studies, and to try to find alternative understandings of diffusion and implementation difficulties.

The discussion basically follows the structure of Chapter 3 starting with the policy process, continuing with an elaboration on logics of behaviour in relation to the translation process. Then the transmission dynamics are in focus in order to investigate whether the policy processes in Laos and Vietnam have been useful in identifying factors either facilitating or restraining policy diffusion. After that policy diffusion is related to globalisation forces by looking at patterns of diffusion and how these forces may affect state-society relations in Laos and Vietnam, subsequently followed by a brief discussion about the globalisation of health issues. In the final section I summarise the main empirical lessons and discuss advantages and disadvantages of the theoretical framework. I also briefly look at the role of the researcher in relation to policymaking.

Towards a comprehensive policy-process perspective

An advantage with diffusion is that it manages to link with issues both within and beyond that of policy analysis. As we have seen, it is possible to connect policy diffusion to implementation, to policy networks, and to globalisation. Diffusion connects international and national policymaking, and invites a search for the origin of the policy. Besides looking at norm diffusion, changes in current development strategies are automatically included in the analysis.

To start with the last issue, Sweden's aid policy obviously influences the policymaking in Laos and Vietnam. From having relied primarily on material support, Sida is now favouring institutional strengthening and capacity-building. Policy work and management issues are thus high priority. In the case of the health sector efforts are directed towards increased efficiency and effectiveness in the Ministry of Health together with improved quality and equity in the provision of health services (see e.g. http://www.sida.se). It is interesting to note that the goals of Sida are acknowledged specifically in documents in Laos as well as in Vietnam. In Laos, for example, the latest NDP document clearly recognizes that the goals of Sida must be considered when planning for the implementation of the NDP programme (see e.g. Project Document 1999: 11; Ministry of Health 2000b).

Sweden's aid policy in Vietnam has changed over the years, partly mirrored in major changes in Vietnam. In the 1970s the assistance was a result of political solidarity in conjunction with the Vietnam War and hospitals were built. In the 1980s the focus moved to programmes of management support and training to remedy the lack of implementation skills. However, the material support remained high. In the early 1990s, Sida emphasised institutional development and policy work. *Doi moi* had taken effect and the basic health system collapsed. Consequently a new approach in health was needed (Jerve *et al.* 2001). The overall goals of the Swedish development assistance strategies in Vietnam are poverty reduction, equity issues, environment, democratisation and respect for human rights, which are reflected in the health sector as well. Health issues receive 12 percent of Sida's total development assistance, and health reforms, especially regarding health systems and pharmaceuticals, constitute one of the priority areas. Policy and legislation are the main concerns in efforts to raise the capacity of the health care and to lessen

the negative effects of the market economic development, as decentralisation and new forms of financing limit the authorities' role to create norms and guidelines as steering instruments. Thus, the changing role of the state is an intrinsic part of policymaking. The support in Laos is similar to that in Vietnam, even if it has been less comprehensive (see www.sida.se; Sida 1999; Ds 1998:61).

In the case of the NDPs, the origin can be traced back to the work of a few individuals at WHO in the 1970s. Since then a large number of countries have adopted NDPs. Even if the development of the NDPs in Laos and Vietnam was part of an aid package from Sweden, the connection with the WHO was there. Some of the consultants had strong links to WHO and were familiar with the NDPs, and Sweden was already a strong supporter of the WHO's work with essential drugs and NDPs. Consequently, there was an opportunity to spread the idea of an NDP through existing bilateral cooperation and established networks.

The actual development of the NDPs took around a year, both in Laos and Vietnam (even if the idea of developing an NDP had been around in Vietnam for a much longer time). Different working groups and committees did most of the job, but there were also opportunities for foreign advisors to give their input during the process. But even if the adoption of the policies was relatively smooth, the implementation has been slow. In Laos there seems to be a willingness to implement the NDP, but resources are lacking. In Vietnam the implementation appears more arduous in the sense that parts of the policy work has been questioned or re-prioritised. This could indicate that the translation process has been more successful in Laos than in Vietnam—which does not automatically mean that the outcome of the project implementation has been more successful. Success and failure are relative notions, and they are dependent on which criteria (goals) they are measured against.

One way to look at the diffusion process and how this process influences the implementation of the NDP is to imagine two processes—one vertical and one horizontal. There is communication from the centre to district level and vice versa, mainly including health officials. The horizontal diffusion process comes from external actors (donor agencies and NGOs) both at central, provincial and district level during the implementation. However, the effect of this double diffusion is that the central level loses some of its control over the policy process. Moreover, the street-level bureaucrats sometimes also have to act as "policymakers" as they deal directly with the donor representatives

and the NGOs. At the same time, institutionalised feedback mechanisms to the government from the lower levels are often missing, which adds to the confusion caused by the lack of donor coordination. Thus, the policy is actually reformulated all the time, and the outcome depends to a great extent on who makes the interpretation. In other words, the filtering of norms and ideas through organisations and different levels of the administration may change them and their effects in ways not intended or anticipated by those originally doing the (re)thinking (Finnemore 1996a: 35).

Diffusion of ideas may occur between departments as well. This is what is happening in Laos. The idea of having a comprehensive policy is spreading within the Ministry of Health cross-sectionally. Different departments have been requested by the Ministry of Health to develop policies in their specific areas, such as national policies on malaria control, on primary health care, on nurse development, on nutrition, and on smoking control. The NDP is also a source of inspiration for a comprehensive health policy to be developed (Jönsson K. *et al.* 1999).

Sida has conducted evaluations, but as they primarily cover the bilateral programme, other issues are neglected. The evaluations focus on goal achievement, in accordance with the contract, but do not question whether the right goals were set up in the first place. In the case of Laos the evaluation has been translated into Lao and used in the revision of the NDP. Thus, Laos is on its "second round," while Vietnam still is implementing the first version of the NDP. One neglected issue in evaluations is equity and the right to health. In this case, the political and economic ideology of the country where the NDP is being developed is decisive. Basically two issues are at stake. The first one concerns whether health is regarded as a basic right that should be upheld in laws. The second issue concerns how far the state accepts that the private sector provides health care, and to what extent the private sector should be regulated. In countries where national health systems are central and the state has a dominant role, health is generally regarded as a right, and the introduction and implementation of an NDP has been easier, in comparison to countries where the private health sector had been larger (Kanji 1992: 80). In this respect Laos and Vietnam are interesting. The state used to have a dominant position in health care, but today the system is moving towards private sector providers, especially in Vietnam. This in turn complicates implementation of the NDPs. The effects of this trend have already been noted with more expensive health care for the poor, while the better off can buy the health care they prefer.

