

**AN ANALYSIS OF LEADERSHIP SKILLS ASSOCIATED WITH THE GLOBAL
HEALTH DIPLOMACY OF INTERNATIONAL HEALTH ATTACHÉS OF THE
UAE**

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**SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS OF THE
DEGREE OF DBA**

UNIVERSITY OF LANCASHIRE

March 2026

RESEARCH STUDENT DECLARATION FORM

Type of Award Professional Doctorate (DBA)

School School of Business

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Dedication

I dedicate this thesis to my beloved family, my husband (Mohammed Saleh) and our Seven children (Hareb, Hind, Saif, Hamda, Afra, Alia and Fares) and the memory of my parents (Abdulrahman and Aisha). This success is especially dedicated to my late mother who passed away during the course of my doctoral work. I wish she had lived to share and celebrate with me this distinguished moment, which was a direct result of her continuous love and support.

ACKNOWLEDGEMENT

All praises and thanks are due to Almighty Allah, the Beneficent and the Merciful, whose blessings have made it possible for me to complete this study. I would like to express my heartfelt gratitude to my Director of Studies (DoS), Dr. Mark Wilding, and my Supervisor, Dr. Iftikhar Bokhari from the School of Business at the University of Central Lancashire, for their keen interest, invaluable suggestions, consistent encouragement and sympathetic attitude throughout this research. I am also deeply grateful to H.E. Nasser Al Budoor the Assistant Undersecretary in the Ministry of Health and Prevention (MoHAP), from the Dubai Health Authority(DHA) Dr. Younis Kazim, Mr. Abdulrahman Owghani, from Department of Health – Abu Dhabi H.E. Dr. Noura Khamis Al Ghaithi Undersecretary, last concluding the United States Dr.Jawad, Health Attaché. for their support and many helpful suggestions during my research. I am immensely proud of my husband his steadfast encouragement has been instrumental in reaching higher aspirations in life.

LIST OF ABBREVIATIONS

Terms	Meanings
BRICS countries	Brazil, Russia, India, China, and South Africa
Non-communicable diseases (NCDs)	Chronic diseases, are health conditions that are not caused by infectious agents and are of long duration and slow progression
Capacity-Building Programs	Initiatives or interventions aimed at improving people’s or Organisations’ knowledge, talents and capacities to boost their ability to solve certain problems or accomplish desired results.
Communication and Negotiation	Effective communication skills are crucial for fostering international partnerships, negotiating agreements and navigating cultural differences to enhance healthcare collaboration.
Dubai Health Authority (DHA)	Its mandate encompasses overseeing the healthcare system in Dubai, including the management of public health facilities and the regulation of private healthcare providers.
Department of Health (DOH)	Including licensing healthcare professionals and facilities, monitoring healthcare quality and developing health policies and regulations.
the Vaccine Alliance (GAVI)	Global health partnership that aims to increase access to vaccination, particularly in poor countries.
GHD Models	The plans, methods and techniques nations and Organisations employ to participate in and carry out global health diplomacy.
Global Health Diplomacy (GHD)	The area integrates public health, law, international relations, economics and management to solve health concerns worldwide via diplomatic negotiations and cooperation among international stakeholders.
Global Health Governance (GHG)	The coordinated actions, collaborative efforts and processes used by national and international players to address global health concerns, foster health equality and advance global well-being.

Government organisation (GO)	A government Organisation or Public agency is often a government-appointed group, it can be a permanent or semi-permanent organisation and is funded by the government.
Health Diplomacy (HD)	Using diplomatic tactics and concepts to resolve disputes over health concerns, advance international cooperation in health and bargain over health-related accords and policies.
International Health Attachés (IHA)	Diplomats from a nation focusing on health problems serve in diplomatic missions to promote cooperation and communication between states on health-related concerns.
International health policy (IHP)	The strategies and actions undertaken by governments, international organisations and other actors to address global health challenges and promote health equity across countries.
K Health (formerly Kang Health)	K Health's main service is its primary care app. The app includes a chatbot called "K", which asks a series of questions to identify a diagnosis.
Leadership Skills	The skills and traits that allow people to successfully motivate, lead and influence others to achieve shared objectives.
Médecins Sans Frontières (MSF)	MSF provides medical assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare. They operate globally, responding to emergencies and providing care where it's most needed.
Ministry of Health and Prevention (MOHAP)	Its mission is to enhance the health of the population by providing comprehensive health services and preventive practices, ensuring the sustainability of the healthcare system and promoting health education and awareness.
Ministry of Foreign Affairs (MoFA)	A government body responsible for managing a country's external affairs, including diplomacy, international relations, and consular services.
Non-Government organisation (NGO)	defined as a non-profit organisation, group or institution that operates independently from a government and has humanitarian or development objective
Sustainable Development Goals (SDGs)	A universal set of 17 interconnected goals adopted by the United Nations in 2015 to end poverty, protect the planet, and ensure prosperity and peace for all by 2030. Each goal has specific targets and indicators to guide global development efforts.
The International Committee of the Red Cross (ICRC)	A humanitarian organisation with a mandate to protect the lives and dignity of victims of armed conflict and other situations of violence and to assist them.

Abstract

The purpose of this research is to analyse leadership skills among overseas treatment leaders and health attachés within the context of the UAE's global health diplomacy (GHD). There is a need for this study on this under-researched area to help address global health issues in an increasingly interconnected world. Utilising a qualitative research design, data collection involved 16 semi-structured interviews with high-level leaders from the overseas treatment departments representing the Dubai Health Authority, Ministry of Health and Prevention and Department of Health Abu Dhabi. These interviewees also included health attachés representing the UAE in countries like the United States, Germany/Switzerland, the United Kingdom and India.

Key findings are that effective global health leadership is attributed to strong communication, intercultural skills and the ability to advocate complex political and health landscapes. Participants highlighted the importance of building collaborative relationships that foster stakeholder trust, leading to increased diplomatic outcomes for health. Based on these findings, policymakers should commit to the development of specialised training programs for health attachés that focus specifically on intercultural communication and strategic relationship-building as core competencies in their leaders. A centralised database of global health best practices would foster knowledge sharing among geographically dispersed health attachés and support the creation of policy responses to global health challenges.

INTRODUCTION

This chapter sets out the United Arab Emirates (UAE) context so that we can explore its activities in GHD. This chapter starts by unpacking how the UAE's geographic positioning, investment in healthcare, and support for partnerships have helped it become a leading player in global health, before examining the key internal and external problems that the UAE encounters in global health, for example, non-communicable diseases, unequal access, and geopolitical stresses. The main skills that health attachés require at the crossroads of diplomacy and health are introduced. The rationale and scope of the study are set out before explicating the aims, objectives, and research questions. The chapter finishes by unpacking the thesis structure and chapter contents.

BACKGROUND

The UAE, with its strategic location at the crossroads of the Middle East, Africa, and Asia, has emerged as one of the leading nations in today's pursuit of GHD (Alkhaldi et al., 2023). Due to these factors, the UAE has effectively contributed to the solution of global health challenges through its foreign policy activities, given its strategic geographical location, strong economic performance, and commitment to international cooperation. Integration of GHD in the UAE serves as a valuable case for exploring its healthcare system, diplomatic relations, and the principles of global health, as highlighted by Alkhaldi et al. (2023). The health care system of the UAE is modern, typified by dynamism, and has undergone significant development in the recent past. At first, owing to the lack of healthcare services in the country, it went through a conversion into a regional hub for medical tourism and healthcare innovation. The core motives behind this transformation are the massive investments into the health sector, including the construction of the physical facilities and infrastructure, hiring of the top professionals in the health sector, and deployment of advanced technologies (Jindal et al., 2023). UAE has considered healthcare as a basic component of its development plan, going by its projects, for example, the UAE Vision 2021 and the National Agenda. The purpose of these programs is to deliver high-quality healthcare services to the people. Public and private healthcare providers form the healthcare sector of a country that provides all levels of care from primary care to complex treatments. Alkhaldi et al. (2023) noted that the foreign health policy of the UAE is now health diplomacy, which is a dynamic component aimed at developing health relations between countries and working against global health problems.

Healthcare relations of the nation are shaped according to its Sustainable Development Goals (SDGs).

According to UN (2023), it can be inferred that the UAE's contribution to global health goes beyond being diplomacy-oriented but incorporates finance, technical skills and humanitarian aid. The country has made huge financial commitments to international health organisations and initiatives geared at improving health in poor countries globally. In addition to this, the UAE has become a major contributor in the field of humanitarian aid with a specific focus on areas of healthcare support and disaster response. The nation has sent medical professionals to different crisis areas across the globe and distributed resources, revealing its dedication to the fulfillment of humanitarian needs and the preservation of global health security. No less remarkable than that is the UAE's great significance on a global stage, which emphasised public health initiatives such as encouraging a healthy lifestyle, preventing diseases, and providing people with access to health services. The participation of the UAE in global healthcare diplomacy is symbolic of its commitment to international partnerships and humanitarian causes (Gökalp, 2020). UAE relies on an advanced healthcare system, diplomatic interventions, and active involvement in global health programs and acts as a regional hub for health projects aimed at the universal enjoyment of health by any person regardless of gender or age (Artaman et al., 2025). With its citizens, as well as countries surrounding it, this approach ensures their safety. The inclusion of GHD in the UAE states the directions for the methodologies of the health diplomacy of the country in light of the global health agenda (Koornneef, Robben and Blair, 2017).

Barriers in the global health arena abound, non-communicable diseases (NCDs) cause the majority of deaths worldwide, particularly in low- and middle-income countries (LMICs). Also, a great majority of people across the globe still lack access to essential healthcare services, and there exists the persistent problem of the distribution of healthcare spending that remains unequal, with the least developed countries carrying the burden. The Global Health Index, ratified jointly by the Kaiser Family Foundation and the Wellcome Trust in 2023, listed the UAE in the 29th position of 195 countries (Loney et al., 2013). The score is meant to show that the country has greatly invested its resources in supporting global health programs and improving health outcomes on a global scale (Warren, et al., 2013). In a like manner, the UAE has been appraised for its transparency in supplying aid to foreign countries. The UAE ranks 19th globally in the 2022 Foreign Aid Transparency Index indicating its dedication to the pursuit of accountability and efficiency in aid delivery to the countries in require, specifically

in health. The UAE outpaces the WHO's average health spending of the world. The UAE allocated 5.2% of its GDP for healthcare spending in 2021, well above the WHO's recommended minimum of 5% (Honig and Weaver, 2019).

The UAE's commitment reflects the firm determination to allow its citizens to use these services and play a full part in global health initiatives. Besides that, the UAE is a major partner of many global alliances and initiatives enacted to deal with global health problems. The country is one of the donors of the above-mentioned organisations, such as WHO, GAVI (the Vaccine Alliance), and the Global Fund to Combat AIDS, Tuberculosis and Malaria (Cochrane, 2021). Such relationships provide the UAE with the scope to have the country influence and leverage expertise in the support of programs that focus on eliminating various diseases, ranging from infectious diseases to maternal and child health. International health attachés work towards the enhancement of the UAE's GHD. They act as ambassadors of the UAE at the international level, building international collaborations and supporting the global health agenda. It entails networking with international organisations, foreign governments and other pertinent parties for cooperation in dealing with health concerns (Ollenschläger, et al., 2004).

The global attention and concentration on global health security and pandemic preparedness have been on the rise due to the outbreak of the COVID-19 pandemic over the past few years (Kandel et al., 2020). The UAE realises the urgent requirement to beef up the global health security mechanisms to triumph over infectious disease outbreaks. As a result, the government is part of the global initiatives that bolster the preparedness and response of nations to pandemics, through establishing healthcare infrastructure, carrying out research and developing capacity (Alotaibi et al., 2022). However, the researcher further added that the UAE contributes substantially to global health cooperation the issues and opportunities that have always influenced domestic diplomacy in this area remain unchanged (Alotaibi et al., 2022). The biggest barrier to eliminating health inequalities is not only within the country but beyond. Although the country has witnessed improvements in healthcare delivery, disparities in attaining good health services and access persist among the different groups as stated by the World Health Organisation (2022). What international health attachés do is promote policies and programs aimed at addressing these inequalities and moving towards health equity, both nationally and internationally.

However, another challenge comes from geopolitical tensions and conflicts which may hinder health care and humanitarian aid in certain areas. In such circumstances, it is expected

that the UAE diplomacy will use sensitive diplomacy and strong alliances to ensure that essential healthcare services are delivered to the affected population as said (Alzaabi, 2023). Moreover, the researcher further cited that, international health attachés must be aware of changing global health trends. Such includes monitoring of the emerging health threats and more focus on health security and pandemics. COVID-19 has shown that health is a global concern and that the world is one village in terms of health and therefore requires collective action in the event of an outbreak or any other health crisis (Harring, Jagers and Löfgren, 2020). The efforts that the UAE has made in this regard will enhance global health security and the role of the UAE in this area will lead to the strengthening of health systems globally as mentioned by Alkhaldi et al., (2023).

However, as stated by Esapebong-Ray (2024), it is safe to conclude that more specifically, the ability to lead is a competence that is essential to operate in the context of GHD since it is international health attachés, in particular, are to represent their countries when addressing the global health issues. These diplomats help in the aspect of mediation since they balance the national interest with the health agenda at the international level and foster cooperation across countries. He also noted that, in GHD, leadership entails many skills such as efficient communication, strategic bargaining, cultural understanding and diplomacy skills as espoused by Esapebong-Ray (2024). Diplomats should be good at showing interpersonal skills, be it engagement with the government, other international organisations, civil society groups, health workers, or any other stakeholder, because while all of them keep health as a major priority, they exist in different political and cultural environments. Hence, given the dynamic character of global health matters, strong leadership should be able to be flexible and proactive in using global diplomacy, as well as resilient enough to react swiftly to fast-changing factors like pandemics, emerging infectious diseases and health emergencies. They further added that an effective leader in GHD needs to have the capacity to utilise available resources and create strategic partnerships to solve health disparities and prioritise health security on a global scale. A high level of leadership proficiency is necessary to enable international health attachés to effectively represent the health problems of their countries within the wider framework of GHD.

RATIONALE AND SCOPE

In the recent past, there has been a growing consideration of GHD in terms of leadership and its importance to social and economic development. Involving health

professionals and inviting attachés are meaningful as the best approach to fighting health issues together (Javed and Chattu, 2020). The health environment in the UAE is evolving and the leadership of health attachés involves a significant part of their work in developing partnerships and in addressing these same pressures.

The endeavour made by the UAE in the development of the healthcare system is worth commending, there is the Dubai Health Authority, Abu Dhabi Department of Health and Ministry of Health. These authorities have not only built a strong health system but have also placed the UAE as the global health innovation and diplomacy hub (Javed and Chattu, 2020). With the increased involvement of the private sector in the provision of health care services, Health Attachés are extremely useful in maintaining and developing countries like the United Kingdom, the United States, India and Switzerland. Consistent with Vision 2030, the UAE government is committed to the continued development of its health sector by focusing on capacity building and health professional skills enhancement. This commitment aligns with the aims of GHD that call for leadership to acquire the skills required for successful international health projects in the 21st century. The United Nations has pointed out that partnerships between health leaders and governments are vital for creatively addressing pressing health issues (UN, 2009).

This study aims to identify and interpret the core attributes of leadership in which health attachés will be expected to effectively implement GHD in the UAE. Based on the experiences and skills of a group of health attachés we intend to contribute to understanding the characteristics contributing to successful leadership in this field. The study also explores areas where current Health Attachés might enhance their skills to better advocate for health initiatives.

The insights gained from this research will not only inform public health professionals and policymakers about the essential leadership skills for GHD but also help develop training programs aimed at improving these capabilities. This will inform recruitment of successful health attachés, in the long run, will lead to enhancing international collaboration to address intricate public health issues. Understanding the leadership competencies that are needed for engagement in GHD is important in enhancing partnerships between the public and private sectors and addressing recurrent social issues such as health inequalities and the availability and distribution of resources in the UAE.

AIMS AND OBJECTIVES

In line with the study objectives, the objective of the study is to assess the leadership skills of the GHD projects presented by the health attachés of UAE. The purpose of this paper is to explore and review the key leadership behaviours of UAE international health attachés in GHD. This involves an assessment of the communication strategies, bargaining approaches and cultural skills that the diplomats apply on issues relating to global health. In light of the above objectives, it is worth understanding how far these leadership characteristics affect the UAE's health diplomacy. Specifically, the purpose of this study is to identify the approaches that UAE diplomats employ to manage the international relations challenges to support the global health agenda while analysing the leadership factors as the key that determines positive diplomatic results (Sharfi, 2021). Another research question is to establish the factors that prevent the utilisation of leadership assets in responding to global health issues by the UAE international health attachés. In addition, it identifies issues such as politics, resources and culture as hindrances to collective struggles in the area of global health. It aims to add to the understanding of the leadership dynamics of GHD given that the study compares these goals (Sharfi, 2021). The intention is to aid policy formulation to enhance the UAE's contribution to the international health diploma. This work has the following objectives:

Objective 1: To explore health attachés' views of their leadership skills.

Objective 2: To identify health attachés' understanding of the relationship between leadership skills and GHD.

Objective 3: To examine health attachés' experiences and insights regarding the key barriers to exercising leadership within the context of GHD.

Objective 4: To understand health attachés' perspectives of how leadership development practices can enhance their contribution to GHD.

RESEARCH QUESTIONS

The following research questions will guide this thesis in addressing its aims and objectives:

1. What are health attachés' views of their leadership skills?
2. How do health attachés understand the relationship between their leadership skills and GHD?
3. What are the key barriers that health attachés report in exercising their leadership within the context of GHD?

4. How do health attachés perceive the development of leadership skill practices that could enhance their contribution to GHD?

THESIS STRUCTURE AND CONTENT

Chapter One: The UAE in GHD Context

This chapter first gives a general overview of the UAE before outlining important aspects of the experience within its healthcare system, cultural environment and diplomatic context. This is done to provide the necessary foundation for understanding the leadership role that the UAE overseas treatment departments/centres and international health attachés play in the realm of GHD. The chapter includes a discussion of the demography and healthcare facilities of the UAE. This is then accompanied by a reflection on the cultural and geopolitical context of the UAE as well as its implications for health diplomacy in the global arena. The chapter further examines the historical evolution of the UAE's overseas health programmes and the commissioning of international health attaché appointments. Last, the chapter describes the major groups and actors which influence the UAE's engagement in GHD.

Chapter Two: Literature Review

In this chapter, GHD and leadership are provided with a historical and theoretical context. The primary concepts, frameworks and theories of leadership within GHD are examined after an examination of GHD's history and evolution. The importance of overseas treatment services and health attachés in advancing health diplomacy is also discussed, along with the advantages and challenges of GHD in the global context. A critical review of the related literature on leadership strategies, challenges and successes of GHD, specifically from the context and proposition of the UAE, is also shared.

Chapter Three: Methodology

In this chapter, the method of research carried out in this study is explained. The first section introduces the epistemological context and the methodology used at the outset, while the second section outlines the data collection processes, interviews and thematic analysis. Sampling methods and participant selection criteria are described, along with the analytical approach to interpret these results. Ethical aspects of this study are described before the conclusion of the chapter where the methodological approach is summarised.

Chapter Four: Findings and Analysis

This chapter reports the outcomes of the research, thematically structured based on the significant dimensions of leadership in GHD. Key themes include the display of leadership abilities by the UAE overseas treatment department and international health attachés,

approaches to teamwork development and solutions to leadership barriers. The analysis also draws attention to conclusions about the role of the UAE in global health programs, as well as insights into the cultural considerations and geopolitical factors.

Chapter Five: Conclusions and Recommendations

In this chapter, the main results of this work, its objectives and aims are reviewed. It discusses the broader implications of the UAE's leadership in GHD according to international health initiatives. This chapter proposes improvements to the effectiveness of the UAE's overseas treatment department and the role of its international health attachés in GHD. The concluding paragraph includes a summary of the study's limitations, recommendations for future research and the author's conclusions. A dissemination plan, future research and a personal reflection on the researcher's own experience.

CHAPTER ONE
GLOBAL HEALTH DIPLOMACY IN UAE CONTEXT

1.1 INTRODUCTION

The factors and attributes rendering the UAE a highly unique and powerful actor in GHD are various (Antwi-Boateng and Alhashmi, 2022). These are the factors such as its strategic geopolitical location, the high level of the primary healthcare system, the culturally heterogeneous society and proactive engagement on the international level. This chapter seeks to offer a broad overview background of the UAE, to describe and further discuss major elements of that nation's health environment and its cultural and diplomatic context, to set the scene for understanding how the leadership of the UAE's overseas treatment facility and its international health attachés play a part in GHD.