Logics of behaviour and roles in the translation process

One of my criticisms of the policy literature is the neglect of variations in context. This neglect means, among other things, that it is assumed that diffusion and implementation are consequences of "rational" decisions made by decision-makers, and that the policy process automatically follows a kind of goal-means rationality. In order to analyse the influences of context and domestic structures, and thus problematise rationality, I found some of the constructivist notions helpful. Constructivism acknowledges that structures in various ways shape the way we interpret the world. Accordingly, the meaning and significance of ideas and norms are dependent on time and place. By applying the logic of consequentiality and appropriateness, the behaviour of the involved parties in the policy process, and thus also the policy process as such, can be contextualised and problematised. By discussing the policy process in terms of translation the effects of, and problems with, the policy diffusion can be better understood. In this way, perceptions and the communication of policy can be highlighted. Translation captures not only language barriers, but also difficulties in understanding new concepts and ways of doing things. Translation also underlines the process of reinterpreting the policy in question.

Let us focus on the two kinds of logics and relate those to the translation process. Assume that identity and place in society are the most important driving force for the Lao and Vietnamese, while their foreign counterparts mainly are interested in fulfilling goals and reporting back home how successful the programmes have, or have not, been. What kind of questions would they pose? The foreigner would ask what can I do to fulfil the goals in the most efficient way within the set framework and set timetable? The Lao and Vietnamese would probably consider goal achievement as well. However, they would most likely also ask how their involvement in the programme affects their situation in a more general sense. In what way would they, and their country, benefit from the work—both in a short-term and long-term perspective. What action would be appropriate considering the situation? If we look at the situation and context of the two sides, foreign and domestic, it becomes evident that the points of departure are different and hence also the behaviour of those involved in the policy process. Some of the cooperation difficulties can accordingly be discerned.

Interestingly enough, other empirical studies have also shown that norm entrepreneurs, or agents of diffusion, often act in extremely rational and goal-oriented ways (Finnemore and Sikkink 1998: 910), and one could expect at least some inconsistency between the behaviour of the foreign agents of diffusion and their domestic counterparts. Besides, the development assistance programmes of today involve more abstract items such as policies, which includes capacity building, training, and restructuring of administration compared to more material objects such as equipment to factories, which was common earlier. This means that today behavioural changes, more or less explicit, are also required part of the aid package.

Simon Gill (1999) has made a study on management styles relating the Swedish with the Lao style. He argues that the differences in styles have impaired both project efficiency and aid delivery. His point of departure is the so-called Logical Framework Approach (LFA), used by many aid donors, including Sida, as a tool to assist in project identification, design and implementation. The approach is participatory, and LFA is based on a systematic and linear approach to problem solving, including clear objectives and ends-means relationships to achieve the objectives, which is different to many management styles in Asia.

The main problems, as he sees them, are several. For example, there are differences in power distances in hierarchies. In Sweden the management style is very informal and participation is emphasised, while in Laos a more hierarchical style is preferred and guidelines, rules and written confirmation of verbal instructions are important. Swedes look for challenging work and personal advancement, while the Lao emphasise belonging and achievement within a group. Harmony and consensus are more important than confrontation. Swedes are trained in analytical thinking based on logics, while Lao are more likely to tend toward associative thinking. Hence, the Swedes feel comfortable with the LFA while the Lao prefer face-to-face communication. Long series of meetings, which are vital for the Lao, may thus seem unnecessary to the Swedes. These are of course generalisations, but still they illustrate how behavioural differences may influence collaboration in practice.

Even if some individuals can understand why their counterparts behave the way they do, others have problems in understanding what is going on. Several professionals with experience of working in Laos express frustration regarding the daily interaction with the Lao. The foreigners in question feel that the Lao do not listen to them, that the Lao do what they want regardless of agreements,

that the foreigners cannot understand what is going on even if they can sense that something is wrong. Laotians do not like to complain, and it can be difficult to know what they really think. There are also Laotians who say that the foreigners do not listen enough or understand the real situation. Every now and then the foreigners are perceived as pushy, interfering where they should not. In short, the different parties do not understand each other's actions and behaviour.

Another aspect of translation is the meaning of what is being said. For instance, in the cooperation between the donors and the Vietnamese government partnership is a keyword. At the same time concern has been voiced that those involved do not always talk about the same things. There is a possibility that the donors misinterpret the situation, which means that they may be too optimistic about the progress of work. Moreover, documents should be treated as what they are, meaning that some of them may have been accepted primarily in order to satisfy the donors (interview with expatriate 2001; also see Dang Phong and Beresford 1998). There seems to be a suspicion on both sides of being "ripped off" or used, which is probably closely connected with the uncontrolled corruption. The feeling that representatives of the other side only act for their own personal gain is a natural consequence of this. The fairly gloomy picture I present of course does not exclude the existence of good examples of cooperation as well, and there are expatriates finding their work in Vietnam rather unproblematic.

Another issue of confusion is the system of appointing people. In Sweden, for example, normally merit decides who gets the job in question, while at least in Laos other criteria have to be taken into account as well. On some occasions there is a certain order of appointment to follow, and selections of candidates are often based more on seniority than on function. When someone is going to be promoted, this person often has to go through political training before being given the position. This training can take several months if the party thinks it is needed. In addition, inter-linked family and regional/ethnic patronage networks that are both hierarchical and personal are important. The lack of transparency in the selection process adds to the confusion for outsiders (Stuart-Fox 1998/99; also see Haque 1996: 322). Consequently, the system of rotating people between positions sometimes appears incomprehensible to the donors, as knowledge is not always used in the most efficient way from their point of view.

The Vietnamese reluctance to implement the NDP can also be understood

in terms of the logic of appropriateness. In other words, the behaviour of the individual must be related to the history dependent routines and norms as well as to plans and projects. Existing structures may resist changes until the benefits of a new system become obvious. In addition, behavioural changes are not easily achieved. Drug use and health seeking behaviour are based on a complex web of tradition and socio-cultural practices. The health care profession has its own code of conduct, traditions and standards, inherited from teachers, (older) colleagues, networks and other environments. Drug sellers and the public in general are also formed by tradition and context (Ministry of Health 2000b). The health officials and other health staff have their roles and are expected to fulfil certain tasks, and the expectations come both from the foreigners and from their own society. First they have to deal with the interaction with the donors and then with officials at the lower levels of the administration. In the countryside, the officials receive directives coming from central level at the same time as they have to cope with the situation in their province or district. In addition, several NGOs may be active locally splitting the loyalty between working for them or the Ministry of Health.