The chapter starts with a description of the UAE's demography and healthcare facilities and some of the rapid growth and global health programmed commitment. This is then addressed with a look at the cultural and geopolitical landscape of the UAE and its relationship with health diplomacy and international politics. The chapter thereafter discusses the UAE's overseas treatment initiatives and the contributions of the international health attachés, featuring their leadership approaches and their role in GHD. Lastly, it addresses the roles of major organisations and stakeholders in the UAE's contribution to tackling global health issues and building international partnerships.

1.2. HEALTHCARE DEMOGRAPHY

As reported by the United Nations (2022), the UAE population has continued to grow in recent decades, from about 2.5 million in 1980 to more than 9.2 million in 2020. This exponential population growth is forecast to reach 11 million by 2050. The population structure of the UAE presents itself as a challenge and an opportunity for its health system and its health diplomacy practice. For stability of economic and social prosperity, the government must take a proactive approach to the needs of a growing and increasingly diverse population. These interventions are required to enhance healthcare, education and employment.

The population of the UAE is 88% expatriate, which is the country's most prominent demographic characteristic (World Bank, 2023). The overseas workforce is significantly made up of migrants from South Asia and the Middle East countries, also from other countries, and it has an immense influence upon the various sectors of the economy, e.g., the health service. The reliance on a diverse expatriate population provides benefits as well as difficulties when facing public health challenges and in the context of carrying out health diplomacy programs.

Most individuals in the UAE are young, with a median age of almost 33. Approximately 85% of the population is in the economically active 15–64 age range (United Nations, 2022). There is, however, an impending rise in the proportion of the population over the age of 65 (expected to reach about 10% by 2050, which is consistent with increasing global ageing rates). To adapt to this demographic shift it is also an unalterable fact, that tomorrow's healthcare politicians are required to tackle the enormous increase in demand for elder care and of management of non-communicable diseases.

Migration has an importance in shaping the demography of the UAE. The country itself is becoming a global centre, drawing healthcare professionals, policymakers and diplomats from every direction. This heterogeneity enhances the UAE' ability to practice health diplomacy worldwide, promoting intergroup relationships and cross-cultural sharing of knowledge.

These demographic tendencies highlight the necessity for strategic leadership in the UAE overseas treatment section and its international health attachés. Through understanding and responding to these demographic shifts, the UAE has the potential to better leverage its position as a) a voice in GHD and b) as the catalyst for generating international health collaborations and initiatives.

1.3. HEALTHCARE INFRASTRUCTURE AND STRATEGIC CAPACITIES

The healthcare infrastructure incorporates all the buildings, frameworks and systems vital to conveying full-scope well-being care to a community (Berry et al., 2024). Within the setting of the UAE, the healthcare framework comprises a varying extent of administrations and offices. These incorporate clinics, wellbeing centres, therapeutic inquiries about offices and computerised wellbeing stages. Over the past few decades, the UAE has experienced momentous change, advancing from a developing country to possessing one of the foremost progressed healthcare frameworks in the world (Union Atlas, 2025). This accomplishment means the government's unflinching devotion to shielding the well-being of its citizens and inhabitants, while also improving its worldwide notoriety in wellbeing and improving its global standing in health diplomacy.

Specialised healthcare complexes and advanced medical centres offering great care are available all over the UAE (UAE) (Alameri et al., 2021). With state-of-the-art hardware and profoundly qualified staff from all over the world, these facilities are prepared to go. The government is working hard to make healthcare more available, and major restorative cities

like Dubai Healthcare City and Khalifa Therapeutic City in Abu Dhabi are serving as centres for worldwide collaboration and therapeutic innovation.

Water and energy management are also the major issues of the healthcare system of the UAE (for example. Due to the arid climate and scarcity of natural water resources in the UAE, the UAE has put in place some new technologies in water desalination and energy to sustain healthcare facilities. Such systems can guarantee a supply of power and drinkable water, which are critical to medical care and research.

The development of communication and transportation networks has significantly enhanced the effectiveness of the UAE's healthcare system (Kim and Hyun, 2022). International airports, seaports and large-scale, well-planned road systems provide patients, medical equipment and health workers with a means to travel. Furthermore, the exponential expansion of telecommunication systems has made it possible to also implement telemedicine and digital health platforms, improving access to health care for all communities, especially for those living in remote parts of the country.

The private sector also plays an important part in UAE healthcare facilities, private hospitals and clinics are the extension of public health facilities (Barhem, Younies and Younis, 2010). Public-private partnerships have also played a key role in improving healthcare provision and stimulating innovation and medical research. The heavy reliance on expatriate clinicians in the healthcare system reflects the UAE as a centre of excellence in medicine and a catalyst of medical collaboration (Strong, 2025).

The discussion of the healthcare system in the UAE highlights the strategic function of integrating healthcare aspects into GHD management within the country. The UAE gives evidence of its capacity to manage such a global health challenge and its ability to become a model of a global health force by drawing from world-class facilities, technological strengths and global alliances.

1.4. HEALTHCARE LEADERSHIP IN THE UAE

Healthcare leadership, within the UAE context, is strongly informed by the cultural values and a vision of national development, as well as by the willingness to collaborate globally. Since the UAE is a country which is recognised for accelerated progress and an international perspective, healthcare has been made an anchor of its strategic development (Antwi-Boateng and Alhashmi, 2021). Authority in healthcare includes an advanced system, an active role of government and a mix of traditional and new medical practices to meet the

needs of its diverse population. Healthcare management in the UAE is influenced by national policies that focus on growth, quality and access. Leadership in healthcare entails having a good health system, an active government and both traditional and conventional methods of treatment to cater for the populace. While this study examines the UAE, Tanzania has made similar strategic choices reflected in its Vision 2030 and health sector development plans. These are outlined in Tanzania's Vision 2030 and health sector development plans to enhance the welfare of the population and residents. The UAE government has been also contributing to the development of state-of-the-art health care and is inviting international talents to provide the best health care services.

In expansion, the UAE's particular cultural and social context, which is a mixture of Islamic and cosmopolitan, influences its style of healthcare management. These approaches are developed while bearing in mind social issues and at the same time being innovative when it comes to healthcare advancement. Healthcare management in the UAE also carries out its operations beyond the boundaries of the country by actively participating in health diplomacy. Through the establishment of partnerships with global organisations and the facilitation of global health conferences, the UAE has underlined its important role in the development of global health care. This double perspective on excelling at the domestic level and partnering internationally highlights the UAE's ability to be a pioneer in GHD.

1.4.1. Healthcare Leadership and Government Policies

The leadership of healthcare in the UAE is directly linked to government health policy, a vision of the country's emphasis on enhancing healthcare and international partnerships. The UAE has, since its foundation in 1971, made notable strides in the development of a strong healthcare infrastructure, and this has been made possible through visionary leadership and marked investment in infrastructure and technology (Karmakar and Sahib, 2017). Governmental involvement in the governance of health care is at the core of setting policy in line with national priorities and global best practices (World Bank, 2021). The healthcare management of the UAE is based on an institutionalised symbiosis between central and emirate-level powers. Institutions e.g, the Ministry of Health and Prevention (MOHAP) are involved in collaboration with emirate-based organisations e.g, the Dubai Health Authority (DHA) and the Department of Health - Abu Dhabi (DOH), for the delivery of high-quality healthcare services within the country (Hamidi and Akinci, 2018). These entities work together

to develop and implement policies to respond to the healthcare needs of an increasingly complex population while respecting local traditions and global standards.

National policies in the UAE focus on innovation, sustainability and accessibility, as referred to in national programs such as UAE Vision 2021 and Vision 2030. However, these policies have promoted the use of the latest technologies like artificial intelligence, telemedicine and precision medicine, thus building on the UAE healthcare infrastructure (Ministry of Cabinet Affairs, 2021). Public-private partnerships (PPPs) have a critical part in encouraging technological utilisation in broadening access to well-being care and supporting advancement (Oxford Trade Gather, 2019).

A one-of-a-kind perspective of healthcare administration within the UAE is its integration of social and devout values into approach advancement. Islamic values are reflected in healthcare practices so that they match with the beliefs and cultural values of the community. At the same time, the UAE's view of the world empowers comprehensiveness and versatility, which makes a difference in the nation meeting the well-being needs of its diverse population (WHO, 2021). UAE healthcare pioneers, moreover, lock in worldwide well-being endeavours beyond their nation. By joining global health programs and offering help during crises, the UAE has shown it wants to aid in achieving fair health for all (UNDP, 2023). This combination of strong health systems at home and partnerships abroad places the UAE in a leading role in influencing the future of healthcare in the region and further.

1.4.2. Healthcare Leadership and International Relations

The healthcare leadership of the UAE not only exert a remarkable influence over the domestic sphere, but it also has a radiating effect through the international sphere and thereby contributes to the role of the UAE as a regional and global healthcare leader (Ahmed et al., 2024). This commitment is rooted in the UAE's key strategy for governance of health delivery, which prioritises both national advancement and global partnership. Management policies for the country are known to be an integrated model providing a base for public health programs, encouraging transboundary collaborations and focusing on humanitarian aid and international health diplomacy (Al Kurdi, 2021).

A key pillar of the UAE's universal healthcare system is its proactive involvement in global health activities and other collaborative efforts with global bodies. Through collaboration with the World Health Organisation (WHO) and other wellbeing-related organisations, the UAE is a key driver in understanding major health problems, including

infectious disease, immunisation programs and medical research (WHO, 2021). Health and well-being policy in the UAE, however, also tackles the United Nations SDGs ie, health and well-being (UNDP, 2023). The UAE's commitment to health equity as well as substantial budgetary commitments to global health programs, warrants recognition of the UAE's ambition to become a GHD leader (Alkhalidi et al., 2023).

In addition, the health leadership of the UAE is defined concerning innovation and technology acceptance, which has allowed it to attract global attention. The policy has promoted developments, including telemedicine and e-health services, which play an important role in ensuring healthcare access in urban as well as remote locations (Alkaabi and ElSORI, 2025). These advances are consistent with the UAE's status as a contemporary, progressive country and support its leadership in the development of health policy and practice worldwide.

1.4.3. Healthcare Leadership and the Role of Women in Diplomacy

The position of women's role in healthcare leadership and negotiation has evolved considerably, if indirectly, in recent times, not through medical leadership but through leadership and control in healthcare organisations (Dhatt et al., 2017). Though advances have been made, there are still challenges to empower women to occupy decision-making positions in health care and policy. In the UAE, women have come to occupy increasingly prominent leadership roles in the health service, shaping national health policy and playing leading roles in public health administration (Mehrajunnisa and Jabeen, 2019). National efforts towards gender equality as manifested in the appointment of female decision-makers to health and international affairs (Smith, 1983) are conducive to bringing women into leadership roles in health and diplomacy.

Women's participation in healthcare leadership has paved the way for a more inclusive model, which prioritises policies and programs that are comprehensive to the needs of various groups. Examples of such activities are community health services, preventive actions and patient-centred interventions which are key to national public health success (Kalaitzi et al., 2019).

UAE foreign policy has also been shaped by women in positions of leadership and diplomacy who are, among other things important actors in the development of regional and international healthcare alliances. Women diplomats play a part in promoting collaborative health projects, medical research and humanitarian relief programs. This development aligns

with the UAE's vision to establish itself as a centre for healthcare innovation and an influential actor in GHD (Alkhalidi, et al., 2023). Through promoting health programs and engaging in global diplomacy, female role models contribute to creating the image of the UAE as an egalitarian progressive country that also prioritises the common good.

Yet, full entry of women into the realm of healthcare leadership and diplomacy is not an easy road. Despite being more open than before, the healthcare industry still retains some gender inequality in executive and decision-making functions. Al-Mansoori and Al-Suwaidi (2018) found that, although more women are now working in the health workforce, women's participation in leadership ranks is still a minor fraction of men's. This is in part due to lingering cultural perceptions and historical practices that have limited women's roles in public spheres. However, the increasing speed of change is happening as legislation of endorsement of women's rights and gender equality is more and more implemented and expanded (Inglehart and Norris, 2003).

The UAE's emphasis on a fair, equitable and modern healthcare model substantiates its overall vision for societal development as depicted in Vision 2021 and Vision 2030. When they also help in implementing these initiatives, women are better positioned to be more actively involved in decision-making and, consequently, contribute to the creation of health care and the formulation of the international health discourse.

1.5. GLOBAL HEALTH DIPLOMACY AND ECONOMIC FOUNDATIONS IN THE UAE

The UAE has developed into an influential entity in GHD, taking advantage of its economic wealth to place itself at the centre of international health collaborations (Alkhalidi et al., 2023). The current economic situation of the UAE has come about over years of economic growth since the 1970s and has its roots in strategic investments in various sectors such as health, telecommunications and physical infrastructure, and not only in energy, fostering the latent development in the economy.

What started with a series of economic growth initiatives in the UAE has assisted in building up its healthcare systems and provided visibly favourable circumstances for the billions of dollars invested by multinational companies. EY (2024) notes that there is enormous potential for growth in the healthcare sector through public-private partnerships and huge taxpayer-funded budgets aimed at delivering the best state-of-the-art medical care. Thus, the medical policies on the economy in the UAE have, over the years, centred on promoting

innovative inventions, technological advancement and research, which forms the basis of making the country most approachable for healthcare investments and even partnerships. In addition, the strategic geographic position of the UAE has further strengthened its position as a connector between East and West, thus promoting cross-border healthcare collaborations and enabling global health initiatives.

The UAE's response to health crises, such as its swift action during the COVID-19 pandemic, demonstrated its capacity to mobilise resources, coordinate with international health bodies and support humanitarian aid efforts worldwide (Abbas Zaher, et al., 2021). Economic resilience has also enabled the UAE to set an example for fostering sustainable health behaviour practices and providing assistance to underserved areas by making investments in health infrastructure and healthcare training capacity. Indeed, this is the case in proposals such as the UAE's assistance to low-lying countries, which through financing, provide medical facilities, medical care education and even delivery of crucial medical supplies. Economic policies in the UAE have not only made it the regional economic powerhouse, but also the global contributor to health and wellness, clearly demonstrating the connection between wealth and health diplomacy.

Although advancement has been made in the U.A.E., there are still challenges arising from finding the right balance between economic growth and sustainable medical practice. This fast pace of development has led to anxiety regarding the provision of long-term healthcare quality and accessibility, most notably when the demand for services of high complexity is increasing (Hassan, 2020). In addition, although the UAE has demonstrated leadership in health diplomacy, continued work is needed to foster greater cooperation, leverage local capacity and ensure equitable access to healthcare services for all populations.

1.5.1. The Relationship between Government and Healthcare Initiatives

The government of the UAE has been instrumental in developing the healthcare industry, by prioritising the role of public policies and private collaboration. The current section discusses the role of government policies in healthcare evolution based on major theories of state-healthcare interaction.

One of these frameworks is the state-driven healthcare capitalism in which healthcare investment is led and coordinated by the government. This paradigm guarantees broad service coverage and induces quality of care improvements. In this context, there is a key role played by state action in establishing regulatory frameworks, establishing financial commitment for

public health activities and encouraging private sector engagement (Al-Mansoori, 2021). This is in line with the UAE's way of streamlining healthcare projects within the mainstream of economic and social development. Policy and investment-driven actions by government leadership have played significant roles in improving access to care and the development of medical technologies (Hassan, 2020). The notion of "embedded autonomy" as introduced by Evans (1995) is relevant here. It describes a dynamic in which the state gains strategic control over healthcare policy and planning while the decision-making process includes the relevant input and innovations of the private sector (Hassan, 2020).

One of the key aspects of the healthcare policy of the UAE is its focus on PPP. This model supports mutual investment, where the government funds essential health services while encouraging private sector expertise in specialised areas. The government has used pretty much every available tool to facilitate PPPs, such as to help build hospitals, bring new medical technologies to market and grow healthcare training programs. This has allowed the UAE to achieve large-scale advances in improving healthcare delivery and position itself as the regional medical powerhouse.

Nevertheless, Hassan (2020) suggests that though the UAE has advanced tremendously, regional inequities in healthcare access remain. Areas with limited infrastructure continue to experience uneven healthcare provision, which requires targeted policies to ensure equitable service distribution. In addition, although the state-driven model has enabled significant innovation, the increasing dependence on private-sector involvement requires a strict legislative framework to ensure the absence of quality inequalities (Panikar and Morozov, 2025).

1.5.2. Governance of Healthcare Organisations in the UAE

To achieve management, operational efficiency and international compliance, governance in healthcare organisations in the UAE remains paramount. Corporate governance is the arrangement of authority, management and communication leading to the management and direction of organisations, especially with a focus on the issues of integrity, accountability and fairness when it comes to distribution of the resources to the stakeholders (Albareda et al., 2007).

In the case of the UAE, the healthcare regulatory structures are also influenced by the public as well as the private sector since the government plays a significant role as a regulator of the private sector's investment. The health care system of UAE is practised with the

framework of policies at federal and emirate levels, the MOHAP, DHA and DOH ensure quality assurance and patient safety practices (Alameri, et al, 2023). These organisations set accreditation, licencing and operational guidelines and cues making the healthcare institutions more accountable (WHO, 2020).

It should be noted that the concept of transparency and disclosure is core to the corporate governance of the UAE healthcare industry. Healthcare organisations are able to adhere to the best practices in reporting practises, including financial reporting and performance indicators (Al-Yahya, 2021). Besides, organisations have also adopted new technology-enhanced systems in the aspect of enhancing transparency such as real-time monitoring and data-driven systems (Smith, 1983). PPPs enhance collaboration between the state and private companies in the construction of health facilities, enhancement of delivery of services and optimisation of the utilisation of the available resources (Gardner, 2017). It has been most useful for spurring innovation since the private sector partners contribute skills on technology and service improvement, which the government provides broad regulation on (Alameri, et al, 2023).

However, it was still challenging to maintain overall compliance with the governance standards across all categories of healthcare organisations. While the major hospitals and the overall international healthcare system in the UAE have a good framework of governance, the clinics and local suppliers have reported their inability to meet these requirements due to constrained resources (WHO, 2020). There is also still an inadequate provision and design of the structures for succession or performance investigation to support long-term stability and leadership for healthcare organisations. Thus, the implementation of governance in UAE clinics is clear-cut and consists of hard and fast regulations, transparency and cooperation between the government and the business sector. Although the general layout of governance is in place, notwithstanding, there is still much to be done to clear the way so that practical implementation can adhere to the growing global rules.

1.5.3. UAE Organisations Key to Global Health and Diplomacy

This section discusses the key organisations in the UAE that are heavily involved in the preservation of global health and diplomacy. Such institutions act as backup for the UAE in its pursuit of international promises, improve cooperation and join the sustainable development for health and health-related activities.

The MOHAP is an essential governmental organisation that has its responsibility to set the executive plan for the healthcare sector in the UAE. The major aims of MOHAP are equality of access to medical services, medical care results and technologies in medical research. The ministry collaborates with other global health institutions such as the WHO to deliberate on international health matters and to meet agreed health standards globally (WHO, 2020). Initiatives such as the National Unified Medical Records System and MOHAP create the needed push for the digitisation of healthcare services to enhance its operations and support data sharing in the region as well (Kumar, 2021).

These facilities (also known as Centres) are designed to be the health reserve for the UAE and make the country ready for participation in international activities and cooperation in the sphere of health and related fields.

MOHAP is one of the premier public institutions that is concerned with the selection of the executive plan of the healthcare system in the UAE. The major activities of MOHAP are; the provision of medical care to all individuals, health status and medical care research as well as medical care technology advancement. For instance, MOHAP has signed working relations with other global health organisations including the WHO for sharing international health information and international health benchmarks (WHO, 2020). In this case, activities such as the National Unified Medical Records System and MOHAP create practices for medical digitisation in healthcare to enhance efficiency in services and contribute to data sharing in the region (Ahmed, 2021).