Thus, the comment among foreigners in Laos as well as in Vietnam that the daily working environment is difficult—regardless of whether they previously had worked in Africa or other parts of Asia—is not remarkable. The lack of transparency and formal arrangements adds to the confusion. Political correctness is coloured by secrecy and an urge to show who is in charge. This results in frustration on the donor side. For instance, documents are produced but are later forbidden to be distributed—even if the content is known by many already and from the donors' point of view may not even be considered sensational. Accordingly, ideas that may seem brilliant at first can in fact be very difficult to implement, something that can be hard to accept for those involved. At the same time it appears that sometimes the Lao and Vietnamese have difficulties handling the frustration of their foreign counterparts. In both Laos and Vietnam people refrain from showing emotions in public, not to lose face, and outbursts from strangers are not well regarded.

Using the idea of the two kinds of behavioural logic in combination with the more traditional top-down and bottom-up approaches in the implementation literature helps us better to understand problems related to policy diffusion and policymaking in a globalising world. The theoretical foundations of the policy centred top-down approach correspond with the logic of

consequentiality, while the bottom-up approach can be related to the logic of appropriateness where context and structure are important. Whilst the implementation models manage to capture the implementation process in each country, the two logics help creating a relational perspective between international and national, national and local, where translation of norms, ideas and policy is central. In other words, it is important to problematise simplified notions about agency and policy. This is done by contextualising the policymaking, acknowledging norms and structures as crucial elements of the policy process.

Of course it is not unproblematic to claim that there are two kinds of behaviour and that they represent either foreign or domestic actors. In reality there are all kinds of behaviour on both sides, and quite often people disagree among their own peers. Accordingly, one should relate the two kinds of logic to different roles, which means that the same person may act according to the different logics at different times. However, this does not prevent individuals to be socialised into different role patterns.

Moreover, the policy process includes a process of learning where the counterparts learn from each other, thus diminishing the gaps in communication and working styles. For example, the Lao have been successful in imitating the Swedish way of handling the NDP programme, at least at the central level, and the Swedish counterparts also have learnt a lot about how things are working in Laos—which has facilitated the cooperation (personal communication with consultant 2001).[73]

Factors facilitating or restraining the policy process

What lessons about transnational policy learning can we draw from the Lao case and what can be learnt from the Vietnamese case? What are the transmission dynamics?

If we start by looking at Laos, the immediate questions arising are why the Lao NDP was adopted at all, and how could it be adopted so quickly? First

73 See Helling-Borda and Andersson (2000: 56) for a similar discussion about so-called learning cycles where awareness is one of the key-words for successful adoption and implementation of policy.

of all timing is crucial. There must be problem awareness both among international and national policymakers in order to initiate the diffusion. There must be an opportunity to introduce the new ideas, and these ideas must be acceptable to the national policymakers. Secondly, pre-existing networks greatly facilitate the process (e.g. the long-term cooperation between Sweden and Laos).

Still, the success of the policy diffusion depends heavily on the participating actors, in this case a few IHCAR consultants and members of the team from the Department of Pharmacy. The agents of diffusion must be sensitive to the wishes of the counterparts in order to create a favourable climate of negotiation. For example, in the Lao case the laboratory was built to please the Lao side, albeit smaller than the original proposal, and the Swedish side managed to introduce an NDP.

Furthermore, it is important that the same individuals handle the communication between the involved parties, and that there is communication on a regular basis. The introduction of new negotiators (e.g. consultants or representatives of the government) means that the process is slowed down, as they have to build a new relationship favourable to the process. The previous experiences of the agents of diffusion (e.g. technical expertise but also access to information) and their relationship to the decision-makers (in order to convince them of the policy) are also decisive. Communication can be more direct, and unnecessary misunderstandings can be avoided. The communication and translation of new ideas become especially important when they are introduced to a completely new political, socio-economic and cultural setting. Hence, both know-how and know-who determine the outcome of the policy diffusion process. The fact that the same individuals have been involved over a long period of time facilitates the continued cooperation. At the same time most officials in the Ministry of Health know each other. This facilitates cooperation—if people are interested in working together. According to the "policymaker questionnaire" health officials are quite devoted to implementing the NDP. Yet, the health officials have not been quite sure of how to translate the policy into practice.

The external involvement in the policy process had a number of observable consequences for the formation of the NDP. For example, the process could be speeded up when information and financial resources were provided, which the governments did not possess. Hence, the NDP could be realised because of the influx of new ideas combined with material resources (money)

supplied by external donors. The governments, in a way, did not have much of a choice but to develop an NDP. However, once that decision was taken, the development was more of a two-way process where ideas from Malawi, Nigeria, Sri Lanka, WHO, IHCAR and so forth played a significant role.

Nevertheless, the success of the policy is much dependent on the relation to local conditions and how the new ideas fit into the new context, or can be translated to fit into the new context. The NDP entered Laos through an elite learning process, but today the policy has spread to provincial and district levels. However, the diffusion is still very uneven, which partly can be explained by the time needed for understanding the policy, and partly because only five provinces have been prioritised. The differences between urban and rural, educated and non-educated, make the translation process quite complicated. While the intent of the policy seems to correspond with existing norms in society, neither the whole content nor all the instruments of the policy have yet been integrated into the domestic norm structure. The motivation of the domestic actors to accept the new policy is to a large extent still lacking. In other words, during the implementation of policy the degree of match between foreign norms and domestic practices is more decisive than during the formulation phase.

Arguably two sorts of ideas spread in regard to the development of the NDP: one concerned with how to develop and implement the NDP (instrumental), and the other concerned with the structure and content of the NDP (substantial). The consultants were crucial for the actual process, while written material (such as other NDPs, the WHO guidelines, and *the Essential Drug Monitor*) were the basis for the structure and content of the NDPs. There was quite a substantial amount of experience to draw on—once the Lao, and later the Vietnamese, obtained access to the information.

It is access to information that makes the individuals participating in the process crucial as agents of diffusion and translators. It was informed individuals who influenced which ideas to use and how to work; they acted as policy-mediators and policy-brokers. If transnational policy learning is going to be really efficient, communication between the different actors must work—both concerning the language and the understanding of the problem. In the Lao case, the NDP was a true innovation, and consequently the agents of diffusion—predominantly medical professionals—had real opportunities to frame the issue and help define the policymakers' interests. The well-developed international network and the scientific language related to the policies certainly increased the legitimacy of the project.