Moreover, regulatory authorities such as the Dubai Health Authority (DHA) and the Department of Health Abu Dhabi (DOH) have significant roles in GHD through their visions of health innovation and regional integration. The DHA is involved in the process of directly partnering with healthcare providers across the globe and hosting international conventions such as the Arab Health Exhibition and Congress that allow to sharing of ideas and advancements in knowledge and technology (WAM, 2025). Likewise, the DOH is concerned with the promotion of health, education on health and disease prevention, together with encouraging research partnerships via international organisations for health crises such as diabetes and cardiovascular diseases.

Therefore, UAE organisations such as MOHAP, DHA, an DOH, are important in the nation's contribution to health and diplomacy. Their work reflects the commitment of the UAE to foster international relations, address global challenges and discover appropriate solutions in the context of providing healthcare.

1.6. SOCIAL TRANSFORMATION IN THE UAE THROUGH GLOBAL HEALTH DIPLOMACY

One of the key processes changing the society has been the UAE's concern for health diplomacy as this has enhanced healthcare, city construction and multilateralism. They have shifted social relations and contributed much to the social programme of modernising the nation (Toth, 2018).

The enhancement of public health as well as solutions to national and global challenges have been promoted by the healthcare activities in the UAE. The continued active participation in international health initiatives such as the promotion of polio eradication with WHO demonstrates commitment towards health. These actions not only enhance the image of the country to the rest of the world but also help in promoting social and community responsibilities (WHO, 2020).

Both the UAE's national policies have introduced GHD as a result of the urbanisation and modernisation process. Cities such as Dubai and Abu Dhabi represent centres for medical tourism and healthcare technology innovation. Due to the advancement in high-tech medical care and the introduction of a smart healthcare system, quality healthcare facilities were made available to residents as well as visitors thereby bringing social changes and health consciousness among the people (Dar and Kashyap, 2023).

Education and research in health sciences are also basic elements in the social reform of the UAE. These figures suggest that facilities such as the Mohammed Bin Rashid University of Medicine and Health Sciences (MBRU) need to build capacity to respond to global health world issues. Through collaborative research activity and partnership with international agencies, the UAE has been able to contribute to medical breakthroughs, creating an environment for innovation and providing health practitioners with the capabilities necessary to respond to the global needs that are changing all the time.

The UAE's international health diplomacy has also played a role in promoting inclusivity and adaptability in its multiethnic population. Given the large population of ethnic minorities, in this country, attention has been paid to culturally appropriate principles in the delivery of medical care and public health promotion. This helps to make the advances resulting from modernisation and improvements in healthcare available in every sector of society (Yasin, 2007).

Although the UAE has made advances, disparities regarding equitable access to health care and socioeconomic status differences between urban and rural areas, etc., still exist.

Policymakers continue to focus on strengthening healthcare infrastructure and expanding services to underserved regions, aiming for a comprehensive approach to social development.

Conclusion GHD has been a key driver of social change in the UAE. By enhancing healthcare systems, by promoting research and teaching and by campaigning for inclusion the country has become a global centre of excellence for health and social development. Further work to deal with the complications and to keep an eye on innovation will be the key to sustaining the progress.

1.7. CONCLUSION

This chapter introduced and presented different features that characterise the UAE. The country has experienced a high rate of population expansion, particularly a young population. This demography offers benefits both as a highly valuable resource and challenges due to the requirement of education, training and jobs. With one of the strongest and most diversified economies in the Gulf Cooperation Council, the UAE is backed by major investments in infrastructure, innovation and key themes such as tourism, health care and renewable energy sectors.

While the private sector has been growing, UAE's economic growth has stayed closely associated with government plans and actions. The government has actively contributed to business climate improvement through entrepreneurship and attracting foreign investment. Firms are made up of regional and global firms incorporated in an encouraging regulatory system.

Organised commitments in the economic and social development of the UAE include the MOHAP and supporting agencies for global health and diplomacy. Such organisations play a critical role in the resolution of public health issues, the promotion of community good and the development of the UAE's contribution to global health endeavours.

The chapter also described the revolutionary effect of modernisation in the UAE, as well as several developments in urbanisation, health, education and technological innovation. These technologies have also gone through a social and economic metamorphosis and helped in the development of an integrated and sustainable culture. In this context, the following chapters in this study will attempt to examine the UAE's health diplomacy abroad and its role in social development, advancement and addressing current challenges.

CHAPTER TWO: LITERATURE REVIEW

An Examination of the Leadership Skills and Development in Global Health Diplomacy

2.1. INTRODUCTION

GHD is rapidly emerging as nations and other players strive to address health challenges that do not respect national borders. In the past few years, there has been an increase in academic literature concerning GHD, especially on how GHD is being practised and leadership competencies (Fidler, 2007; Kickbusch, 2010; Lee and Smith 2011). GHD hence is a consensus process that is diplomatic and in which countries and partners come together to enhance the general health of the society by sharing various information, resources and technical knowledge in the management of the health risks and capacity building of the health systems (Horsfall, 2013; Buss and Dry, 2015).

Health attaché's work as key players in international health dialogue has recently come to the foreground as it is now apparent that they can enhance national health agendas and foster global cooperation (Yach, 2012; Buse and Hawkes, 2015). Leadership in the GHD context requires a mix of personal attributes and competencies that are required for developing cross-cultural relations, bargaining for policies, handling emergencies and conveying with various actors (Lee and Smith 2011; Ratanawijitrasin, 2017). These characteristics are not only useful when it comes to diplomatic relations but are crucial when it comes to the health policies which may have relevance to the national and international health agendas (Fidler, 2007; Buss and Dry, 2015).

In this chapter, the emphasis will be placed on the literature review of leadership competencies' development and their application in the sphere of GHD according to the experiences of the UAE international health attachés. The first will discuss the nature and development of international health diplomacy and the second will be about the characteristics expected of health attachés. This chapter will also uncover some of the most important theories of leadership regarding GHD and how these theories influence policy and practice. Finally, the challenges and opportunities that health attachés experience in executing their functions will be analysed to explain their role in international health initiatives.

A narrative literature review was employed in this study. A narrative literature review is a method of synthesising and interpreting existing research on a particular topic in a descriptive and integrative manner, rather than through formal statistical or systematic procedures (Theile and Beall, 2024). This approach was chosen because it allows for a comprehensive, interpretive, and context-sensitive examination of the research topic, which aligns closely with the study's objectives. Given that the study seeks to explore the views,

experiences, and insights of health attachés regarding leadership competencies and their role in GHD, a narrative approach enables the integration of diverse studies, theories, and conceptual frameworks in a coherent and meaningful way. Specifically, the narrative approach supports the study objectives by allowing the researcher to synthesise existing literature on leadership competencies in health diplomacy, and highlighting different perspectives and conceptualisations of leadership relevant to this professional context. The narrative review helps to capture the complexities, contextual challenges, and practical barriers identified in prior research, providing a richer understanding of the issues faced by health attachés. The narrative method facilitates the identification of existing frameworks, best practices, and interventions in leadership development, allowing the researcher to connect these insights to potential improvements in health attachés' contribution to GHD.

Though a narrative review, the search terms that guided the initial search were 'GHD, 'leadership competencies', 'health attachés', 'intersectoral international cooperation in health', 'policy bargaining', 'intercultural leadership', 'co-governance' and 'health diplomacy theories. One of the aspects of the search strategy was the use of a great number of various electronic databases available in academic libraries such as Web of Science PubMed and Scopus. To ensure an extensive review, extra sources, for instance, Google Scholar, journals such as *Global Health Action*, *Health Policy and Planning*, *Journal of Global Health*, official reports and policy framework were used. Based on need, the goal of the present literature review is to provide the reader with the overall picture of the leadership competencies in the context of international health diplomacy and their applicability to the case of the UAE's health attachés. Table 2.1 shows inclusion and exclusion criteria of the study.

Table 2.1: Inclusion and Exclusion Criteria.

Criteria Type	Details
Time Frame	Literature published between 2019 and 2024.
Language	English (as databases and journals listed are mainly English-language sources).
Focus/Topic	Studies and sources addressing: GHD, leadership competencies, health attachés, intersectoral international cooperation in health, policy bargaining, intercultural leadership, co-governance and health diplomacy theories.
Type of Sources	Peer-reviewed journal articles, Official reports, Policy frameworks, Additional relevant academic sources (Google Scholar, <i>Global Health Action</i> , <i>Health Policy and Planning</i> , <i>Journal of Global Health</i>)
Databases Used	Web of Science, PubMed, Scopus, Google Scholar.
Geographical Context	Global perspective, with relevance to UAE's health attachés.

Study Design	Narrative reviews, qualitative studies, theoretical frameworks relevant to leadership competencies in health diplomacy.
Exclusion Criteria	Sources outside 2019–2024, Non-relevant topics outside leadership competencies or health diplomacy, Non-academic or unverified sources (unless official reports or policy documents), and Sources not accessible in the databases or journals listed.

2.2. HISTORICAL OVERVIEW OF GLOBAL HEALTH DIPLOMACY

The concept of GHD has evolved in parallel with changes in global health challenges, in the general foreign policy and the framework of multisectoral cooperation. Originally, the link between health and diplomacy was observed in the development of the first international health organisations at the end of the 19th Century (International Sanitary Conferences) to prevent the spread of certain diseases, such as cholera and plague (Fidler, 2001; Youde, 2018). These conferences laid the framework of modern international health governance since they marked the beginning of the efforts to address the need for health as an international concern.

The formation of the League of Nations Health Organisation (LNHO) in 1938 and later the World Health Organisation (WHO) in 1948 influenced the evolution of GHD in the twentieth century. These agencies formalised health as one of the major components of global politics and emphasised the role of the states in addressing issues in overcoming diseases and improving health care worldwide (Kickbusch, 2011; Davies, 2015). The campaign for the eradication of smallpox by the WHO in the 1960s and the 1970s was an excellent example of health diplomacy to achieve a common goal as pointed out by Fenner et al (1988).

GHD entered new dimensions during the Cold War period (1945-1989) in a way that health programmes became instruments of the soft power of the Western and the Eastern blocs (Birn, 2009). For instance, in the Third World countries, giving medical assistance and participating in social projects in terms of the health sector was a means of creating allies and thus increasing power. When geopolitical tensions eased in the 1990s globalisation emerged and with it came new problems like the HIV/AIDS epidemic and the necessity of global instruments to tackle inequalities in health (Poku and Whiteside 2004).

In the past few years, GHD has evolved from a concept that primarily involved state actors to involve non-governmental organisations (NGOs), private companies and charitable foundations. This wider involvement is an acknowledgement of the fact that, in today's world, the idea of solving global health challenges entails the participation of all stakeholders involved (Gostin and Katz, 2016). The COVID-19 pandemic also outlined why the world

needs GHD to act and ensure that global responses are fair regarding the distribution of vaccines and to discuss global health inequalities in healthcare systems (Moon et al., 2020).

The UAE has also assumed the status of a GHD leader through its diplomatic efforts in addressing global health concerns and its capacity. Through such processes as financing disease elimination and other humanitarian health initiatives as well as cooperation with large intergovernmental organisations, the UAE has effectively claimed its place among world health governance actors (Alshamsi and Hunt, 2022). This history demonstrates the growing role of GHD in addressing the more complex and connected challenges related to health, diplomacy and international relations.

2.3. DEFINITIONS OF GLOBAL HEALTH DIPLOMACY

The concept of GHD has been defined in many ways in the literature and there is no clear understanding as to what GHD means. Outlining and evaluating the various definitions found in the literature is the aim of this sub-section. These definitions are also diverse ranging from those that focus on organising the strategic management of health policy to those that cover a wide range of stakeholders including governments non-governmental organisations and international organisations (Ruckert et al., 2016).

Breaking GHD into its components provides a good springboard for discussion. “Global health” is, in general, referring to the intercountry, transdisciplinary and multidisciplinary work, necessary to enhance health outcomes and to tackle global health disparities (Ruckert et al., 2021). Meanwhile, "diplomacy" describes the mediation, negotiation and conflict settlement in international relations. When taken alone they serve as a bridge connecting foreign policy and health issues typically by attempting to resolve disputes between nations that are interested in global health issues or to come to a consensus on shared health goals (Kickbusch et al., 2007).

One view of GHD is as a tool for resolving global health concerns and as a means of expanding health initiatives to improve bilateral ties. In the same way, Lee and Smith (2011) identified the concept of GHD as the activity of government and NGO actors in resolving the sharing of resources, roles and activities for better health outcomes around the world.

Alternatively, definitions broaden the application of GHD to health security and governance. For example, Katz et al. (2011) described GHD as the practice of employing health initiatives as a means of achieving broader security and economic objectives, particularly in the context of emerging infectious diseases and pandemic preparedness. This

perspective is in keeping with the enhanced appreciation of health problems as key components of national and global security policies.

Provision for a less restrictive and more subtle definition is made by Kickbusch et al. (2007), who focus on GHD as a multi-tiered process in which actors, including state and non-state actors, cooperate to construct, implement and advocate for global health policies while promoting equitable health outcomes. This definition emphasises the importance of such multilateral organisations, as well as the WHO, as important diplomatic tools and policy coordination centres.

Although, for most definitions, the operational and collaborative features of GHD are central, other definitions challenge the GHD's power dynamics. Labonte and Gagnon (2010) argue that GHD often reflects the interests of more powerful states and global health institutions, raising questions about equity and inclusivity in the negotiation process. This review highlights the need for the fact that the GHD practices should not just be efficient but also ethical and fair.

According to the current thesis, GHD is the deliberate application of discussion, cooperation and negotiation between a variety of actors such as governments international organisations and civil society to address global health issues, enhance health outcomes and fortify international ties. According to this definition, GHD is interdisciplinary and capable of simultaneously considering priorities that are both health-related and geopolitically significant. This definition is like those commonly used in literature which also note the relationship between health and foreign policy. Yet, this thesis highlights the part that diplomacy plays in building international connections, whereas some other explanations may focus more on the daily operations of global health governance or the role of power during international meetings.

2.4. DRIVERS OF GLOBAL HEALTH DIPLOMACY

At the intersection of international relations global governance and health policy, GHD is an interdisciplinary field. It aims at solving transnational health problems by way of concerted action and bargaining. Drivers of GHD are varied and arise from political, socioeconomic, moral and environmental implications. This subsection investigates these moderators, using major theoretical frameworks and empirical research to better understand the role they play in shaping the structure and implementation of GHD strategies.

Political Drivers: Health often serves as a political instrument, and, in the case of GHD, health systems are the means for political and soft power. Countries may take part in health programs to enhance their geopolitical leverage, build relationships, or heighten their global standing. Kickbusch et al. (2007) claimed that health has now evolved into a portion of strategic foreign policy, in which states use health movements for the sake of national diplomacy. For example, the formation of the Global Health Security Agenda (GHTSA) is an example of worldwide cooperation to address infectious disease risks, plus to strengthen international political stability (Fidler, 2004).

Among other things, the strength of political will is of great importance in the acceleration of GHD. Leaders who make health a central theme in their foreign policy agendas are commonly credited with making important progress. The President of the USA's Emergency Plan for AIDS Relief (PEPFAR) serves as an example of a politically driven health initiative that has delivered substantial global health benefits while also strengthening diplomatic ties (Dybul et al., 2007).

Economic Drivers: Economic factors play a key role in GHD through which time, finance and the priority of health interventions are disposed of. Health aid is used as a tool to build economic ties and strengthen trade relations, by wealthier countries and agencies¹. The economic benefits of health spending in low- and middle-income nations such as improved economic resilience and access to new markets were emphasised by McInnes and Lee (2012).

Furthermore, health crises can have significant financial consequences which encourages cooperation in risk mitigation. Lessons from the 2014-2016 Ebola outbreak in West Africa made it clear that insufficient health system capacity has an economic cost - investments in international funding and partnerships to improve global health security (Gostin and Katz, 2016).

Social and Cultural Drivers: There is a relationship between social and cultural forces and the landscape in GHD. Societal demands around governments and international organisations to tackle global health inequalities have been on the rise, fueled by media and advocacy attention (Campbell, 2019). Special mention should be made of the role of civil society organisations/ NGOs in raising these expectations. Nonprofits frequently serve as go-betweens supporting underrepresented groups and ensuring that governments fulfil their pledges to promote global health (Youde 2018).

Cultural factors continue to influence GHD by influencing attitudes toward acceptable interventions and health priorities. For health diplomacy programs to effectively

address HIV/AIDS in sub-Saharan Africa cultural taboos and belief systems must be taken into consideration (Poku Whiteside 2002).

Technological Drivers: Technological advances and innovation have become critical accelerants of GHD. Digital health technologies (ie, telemedicine and health informatics) support the wide and rapid spread of information and resources across borders. This technological advance allows collaborative global disease surveillance, research and intervention. Brown et al. (2018) highlighted the revolutionising role of technology in closing healthcare delivery gaps, especially in resource-poor countries.

Environmental Drivers: Environmental factors (e.g., climate change and natural disasters) have been gaining recognition as important causes of GHD. The struggle between health and the environment is exemplified by the outbreak of vector-borne diseases, water scarcity and food shortages. Ebi and Hess (2020) highlighted the need to take environmental factors into account when health diplomacy is used to suit these challenges appropriately. Examples of these are collaborative efforts like the Paris Agreement, which illustrate the recent recognition that health is an aspect of environmental diplomacy.

While perspectives have emphasised certain drivers of GHD, as outlined above, this thesis takes the perspective that GHD is a complex phenomenon, underpinned by a wide range of factors. Political economic social technological and environmental factors interact intricately to produce the many interconnected drivers of GHD. Importantly, knowledge of such drivers is necessary to formulate strategies that fight the world's health problems with the use of international cooperation.

2.5. GLOBAL HEALTH DIPLOMACY AND UAE LEADERSHIP

Health attachés are representatives of countries in charge of the relationship between international relations and health; GHD is a discipline that entails some leadership attributes. Leadership skills and competencies are vital when it comes to the interface of IR and health in GHD as argued by Ruckert et al. (2016). The skills of negotiating agreement and interpersonal communication in an ability to describe health problems, as well as cultural sensitivity skills are valuable. Moreover, as stated by Javed and Chattu, (2020), there is a need for teamwork to develop formation and cooperation while strategic planning and analytical skills are essential for developing comprehensive strategies. There is a requirement for legal intelligence when it comes to international health legislation and crisis management skills, especially in the event of a medical emergency. Ross et al., (2020), explained that GHD is based on the principles of

ethical leadership and these include; truthfulness, being open and being just. It is also necessary for the leaders in GHD to display certain competencies in crisis management, negotiation, intercultural sensitivity, communication, strategic thinking, legal, collaboration and ethical reasoning.

According to Jogerst et al., (2015) in the study, the interprofessional competencies for global health for health care professionals of the 21st century include leadership, collaboration, communication and ethics. These skills and competencies can be considered important for GHD. Thus, UAE health attachés should be able to collaborate, address ethical dilemmas and engage in purposeful interprofessional communication. Gauttam et al., (2020) underline that the geopolitical implication of the COVID-19 pandemic was that it placed a lot of value in diplomatic, negotiating and strategic planning skills. While advocating for International Health Regulations (IHR) and the powerful leadership of the WHO, Burkle, (2015) relates to the necessity of having strong leadership competencies in the process of enacting legislation and the need to enhance the legislations that governs the health sector in the global market. It is expected that UAE health attachés should know the international health legislation and be ready to lead in the enhancement of health security globally. In the work of Emerson (2018), the author focuses on cooperation in public health in LMICs and, as a result, the significance of teamwork and relationship management skills in GHD is highlighted. The UAE health attachés need to be able to build relationships and partnerships, gain an understanding of the different contexts and address other's needs.

In their paper on corruption in global health, Mackey et al., (2016) point out that GHD needs to be open, honest and accountable. These are the characteristics that UAE health attachés should possess and drive the fight against corruption in the global health sector. Fazal, (2020), in the discussion of health diplomacy during pandemics, places a strong emphasis on the value of flexibility, clear communication and crisis management abilities. These abilities are useful for UAE health attachés in responding to and dealing with health emergencies, as the threat is still present given the occurrence of various health crises around the world. Gostin and Katz, (2016) point out the need for legal awareness, policy review and the possession of strategic planning skills while introducing the International Health Regulation as the global health law. A grasp and application of this framework are crucial to various diplomatic responsibilities of UAE health attachés. The article by Harmer and Buse, (2014) elaborates on the shift in the global health paradigm by the BRICS countries (Brazil, Russia, India, China, and South Africa). This shows how important it is to have flexibility, vision and strategic

planning from leadership. UAE health attachés must be prepared to respond to new trends in the development of the healthcare system and to be proactive about the practices that stem from these changes.

Since leadership is a complex construct, it should involve multifarious facets of skills and traits that are found in effective leaders (Karwa et al., 2023). Communication as one of the basic skills can be defined as the ability to connect, listen and define the vision. Critical thinking, decision making and adaptability, when faced with issues in problem-solving, constitute important problem-solving skills. Ruckert et al., (2016) state that empathy is important in leadership since it leads to development of trust, teamwork and a positive organisational culture. Leaders understand and take their subordinates' sentiments and opinions into consideration. Another crucial element is motivation. Engaging the employees' desire to achieve a purpose provides them with clear goals and objectives to pursue, as well as encouraging and rewarding success. According to Sinnema et al., (2020), leadership skills in conflict management guarantee that any challenge can be handled and resolved in a positive manner providing the necessary safeguard to teamwork and productivity. Flexibility is the key requirement which should be met by leaders especially as the environment is dynamic and people need to embrace change. A more inclusive theory of leadership may encompass these many skills and competencies and may prove to be more useful in guiding research in the field of leadership. An analysis recognises that leadership is a multifaceted concept in general leadership literature. Some of the skills that are evident in leaders include interpersonal communication skills, critical thinking skills, problem-solving skills, interpersonal perceptions, motivational skills, conflict-solving skills and flexibility. This is because these many talents and competencies are vital in enhancing a more comprehensive understanding as well as the practical application of good leadership.

Role of Leadership in International Health Attachés of the UK, USA, India, Switzerland

The leadership of international health attachés including those from the UK, USA, India and Basel Switzerland promote GHD. Health attachés in the UK are involved in the formulation of the WHO's global health priorities and have been participating in communicating with international partners. Health attachés are required to engage in negotiations with the countries of interest and offer their professional insights into the USA's global health endeavours and aid activities (Singh and Chattu, 2021). In the framework of an increased participation of India in GHD, health attachés are useful for building bilateral and

multilateral partnerships, in particular in South Asia and for exporting Indian generic medicines. Switzerland has many multinational organisations in the field of health, and it also has health attachés to engage in discussions and establish consensus on health issues of the world. As stated by Gauttam et al., (2020) health attachés in these countries have to negotiate, cooperate, understand policy and manage crises in addressing and promoting global health issues. Because of the political, historical and health circumstances, different countries have different leadership in terms of their international health attachés. This is shown when the leadership roles of the UK, USA, India and Switzerland are compared to see the multiple strategies these countries use.

Wang et al., (2019) have conducted an analysis of the health literature around the world. The emerging global health issues require that the international health attachés be up to date. For instance, health attachés from the UK and the USA represent governments that have spent much money on health research and may use the research capacities of their countries to set their agenda to influence health policy internationally. India and Switzerland, however, could focus on a niche sector in which India had some expertise or interest. The fragmentation of global health was under discussion in the article by Spicer et al., (2020). The situation in the UK is different from the USA, India and Switzerland because it belongs to the European continent. The health attachés from the UK may focus on the coordination of the efforts in the European countries. Because the USA is among the world's leading countries, health attachés may be likely to mediate between different stakeholders. Therefore, since India is one of the leading countries in the Global South, the emphasis may be on South-South cooperation. Health attachés in Switzerland, which is host to several international organisations, could focus on working with national governments (Brown et al., 2018).

For instance, in COVID-19, Sparke and Williams, (2022) examine the roles of neoliberalism on global health. The authors suggest that the health attachés of the USA, which is a representative of neoliberal policies, could reconsider these policies. Swiss health attachés could facilitate the discussion on neoliberalism's practices between nations and international organisations. Health attachés from both the UK which finished Brexit and India, a leading global health player, have focused on their own nations' needs while helping to secure global health.

Paul et al., (2020) underlined that there is the need to shift in the integration of local, national and global health. They note that a shift in emphasis may have occurred regarding integration within post-Brexit Europe for the UK's health attachés. The USA may focus on

the fact that domestic policies are aligned with international health goals. India may connect both domestic health goals and related objectives with the larger South Asian region. Switzerland may act as a mediator and participate in the discussion of international health problems. The two issues of cholera and migration are covered by Awofeso and Aldbak, (2018). Because of the internal and external migration, the health attachés of India may participate in regional cooperation. To address these illnesses associated with migration, the UK and the USA may focus on travelling practices, immigration policies and bi-lateral conventions. Switzerland's tradition of humanitarianism might assist in discussing the issue of migrants' health. Singh et al., (2022) analysed GAVI and its working as a new model of global health partnerships. The country that hosts GAVI is Switzerland which plays a crucial role in the functioning of the organisation. The UK and the USA, being major funders in GAVI, may realise that their health attachés engage in organisational decision-making. Some health attachés from India, a GAVI donor as well as a beneficiary, might focus on acquiring vaccines, as well as sharing experiences.

2.6. ANALYSIS OF CURRENT AND EXISTING MODELS OF GHD

GHD Model of the United States: Brown et al., (2018) investigated the profile of health ambassadors accredited to the United States to stress the role of diplomacy in world health. Historically, the United States has been one of the most active countries in the field of GHD through such organisations as the Centres for Disease Control and Prevention and USAID. Godinho et al., (2023) coined the term 'digital health diplomacy' for the first time in this piece where it can be defined as the use of the internet and other platforms in health diplomacy and 'digital vaccination passport'. Afshari et al., (2023) in their argument for improving GHD, especially in non-communicable illnesses, noted that global health networks are essential in GHD. The United States has a mixed approach to GHD, whereby it participates in multilateral organisations and fosters bilateral ties with particular countries.

GHD Model of the United Kingdom: Wang et al., (2019) categorised the UK as one of the contributing countries in the analysis of global health research. The UK has been investing significantly in global health-related research and development. In the aspect of health diplomacy, it was found that the UK employs both bilateral and multilateral approaches in its health diplomacy. It also plays a significant role in major international health organisations such as the WHO and the United Nations for contributing to the worldwide health policy and collaborating on projects related to health. The Beveridge healthcare model

can be exemplified by the National Health Service (NHS) that is practised in the United Kingdom. This strategy is closely connected with the principle of equal access to healthcare services and the concept of state healthcare insurance. NHS is a symbol of the UK's commitment to the provision of healthcare equity and it is a free service for all citizens, but there has been an upsurge in recent years of private health facilities. This policy of the government is to provide the citizens with easy access to healthcare facilities while at the same time expanding health coverage. The NHS promotes health care as a basic human right and thus the services are free to the consumer, though the providers have been tending to privatise. The NHS is a true testament to the UK's resolve to improve the quality of health of its people and the fair provision of the same.

Wang et al. (2019) in their review of international health research also identified the UK as one of the major donors. The UK has developed a significant number of research and development to do with global health. The United Kingdom uses a mixed approach with both bilateral and multilateral approaches when it comes to its health diplomacy. As a result, it actively participates in the policy-making processes of key global health organisations such as the WHO and the United Nations on issues that relate to health.

Further, McMullen (2020) analysed the role of the UK in protecting worldwide health security. Several funds are dedicated to the UK approach to GHD as the Department for International Development (DFID) and other organisations, as well as substantial funding is allocated for research and development. The UK government relies on diplomacy in fostering cooperation and partnerships in the global health sector. Analysing such well-defined categorisations as classic diplomacy, new diplomacy, contemporary diplomacy and different healthcare regimes discussed by theorists like Esping-Andersen (1990) aids in defining GHD models. This knowledge helps to place the various approaches to GHD employed by the investigated countries and can be used as a basis for analysing their respective GHD policies.

McMullen, (2020) has comprehensively discussed the role of the UK in supporting global health security pointing out that it benefits the country to do so. Another key feature of the UK's GHD strategy has been manifested by the financial commitments including through the DFID and massive spending on research and development. The UK government also employs diplomacy in establishing partnerships and friendships in the international health system.

GHD Model of India: In the context of GHD, Chattu et al., (2021) discussed India's increasing role and involvement in the COVID-19 vaccine and the Agreement on Trade-

Related Aspects of Intellectual Property Rights (TRIPS) at the World Trade Organisation. Especially for the poor world, India is rapidly offering resources as a source of cheap medicines and vaccinations. Pursuing capacity development in GHD is based on the knowledge of education by Pati et al., (2017) on the assessment of global health education in India. Therefore, the Indian government is capable of making a substantial contribution to GHD as it has its strong pharmaceutical industry and universities to produce human resources and inexpensive healthcare facilities. India is not limited to only one way of international health diplomacy. It employs traditional and innovative diplomacy approaches to address the challenges that affect health in the international community. India has been actively participating in the process of partnership with other emerging countries which signifies South-South cooperation. Additionally, Chattu et al., (2021) note that it is involved in BRICS-based health partnerships and therefore is part of global health governance. The healthcare industry in India is quite distinct as it comprises both the public and private sectors. This fact occurs due to the large and diverse population of people in India, which makes it challenging to reach out to every single person and provide them with necessary healthcare services. However, in the recent past, there have been practices that seek to enhance access to health services coupled with the improvement of the healthcare system as the nation seeks to improve the quality of its citizens.

GHD Model of Switzerland: Switzerland can be best suited in the category of GHD because it has been historically neutral and concerned with humanitarian issues. Flahault et al. (2017) critically reviewed the concept of precision global health. They called for the use of information technology and encouraged the right use of IT for enhancing and improving health outcomes. Thanks to its geographic position, Switzerland has been actively involved in supporting and developing particular global health initiatives taken by many worldwide organisations with a focus on the WHO. Wernli et al., (2016) provide an informative analysis of how academic institutions could enhance world health. More specifically, Switzerland's connection to academics and international health organisations has been identified and is well-established. The Global Health Centre needs to work towards establishing specialised programmes that will enhance the existing knowledge and offer a wider range of educational programmes on leadership. Currently, Switzerland has been conducting a GHD training institute in Geneva. In this regard, the graduate institute is offering the best possible training and participating effectively in the GHD model in Switzerland. Kickbusch et al., (2007) also note that during the 2007 Summer Programmed on GHD, the Graduate Institute of

International Studies, Geneva (HEI), enrolled 18 students from 10 nations and all of them had diplomatic and health care experience. As it is mentioned by Kickbusch et al. (2021), there is a vast network of regional coordinators for health attachés in Geneva. The WHO has six regions and an annual nomination of a coordinator for each region. These people perform several functions including managing several interactions between the WHO governing bodies, the WHO Secretariat and delegations of Member States and election of chairman and vice-chairmen for the international talks. The Swiss version of GHD differs from the other versions in terms of accuracy, effectiveness, teamwork and creativity (Soherwordi, Qayyum and Qayyum, 2022). Most of the Swiss GHD initiatives employ exquisitely designed strategies which include the research, data analysis application of state-of-the-art technology and critical scholarly analysis. Nonetheless, Flahault et al., (2017) also underscore the process of negotiation and dialogue among many actors, including the governments, non-governmental organisations and the commercial sphere which is a part of Swiss health diplomacy. Unlike most countries, Switzerland is a neutral country which makes it suitable to mediate and negotiate in the field of health internationally.

According to Flahault et al., (2017), Switzerland, known for its neutrality, has a rich tradition of engaging in international relations in the health field. The nation frequently takes a leading role in debates on international health issues, and contributes to driving and influencing international health systems. Switzerland is one of the countries that has adopted the Bismarck model of healthcare through the provision of mandatory health insurance (Hassenteufel and Palier, 2007). In terms of residents, that is a clear paradigm that comes with free healthcare services to the residents. Healthcare is competitive in Switzerland and choice and efficiency are key concepts of the Swiss health care system as it relates to competition among healthcare insurers and healthcare providers. The people of the country must have health insurance and there is comprehensive coverage. As with many of the models presented in this report, this one also underlines Switzerland's commitment to healthcare competition and choice. It becomes possible to go beyond the specified spheres of a republic, by using networking skills and cultural intelligence to include the other leadership competencies that turn out to be useful in real-world debates and implementations in this regard. This will help in getting a deeper insight into leadership in GHD.

GHD Model of UAE: According to Brown et al., (2018), in the recent past, there has been a growing commitment to the health diplomacy of the UAE. In particular, it actively develops diplomatic partnerships and cooperation with other countries and international

organisations, especially in the sphere of healthcare. To this effect, the UAE avails itself in addressing major health challenges at the international level through the provision of humanitarian assistance. The health care system in the UAE is generally, inspired by the Bismarckian model and contains both the facilities of private and public nature. To lure more and more medical tourists to the country, it has spent a lot of money on the health sector to offer good quality medical treatment to its people and international tourists.

Other Models of GHD: GHD requires numerous networks and models and is made in a way that suits the unpredictability of international issues to health. The current literature identifies strategic planning, cultural responsiveness and technology advancement as helpful in promoting GHD as pointed out by Kickbusch et al. (2007) and Gostin and Katz (2016). Of these, the South Korean model is specifically worth mentioning as one of the samples of the actively responsive and responsive model of GHD.

The vast improvements in the health sector in South Korea and the general technology of South Korea have placed South Korea in the global health sector. Even in the era of the COVID-19 pandemic, the country was seen to have displayed prudent leadership in the approaches taken towards the crisis-response strategies of ‘novelty and breaking the conventional. Information technology solutions such as contact tracing applications and telemedicine platforms not only helped to stop the local transmission of the virus but also showed that South Korea is a world leader in terms of innovation (Kim et al., 2020). This methodology focuses on the increasing importance of technology applications for GHD initiatives, which propose the process of integrating digital innovation into health diplomacy.

Further, the Republic of Korea’s participation in international health initiatives, such as its contribution to the Global Fund and WHO shows its commitment towards developing international partnerships. The countries’ priorities for capacity development, particularly the LMICs affirm their desire towards universal health and sustainable development. In the process of training and technical support, South Korea links its diplomacy with the nature of effective GHD according to the findings of greater literature (Lee and Smith 2011).

2.7. IMPLEMENTATION AND REPORTING IN GLOBAL HEALTH DIPLOMACY

This is evident from the discussion in this chapter in which the field of GHD is demonstrated as a growing and dynamic area. It deals with complex questions on the intersection between international relations, health and governance and provides an

opportunity to discuss more general topics related to global cooperation, justice and responsibility. Implementing GHD strategies is a stepping stone to address significant health issues around the world, but at the same time carries the potential risks and benefits that hinder its diffusion and image.

Practically, GHD provides channels to advance global health equity and facilitate international partnerships. Nevertheless, it can also be criticised if seen to be driven by the strategic aims of powerful countries and/or organisations. There are however actors who focus on primary health interventions, but others on building health systems, universal health coverage and the social factors of health. The most common differences in GHD implementation usually result from different motivations, capabilities and methodologies of stakeholders. For instance, GHD initiatives may vary from targeted disease eradication campaigns to broader efforts addressing health security and pandemic preparedness (Fidler, 2004).

The development of GHD approaches has received increased interest and different international organisations and governments are using formal regulations to institutionalise and coordinate their actions. Such as the creation of organisations, such as the Global Health Security Agenda (GHTA) and the IHR, show a programmatic, global effort to develop and deploy GHD (Gostin Katz, 2016). These frameworks support more inclusive interventions like disease intelligence, capacity development and synthesising policies so that global health risks are well managed efficiently.

Three strategies in implementing GHD have been described as follows (Asadi-Lari et al., 2021). The first strategy in implementing GHD concerns health systems' ability to resist shocks and enhance infrastructure, staff and management. This method is especially popular in the areas where health systems are underfunded and need continuous funding to provide vital services. The second one is the response strategy which aims at efficient and timely management of health emergencies for instance an epidemic, famine natural disasters and the like. As stated by McInnes and Lee (2012), this requires the use of resources, expertise, and technology at the disaster site, which has a positive association with reducing mortality and morbidity rates. The third strategy is advocacy by engaging in diplomatic negotiation to ensure that governments and multilateral organisations support ongoing funding and programmes for global health (Kickbusch et al. 2007).

Effective reporting is increasingly required to support GHD strategies, as elsewhere in the business world. Accuracy and consistency in reporting fosters credibility among the

parties and, therefore, the right decision-making is made alongside accountability. Specifically, analyses such as those from the WHO enable exposure of the successes and failures of health diplomacy activities and assist in future activities. Practices and skills regarding health outcomes, financial reporting and stakeholders' involvement are also considered crucial, even though reporting procedures are quite diverse. External endorsement of health diplomacy outcomes has been appreciated in the recent past as a way of seeking legitimation (Mattingly, Harrast and Olsen, 2009). Another approach to enhancing stakeholders' confidence and enhancing the credibility of reports is through external assurance that is conducted by either auditors or evaluators. For instance, evaluations of health programmes regarding frameworks like SDG have had both achievements and areas for improvement (Brown and Sridhar, 2018).

Thus, even today there are some issues in reporting on GHD. These are for instance errors arising from variation in the data collection methods, differences in the reporting formats and the challenges in determining the effect over a long period. Solving these issues and achieving clear and efficient GHD programmes calls for the subsequent reporting standards and integration of stakeholders. It remains unclear how strong the influence of stakeholders is in the realisation and reporting of GHD still is. On one hand, the involvement of such factors as governments, NGOs and civil society can on the other hand enhance the effectiveness and significance of health diplomacy activities. As pointed out by Youde (2018), inequality of power among the stakeholders is likely to lead to inequality in their priorities and results especially where some key players are locked out of the bargaining table. To solve these problems and facilitate the accomplishment of sustainable health GHD programmes should focus on enhancing equitable participation and the mechanisms of participation.

2.8. THE ROLE OF GOVERNMENT IN PROMOTING AND IMPLEMENTING GLOBAL HEALTH DIPLOMACY

For the establishment of a proper structure required for GHD, the government plays a very crucial role. They help in developing the right culture for multi-sectorial cooperation, minimising and maximising the possibilities of tackling global health challenges through partnership and policies (Buse and Harmer, 2007; Kickbusch et al., 2012). In centuries past, governments moved from being mere passive bystanders to being active proponents and supervisors of the GHD environment, partnering with intergovernmental agencies, non-governmental agencies (NGOs) and the private sector to influence the health agenda.

Governments play several strategic roles in promoting GHD. These roles include (i) regulation, which involves the establishment and enforcement of legal frameworks to ensure compliance with international health standards and agreements (Gostin and Katz, 2016); (ii) facilitation, which includes providing funding, infrastructure and incentives to support collaborative initiatives aimed at improving global health outcomes (Kickbusch et al., 2012); (iii) brokerage, where governments act as intermediaries to bring diverse stakeholders together to address complex health issues (Fidler, 2010); and (iv) advocacy, which involves championing global health issues at international forums to ensure they remain high on the global agenda (Lee and Smith 2011).

Facilitation means the establishment of an environment for the delivery of GHD programs. Governments attain this through the awarding of resources, encouragement of innovation or creation of public-private partnerships. For instance, the willingness of the governments to foster cooperation among the states in the identification and fighting of threats in the health sector is evident with the formation of the Global Health Security Agenda (GHSA) (Kamradt-Scott et al., 2016). It is for this reason that programmes for capacity building and financial incentives are useful in enabling stakeholders to embrace sustainable health practices.

In many instances, the government acts as an intermediary that interacts with several other parties to address significant health issues. They create platforms through which dialogue can occur between international organisations, businesses and civil society to build agreement and spur collaborative action (Fidler, 2010). Government advocacy is also very important; it encompasses the use of diplomatic channels to mainstream health priorities in global governance. This advocacy has played a central role in the development of agreements such as the Framework Convention on Tobacco Control (FCTC) which serves as the benchmark for the fight against non-infectious diseases across the world (WHO, 2003).

The application of soft power, no political influence, has become a focal point of government approaches to advancing GHD. This paradigm involves creating awareness, financial support for research and sponsorship of programs that are consistent with global health targets (Kickbusch, 2011). Eg) Governments have actively supported the implementation of SDGs embedding them within national health plans thus making a public commitment to fielding universal health coverage (UHC).

Across regions, there are divergent paradigms about GHD depending on political, cultural and economic contexts. In Europe, responsible authorities tend to focus on joint work

by exploiting local structures, such as the European Union, to implement health policies. On the other hand, the nations in the Global South emphasise bilateral compact and focused capacity-building initiatives that are specific to the local health situation (Gostin and Katz, 2016). These differences suggest the importance of culturally adapted GHD that addresses local needs.