Much of what has been said above applies to Vietnam as well. However, in the case of Vietnam other, additional, lessons can be drawn. For example, the idea to develop an NDP was pushed harder by Sida in Vietnam than in Laos, and the question has even been raised whether a genuine development partnership has evolved or whether the programme primarily is a framework for accommodating the needs of the Ministry of Health (Jerve *et al.* 2001: 23). In Laos, the NDP programme seems to have met little resistance compared to in Vietnam—possibly because a lack of competition from other donors but also because the policy and its components have not been questioned to the same degree.

In a comparative perspective Vietnam is stronger as regard management and political steering. There is less transparency in the health sector compared to Laos, which is relatively open in this specific area. According to one consultant (personal communication 2002), who is experienced in working in both Laos and Vietnam, the Vietnamese are harder to persuade to accept "innovations" unless presented with hard proofs. The Lao accept new information more easily. The attitude in Laos is more laid-back and open, as reflected in the *bo pinh yan* syndrome (never mind—do not worry about it) of the languid pace of administration (Zasloff 1991: 25). Thus, sensitivity to the domestic context is crucial, and reform must be integrated in the institutional and political environment competing with other forces than the aid relationship. The recipient must be interested in mutual learning. Also, individuals themselves matter. They are builders of trust, and carriers of insight and empathy vis-à-vis the other party (Jerve *et al.* 2001: 97-98).

An illuminating example of how ambitions may differ between the donor and their local counterpart is the German GDZ's support to the National Institute of Public Health (NIOPH) at the Ministry of Health in Laos. The GDZ had initially very ambitious plans about what to do, but the progress seems slow. When I last visited the institute only a few of the planned projects had been agreed upon. The reason I was given was the crowdedness of donors in combination with a lack of people to work with the projects (interview 2001). Another possible reason could be that the long-term consultant appointed to work with the institute was not asked for. The appointment was an attached condition to a large grant which included a new building for the institute.

The development of NDPs shows that even smaller states and non-state actors (e.g. Sida/IHCAR/WHO) can be influential in diffusing global norms. This is often ignored in analyses of power focusing on military coercion and market incentives alone (Klotz 1995:165). We have seen that the diffusion

process is directly related to the national policymaking process through the agents of diffusion, and that it is important to look beyond national decisions in order to explain policy shifts within a single country. Current development strategies of bilateral donors and increased internationalisation obviously affected policymaking in Laos and Vietnam.

Policymaking in a globalising world

Diffusion patterns

Though Laos and Vietnam are special in many ways, one could easily argue that they fit the general diffusion pattern that has emerged globally. More and more countries adopt NDPs, and the knowledge about NDPs increases every year. At the same time, there is a general trend of health-care reforms, which at least to a certain degree is caused by new economic situations and neo-liberal ideas. The economic reforms in Laos were to some extent driven by major international agencies such as the World Bank and IMF (Holland *et al.* 1995). In Vietnam, *doi moi's* central elements paralleled those promoted by the World Bank and IMF within the framework of structural adjustment (Güldner 1995; see also Moghadam 2000). As a result, health financing, for instance, has increasingly relied on financial sources outside the fiscal system, such as user fees and private insurance (Jerve *et al.* 2001).

Of course there are occasions when ideas and norms do not diffuse. For example, after the breakdown of Soviet communism, a large-scale process of international socialisation began in the new Europe. Various organisations started to transmit their constitutive liberal values and norms of domestic and international conduct to the Central and Eastern European states (Schimmelfennig 2000). The same is not happening in Laos and Vietnam—not at the moment anyway. The Lao and Vietnamese regimes are carefully watching the development in Europe and Russia, trying to avoid similar developments. The Western political models do not have the same degree of influence as the communist model once had. The West was able to establish its liberal order all over Europe as a result of the de-legitimisation of communism. However, the former East European states' preparedness to adopt liberal norms varies mainly with their domestic conditions of power preservation. Where Western orientations in society are weak and governments owe their power to

nationalist-authoritarian programmes, Western reactive reinforcement will not make much of a difference. The effect of Western socialization policy will be most important if societal and governmental orientations diverge (ibid.). In the case of Laos and Vietnam there are other models to copy than the European ones, from their point of view preferably from Asia.

Nevertheless, policymakers may be interested in learning from other countries or organisations and actively seek new policies. What often appears to be coercive policy diffusion can be the opposite. Policymakers may go knocking at the door of the international organisations in order to raise funds. The search for policies can be systematic or *ad hoc*, it can be formal (fact finding groups, official visits etc.) or informal (through various networks). The role of international organisations is ambiguous in relation to the spread of public policy, and states may retain considerable autonomy in deciding whether or not they will allow themselves to be influenced by them (Common 2001: 75). Moreover, projects may be chosen for fringe benefits, such as cars and computers. International conferences and international organisations not only function as channels of diffusion but also give the regimes a say in international decisions and access to internationally distributed material gratification such as development aid or military assistance. The material benefits are important because they enhance domestic legitimacy and strengthen domestic rule (see Schimmelfennig 2000).

Donors, including Sweden/Sida, serve as promoters not only of material objects but also of ideas and behaviours. New knowledge and new concepts do influence policymakers and eventually policymaking. However, access to information cannot substitute for domestic policy innovation. Yet there is a market for "one-size-fits-all" reforms, as reflected in articles, speeches and conferences on the state of medical care. In other words, there is a global market for ideas where governments can "go shopping" (Common 2001: 238). Naturally there are still different opinions, perspectives and interpretations that cut across professions, culture, generations and social backgrounds. However, consultants and foreign experts have to work regardless of context, and consequently models are developed to "fit" everywhere. General guidelines are developed, even if the underlying norms and ingrained practices are not openly discussed.

This is one reason why it is important to study policy diffusion. Policymakers learn about and imitate successful ideas. Actors change not only the way they deal with a particular policy problem but also their very concept of problem solving (Ruggie 1998a: 20). The power of ideas and ways of thinking about

development can be considerable and far-reaching. New ideas can change the definition of interests, which in turn can influence both individual and group behaviour. The ideas and their conceptual framework help to frame issues and define what is important and what should be the core units of analysis. The language employed has the power to determine what appears to be natural or taken for granted with no further explanations. Consequently, ideas can define away problems as much as they define them.