Governments worldwide have implemented various initiatives to promote GHD. For example, the creation in the US of the Centres for Disease Control and Prevention, its leading role in global health, highlights the mission of governmental organisations to facilitate technical solutions and financing for global health initiatives (CDC, 2020). Also, The European Commission's funding of the European Developing Countries Clinical Trials Partnership (EDCTP), highlights the value of regional partnership in medical research and innovation (European Commission, 2018).

Governments have a complex role in GHD promotion and implementation. Through monitoring, coordinating, mediating and speaking in favour of global health programs, they play an important role in the solution of complex health issues. The convergence of soft power policy and regional focus further strengthens the government's action in this area.

2.9. A CRITIQUE OF LEADERSHIP APPROACHES IN GLOBAL HEALTH DIPLOMACY

Leadership approaches in GHD have drawn a lot of attention because they can help address complicated international health issues and advance equitable health outcomes as this chapter examines (Kickbusch et al. 2013). The current leadership strategies are intended to promote health equity strengthen international health systems and foster transnational cooperation. Nonetheless, despite such hopes, the use of leadership strategies in GHD has been marked by significant restrictions and criticisms, as explained in the following.

One criticism is that governments and operational policies have focused too much on soft power diplomacy, maybe at the cost of real action. Leadership in GHD is sometimes described as the building of relationships and the creation of conversation and thus the utilisation of “soft power” tactics (Kickbusch et al., 2007). While these could help in nurturing and maintaining the culture of collaboration and teamwork, they do not necessarily offer additional practices to ensure that individuals are held responsible for their actions and that change is visibly observed. For instance, negotiations will result in the formation of soft power agreements which, in low-resource countries, may not yield tangible health outcomes (Youde,

2018). Global health agenda-setting is also criticised for the influence of high-income countries. Leadership in GHD is often made by powerful countries in terms of their economic and political weight, resulting in power imbalance (Birn et al., 2017). This hegemony may exclude the voices of low- and middle-income countries, in which health issues and requirements could be underrepresented. Such imbalances continue to fuel global health disparities and are not the solution to their effectiveness (Hoffman Rottingen, 2014).

Concerns have also been raised about the long-term viability of global health programs under charismatic leadership (Figueroa et al., 2019). While visionary leaders play a crucial role in advancing global health agendas relying too much on one-on-one mediated leadership can harm the resilience and continuity of the institution (Frenk, 2010). That dependence is often followed by short-lived projects without institutional anchorage, which prevents sustained progress on GHD.

Other criticism is related to the incongruity between health diplomacy targets and priorities of recipient countries. Leadership approaches are often commercial of the logic of the donor countries and do not aim at the real and deep health needs of the populations that the donor countries are trying to serve (Labonté Gagnon, 2010). This kind of funding is systematically focused on diseases that are a threat to the donor countries, e.g., pandemics, whilst often completely ignoring endemic diseases, e.g., malnutrition, or non-communicable diseases in the recipient countries (Rowson et al., 2012). This narrow focus poses questions about the equity and effectiveness of GHD initiatives.

In addition, leadership styles in GHD have been criticised for their lack of integration into non-state actors. Despite increased examples of partnerships between governments, NGOs and the private sector, these partnerships frequently suffer from the absence of needed structural frameworks of support for successful partnerships between different entities (Kickbusch, Cassar Szabo, 2014). This may lead to piecemeal efforts that do not deliver a systemic outcome on global health at the level of the system.

Lastly, the lack of a cultural and contextual awareness of certain approaches to leadership is yet another limitation. World health diplomacy programs do not foreseeably adopt a "one size fits all" approach and incapacitate themselves from the socio-cultural and economic considerations of the countries they wish to reach out to (Gostin and Katz, 2016). Such methods may inadvertently compromise the acceptance and usability of health interventions resulting in a backlash from local actors and a weak effect. Thus, the management of high-level health matters through excellent leadership in health diplomacy is

good but it is not a walk in the park. It is imperative to embrace fair, inclusive and culturally sensitive leadership practices due to these concerns regarding the cultural relevancy and sustainability of the Anglophone high-income countries' soft power dominance (Lo, 2011). To further the progress of the field and to promote positive, sustainable changes in the health of individuals across the world, it is necessary to respond to these criticisms.

2.10. RESEARCH GAP

This chapter has highlighted five key gaps in the GHD leadership literature: limited insight into attachés' lived experiences, lack of focus on individual competencies, lack of integration of leadership theory with GHD practice, minimal exploration of leadership barriers, and underrepresentation of attachés' perspectives. This section will now explain these gaps further.

Despite much being written about GHD, little is known about how leadership is experienced by those directly involved, such as health attachés and senior diplomats. (Chattu et al, 2023; Rosenbaum et al., 2025). While existing literature explores the rules, structures, and strategic dimensions of GHD, there is a notable gap in understanding how leadership competencies, such as intercultural communication, negotiation, public speaking, advocacy, and crisis management, influence its effectiveness (Rosenbaum et al., 2025). Investigating these competencies is critical for developing a more practical and human-centred framework of leadership in GHD (Ross et al., 2020). There is not much research available on the everyday lives, choices and ways of working of health attachés and stakeholders who mix diplomacy and public health (Sharfi, 2021; Dialer, 2025). Many studies focus on organisations' actions in global health (Karačić Zanetti et al., 2023; Balkhy, 2025), rather than on how individuals view their responsibilities, interact in global negotiations and influence the overall health of the world (Luh and Baltag, 2021; Ruckert et al., 2022). This thesis aims to address this gap by using direct input from UAE international health attachés. By gathering these special insights, the study adds a new layer to understanding GHD, joining other studies that look at policy matters with real-world examples of leadership (Birn et al., 2017).

A key research gap lies in the limited scholarly exploration of how leadership theories and skills are specifically applied within the specialised field of GHD, where technical health expertise intersects with diplomatic negotiation and international policy influence (Karačić Zanetti et al., 2023). While numerous studies have examined leadership in public health management and diplomatic contexts separately (Chattu et al, 2023; Rosenbaum et al., 2025),

there remains a significant absence of empirical research that integrates these domains to understand how international health attachés navigate complex political, cultural, and institutional environments through their leadership behaviours (Ruckert et al., 2022). Existing literature tends to focus on the political, structural, or institutional dimensions of GHD (Brown et al., 2018; Chattu et al, 2023), yet it rarely investigates the interpersonal and leadership competencies that enable attachés to translate global health goals into actionable diplomatic outcomes (Chattu et al, 2023; Rosenbaum et al., 2025). This study highlights the unique requirements of health attachés working in high-pressure areas of GHD, despite the fact that the great bulk of the literature has concentrated on general diplomatic abilities (Kickbusch et al., 2007; Lee and Smith, 2011). Therefore, this study seeks to provide a comprehensive and integrated framework that encompasses both diplomacy and health-related leadership skills. In doing so, it examines how the UAE's unique geostrategic position, its multi-ethnic workforce, and its initiatives toward a national strategic policy for global health influence the development and exercise of these capabilities. By focusing on the perspectives and experiences of UAE health attachés, this thesis aims to illuminate the ways in which leadership competencies are shaped by contextual, organisational, and policy factors, offering insights that are directly relevant to enhancing the practice of GHD. This thesis seeks to bridge a significant gap in the literature by combining diplomatic and health-oriented skills (Horsfall, 2013; Buss and Dry, 2015).

Moreover, most prior research on health diplomacy emphasises the role of national health ministries, global organisations, or state representatives (Javed and Chattu, 2020; Balkhy, 2025), without paying sufficient attention to the individual-level leadership dynamics that shape negotiations, coalition building, and policy advocacy at the diplomatic interface (Kamradt-Scott et al., 2016; Rosenbaum et al., 2025). This gap is particularly pronounced in the absence of models or frameworks that capture the lived experiences, strategic decision-making processes, and leadership development needs of health attachés who operate in multicultural and high-stakes diplomatic environments (Ruckert et al., 2022; Karačić Zanetti et al., 2023). Additionally, there is limited understanding of how leadership skills such as emotional intelligence, cross-cultural communication, and ethical reasoning influence the effectiveness of GHD in addressing transnational health challenges (Brown et al., 2018; Chattu et al, 2023). Addressing this gap is essential to advance both theoretical and practical knowledge, enabling the identification of leadership competencies that not only enhance

diplomatic performance but also contribute to more equitable and collaborative global health governance (Kickbusch et al. 2013).

A major research gap in the study stems from the scarcity of empirical evidence examining how health attachés themselves perceive and interpret the challenges that hinder their ability to effectively exercise leadership in international health negotiations and diplomatic engagements (Ruckert et al., 2022; Rosenbaum et al., 2025). While GHD has increasingly been recognised as a vital mechanism for advancing global health agendas and strengthening international cooperation, most existing studies have focused on institutional frameworks, policy outcomes, or state-level interactions (Luh and Baltag, 2021; Lal, 2025), leaving a limited understanding of the personal, organisational, and systemic barriers that affect individual actors within this space (Chattu et al, 2023; Dutta, 2025). There is also a lack of research exploring how the unique position of health attachés, situated between the worlds of diplomacy and public health, creates specific leadership challenges related to authority, legitimacy, inter-sectoral coordination, and communication across cultural and bureaucratic boundaries (Kamradt-Scott et al., 2016; Rosenbaum et al., 2025).

Additionally, previous literature has often emphasised the strategic and technical functions of health attachés (Esapebong-Ray, 2024; Balkhy, 2025), without adequately considering the leadership dimensions of their roles, particularly how power dynamics, institutional constraints, and political sensitivities limit their capacity to act as influential leaders in GHD settings (Ruckert et al., 2022; Karačić Zanetti et al., 2023). The perspectives of health attachés themselves are underrepresented in scholarly discourse, resulting in an incomplete picture of how they experience, negotiate, and attempt to overcome barriers such as limited resources, conflicting mandates, or insufficient recognition within diplomatic hierarchies (Horsfall, 2013; Buss and Dry, 2015). This absence of qualitative insight into their lived experiences represents a crucial gap, as understanding these perceptions could inform more effective leadership development, training programs, and policy reforms that empower health attachés to navigate the complex interplay between diplomacy, health policy, and leadership more effectively.

More specifically, the role of international health attachés has remained underexplored within the GHD literature (Lal, 2025; Dutta, 2025). While some studies acknowledge the importance of diplomatic representation and technical expertise in global health negotiations (Millar et al., 2025; Rosenbaum et al., 2025), there is a notable lack of empirical research examining how leadership skills are enacted, perceived, and constrained within the day-to-day

professional responsibilities of health attachés (Ruckert et al., 2022; Esapebong-Ray, 2024). Existing leadership studies in global health tend to focus broadly on public health leadership competencies or organisational leadership within health systems (Alkhaldi et al., 2023; Dialer, 2025), without sufficiently situating these competencies within diplomatic contexts that require negotiation, advocacy, cultural sensitivity, and strategic policy alignment (Millar et al., 2025). Furthermore, the literature reveals a methodological gap, as much of the current research on leadership and GHD relies on conceptual models, policy analyses, or secondary data, rather than qualitative, experience-based inquiry (Lal, 2025). As a result, limited attention has been paid to the lived experiences and perceptions of practitioners who function at the intersection of diplomacy and global health (Dutta, 2025). This has constrained scholarly understanding of how leadership skills are practically developed, challenged, and adapted in dynamic international health environments, particularly during global crises or politically sensitive negotiations (Rosenbaum et al., 2025).

In addition, there is a clear contextual gap pertaining to the UAE. While the UAE has emerged as an increasingly influential actor in GHD, through international health partnerships, humanitarian aid, and participation in global health initiatives, academic literature remains scarce regarding its diplomatic health workforce (Alkhaldi et al., 2023; Dialer, 2025). Specifically, there is a lack of systematic research examining how international health attachés of the UAE perceive their leadership roles, the skills they associate with effective GHD, and the barriers that may limit their leadership capacity within international settings (Sharfi, 2021; Millar et al., 2025). Consequently, the intersection of leadership skills, GHD, and the professional experiences of international health attachés, particularly within the UAE context, remains insufficiently theorised and empirically grounded (Antwi-Boateng, 2022). This study will address this gap by providing an in-depth qualitative analysis that integrates theoretically informed themes with inductively derived insights from practitioners' experiences. In doing so, it seeks to contribute original knowledge to the GHD literature by illuminating how leadership skills are understood, enacted, and developed by international health attachés operating within a distinctive national and diplomatic context (Sharfi, 2021; Dialer, 2025).

2.11. CONCLUSION

This chapter aimed to explain what leadership entails in addressing the GHD and presented how the need for leadership in addressing complicated global health challenges is being embraced. The issues of leadership and diplomacy in this context go hand in hand with

the need for equal access to health care and attending to health concerns on the transnational level. In the chapter, various definitions, paradigms and initiators of leadership in GHD were analysed in line with theoretical and historical developments.

The earliest international public health activities that involved diplomacy and its stopping of pandemics as well as encouragement of diplomatic relations worldwide are where the first leadership strategies in GHD originated. In theoretical terms, the bases of leadership in this area were enriched step by step with the use of adaptive, transformational and collaborative leadership theories. The models also emphasise not only the response to crises but also the creation of effective structures that can be built and easily adapted for global health equality.

In GHD, leadership has shifted from a short-term and crisis-based approach to a strategic and organisational approach. The current plans acknowledge that leadership is linked to the interaction with various stakeholders including the government, NGOs, international agencies and the private sector partners. For them to achieve these goals of society's public health, the leaders of these societies have to take into consideration the political, economic and ethical factors.

Nevertheless, the chapter revealed various issues and concerns regarding GHD leadership, which is rather surprising given its importance. These include the problem of how to manage political stress, the problem of aggravating existing injustices arising from power disequity, and the problem of dealing with conflicts of interest in the progressively internationalised health arena. Also, leadership strategies may or may not work depending on the context and this is a clear indication that strategies should always be sensitive to the local and regional contexts.

This work is based on a view which sees stakeholders, ethical leadership, and networks as key to the functioning of leadership in GHD. These stress the need to understand the wider context, responsible use of resources, and decision-making involving the public. Therefore, the field of GHD leadership is complex, active and full of potential to contribute to global health challenges. Still, there currently is no clear consensus on the most appropriate and effective model of GHD leadership.

The reviewed literature reveals significant gaps in understanding leadership within GHD, particularly with regard to the lived experiences and leadership practices of health attachés who work at the intersection of health and diplomacy. Existing studies, with their focus on institutional and policy frameworks, offer limited insight into how individuals enact

leadership in complex, multicultural negotiation environments or how key competencies shape their effectiveness. The absence of empirical, experience-based research leaves critical questions unanswered about how health attachés navigate political sensitivities, authority boundaries, contextual pressures, and resource constraints, especially in high-stakes diplomatic settings. These gaps are especially evident in the UAE context, where health attachés play an expanding role in GHD but remain under-examined in academic discourse. This study seeks to address these shortcomings by providing a theoretically grounded yet practice-informed exploration of how UAE health attachés perceive, experience, and enact leadership.

CHAPTER THREE: METHODOLOGY

3.1. INTRODUCTION

This chapter details the research frameworks that informed the research into the leadership skills associated with the GHD of UAE's international health attachés. The chapter discusses the philosophical aspect of selecting the research design, data collection strategies, data analysis process, ethical concerns, limitations and the conclusion. This is important as it demonstrates alignment of the approaches used to organise the research and the procedures of data collection, analysis and interpretation (Carcary, 2020).

The aim of the research was to understand leadership behaviours amongst the UAE's international health attachés, with qualitative research used as the guiding approach. Through this, the process involved eliciting the views of elite participants who play an instrumental role at the centre of the GHD story. Following that, thematic analysis was applied to the interviews, and the data grouped into themes. During the process, the researcher gave priority to participants' experiences and insights. The research pivoted on the central issues of obtaining clearance from the relevant ethics panels and maintaining the confidentiality of participants (Surmiak, 2018). This helped to support the quality and trustworthiness of the study.

This model is exemplified by the onion technique developed by Saunders et al., in 2012 to elucidate the researcher's research methodology which is composed of various specific practices at different stages of the study. The structure of the entire process is about five levels and they all map to the stages of conducting research. Together with the foundational philosophical questions, these stages concern the integrity of the data, as well as rigorous collecting, and analysis (Murthy et al., 2022). The outermost layer within a research onion is the philosophy, and the inner layers are the specific technique, although the approaches vary. After discussing the research's ethical considerations and a section on general reflexivity the chapter concludes.

3.2. EPISTEMOLOGICAL FRAMEWORK

This work sought to collect information on the attitudes, beliefs, and mindset of stakeholders directly involved in and affected by GHD activities. Because GHD involves a heterogeneous group of participants who are situated in a variety of global health and diplomacy intersections, a method was needed to capture the complex, multilayered meanings ascribed by those actors. Participants were anticipated to be able to offer a range of perspectives depending on their position, background and experience of working with GHD

practices. Therefore, the data collected needed to reflect these diverse viewpoints and realities, capturing a spectrum of understandings about GHD.

To tackle this complexity, the interpretivism was deemed to be the most suitable epistemology as it permitted the discovery of the specific, subjective meaning that participants credit to their experience of GHD. The interpretative approach recognises that every participant's reality is the outcome of their personal experience, their culturally informed environment and also what happens in their professional setting. This methodological choice facilitated the understanding of GHD through the lens of those actively engaged in or affected by it, enabling a holistic appreciation of their experiences and interpretations (Miller, Chan and Farmer, 2018).

Interpretivism has been defined as the assumption that individuals build meaning through their interaction with the environment and that this meaning is always subjective (Burns et al., 2022). This framework stresses that meaning is not deterministic and takes into consideration the individual with his/her context and circumstances (Ryan, 2018). Here, interpretivism is most appropriate to the study of GHD, because it can account for the presence of multiple realities and the socially contingent nature of knowledge (Lincoln and Guba, 1985; Hudson and Ozanne, 1988). Interpretivist epistemology suggests that, as individuals form their worlds, there is no objective reality, but realities are dynamic and based on the subjective experience and worldview of social agents (Berger, 2015).

Importantly, from an epistemic perspective, interpretivism enables researchers to understand phenomena, in effect, by knowing what individuals make of them. In contrast to positivist methods, which seek to predict cause and effect, interpretivism aims to interpret motives, meanings and subjective experience in their own time and context (Hudson and Ozanne, 1988; Neuman, 2000). That approach is very much in keeping with the goals of this work, which is to shed light on the broad range of interpretations of GHD among stakeholders and the social, cultural and political elements which inform those interpretations. Explanatory qualitative researchers operating in an interpretive tradition recognise that the research process itself involves a dynamic relationship and a two-way, mutual, interdependency between the researcher and the participant(s). Although researchers have previously experience (the "background" of the field) to inform their research, they also have to face the fundamental unknowability of the process of research itself (the unpredictability of the "serendipity" effect), acknowledging its difference in participants' assessments of reality (Hudson and Ozanne,

1988). Walsham (1995) proposes, however, that due to this method, participants can think over and describe their perception of the world to enhance the study.

In this work, the interpretivist epistemology was particularly important, because it enabled the analysis of how actors in GHD build and understand their world. In a bid to do so, using an interpretative design, the study sought to record the range of meanings and understanding of GHD practices held by participants so as to explore their perceptions, values and motivations.

3.3 RESEARCH APPROACH

According to Opie (2019) the research approach is described as the reasoning path used by the researcher to establish the connection between theory and empirical information to answer a certain research question. Research is traditionally carried out in either a deductive or inductive way. Deductive reasoning starts with some preconceived theories or hypotheses and then checks them out using empirical observation, which is usually linked to positivist paradigms (Okoli, 2023). Conversely, inductive reasoning starts with observations and creates theories or patterns, which are often in line with interpretivist schools of thought (Harris and Alderman, 2025).

The combination of inductive and deductive approaches is valuable in research because it allows the study to benefit from both data-driven discovery and theory-driven analysis (Bonner et al., 2021). The inductive approach enables researchers to explore data without imposing preconceived categories, allowing themes and patterns to emerge naturally from participants' experiences. On the other hand, the deductive approach, in contrast, allows researchers to examine data through the lens of established theories, models, or conceptual frameworks (Proudfoot, 2023). This ensures that findings are linked to the existing body of knowledge, allowing the research to confirm, extend, or challenge prior understanding (Bruno et al., 2024). By combining these approaches, researchers can maintain a balance between discovering new insights and situating them within a theoretical context, enhancing both the depth and validity of the analysis (Ismail et al., 2023).

The study employs a combination of inductive and deductive approaches to identify and analyse themes, which aligns with the principles of interpretivism. Using an inductive approach, themes emerge organically from the data, capturing participants' perspectives, experiences, and contextual nuances. Simultaneously, a deductive approach allows the researcher to examine the data in light of existing theories and conceptual frameworks related

to leadership competencies and GHD. This combined approach supports an interpretivist stance, emphasising the understanding of meaning, context, and subjective experiences rather than seeking to generalise findings or establish causal relationships (Yuwono and Rachmawati, 2023). In the context of this study, combining inductive and deductive approaches is particularly important for identifying health attachés' understanding of the relationship between leadership skills and GHD. Using an inductive approach, the researcher can capture participants' lived experiences, personal interpretations, and context-specific examples of how leadership skills influence diplomatic effectiveness in health. At the same time, the deductive approach enables the analysis to draw on existing theories of leadership, global health governance, and diplomacy, providing a framework to interpret these experiences meaningfully.

The thematic structure of this study reflects a deliberate and methodologically justified integration of deductive and inductive approaches to qualitative analysis. The primary themes were generated deductively, grounded in the study's conceptual framework and informed by the extant literature on leadership skills and GHD. This deductive orientation ensured conceptual alignment between the research questions, the analytical framework, and the overarching purpose of the study, particularly in examining leadership competencies associated with the GHD roles of international health attachés of the UAE. By establishing themes a priori, the analysis maintained theoretical coherence and facilitated a structured examination of leadership within recognised domains of GHD.

Within this deductive thematic framework, sub-themes were developed inductively through systematic and iterative engagement with the qualitative data. Rather than imposing predetermined categories at the sub-theme level, the analysis allowed patterns, meanings, and emphases to emerge directly from participants' narratives. This inductive process involved repeated coding, constant comparison, and refinement of codes to ensure that sub-themes authentically represented participants' lived experiences, professional practices, and perceived challenges in executing leadership roles within GHD contexts. As such, the sub-themes capture contextual nuances and operational realities that are not always fully articulated in existing theoretical models of leadership or diplomacy.

Threading this analytic logic throughout the findings enables the reader to understand how each theme functions as a theoretically informed domain, while each sub-theme represents an empirically grounded manifestation of that domain. For example, while the deductive theme of "Leadership Skills in GHD" was guided by leadership and diplomacy

theory, the inductively derived sub-themes, such as communication and negotiation, public speaking and advocacy, and team management, emerged from participants' descriptions of their daily diplomatic practices and leadership responsibilities. This structure demonstrates how theoretical constructs are enacted, interpreted, and sometimes reshaped within real-world diplomatic health settings.

This hybrid analytic approach strengthens the credibility and trustworthiness of the findings by balancing theoretical direction with data-driven sensitivity. The deductive themes provide analytic boundaries that prevent thematic fragmentation and ensure relevance to the research objectives, while the inductive sub-themes preserve the authenticity of participants' voices and allow unanticipated insights to surface. Consequently, the findings do not merely confirm existing leadership frameworks but extend them by illustrating how leadership skills are operationalised within the specific institutional, cultural, and geopolitical context of the UAE's engagement in GHD.

Within an interpretivist paradigm, deductive and inductive reasoning are not treated as mutually exclusive but as complementary logics of inquiry that together facilitate a deeper understanding of social meaning and context (Harris and Alderman, 2025). While inductive reasoning is traditionally associated with interpretivism due to its emphasis on generating understanding from participants' lived experiences, interpretivist research can also legitimately employ deductive reasoning when existing theories are used as sensitising frameworks rather than as instruments for hypothesis testing or causal explanation (Okoli, 2023). In this sense, deduction within interpretivism does not seek statistical generalisation or theory verification, but instead guides the analytical focus and supports the interpretation of subjective meanings embedded in social practice. The inductive process allows themes to emerge from the data, reflecting participants' perspectives and contextual realities, whereas the deductive process enables these emergent meanings to be interpreted through established theoretical lenses. This integration aligns with interpretivist assumptions that knowledge is socially constructed and context-dependent, and that theory and empirical data engage in an ongoing dialogic relationship rather than a linear process of testing and confirmation (Burns et al., 2022).

In this study, the combination of inductive and deductive approaches is therefore methodologically congruent with an interpretivist stance. Inductively, the analysis prioritises participants' narratives to capture how international health attachés construct meaning around leadership and Global Health Diplomacy (GHD) within their specific professional and cultural

contexts. Deductively, existing theories of leadership, diplomacy, and global health governance are used to inform the analytical structure and deepen interpretive insight, rather than to impose rigid categories or measure predefined variables (Harris and Alderman, 2025). By integrating these approaches, the study advances an interpretivist understanding that leadership competencies in GHD are both theoretically informed and contextually enacted, allowing the research to generate rich, nuanced interpretations that extend existing knowledge without departing from interpretivist epistemological principles (Miller et al., 2018).

3.4. RESEARCH METHODOLOGY

As has been discussed in earlier chapters, this study examines the leadership of overseas treatment leaders and health attachés in the UAE, specifically applied to the issue of GHD. The study aims to draw out the plurality of opinions of contributors and to uncover the determinant factors driving leadership practices in this unique social-cultural and geo-political context. The primary goal of the study is to comprehend the subjective realities and leader experiences of GHD stakeholders as there is currently little evidence on this topic in the literature. A qualitative approach was chosen to address this because it provides a depth of comprehension and insight into the intricate and subtle experiences that quantitative methods might miss. The selection of a qualitative paradigm is consistent with the study goals and with the requirement for the generation of meaningful and reproducible results. Moreover, the qualitative paradigm is better able to capture the full complexity of leadership practices and stakeholder perspectives than other paradigms.

Quantitative research is based on empirical evidence and put in other terms, the endeavour seeks to identify what is specifiable, i.e., such facts which can be explored. The use is based on the assumption of an objective reality, unmediated by human perception and the attempt to resolve confusion using organised procedures, such as questionnaires and experiments (Guba and Lincoln, 1994). Within this paradigm, the researcher and the entity being examined are treated as two entities, where there is minimal subjective involvement. Quantitative research often employs large, randomised samples analysed statistically, making it a robust choice for generalisable findings (Carey, 1993). Yet, its interpretability may lead to over-generalisation, i.e., the oversimplification of so-called multi-faceted, context-specific phenomena, as in the case of the leadership approaches discussed in this research.

By contrast, qualitative research emphasises the subjective reality of individuals and groups and their social constructions (Guba and Lincoln, 1994). It acknowledges that within

specific social cultural and historical contexts, reality is jointly created by the researcher and participant (Smith 1983). This method gives researchers more freedom to examine the complexities of human interactions and behaviour (Carson et al. 2001). As a tool for embedding data, qualitative methods allow for contextual richness and depth and thereby give greater depth to an investigation into the phenomenon being studied (Creswell, 2003).

The qualitative approach is especially appropriate for this research due to the inherent complexity of leadership practices in the multicultural and dynamic field of GHD. Using qualitative methodology, this study looks at the lives, motivations and realities of stakeholders and illuminates social, cultural and political factors that shape leadership in this situation. Quantitative approaches, although useful for particular applications, would not be sufficient for this work and failing to do so would result in losing the depth and richness needed for this work. For instance, structured questionnaires or surveys were probably reduce the complex and situation-specific experiences of GHD leadership to generic data points. To delve deeper into the research question however qualitative methods such as thematic analysis and semi-structured interviews can be employed.

Data for this study were collected mainly through semi-structured interviews. Through this method, it is especially useful to derive rich, qualitative understandings of participants' subjective experiences as well as provide flexibility to explore emerging themes. The semi-structured format allows the research to be both guided by targeted questions and flow with the conversation, thus providing a wide variety of viewpoints and thoughts (Lim, 2024).

The gathered information was examined by thematic analysis, a qualitative technique that extracts and classifies the data patterns and themes (Braun and Clarke, 2006). Thematic analysis is particularly suitable for this between-case study because it allows the researcher to identify contextually unique meanings and contributions of leadership practices in GHD. This technique also allows for the structuring and classification of data in a manner that emphasises the recurrence of themes and changes in the pattern of stakeholder conceptions.

The top-down approach employed in this study is in line with the study's aim of exploring leadership capabilities and strategic decision-making across the expanse of GHD. The data is based on the experience of senior participants, including UAE health attachés and leaders of health institutions. These participants are participants in direct high-level decision-making and strategic planning, so their understanding can be very valuable in understanding leadership in GHD. The top-down viewpoint has also been defended in qualitative studies, as

an approach to capture the fine-grained, rich understanding of the experts' points of view and strategic-level events (Goldstein, 2002; Harvey, 2011).

A bottom-up perspective has been proposed by some, but because of the nature of the focus of this work, on leadership and diplomacy, a top-down approach is warranted (Sabatier, 1986). The participants' level of competence in strategic negotiation, in terms of cultural agility and managing crises, reveals the important role that an elite stakeholder plays in GHD projects, over and above the important role that can be identified in the grassroots data. In addition, as mentioned by Bryman (2016), top-down approaches are particularly relevant when researching phenomena influenced by organisational hierarchies and leadership logic.

In sum, this study adopts a qualitative methodology rooted in interpretivism to explore leadership dynamics among foreign health stakeholders in the UAE within the framework of GHD. In this direction, the research objectives are met by this approach, to give depth and context to understand the complexities of the subject. Through semi-structured interviews and thematic analysis, the present study seeks to produce relevant insights into the leadership required for GHD.

3.5. RESEARCH METHODS

To obtain primary data and explore the leadership ecology of foreign treatment leaders and health attachés in the country, this section outlines the practice of conducting semi-structured interviews. The approach involves analysis of participants' profiles, interview modes, sampling modes, question modes and discussion topics. This method has the benefit of ensuring that a spectrum of stakeholder perspectives is incorporated. This is a benefit that this study hopes to achieve, leading to a better understanding of the dynamics of leadership in international health diplomacy (Saunders et al., 2007).

3.5.1. Data collection instruments

As for the Data collection instruments of this study, the deductive process, outlined below, has been applied in practice. The first one is the review of the literature as a way of determining the most relevant theories and concepts in leadership with a focus on GHD. This fact underpins the need for this literature review so that it can facilitate the conceptual framework as well as the formulation of research hypotheses. For example, this study seeks to analyse the transformational and situational leadership theories where the results of the study are stressed to determine their applicability in the field of GHD. This research examined

directors and assistant directors of the health attaché offices and heads/others in the Overseas Treatment Departments of the MOH, DHA and DOH in the UAE in GHD using thematic analysis.

Participants were questioned about their work and their perspectives on it. Participants were recruited using a purposive sampling technique for this investigation, ensuring a complete dataset. Semi-structured interviews were selected as they let interviewers make questions ahead of time but also leave room for free answers. The semi-structured interview approach was selected as it enables open dialogue and allows participants to elaborate on their experiences in nuanced and meaningful ways. The development of interview questions was directly informed by the study's overarching research objectives, ensuring alignment with the investigation's core aims. Specifically, the questions were constructed to explore themes emerging from the literature review, with a particular focus on transformational and situational leadership theories as they relate to GHD. Emphasis was placed on eliciting detailed responses regarding communication competencies, leadership behaviours, strategic decision-making processes, and the diplomatic roles assumed by participants. This approach ensured that the interviews generated rich, relevant data tailored to the specific focus of the research. It also collects valuable qualitative information that can be compared to similar research, helping to understand leadership in GHD more fully.

3.5.2. Sampling strategy

The sampling strategy employed for this research was purposive sampling of international health attachés and senior staff from the Overseas Treatment Departments of the MOH, DHA and DOH. The attachés have a very important function of promoting UAE in international health forums, engaging in diplomacy and pressing for UAE's agenda on any health matters on behalf of the government of UAE. As professionals with a foot in the diplomatic and public health arenas, HA participants are apt to provide the field with a bird's eye view of the diplomatic protocols and difficulties relating to global health engagements. Based on the research problem highlighted above, the sampling technique used in this study is purposive sampling, which is a non-probability sampling technique for selecting participants based on certain criteria that are important in the study (Vehovar et al., 2016). Therefore, purposive sampling is ideal for use in research on specific groups or when it is necessary to investigate certain aspects that require specific knowledge or experience in the subject (Nyimbili and Nyimbili, 2024).

On this premise, the subjects were chosen based on the interview questions prepared for the study, where participants with proper background and knowledge were required. Hence, the study targets the international health attaché because it comes with targeted diplomatic insights and experience on the state of diplomacy as well as its challenges and successes in the international health arena. It proves to be an appropriate way of researching because it enables one to develop clear and specific knowledge and interest in the matter under study and, therefore, gather pertinent and detailed information (Stratton, 2021). Hence, purposive sampling is suitable for this study because the research focussed on a particular population type within the health sector and the questions posed in the interviews are specifically aimed at achieving set objectives. Since international health attachés have access to the diplomatic and negotiating initiatives and processes involved in world health affairs, they are the proper subjects for this research. Also, when recruiting participants from the identified target population, the study can make sure that only participants with certain roles and, therefore, likely to possess specific knowledge pertinent to the research questions and objectives, are included in the study. Participants were identified through official directories and departmental records obtained from the UAE Ministry of Health and Prevention (MOHAP), Dubai Health Authority (DHA), and Department of Health (DOH). As the target group comprised elite professionals not easily accessible through public means, access was formally granted following the submission and acceptance of the ethical approval by the Undersecretary's Office. Contact details were provided by the relevant authorities, after which the researcher directly approached each participant via email. No intermediary or gatekeeper was copied in the correspondence in order to maintain ethical standards of confidentiality and to prevent any undue influence on the participants' voluntary decision to engage in the study. Emails included a brief of the study's aims, ethical approval confirmation, and consent forms.

The study group consisted of 16 people, including international health attachés and senior healthcare officials at MOHAP, DHA and DOH. Those taking part had a range of roles and were found in the UAE, the UK, Germany/Switzerland and India, sharing knowledge in health policy, diplomacy and international relations. The justification for this sample size is anchored on a pertinent tenet that advocates for an optimal ideal sample size; the principle of data saturation; the issue of available resources and most importantly, the human-interest research design, which requires an intensive investigation of the chief ideas and themes (Stainton Rogers, 2017). This is because, from the rationale of the target population and the proposed research methodology mainly relying on qualitative data collection techniques

including semi-structured interviews, it was possible to ensure, through the 16 participants, a sufficient and comprehensive data source. Difficulties in recruiting elite participants have been noted in the methods literature (Collett, 2024), and thus sample sizes tend to be smaller. It is important to note, however, that towards the end of the interviews, “data saturation” started to occur, with participants giving similar responses to those already interviewed (Guest et al., 2006). Given these factors, along with qualitative research’s focus on quality over quantity, the dataset obtained can be seen to offer a detailed comprehension of the diplomatic processes and issues in the GHD, which could be helpful for policymakers, practitioners and scholars in the field.

3.5.3 Conducting the interviews

The participants gave information about their gender, nationality, roles in the health sector and educational background, which gave a thorough picture of the skills needed for leadership within GHD in the UAE. Due to the diverse professional backgrounds of the participants, the study was able to explore how variations in leadership rank, organisational context, and levels of international exposure shaped their contributions to GHD. This diversity provided valuable insights into how leadership dynamics function differently across institutional settings and experience levels, particularly in high-stakes diplomatic and health crisis environments. A complete list of participant details can be found in (Appendix 8: Participants’ Characteristics, Professional Backgrounds). The participants consist of male and female people who are nationals of the UAE and even non-nationals of the UAE. These participants work in important capacities in health diplomacy, including consultants, medical attachés and directors of overseas treatment departments/centres, suggesting their decision and policy formulation and implementation in exclusively international health realms.

All participants were affiliated with reputable government health entities, such as the Ministry of Health and Prevention (MOHAP), the Dubai Health Authority (DHA) and the Department of Health - Abu Dhabi (DOH), stressing the participants’ direct involvement in health diplomacy internationally. Generally, the participants’ education levels are fairly suited to their positions, some of the participants had bachelor’s degrees in fields like International Relations and literature while others had PhDs in medical and health sciences. The latter is attributed to the fact that the educational requirements for practitioners of GHD include both health and international relations.

Participants were interviewed online, with interviews lasting between 30 minutes and 2 hours. Interviews took place with individuals based in global health centres, including the United States, the United Kingdom, Germany, and the UAE. The German-based health attaché also covered the wider European region, including Switzerland, thereby offering regional insights relevant to multiple European contexts. Thus, their leadership roles call for ultimate flexibility and cultural consciousness. Altogether, the demographic data offer an insight into the leadership characteristics concerned with furthering the UAE's GHD agenda and they help elucidate the dynamics of the problems and possibilities that these professionals experience in their line of work.

3.6. THE DATA ANALYSIS PROCESS

Before initiating the thematic analysis, all interviews were manually transcribed by the researcher of this thesis to ensure the preservation of contextual richness and narrative depth. A total of sixteen interviews were conducted, of which eleven were in English and five in Arabic. Several English-language interviews particularly those with health attachés, senior officials from the Department of Health in Abu Dhabi, and the United States Health Attaché Coordinator were conducted in English either because the participants operated professionally in English or did not speak Arabic. For the five interviews conducted in Arabic, the researcher, being bilingual in Arabic and English, personally translated the transcripts into English. To ensure the accuracy and integrity of these translations, the researcher cross-checked the translated versions with the respective participants, verifying that no meaning had been lost or altered. This rigorous approach aligns with best practices in cross-language qualitative research, where careful attention to translation fidelity and meaning preservation is essential (Regmi, Naidoo and Pilkington, 2010). Throughout the transcription and translation process, the researcher aimed to uphold the clarity, authenticity, and intended meaning of participants' narratives.

Thematic analysis is a methodical and detailed way of interpreting qualitative data that enables the possibility of identification of patterns and themes that recur within the dataset (Christou, 2022). This thesis uses a thematic analysis to be able to identify and classify the GHD leadership skills that international health attachés from the UAE possess. Thematic analysis was used to recognise underpinning themes including leadership, communication, policy and stakeholder views by systematically analysing interview transcripts (Terry and Hayfield, 2020). In this way, the data collection and analysis was conducted to identify the

most important insights and findings. This further ensured that the thematic analysis could explore multiple perspectives and experiences.

Thematic analysis of qualitative data, deductively categorising recurrent patterns from inductive coding, is employed as a systematic component of analysing a dataset and subsequently presenting meaningful information about these patterns. They show how we perceive our knowledge and subdivide it into segments, motives and themes. Along those lines, they assist in introducing crucial ideas for further discussion. One type of thematic analysis includes data familiarisation, initial coding, finding themes, especially reviewing and clarifying the themes and finally providing the thematic analysis (Dai et al., 2023). From the development of more technologies to analyse data to varying approaches for different data and questions, it is the very nature of research that drives the continuous acquisition of knowledge. Chosen from among a range of analytical approaches, including thematic analysis, content analysis, grounded theory and narrative analysis (Maxwell et al., 2020), a thematic approach is important because it helps to elucidate the inherent meaning that is pertinent to the qualitative portrayal such as in interview transcripts. The theme identification process was intentional and included leadership, communication, policy, and stakeholders' perspectives amongst others. As well as clustering the information based on themes we can look for parallels and conclusions as to the range of health concerns that the attachés have to deal with as part of their GHD position (Jaspal, 2020). Instead of hermeneutics, a better alternative is proposed as a source for deciphering the subtleties and complications that might be behind the testimony of participants. This method exploits thematic analysis to provide exhaustive information concerning leadership qualities in the GHD. Therefore, in the course of the study, a full picture of the leadership development process with its typical patterns and differences were provided (Thukral et al., 2021). The professional capabilities and experiential practices of UAE international health attachés can be sufficiently examined using thematic analysis, as shown by this study, which implements it to analyse their qualitative data. Whilst asking questions and defining research objectives, thematic analysis is applied to uncover and understand the existing themes that capture participants' feelings and understandings greatly (Lakh et al., 2021). Nevertheless, researchers must go further and analyse overall study data via the constraints of theme analysis and other data analysis techniques to present a balanced investigation.

Thematic analysis is a strong and adaptive instrument that does the job of detecting themes and patterns in qualitative data quite easily. This paradigm, which advocates the

systematic approach, serves as an immersion in different perspectives that allow decision-making on global health issues, hence improving their health outcomes. On the flip side, though, the type of thematic analytical studies allows us to collect differing levels of information used in our judgments, whose conclusions are endorsed (Odden et al., 2020). On the other hand, researchers should consider the limitations and biases connected to this method. Thematic analysis research can be effective by reminding the researcher of the real context so its significance is elevated (Mason et al., 2023).