However, the reception of ideas in particular national contexts is rarely identical from country to country. The reception depends on the institutional configuration of the state, its prior policy experiences and recent failings, as well as the viability of new ideas. Ideas may have an independent political effect, but they also need an enabling environment. So, even if the states are moving in the same direction, they may not end up in the same place (Biersteker 1995: 174-175, 187-188). Thus, the way of framing problems can diffuse just as well as solutions to the problems. Problems that are discovered in one country may more easily be discovered in another, and in the same way reforms adopted in one country are more likely to be adopted in another. International organisations, professional organisations, and various consultants facilitate this process (March and Olsen 1995: 196-197). This may shed some light on why Laos developed an NDP before a comprehensive national health policy and why Laos developed an NDP before Vietnam, for example. In other words, theorising about domestic diffusion pathways can equip policymakers with a better set of analytic lenses for understanding how and by what mechanisms norms and policies have an impact at the national level (Checkel 1997: 489).

Thus, the globalisation of many activities forces administrations to tackle new problems or old problems with new twists. World trade is opening up, MNCs are getting more influential, and the mobility of persons, ideas—but also diseases and pollution—is increasing. The Asian financial crisis has shown that it is impossible to stand isolated from other countries' policymaking, even if the consequences of the crisis were less severe in Vietnam and Laos than in many other countries due to their relatively limited integration in the world economy.[74] Accordingly, many policies cannot be conducted on a national

74 See Tønnesson (2001) for a detailed account of the effects of the Asian crisis in Vietnam and how these effects have been interpreted. For a discussion about the effects on state owned enterprises and the role of the state see Kokko and Sjöholm (2000). Also see Dittmer (2002) for a general discussion about the crisis in the region.

level only, as the consequences of the policies may reach across national borders. At the same time globalisation forces put pressure on the political system when new needs of governance have to be met.

State-society relations

Reforms in the pharmaceutical sector must thus be viewed in a wider context, not only in relation to health care reform but also in relation to society in general. Socio-economic and political changes influence the formulation and, maybe even more, the implementation of NDPs. In the case of Laos and Vietnam the awareness of this relationship is even more important, as we are dealing with countries in transition.[75] In a very few years the two countries have opened their economies to the rest of the world, which naturally will have consequences for the whole society. For example, the role of the state has been challenged in the presence of a rapidly expanding private sector[76] —even if the state remains the authoritative source of policymaking. Elections and media are other areas where the control is strong. However, the societies are diverse, and so is the control of the party-states (Moghadam 2000; Koh 2001: 535). There are noteworthy differences between Laos and Vietnam, though: In Vietnam the state is relatively strong despite the fact that the market has taken over to a large extent. In Laos both the government and the market are weak, which naturally has consequences for policymaking.

The social gaps between urban and rural areas, between the majority and the ethnic minorities and between different groups in society are becoming increasingly visible, which in turn affects the legitimacy of the regimes. The previously subsidised equity-based system has eroded considerably, and the irony is that, at least in Vietnam, it is in the health and the educational sectors that subsidies are disappearing in favour of user fees. In other words, traditionally public areas are now being sold out to commercial interests and market incentives. Today health is increasingly treated as a consumption good,

75 According to Bourdet (1996) the problems Laos faces today should be considered more developmental than transitional. As an illustration he mentions the stagnation and low productivity of the agricultural sector. Moreover, even if there has been a shift in balance between different groups and/or persons, the transition process has been managed by the same political regime.

76 See e.g. Jerneck (1995) who looks at how the Vietnamese state as owner and a producing sector is changing under *doi moi* scrutinising the functions of enterprise unions, as well as how the state as authority with legislative capacity is changing in the emerging market-oriented economy.

and those with the most money get the best treatment—especially in Vietnam where health is an individual choice and the government has a gradually more limited role. Thus, equity is increasingly giving way to elitism.

If one looks at drug regulation—which is an important part of the NDPs—on a global scale, it becomes apparent that regulation more and more has come to depend on some sort of civil society, with such manifestations as consumer activism, civil courts, media and wide access to product information—something still lacking, or at least restricted, in Vietnam and Laos. And as we have seen, the awareness among drug sellers and consumers is low in these countries. However, the view of the state, as reflected in the constitution, allows for no separation between the state and the society. The state has certain duties and the people certain obligations that should be fulfilled. Consequently there is no natural space for an autonomous civil society separated from the state (Tønnesson 2000: 249; also see Harper 1996). At the same time new, global, regulatory forms must be negotiated into Vietnam's regulatory domain, reconciling bureaucratic hierarchy and personal familiarity, abstract rational correctness, and explicit relativism of local compatibility. The bureaucratic polity, or bureaucratic socialism, influences the policy process together with networks, factions, patron client relations and other groups competing for scarce resources and influences (Craig 1997: 301-304).

Often globalisation[77] is said to have effects on economic development and modernisation that may eventually lead to political pluralism and democratisation. However, democratisation tendencies in Laos and Vietnam are quite limited, and any political change will most probably take place within the framework of a one-party state (see e.g. Tønnesson 1993; Gainsborough 1997; Jönsson, K. 2002). Liberal democracy is not an option in Vietnam, as a multi-party system has been one of the three no's: no calling into question of the leadership of the communist party, no calling into question the one-party state, and no pluralism or multiparty system (Morley 1997).

The view in Laos has been similar. Pluralism is not on the agenda, and any kind of democracy must be under the party's leadership, as the leadership claims it is afraid of anarchy. Experiences in Eastern Europe have reinforced this view. Opposition is practically non-existent, and previous calls for

77 For an interesting discussion about globalisation and *modernism* and how modernism can be expressed in contemporary Vietnam, see Tran Hoai Anh (1999).

democratisation have been efficiently suppressed (Thalemann 1997: 101; Stuart-Fox 1996). Accordingly, political change cannot be expected to go towards liberal democracy. Possibly a softer version of authoritarianism may be the result of the on-going liberalisation process (see e.g. Ivarsson *et al.* 1995; Tønnesson 1993; Scalapino 1997; Ljunggren 1994).

At the same time the leadership is not as united as sometimes perceived. In Vietnam the power-balance is partially regulated by appointing candidates both from the reformist camp and the ruling communist party's old guard to top positions. Disagreements within the party are increasingly difficult to keep secret, even if the Central Committee Plenum recently has instituted new rules forbidding party members to voice their personal opinions in public (Tønnesson 2000: 260). The main issues of debate concern the speed, depth, and pace of further reforms (Quan Xuan Dinh 2000). An interesting question is whether a communist party-state can liberalise its economy without weakening the power of the party (see e.g. Morley 1997).