As a qualitative tool, thematic analysis has been selected as the main instrument for interpreting data in research centred on the core leadership skills of international health attachés from the UAE in the realm of GHD. The concept behind this methodology pursues its pattern processing abilities that are not only logical but also able to recognise the problems and do them with ease and perfection (Bhatia, 2021). Thematic analysis tools are critical, as such as they enable researchers to detect, interpret and extract leadership features, dynamics of communication, politics and other stakeholders' views in the context of GHD. Therefore, through theme categorisation and classification, one can see the complexity of the decision-making process for which a manager is required to take a position as a leader, with the global health industry being so broad (Waradas, 2022). Moreover, the thematic structure can be adapted considering the wide range of perspectives on the issues and several sources which can be utilised for the subjects under study for deeper comprehension and breadth.

The limitations of this approach should be paid attention such as the inherent subjectivity of the analysis. As such, researchers must be careful to apply sufficient consistency and rigour to the analysis. Also, a risk in thematic analysis is prioritising breadth, thereby identifying a wide range of themes without deeply exploring them (Braun and Clarke, 2023). As such, it is important to appreciate the complexity and interconnectedness of themes. In this way, such limitations of thematic analysis can be mitigated when care is taken (Finlay, 2021).

3.7. QUALITY IN QUALITATIVE RESEARCH

For qualitative research to be credible, rigorous and reliable quality control efforts are essential. To preserve its integrity, this study focuses on standards like dependability, confirmability, transferability, credibility and trustworthiness (Lincoln and Guba 1985).

In this study, credibility was achieved by recording participants' views in semi-structured interviews. These interviews enabled participants to describe their experiences and

difficulties as a leader in GHD, in their voice. Sense-checking was implemented in the study by circulating and discussing summary results with participants to validate the interpretations, leading to transparency and trust. The extended interaction between participants and researcher including post-discussion conversations provided the researcher with opportunities to more closely understand their life experiences. To guarantee contextual relevance the study's background, such as the absence of a specific health attaché for Switzerland and the German health attaché serving the larger European region, was also carefully considered and incorporated into the data collection and analysis.

Transferability was accomplished by presenting a comprehensive description of the research process and the background, enabling others to investigate the relative applicability of the results to other environments. For instance, the research carefully chronicled the organisational structure of UAE health attachés and the specific challenges they encounter in advancing the health diplomacy agenda of the UAE. Although drawing attention to the context of a particular case, the complete descriptions of processes and topics were made to make the reported findings useful to other countries whose diplomatic systems have similar frameworks.

Dependability was maintained by the application of an audit trail which recorded all decisions and activities carried out throughout the process of the research. To ensure transparency and consistency in the analytical process for example the procedures of thematic analysis including theme development and coding choices were painstakingly documented.

Confirmability was ensured by the reflexivity of practice (i.e., by recording the private and personal experiences of the researcher by keeping a journal) so that the researcher could continue to think critically about concerns related to personal biases and possible confounding effects on the study. For instance, before coding each interview, the researcher read through their notes to help reduce subjective bias in coding participants' answers. Also, debriefing sessions with peers were used to confirm interpretations and to keep the findings firmly based on the data.

The study's quality was further improved by the ethical principles maintained throughout. Before the interview participants were fully informed about the study's objectives and their rights and their informed consent was obtained. All data was anonymised to ensure strict confidentiality and allow participants to freely share their insights. The study was believable, repeatable and applicable because of these practical applications of qualitative research principles.

3.8. ETHICAL CONSIDERATIONS

The issues of ethics in this research are of critical importance with the key areas including informed consent, anonymity, confidentiality, and data protection. Due to the sensitivity of the research, the study required clearance from both the UAE Ministry of Health and the University of Central Lancashire (UCLan). The study objectives were clearly explained to potential participants, who were only included in the research after giving their informed consent for interviews. Moreover, the participants maintained the freedom to opt out of the particular study at any point before data analysis without any consequences, to protect their rights. Data security was managed with great delicacy; all the gathered data was kept in passworded systems to which only some selected particular persons including the Head of Studies, academic advisors and examiners at UCLan had access. The site users' demographic information was collected in line with the highest ethical standards to ensure the data collected was comprehensive, valid and relevant to the research objectives.

Ethical issues were not only related to data protection but also touched on the participants' right to self-determination and their consent. All participants were informed of the aims and objectives of the study and willingly agreed to participate in the research. Participants' rights and privileges were well respected and as such, ethical guidelines were complied with to ensure that respondents do not feel pressured. Other issues that qualitative methodologies might have experienced are that they respect the individual's right to privacy and anonymity though it may be hard to achieve in small or close-knit population settings. Still, the essentiality of preserving the reliability and credibility of the research cannot be undermined. This research followed certain ethical conditions so that a quality and relevant result would be provided.

Ethical conduct is of special importance, particularly because it provides safety to participants, including their data and anonymity. It is also imperative to ensure that the data collected is of great quality, sufficient to provide adequate information and well-targeted at the issues being examined and the objectives that are being pursued. This means applying the appropriate data delivery strategies that involve strict adherence to error-free and accurate data collection methods, assuring accuracy and the use of ethical norms whilst analysing and organising collected data. Nevertheless, it must be stressed that despite the built-in limits and uncertainties of the principles of ethics, there are certain mannerisms of conduct which remain valid for everyone to abide by. This raises the question of keeping participants informed and getting their consent. Moreover, in research on conservative areas that require the engagement

of foreign missions, such as diplomacy, the researcher should be aware of interpersonal dynamics (Erlich et al., 2021). More specifically, it can be difficult to get participants to go beyond the formal and to open up to the interviewer about their perspectives and experiences. Thus care must be taken to obtain data that offers an insight into the study objectives.

As with quantitative methods, qualitative researchers, despite taking steps to ensure the privacy and anonymity of the participants, may be faced with challenges of ensuring anonymity in small or tightly knit communities in which anonymity is difficult to achieve. Data accuracy and validity can be difficult to achieve, especially when the environment under investigation is complex and dynamic and any previously collected data may be affected and result in incorrect findings (Erlich et al., 2021). Hence, as almost all studies associated with studying the GHD leadership skills amongst the senior health staff of the UAE avoid unethical research practices, we can confirm that research ethics play an important role in making sure that the quality and validity of the research on this topic meet the key criteria and goals (Erlich et al., 2021).

The accomplishment and utilisation of the obtained data are the key points to the evolution of global health crisis management through data analysis. The data for the purpose must be both precise and high quality. Interviews were recorded (with permission) and then transcribed word by word to keep the information accurate. Informed consent forms were signed by the participants after the University of Central Lancashire's Research Ethics Committee approved the study. All participants' data was coded so their privacy was protected and only the researcher had access to the files on safe password-protected drives.

3.9. REFLEXIVITY

Reflexivity is a fundamental component of qualitative research, which both minimises the bias of the researcher and builds and demonstrates trustworthiness within the course of the research. Reflexivity enables the researcher to critically examine the positionality, including factors such as age, gender, professional background and cultural context, on the research process and outcomes (Kvale, 2002). It acknowledges that the researcher's personal opinions invariably influence how data is interpreted and that reality is socially constructed. Due to the participant's professional backgrounds, reflexivity was crucial in this work. Securing one-hour interviews was difficult because accessing participants required negotiating institutional procedures with various government health organisations, establishing trust and adjusting to participants' hectic schedules. My gender, professional background, and prior experiences in

health systems likely shaped not only how I framed interview questions but also the relational dynamics established during qualitative data collection, influencing participants' willingness to disclose sensitive insights about leadership, organisational practices, and diplomatic engagement.

Due to my work in Dubai Health Authority Data Analytics and Research Department, I possessed an informed understanding of the organisational culture, communication norms, and hierarchical structures that characterise diplomatic and health-related institutions (Bandola-Gill et al., 2023). This familiarity allowed me to approach gatekeepers with an awareness of appropriate protocols, formal communication styles, and the importance of confidentiality and respect for institutional boundaries (Gilson and Grandsoult, 2025). Because I understood the sensitivity surrounding international health roles and the demanding schedules of attachés, I was able to frame my requests in ways that acknowledged these constraints, which helped build trust and credibility during the access negotiation process (Freeman et al., 2023).

Additionally, my cultural background and knowledge of the UAE context helped me navigate subtle expectations related to respect, professionalism, and relational engagement. Being aware of how authority and status operate in these settings enabled me to engage with gatekeepers in a manner that aligned with their expectations, demonstrating patience, formality, and transparency throughout the process (Bandola-Gill et al., 2023). At the same time, my academic training provided me with the methodological discipline to remain reflexive and avoid relying on assumptions or pre-existing professional relationships. Instead, I approached each interaction with gatekeepers as a deliberate and ethical step, ensuring that participants felt voluntary, safe, and respected (Gilson and Grandsoult, 2025). Overall, my background facilitated smoother access negotiations, but it also required continuous reflexivity to ensure that familiarity did not influence data collection, participant dynamics, or the interpretation of findings (Olukotun et al., 2025).

3.9.1. Research Questions

In formulating the research questions for this qualitative study, the researcher engaged in an explicit reflexive process that acknowledged how prior academic exposure to leadership theory, global health governance, and diplomatic practices could consciously and unconsciously shape the framing of inquiry, particularly in privileging certain conceptual understandings of leadership skills over others; therefore, the research questions were

deliberately constructed as open-ended and exploratory, rather than theory-testing or prescriptive, to allow the perspectives of international health attachés to guide the direction and depth of the inquiry and to minimise the imposition of the researcher's pre-existing assumptions about what constitutes effective leadership within GHD (Karačić Zanetti et al., 2023). For example, the author used strategies to improve rapport and engagement after realising these difficulties. The study's participant recruitment interview scheduling and interview experiences were all documented in a reflective journal. The journal included ideas on how to adapt communication styles to participants' professional needs and how to gently and appropriately tailor questions to the participant's fields of expertise. For instance, "the participant relied heavily on protocol-based language, so I mirrored that formality. I replaced casual wording like 'work together' with terms such as 'bilateral coordination' and 'strategic alignment.' This shift improved the flow of the interview and signaled that I respected their professional discourse."

3.9.2. Data Collection

In the process of conducting research with health attachés, it is critical to recognise that my positionality as a researcher, particularly as a woman, inevitably shaped both the qualitative data collection and the interpretation of findings, given that positionality is never neutral and always influences the ways in which participants respond and the perspectives through which their experiences are analysed (Olukotun et al., 2025). Being a woman conducting research in the context of health diplomacy, which is often male-dominated and hierarchical, may have influenced the openness, candour, and emphasis that participants placed on certain aspects of leadership, negotiation, and organisational dynamics (Hoskins, 2015). For example, it is possible that some participants emphasised collaborative aspects of leadership or downplayed hierarchical tensions to align with perceived expectations of a female researcher. Similarly, responses on negotiation strategies may have been framed to reflect socially acceptable norms around authority and gender roles. These tendencies could have occurred consciously or unconsciously, shaped by social norms or cultural assumptions about gender and authority.

During interviews, active listening techniques were used and the researcher remained flexible to allow participants to steer discussions towards areas they deemed important, even if they extended beyond the planned questions. For example, during data collection, reflexivity guided the researcher's interactions with participants, particularly in semi-structured

interviews. Attention was paid to power dynamics, professional hierarchies, and cultural contexts, especially given the diplomatic status of international health attachés and the sensitivity of global health negotiations. The researcher consciously adopted a neutral, open-ended interviewing approach to encourage participants to articulate their experiences and viewpoints freely, while avoiding leading questions or confirmation-seeking behaviours. This reflexive stance helped ensure that the data reflected participants' meanings rather than preconceived expectations.

To reinforce this section, several illustrative excerpts from my reflective journal make the reflective processes underlying the interviews more vivid and empirically grounded. These excerpts reflect on my self-reflection on decision-making at every moment and enhance the overall accuracy of the data collection process (Freeman et al., 2023). For example, the following journal note illustrates how awareness of power dynamics shaped my interviewing approach: "The participant paused and appeared reluctant when discussing cross-ministerial coordination; I recognised this hesitation as a potential sign of discomfort linked to hierarchical sensitivities, prompting me to reformulate the question in broader, less direct terms". Similarly, reflections captured in entries like "I consciously allowed longer periods of silence to give the attaché space to construct their narrative, reminding myself to resist the impulse to summarise or direct their response" illustrate how I enacted an active listening stance aimed at privileging participants' meanings over preconceived analytical categories. Another recorded observation "When the interviewee shifted the conversation toward cultural constraints encountered in diplomatic settings, I decided to follow this line of thought as it offered rich insight into leadership challenges not initially anticipated in the interview guide" helps to clarify how flexibility was operationalised during the interviews. These examples are incorporated not only to demonstrate my reflexive engagement but also to provide transparent evidence of how data collection practices were continually adapted in response to participants' cues, contextual dynamics, and ethical considerations. This enhances the credibility, trustworthiness, and methodological coherence of the study (Gilson and Grandsoult, 2025).

3.9.3. Data Analysis

My positionality may also have affected the data interpretation process, as my own experiences, values, and perspectives on leadership, gender equity, and professional collaboration likely guided the coding, thematic development, and analytical decisions, potentially privileging some insights over others or attributing significance in ways that might

differ if interpreted from a different positional lens (Goundar, 2025). Acknowledging this positional influence does not undermine the validity of the research; rather, it underscores the importance of reflexivity in qualitative inquiry, requiring continuous self-examination, documentation of assumptions, and deliberate strategies to mitigate bias (Corlett and Mavin, 2018). It also embraces the unique interpretive insights that my perspective brings to understanding health attachés' perceptions of leadership and their engagement in GHD (Luh and Baltag, 2021; Ruckert et al., 2022). Moreover, I maintained a research diary throughout the study to record my assumptions, emotional responses, and initial interpretations during interviews with health attachés. For example, "After today's interview, I noted my initial assumption that the health attaché would prioritise technical public-health concerns over political considerations. However, as the conversation unfolded, I found myself emotionally responding to the diplomat's emphasis on geopolitical sensitivity and negotiation pressures. This challenged my early interpretation of their role and reminded me to remain open to the complex blend of technical expertise and political navigation that shapes their daily work." This helped me become aware of potential biases and ensured that emerging themes reflected the research objectives and participants' perspectives rather than my preconceptions.

By consciously reflecting on how my positionality may have shaped access, questioning style, and analytical focus. For instance, being familiar with the UAE health system and having prior professional experience in health policy may have made participants more open and willing to share insights, thereby facilitating access to rich information. I am better able to situate the findings within their broader social, organisational, and gendered contexts, recognising that both the data and its interpretation are co-constructed through the interplay of participants' experiences and my own interpretive lens, which ultimately contributes to a richer, more nuanced understanding of the complexities inherent in leadership and diplomatic practice within health systems. For instance, I adopted an iterative analytical process that deliberately prioritised inductive engagement with the data at the sub-theme level, supported by reflexive memo writing and repeated comparison across transcripts to ensure that analytical insights remained grounded in participants' accounts rather than exclusively shaped by established scholarly models.

3.10. CONCLUSION

This chapter introduced the research methods used to assess the competence of the UAE health attachés on GHD. The map design draws upon a qualitative approach called theme

analysis, which involves in-depth studying of what the participants can truly say and the way they see things. With the aim of concealed patterns and characterising their qualities, the current qualitative research approach thematic analysis was applied to find the links between leadership skills in general and their adaptation to the context of GHD. The data was collected through semi-structured interviews with key respondents.

Ethics in research cannot be just considered at the first phase of the process but throughout the research process. This involves adherence to the principles of ethics, seeking approval and preserving the privacy and confidentiality of participants. Within the selected study, there are limitations regarding subjectivity involved in the analysis of qualitative data, the restriction imposed by sample size and category on generalisation of the results. Although these limitations are presented, this method is still essential for getting a detailed insight into leadership issues in GHD. This is significant, especially in circumstances where transparency and inner-criticism which are normally required to make the challenge easier to overcome are quite important for the success of the study.

Reflexivity was essential throughout this qualitative study, as my positionality, shaped by gender, cultural background, and professional experience in health systems, influenced access, interview dynamics, and the interpretation of data. My familiarity with the UAE context facilitated smoother access and trust-building, yet also demanded continuous reflection to ensure that my assumptions did not shape participants' responses or the direction of inquiry. This reflexive stance informed the development of open-ended research questions, the adaptation of my communication style to participants' professional backgrounds, and the tailoring of interview prompts to their fields of expertise. Reflexivity also shaped data collection and analysis, particularly because the interviews took place within a predominantly male and hierarchical field such as health diplomacy. Participants may have adjusted their responses based on perceived gendered expectations, emphasising certain leadership traits or downplaying sensitive issues. These insights prompted continuous reassessment of methodological boundaries and reinforced the need for an iterative analytical approach, combining deductive and inductive approaches, and supported by reflexive journaling.

CHAPTER FOUR

Findings and Analysis OF The Leadership Dynamics of UAE Health Attachés in Global Health Diplomacy

4.1. INTRODUCTION

This chapter builds upon the above three chapters' exploration into the leadership competencies and practices of UAE overseas treatment department/ centre and health attachés within the framework of GHD. Findings from the semi-structured interviews are discussed. Using thematic analysis, the thesis explores the lived experience and knowledge of participants to identify and connect key themes.

To support the study's objective of analysing the competencies and challenges experienced by the UAE overseas treatment department and health attachés in GHD, the interviews were designed to elicit insights on several key dimensions. These included health attachés' perceptions of their leadership skills, health attachés' perceptions of the perceived relationship between leadership skills and GHD, health attachés' perceptions of the key barriers to using their leadership roles with GHD, and health attachés' perceptions of developing leadership skills practices to improve their contribution to GHD. Participants were further queried on strategies used to navigate intricate international health agreements and on their views of the assistance offered by UAE governmental health authorities.

The findings are presented thematically under the following main headings:

- Understanding GHD Phrase and Priority
- Leadership Competencies in GHD
- Barriers to Effective Leadership in GHD
- Relationship Building in GHD
- Training and Development Needs

THEME 1: LEADERSHIP SKILLS IN GLOBAL HEALTH DIPLOMACY (GHD)

The first theme concerns the competencies required in the leadership of GHD. According to the interviewees, leadership is not merely about managing one's team and projects. Instead, they emphasised that it involves designing and developing ideas, establishing effective communication, persuading and negotiating. They also noted that leaders need to understand and navigate interactions with numerous countries (Javed and Chattu, 2020). The participants highlighted that leaders in GHD must demonstrate versatility to build cooperation with governments, international organisations and healthcare providers to advance health agendas both nationally and internationally.

Centring on the roles assumed by leaders in GHD, critical leadership skills possibly entail communication and negotiation in which the health attaché has to ensure positive results through influencing. Further, communication skills that involve public speaking and political negotiations in international forums to advocate for the nation's health agenda are essential. Another is cultural intelligence which is also emphasised as the leaders operate in environments that are cultural or have diverse subcultures. Stakeholders also seek strong leadership in managing crises, which emanate from codes which are random globally (Burkle, 2015). Therefore, leadership needs to show great resilience during the management of such issues as well as defend diplomatic relations. The following are the subthemes that are being discussed within this theme:

- Subtheme 1.1: Communication and Negotiation Skills
- Subtheme 1.2: Public Speaking and Advocacy
- Subtheme 1.3: Leadership and Team Management

Subtheme 1.1: Communication and Negotiation Skills

The subtheme explores how UAE health attachés utilise communication and negotiation strategies to advance the nation's GHD. The research focuses on diplomacy and negotiation skills in global health, emphasising the critical communication abilities needed for developing international partnerships and managing health crises. To gather insights for this subtheme, participants provided data through interviews (see Appendix), which aimed to capture their perceptions on agreements and issues arising from international health partnerships. On the other hand, Gostin and Katz (2016) discussed the significance of regular engagement, as during the COVID-19 pandemic, all countries recognised that no one could face it alone. It has increased the number of global health threats, and the government has been highly affected, facing numerous obstacles. For instance, Participant 1 emphasised the importance of regular engagement with international health actors. They suggested that the Ministry should enhance its involvement through diplomatic channels such as conferences and external health offices. Participant 1 reflected on their own experiences with health diplomacy, stating: "Indeed, our health diplomacy efforts have been pursued through various diplomatic formalities and regular interactions with international counterparts." This feedback underscores the importance of maintaining robust diplomatic relationships to effectively promote the UAE's health agenda globally:

“Through official visits to health service providers from health centres and hospitals and meeting with them at global health conferences (Arab Health Exhibition) annually, as well as assigning our external health offices to visit them and negotiate on an ongoing basis.” (Participant 1)

As such, Participant 1 exhibited a positive approach to the diplomacy of arranging regular appointments with several health service providers. This can be considered in parallel with Gostin and Katz (2016), who underlined the main point of using diplomatic approaches to engage stakeholders in discussion processes to reach successful results in the sphere of global health.