David Koh (2001) talks about a divided party in Vietnam and a Parkinson's state—the latter referring to management problems, corruption and personal interests that overrule laws and what the party-state says. He claims that portrayal of an "old-style communist state" is misleading. Even if the written rules and legal framework are authoritarian, the unwritten rules of the elite are pluralistic in character. According to Irene Nørlund and Melanie Beresford (1995: 10), the leaders in Vietnam act like leaders in most other political systems in the sense that they build their power on coalitions of interests to support certain policies. The difference is that they do it within a one-party structure. The affiliation can be based on ideology, friendship, regional bonds, economic interests, personalities, and loyalty to groups, but there are no fixed rules or fixed groups (Koh 2001: 538). At present it seems that new groups are forming, but that the supremacy for new groups in society primarily is based on economic success (see Beresford 1993).

Thus, the outcome of the political developments in Laos and Vietnam is hard to predict. Both countries are striving to develop economically at the same time as the leadership tries to control the political sphere. Even though Vietnam's latest party leader Nong Duc Manh was expected to be reform-friendly, so far he has been moving cautiously following the previous ideological line. However, his predecessor Le Kha Phieu was criticised because he reverted to the language of "old-socialism" in connection with former President Bill Clinton's visit in November 2000. The authorities were taken

by surprise by the warm reception Clinton received from ordinary Vietnamese on the streets (Koh 2001: 540-541), and Clinton's plea for greater freedom of information and remarks on human rights live on TV were never mentioned in the state press afterwards. Russia's president Vladimir Putin's visit some time later did not attract the same attention from the public, and most people stayed at home *(Agence France Presse* November 18, 2000; Brunnstrom 2000).

Globalisation may be seen as elite behaviour (Common 2001: 9), at least as far as policy diffusion is concerned. The focus is on (central) policymakers and bureaucrats and those in contact with the donor community. The political structure in Laos and Vietnam leaves power very much in the hands of a few individuals at the top of society. Not only politically but also socially and culturally, Vietnam and Laos are elitist in character. Ove Bring *et al.* (1998: 10-11) describe how patronising town people in Vietnam are when talking about people from rural areas, especially if they are uneducated. However, the grass-root levels in Laos and Vietnam are also affected, and policy diffusion, and especially its translation dimensions, can only be understood in relation to local context and not only to policymakers at the central level. A form of "glocalisation" is taking place where international organisations introduce ideas and programmes at local level, and where those working in these projects may have world wide contacts without leaving the home environment.

At the same time the diffusion of new ideas is very uneven—only a limited number of individuals have access to information, and the gap of knowledge between people in the urban and in the rural areas is after all considerable. For example, use of the Internet has increased in the last few years but it is still only accessible to a relatively small group in the urban areas. In the case of health there are similar problems in the sense that health resources favour urban over rural areas, lowlands over mid- and highlands, and some provinces over others (Holland *et al.* 1995).

Nonetheless, remote areas are also exposed to change. For example, the region between Laos, Vietnam, Thailand, China, and Burma (Myanmar) has been, and continues to be, an area where people, goods and ideas blend across borders—with or without the consent of the authorities (see e.g. Evans *et al.* 2000). The relationship with the neighbouring countries is not unproblematic, however. For example, when Laos started to open up the country many private Thai businessmen bought land and logging concessions, which normally belongs to the government. Before the Lao learnt the rules of the market, many mistakes were made and money lost (interview with expatriate 1998).

It is important to remember through, that globalisation does not only mean openness towards industrialised countries in the Western hemisphere. For example, most countries investing in Vietnam in the first half of the 1990s were based in Taiwan, Singapore, South Korea, Japan and Hong Kong, and they rarely made their views known through the English-speaking press. They do not necessarily push for more transparency and rule-oriented decision-making (Tønnesson 2000: 265).

Globalisation of health issues

Rational use of drugs (RUD) has been mentioned several times in this study. However, the global discourse of RUD does not necessarily need to be the same as the local one. The RUD of antibiotics, for example, is based on a regime of close biomedical authority and knowledge, and requires compliance by consumers for safety and long-term effectiveness. The problem is that drugs, as commodities, travel faster than the knowledge which should define and prescribe their use (Craig 1997: 7-8). The result is that modern medicine is partially used within the framework of "Eastern" traditional medicine. According to Craig (ibid: 306), RUD, as presently constructed, cannot be anything less than global in its approach, much due to its inability to surrender any part of its systematic order to local contingency and culture without becoming internally contradictory.

Another related problem is that many of the WHO indicators developed for practical use are not always applicable in Vietnam and Laos (see e.g. Nguyen Than Do *et al.* 1998). According to Craig (1997: 300), international and global policy directions tend to dominate the NDPs, especially in low-income countries, despite the fact that WHO wants to create NDPs that reflect local and national situations. Furthermore, the NDP is based on an idea that the policy should provide mechanisms whereby the health sector can influence and be actively involved in decision-making in other sectors (WHO 1988). This has yet to happen in Laos and Vietnam. Also, it is assumed that WHO coordinates guidance and information based on information from national health systems (Lee and Dodgson 2000: 229). In the case of Laos and Vietnam the health information systems are not functioning properly. Consequently experiences from those two countries are not included in the global diffusion of policy ideas.

In the evaluation of the Vietnamese NDP one section discusses the relevance

of international trends, and the connection to WHO and global norms is obvious: "(t)he activities implemented by ADPC are in line with current international preferred practices in response to trends of diminishing public resources, rapidly developing private practice and global market pressures" (Jerve *et al.* 2001: 67). This indicates that the NDP is based on an idea that the world is constituted in a certain way, that one kind of governance is preferable to others. The NDP concept takes for granted that suggested tools for improving the situation in the pharmaceutical sector are applicable worldwide. However, as we have seen, the policy is not always effective due to the lack of the most fundamental functions of a state, such as coordination of ministries, and of legal frameworks.

The other side of the problem is that today public health problems are perceived as global to a greater extent than earlier, which makes the fields of international public health and international relations intertwined. Craig N. Murphy (2001) talks about a new politicised sphere of international public health, of new global health politics. The point he makes is that health problems of the world's poor have penetrated enclaves of the world's rich, and that there is a new international politics surrounding these new disease patterns that connect the two worlds. For example, drug-resistant tuberculosis from newly impoverished Siberia rapidly moves to every continent, and the disease becomes nearly as great a killer at the end as in the beginning of the twentieth century. Cholera moves from Andean barrios to suburbs of Boston. AIDS follows the routes of the international sex trade to the homes of its wealthiest consumers.

In Laos and Vietnam malaria resistance is a growing problem, and the EU is sponsoring a project involving Laos, Vietnam and Cambodia (interview with programme officer 1998). Increasing antibiotic resistance is another problem of great global concern. Several studies show that the free sale and self-medication of antibiotics has led to an epidemic spread of antibiotic resistance (Nguyen Than Do *et al.* 1998). Thus, the resistance is likely a reflection of the current drug sale and use. For example, in Vietnam, as in most developing countries, it is possible to buy antibiotics without prescription. A majority of illnesses, up to 80-90 percent, are self-treated with modern pharmaceuticals. The resistance has led to demands for more expensive drugs, which in the end affects the poor. Maybe even more alarming is the rate of resistance among the most common pathogens (see Törnquist et al 2000; Larsson *et al.* 1999; Chuc and Tomson 1999; Nguyen Than Do *et al.* 1998).

Kelley Lee and Richard Dodgson (2000) bring together international relations and health by looking at globalisation and cholera, and the implications for global governance. They argue that globalisation has created social conditions that have influenced the transmission of, incidence of, and vulnerability to the disease among individuals and groups. They compare epidemiological patterns of the disease with changes in patterns of human migration, transportation and trade over time. Thus, globalisation has many faces and dimensions.

What can we learn?

Empirical lessons

One lesson of this study is that the diffusion of ideas occurs on several levels, and that policy formulation and implementation for that reason must be analysed in relation to each other. Policymaking is a complex process, and much may happen on the way from problem identification to the practical use of the NDPs, both in terms of how the policy is perceived and the effect of the policy. Another lesson is the necessity to include context to understand the policy process, as context not only determines who participate in the process but also influences the preferences of those involved. The political systems in Laos and Vietnam only allow a limited number to participate in policymaking, and their priorities are coloured by historical legacy, socio-economic factors and their roles and place in society. The reason why policymakers choose the same solution to their problems is in other words not straightforward. The policymakers may choose similar policies for different reasons and with different results.

Why certain policies are adopted while others are not can partly be explained by how successful the agents of diffusion are in combination with favourable timing. The new ideas must be understood and appreciated to gain influence and eventually be adopted. There must be a "fit." The learning process should not be underestimated. What originally has been rejected can over time be accepted—or vice versa. Foreign, or external, ideas that are integrated and translated into a new context eventually influence national policymaking. International collaboration in general and information from international organisations and agencies, such as the WHO, facilitate the spread of new ideas and specific policies—both as channels of diffusion and as legitimate

bearers of information. In the case of the Lao and Vietnamese NDPs the bilateral cooperation naturally played a significant role in the diffusion process as well.

In the case of public policymaking, such as NDPs, the effects are profound at least in a short-term perspective. The effects of these polices in a long-term perspective are more difficult to predict. What is certain, though, is that the legislation and rule of law have expanded on the expense of normative party directives. What can be seen today during the first few years of implementation of the policy is that it takes time and a great deal of effort for the policy to be translated into action in a local context. Moreover, not all parts of the policies are implemented at once. Especially in Vietnam the implementation is delayed and project items re-prioritised.

One should not forget the difference between urban and rural, highly educated policymakers and ordinary people, people with access to power and those without a voice. Well-educated policy makers at central level may relate to, discuss and criticise new ideas and policies without difficulty. However, both Laos and Vietnam favour top-down policymaking at the same time as the feedback channels from the grass-root level seem less developed. This together with a lack of consumers groups and media, critically scrutinising the health sector, may not only create a distorted picture of the situation in the pharmaceutical sector, but may also affect the achievements of the NDP. If the policy does not reflect the reality, the measures may be toothless.

Perhaps the origin of the policy and the norms on which it is based can explain some of the difficulties. The NDP concept assumes that certain priorities can be taken for granted, such as the quality of drugs. In reality other issues may be at stake. The most important factors in the diffusion and translation process are consequently an understanding of the policy and the compatibility of the ideas with a new context. There are of course other factors influencing the policy process, such as lack of resources and material gains, but resources and profit alone cannot explain the success or failure of policymaking.

Theoretical lessons

The main message of this study is the importance of following the whole policy process from origin to implementation, especially in times of globalisation; otherwise it will be difficult to understand why policy diffusion and implementation work or do not work as intended. The translation

concept bridges the gap between different phases in the policy process as well as between theoretical traditions. For example, diffusion does not necessarily mean translation, and implementation does not automatically follow upon adoption of a policy.

To put it differently, it is too simplistic to look for reasons of failure, or success, within the national sphere when external actors participate in the policymaking process. By connecting national and transnational policymaking, we might shed new light on the reasons for some of the successes and failures. Moreover, policymaking in democratic societies differs in several substantial respects from policymaking in authoritarian societies, for example, concerning the degree of transparency and participation. Thus, the use of theoretical models based on the way democratic systems work will be problematic in a different political context.

Nevertheless, there are both advantages and disadvantages of the framework developed in this study. The danger associated with eclecticism is that underlying theoretical assumptions may contradict each other at the risk of an incoherent analysis. However, from my point of view the issue at stake is not whether the world is socially constructed or consists of material building blocks, whether all actors behave in a "rational" way, or whether norms and structures govern life, as I believe in a middle way where ideational as well as material factors are important. My interest concerns what the consequences are of discrepancies in perceptions among those involved in international cooperation, and how these perceptions are reflected and reinforced in collaboration patterns.

Another consequence of eclecticism is that the analysis may become shallow and simplified. There is not enough space for a thorough discussion of each and every one of the theoretical building blocks. However, my point of departure was to find analytical tools that would help to capture and problematise the object of study rather than to develop theory, and as such I find the framework useful. The framework has made it possible to contextualise the policy process both theoretically and empirically, at the same time as the foundation of international cooperation, namely communication, has been problematised through the concept of translation and the two logics of behaviour. It is possible that I have pushed the "rationality argument" more than necessary. However, unless we problematise underlying assumptions, be they theoretical or practical, it will be hard to find alternative ways of understanding contemporary processes.

An advantage of the framework is that it provides a non-ethnocentric approach to the study of policymaking. The framework is open to variations in context as well as to role-related behaviour. My aim has thus been to avoid essentialist arguments, which often try to explain differences primarily through biology or culture. Naturally I acknowledge differences between people, but those differences depend on time and space as much as on culture and identity. The problem, as I see it, is that we perceive what is appropriate differently, and that this affects cooperation and consequently also policy diffusion. The reasons for the differences are thus less important in my case. Much of the materials I have used are part of the social constructions I try to capture. This implies that the materials, which to a large extent consist of policy documents and interviews, are coloured by various preconceptions. However, it is the translation of these preconceptions I find intriguing.

The purpose of this study is accordingly not to give any policy recommendations—or to make an evaluation. Evaluations focus on accountability to donors who are supporting a particular programme. Research, however, can seldom attract either unambiguous support or provide unambiguous results (see e.g. Walt 1994: 187), but at the same time it can focus on issues neglected in evaluations. Practitioners are mostly goal-oriented, looking for policy recommendations and policy development. This study has focused on perceptions of policy, how policies are communicated and understood. In other words, it is a study *of* policy where the policy process is highlighted instead of policy content.

In other words, scholarly knowledge can have an impact on policymaking, although it may be limited and indirect. The contribution concerns an attempt to meet the policymakers' need for clearer explanatory concepts, for critical re-examination of established concepts, and for careful empirical studies to test alternative explanatory concepts (George in Wallace 1996: 321). As we live in an ever-changing world, the way we look at it ought to change simultaneously. New problems arise which need new solutions.

Naturally the question arises whether pharmaceutical policy differs from other policies, and whether conclusions regarding policymaking in general can be made on the basis of findings from policymaking in Laos and Vietnam. I would say it is possible. Of course the theoretical tools we use guide what we see. I present one picture, one story; there are many more. How one looks at the world is partly determined by one's past. For example, the histories of Laos and Vietnam can be told differently depending on who is telling it, a

communist party ideologists or a Western scholar. Although the Lao and Vietnamese cases are special in some senses, such as context and historical legacy, the meeting between different kinds of behaviour is a universal occurrence. Communication difficulties may arise in any situation where people with different background and training meet and cooperate—regardless of country of origin. Arguably, the Lao and Vietnamese NDPs have proven the value of case studies researching how foreign ideas are translated into domestic practices. This study also shows that politics matters in health.

Svensk sammanfattning

Från externa idéer till inhemsk praktik – läkemedelspolicy i Laos och Vietnam

Hur kommer det sig att liknande reformprogram återfinns i olika länder? Varför väljs vissa idéer framför andra? Avhandlingen syftar till att öka förståelsen av så kallad policydiffusion, spridning av olika typer av policy, och den dynamik som omgärdar spridningen. Detta görs genom att undersöka hur externa, eller utländska, idéer integreras och översätts i en ny omgivning. På vilket sätt påverkar de nya idéerna det nationella beslutsfattandet och påföljande policyimplementering? Två läkemedelspolicies, en i Laos och en i Vietnam, studeras mer i detalj för att på så sätt identifiera faktorer som antingen underlättar eller försvårar policyprocessen. Även effekterna av policydiffusion på ett mer generellt plan diskuteras.

Bakgrunden till att Laos och Vietnam antog nya läkemedelspolicies var bland annat konsekvenserna av den ekonomiska liberalisering som initierades i mitten av 1980-talet. Även hälsosektorn inkluderades i reformerna, och framför allt läkemedelsektorn privatiserades. Detta ledde i sin tur till att tillgången på läkemedel ökade samtidigt som självmedicinering och undermåliga läkemedel blev allt vanligare.

Situationen var följaktligen närmast kaotisk när de laotiska och vietnamesiska regeringarna fick ta ställning till om man skulle utveckla ett handlingsprogram inom läkemedelssektorn som en del av det svenska biståndet. År 1993 antogs den laotiska läkemedelspolicyn och 1996 den vietnamesiska. Studien omfattar med andra ord en tioårsperiod fram till år 2001. Det intressanta i sammanhanget är att det tycks som om implementeringen har fungerat smidigare i Laos än i Vietnam. Detta trots att Vietnam har bättre förutsättningar eftersom hälsoindikatorer och utbildningsnivå är högre än i Laos.

I debatten om läkemedel och sjuk- och hälsovård ställs ofta kostnadseffektiva aspekter i fokus på bekostnad av de politiska. Man glömmer bort politiska processer och politiska möjligheter att implementera de riktlinjer

man beslutar om. Situationen blir extra känslig då internationella överenskommelser och aktörer kommer med i bilden. Tanken är med andra ord att koppla samman internationella beslutsprocesser med nationella genom att se hur idéer och reformprogram sprids och hur dessa program förverkligas.

Tidigare studier har en tendens att antingen fokusera på relationer mellan stater eller på hur reformprogram genomförs i enskilda länder. Detta leder i sin tur till att man förbiser viktiga förklaringsfaktorer till varför vissa program i utvecklingsländer är framgångsrika medan andra inte är det. Idag sträcker sig kontakter och samarbeten över sakområden, hierarkier och maktsfärer lika mycket som över nationella gränser. Stater, organisationer och individer ingår detta samarbete, som dessutom leder till en snabbare spridning av idéer och reformer.

För att studera ovan nämnda problematik används ett teoretiskt ramverk baserat på forskning inom policystudier, konstruktivism, nyinstitutionalism samt globalisering. Syftet är att studien genom detta ramverk ska kunna överbrygga åtskillnaden mellan den internationella och den nationella sfären såväl teoretiskt som empiriskt. Detta är särskilt viktigt i en tid av ökande globalisering där idéer i allt högre grad och hastighet sprids över världen. I studien understryks vikten av att kontextualisera policyprocessen och att problematisera den målmedel rationalitet som så ofta präglar policylitteraturen.

Resultaten pekar på att trots att det kan vara relativt smärtfritt att utveckla och anta en ny policy så bör man vara försiktig med att anta att ett framgångsrikt genomförande automatiskt blir följden. Anledningen till detta går inte endast att finna i resursbrist eller dålig planering. Även hur policyn i fråga har spridits och översatts till en ny omgivning spelar avgörande roll för hur väl den kommer att integreras och faktiskt göra någon skillnad i praktiken.

Studien är ett resultat av ett samarbete mellan Statsvetenskapliga institutionen vid Lunds universitet och IHCAR ("Division of International Health"), Karolinska institutet, i Stockholm.

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