The same participant discussed the strategies used during the COVID-19 pandemic when communication and negotiation took on heightened importance:

“During the coronavirus pandemic, we had to negotiate the transfer of our Emirati patients smoothly and safely from international hospitals outside the country, without affecting the health safety of our patients, to our local hospitals in a safe manner and this was done, praise be to God, in a successful manner.” (Participant 1)

This goes to show that negotiation plays a central part in tackling patient safety and organisational management risks in the course of a pandemic. Their experience is a perfect illustration of what Gostin and Katz (2016) have noted as the need to have flexibility and communication in international work due to the negotiations, particularly in emergencies. Thus, the capability of handling more complicated international coordination can be identified as the need for negotiations in the health diplomacy field.

Furthermore, Participants stressed that the skills of negotiators in the context of GHD are not only related to professional experience but also to the cultural and political environment. As participant 6 expressed:

“We have always found that our effectiveness when it comes to bargaining greatly depends on our knowledge of cultural differences and political situation of the partner country.”

This perception was in line with the literature as it emphasises that organisational members require strategic negotiation skills and cultural intelligence while engaging in discussions on international health (Gauttam et al., 2020). All these are now considered essential skills for the health attachés in different geopolitical systems.

Subtheme 1.2: Public Speaking and Advocacy

This subtheme relates to the role of UAE health attachés in promoting the health policy agenda in international organisations, conferences and media outlets. Oral presentation and lobbying are significant steps in GHD and help in preparing health leaders for presenting their NHF and engaging in healthy discussions and negotiations with other countries (Al Kurdi, 2021). While the participant 5 had been quite proactive:

“Many conferences were participated to share our experience in handling the pandemic. They were in Barcelona, Portugal as well as in the Gulf. The series of conferences was remarkable in showcasing how the UAE dealt with and handled the COVID-19 pandemic situation. That way, our involvement demonstrated that we are constantly preparing ourselves for any eventuality of such a global health issue.”

Some had engaged less than others, but all acknowledged the significance of speaking in public. The subject of international participation was highlighted by both participants, but their approach to the level of engagement differed. Participant 6 (for instance) emphasised the proactive attitude of the UAE in terms of the virus pandemic and providing other states with lessons learnt, as well as debating in international forums. This is in line with Ayotte et al. (2020), who opine that international health forums are critical knowledge-sharing and international health policy-making platforms. Moreover, the article by AlKhaldi et al. (2023) demonstrated the role of the UAE in terms of SDGs and the importance of the above forums in developing inclusive health approaches. The intent to take an active part in international health-related events also implied that patients can make a difference in spreading the word about health-related efforts to promote the national agenda in the field of diplomacy.

Both participants emphasised international participation though the level of participation may not be the same. An example of a proactive role in the sharing of pandemic management experiences and lessons learned was given by Participant 6 while underscoring the UAE’s proactive interventions. This is similar to the Ayotte et al. (2020), assertion that international forums are critical in GHD as these are places where countries can share knowledge and shape global health policies. Furthermore, the study by AlKhaldi et al. (2023) provided an analysis of the UAE’s contribution in the context of SDGs and the entire focus of the analysis revolved around global health. In addition to this, the study by Elbarazi et al. (2024) highlighted the importance of health programs to increase personal engagement. Although there is only the potential aspect in the contribution of Participant 14, Participant 6 showed personal engagement toward UAE’s priorities in the sphere of international health. It

is such involvement that enhances the country's standing in this subject area of health diplomacy more so under the context of an unprecedented pandemic such as COVID-19.

In addition, Participant 7 noted the level of international participation needed and outlined their involvement:

"[I have] update[d] on the experience of the UAE in confronting the COVID-19 pandemic, in official meetings with global partners and during scientific conferences and workshops." (Participant 7)

In the same regard, Participant 15 also expanded:

"Effectively advocating for UAE's global health priorities involves highlighting healthcare achievements, addressing misconceptions and showcasing advanced infrastructure, aiming to promote understanding and appreciation for the country's contributions to global health." (Participant 15)

Both responses are well aligned which emphasises the key components of effective and convincing speech especially when promoting the UAE's role in health care. Respondents are alike in stressing the use of the speech not just as a means to showcase UAE's accomplishments but also as a tool to address misconceptions and explain the specifics of the country's approach toward the provision of healthcare services. The approach described by the participants conforms to the larger literature on global health advocacy. Chatto and Chami (2020) pointed out that in the context of global health communication, public speaking is not just the communication of one's positive performances of the nation but rather the discussion of issues and conversations about contentious matters. This is important especially when working in another country where the patient's perception and practices of the hospital and overall healthcare may differ vastly.

Therefore, these participants are in harmony with the best practices that dominate health diplomacy that call on the nations to employ public forums to showcase both their medical infrastructure and healthcare expertise. Both questions underscore public speaking as well as advocacy as equally core components of GHD. Additionally, participants show differences in their involvement but it is clear that both are aware of UAE's possibilities to participate and its participation in international opportunities. The analysis of differences between Participants 7 and 15 highlights the need for simpler, clearer communication and advocacy. This involves not only promoting national achievements but also removing barriers to understanding the country's healthcare system as per Fazal (2020). This is in line with

evidence outlining the need for health diplomacy in setting the global health agenda and building partnerships.

Subtheme 1.3: Leadership and Team Management

The subtheme focuses on UAE's GHD on how the practice of leadership and management of teams to promote international health is achieved. Responses under this subtheme were mostly geared towards how leaders of the country support UAE's health initiatives within international settings and how they engage their teams in the actualisation of health-related initiatives internationally.

Both Participant 15 and Participant 11 provided some information that though they had different experiences in their advocacy, they had a similar kind of approach to it. Participant 15 stated that:

“To advocate for the UAE in the international forum, during conferences, or in the media, one should be able to communicate the country's success and objectives in the health sector effectively. In such cases, I tend to emphasise the improved quality of the health care services offered in the UAE. This involves highlighting our highly developed medical facilities, well-equipped units and highly qualified specialists. Therefore, by presenting these strengths, I will be in a position to show that the UAE not only meets international health standards but also contributes to improving global health. Likewise, there is the need to defend and explain our choices regarding the health priorities that we have set. This could include clarifying cultural practices that influence healthcare delivery in the UAE or explaining how our healthcare system integrates modern medical practices with traditional values.” (Participant 15)

This response points towards understanding the role of public health in addressing the UAE's position in the global health agenda. However, it also exposes the lack of first-hand engagement. To the same question, participant 11 stated that:

“Advocating health issues is a crucial aspect of GHD. Let me share my experience as a project manager in this regard.” (Participant 11)

As per this response, the proactive engagement highlighted the UAE's active participation in setting the international health agenda and building diplomatic capital out of exhibiting flexibility in learning from crisis management. This has further demonstrated the indeterminacy of advocacy in GHD, where speaking and presenting in global forums themselves become acts of advocacy within the GHD landscape. This is supported by the study

conducted by Brown et al. (2018) because public health diplomacy is the kind of diplomacy that is on the rise as the most important tool for countries to wield soft power and build partnerships worldwide.

The kind of participation demonstrated by participants signifies that although there is the possibility of increasing individual participation, the general strategy is consistent with practices being promoted globally within international health environments that stress visibility and knowledge transfer. While addressing the issue of motivation and leadership of overseas treatment teams, the study by Dabou et al. (2022) discussed work-related management by stressing the delegation of responsibility in decision-making. For one participant, this stemmed from the model of leadership established by Sheikh Mohammed bin Rashid. This was about holding responsibility and serving the community, which made individuals within the team feel loyal and dedicated. This leadership model emphasises visionary governance, community-centric growth, and the empowerment of individuals through delegated responsibility and motivational engagement. As by Participant 5 states:

“Inspired by Sheikh Mohammed bin Rashid, I lead a team focused on community growth, fostering loyalty and improving welfare with government support.”

Similarly, Participant 13 stated that:

“I empower my team by giving them responsibility and involving them in decision-making, fostering ownership, collaboration and accountability. This approach led to a successful overseas treatment project, demonstrating teamwork and shared responsibility.”

This response showed that members get posted to a team and then they are endowed with ownership of the cases, therefore work becomes more spirited. This empowers the team members and helps in improving accountability as well as results in better collaboration within the team and improved patient care. This view of leadership is supported by research of Latifi (2022), on transformational leadership in healthcare, which is focused on the benefits connected with delegation of powers and teamwork. Latifi (2022) explains the idea that motivation by transformational leaders can be an effective way of achieving this through providing autonomy and group cohesiveness.

The study by Hwang et al. (2023) highlighted the importance of outcomes of overseas treatment projects which involve proton beam therapy. This can be considered as one of the examples of an overseas project. A successful overseas treatment project, completed through active and accountable team participation, aligns with research showing empowered teams exhibit greater creativity, problem-solving skills and resilience in overcoming challenges

(Lawson and Morgenstern, 2020). This means that the model of leadership adopted by the UAE health attachés meet global best practices in health care management. Similarly, Participant 16 explained how their team manages overseas treatment cases by clearly distinguishing between medical tasks and administrative responsibilities.

Everything from clinical assessments to organisational matters concerning transportation underscores the rigorous process that has to be put in place to guarantee every patient's safety as well as comfort. In this case, the participant shows how leadership in GHD involves not only medical analysis of individual circumstances but also the ability to steer the team through particular practical and legal specifics of each case. This approach supports the concept of clinical and operational management of teams in health diplomacy to achieve patient-centred care on an international platform (Lawson and Morgenstern, 2020).

THEME 2: THE PERCEIVED RELATIONSHIP BETWEEN LEADERSHIP SKILLS AND GHD

The second theme is the leadership skills of UAE health attachés who work in formulating the health partnership with other countries and the consequences of it. Leadership is another factor positively linked to international relations, international health cooperation and the UAE's health diplomacy mission. Well-educated, professional and experienced in communication and negotiations, crisis management, the Emirati health attachés are involved in the formation of strategic partnerships with various international health-related organisations and governments.

Such leadership skills make them capable of comprehending different international health settings, promoting relationships with foreign health organisations and ensuring the proper enforcement of any health-related initiatives. In addition, an individual has to demonstrate cultural adaptability to foster this partnership which helps to enhance the health of UAE citizens living in other countries. Ruckert et al. (2016), have also established leadership in GHD by setting up successful international collaborations with the UAE's Health Attachés leveraging their skills to form solid, sustainable collaborations that are mutually beneficial to the country and its partners in setting up this foundation. The main theme is discussed in two parts listed below:

- Subtheme 2.1: Strategic Vision and Planning
- Subtheme 2.2: Stakeholder Engagement

Subtheme 2.1: Strategic Vision and Planning

The subtheme is based on the concept dealing with what leadership in the UAE's GHD does to ensure different initiatives work towards achieving strategic goals. This subtheme looks at what the health attachés do to come up with programs that align with the overall vision of healthcare in the UAE. For example, participant 6 who spoke about the difficulty of linking programmes with national goals, referred to the visiting doctor program and teleconsultations between international practitioners and Emirati doctors as key strategic steps:

“Aligning our initiatives with the UAE's long-term strategic vision for global health cooperation can be challenging. However, we've developed several programs that support this vision. For example, our visiting doctor program brings medical experts from around the world to Abu Dhabi, enhancing our local health sector and providing valuable training for our healthcare providers.”

This response is well aligned with the study conducted by Ross et al. (2020), which stated that such endeavours support collaboration with other countries and improve the identification of local health care, consistent with the UAE approach toward health diplomacy by improving patient care and medical education. Similarly, Participant 4 stated that:

“The UAE has long been dedicated to developing health tourism, with a particular emphasis on enhancing domestic health services and attracting investments in the healthcare sector within the country.”

This response stressed the UAE's commitment to building efficient health tourism alongside improving health services in the domestic context by attracting foreign investment. Both participants stressed the importance of the formation of cooperation with other countries, even bypassing direct healthcare cooperation through the construction of the necessary healthcare infrastructure to attract international professionals. These responses are supported by the findings of Gredicak and Demonjia (2020), who observed that in countries forming strategic health partnerships, medical tourism tends to bring parallel improvements in healthcare investments and the quality of service delivery. The study also described that the UAE has strategically positioned itself to partner with other countries to develop sustainable healthcare models, which is similar to the global movement to build reliable healthcare systems throughout the world. This underlines the significance of international influence in the formation of domestic health policies and supports the UAE's strategic plan of turning the country into an international healthcare hub.

Health tourism relies on reputation, of course. Interestingly, for some participants reputation lies in doctors more than in hospitals:

“It does not matter how famous the hospitals are, but rather the expert doctors must be famous.” (Participant 5)

. This shows an acknowledgement that qualities that the individual practitioners bring into the health diplomacy efforts can go a long way in determining the success or otherwise of those efforts. In contrast, here’s what Participant 10 proposed:

“We prioritise UAE’s health diplomacy by considering each emirate’s unique healthcare needs, ensuring equitable access and strategically allocating resources to address specific health challenges while fostering collaboration across emirates.” (Participant 10)

This response also explained how activities are planned and executed about the various aspects and the demands of the emirates and their health sectors. As stated by the participant, it means that patients are referred via different processes in Abu Dhabi and Dubai and thus there are different levels of referral in the use of resources and health care services. In the case of strategic planning, Participant 10 stressed the need to consider the needs of the country’s emirates, as well as the need for them to cooperate. Nonetheless, equity in healthcare was also cited as one of the key aspects of UAE’s successful development. This was evident from the interviews and in line with the study by Gauttam et al. (2020) which notes that high-level professionals are the most important anchor to international health cooperation. This work confirms that the competence and appearance of healthcare workers are the factors that influence the outcomes of GHD because they act as the country’s health diplomats.

In the same way, Participant 10’s steps regarding the modification of the healthcare strategies according to the regions’ characteristics are under the contextual approach being considered highly relevant to the healthcare management field. Political engagement is crucial in health diplomacy because it involves forming partnerships and developing programs tailored to local communities. This approach ensures resources are used efficiently while also addressing broader national objectives (Mackey et al., 2016). Therefore, the answers to both questions underline the fact that the UAE’s leadership in GHD is driven by strategic vision, cooperation and adaptability.

In addition, using active participation, the participants established that coordinating the health-related activities to the strategic vision of the nation calls for the development of international relations, capacity within the country and emphasis on the practitioners. These are leadership approaches that have been highlighted in the study by Mackey et al. (2016),

which have promoted strategic planning as well as skilled professionals on the outcomes of GHD. The health attachés of UAE work to achieve UAE's health diplomacy goals in the context of local and global health goals by developing long-term strategies with a view to the regional environment.

Subtheme 2.2: Stakeholder Engagement

This subtheme addresses aspects such as UAE health attachés' interactions with different stakeholders in GHD and the changes in communication and leadership to address problems in international healthcare relations. Management of relationships is a key element of GHD because of the need to manage stakeholders' expectations and work within a strategic framework with a focus on allied international health institutions. Generally, achieving results in an ideological and geopolitical environment while respecting cultural and/or gender-diverse issues presents several challenges (Kujala et al., 2022)

To identify the approaches of participants toward addressing global health concerns and overcoming the challenges in inter-Healthcare Relations.

Participant 1 stated:

“To attract the largest and most modern international health centres to the country, we are working closely with the government and providing health advice.” (Participant 1)

This response shows how UAE health attachés are not only communicating with stakeholders but are actively selling ‘the UAE story’ in GHD. For the same question, participant 11 stated that:

“We improve global health by conducting comprehensive studies, addressing deficiencies and enhancing patient outcomes through collaboration.” (Participant 11)

This response shows that the participant is concerned about global health by doing the proper study, identifying gaps and developing collaborative efforts to increase patient beneficence. Both of the responses suggest that stakeholder engagement is a deliberate process whose main goal is the creation of a partnership to support the achievement of optimal health. The study by Deeb et al. (2023) discussed how bringing the exchange of healthcare information can securely connect private and public healthcare providers in the Gulf. Furthermore, comparing Participant 1 with Participant 11 it can be concluded that UAE health attachés have a common approach to cooperating with the Integrated Health Information System (IHIs) stating that collaboration and coordination are the principles to tackle the international health threats.

All these strategies align with the study conducted by Storella (2023), on GHD and support the idea of multi-stakeholder engagement in the attainment of global health goals. The study stated that the involvement of the various stakeholders from government, health facilities and international health organisations is crucial to managing the political and technical realities of global health. As a result of the close technical cooperation between the UAE health attaches and governments and international organisations, one can discover the gaps in the healthcare system that exist. By identifying these loopholes, they could be able to bring the international care endeavours in line with the UAE-specific requirements, and these efforts can therefore become truly beneficial to the national healthcare process, with no unnecessary overlaps or wasted potential. This strategic partnership also shows a type of leadership that is pulled from diplomacy because health attachés work to protect national health concerns while promoting international health agendas.

In addition to this, elaborating on the challenges participants face when they aim to modify the interactions with stakeholders, Participant 5 noted:

“We maintain institutional diplomatic relationships unaffected by personnel changes, ensuring continuity through an approved system, prioritising patient care per Sheikh Mohammed bin Rashid's decree for citizen patients in Dubai.” (Participant 5)

This response pointed out that there are diplomatic institutional relations irrespective of the human exchange wherein there is an approved mechanism in place. This system complies with the decree of Sheikh Mohammed bin Rashid, which mandates the prioritisation of citizen-focused healthcare delivery, and aims to provide healthcare services to the citizens of the UAE even if there is a change in leadership. Likewise, Participant 13 continued the explanation of the leadership and stated that:

“When it comes to leadership within the Overseas Office Section, we have a clear and well-defined approach to managing relationships with business owners. In the event of any leadership changes of stakeholders, individuals such as our representatives and health attaché are well-prepared and positioned to smoothly assume additional responsibilities.” (Participant 13)

This response showed that the participant knows how to manage the relationships between POs and business owners. They also stressed that whenever there is a change in leadership of the stakeholders, the UAE's Health attachés and representatives are in a position

to take up any other responsibilities whenever the need arises while maintaining healthy diplomatic relations between nations.

Comparing these two responses shows a strong focus on the intent of continuing the positive narrative of the relationships with stakeholders and being committed to the idea that no matter how the field of international relations (IR) and the leaders in the respective countries evolve, they can and will be capable of finding ways to renew their cooperation. This focus on systematisation in leadership and communication is indicative of a larger shift in GHD for developing multi-institutional partnerships which do not rely on the continual turnover of leadership. In this regard, this approach aligns with research by Brown et al. (2018) because health attachés are prepared to adapt whenever leadership changes occur, and the UAE is well-positioned to keep its international health initiatives on track.

In addition, the responses show the role that the UAE plays as a global member of the health system. Therefore, the UAE health attachés can ensure continuity of communication and leadership in health diplomacy such that long-term relations are developed and maintained with the stakeholders. The current debate based on research by Shin (2023), is focused on long-lasting forms of communication and leadership as being critical for the effective functioning of international collaborative projects in the field of global health as they promote continuous working relationships and the development of trust. The views expressed herein by Participants 5 and 13 are also in similar regard, illustrating how UAE health attachés assert and sustain diplomacy and direction where necessary.

THEME 3: KEY BARRIERS TO USING THEIR LEADERSHIP ROLES WITH GHD

Barriers to Employing Leadership Skills addresses the challenges that leaders encounter in effectively using their leadership capabilities in the context of GHD. This type of leadership calls for technical skills, cross-cultural understanding, flexibility, as well as the ability to respond appropriately to a crisis (Bhaduri, 2019). However, there may be some challenges that may hinder the use of these leadership skills. Some of the barriers may include; organisational constraints, lack of resources, political and cultural barriers and communication barriers. These barriers can hinder a leader in many ways including failing to make the right decisions, managing the employees as well as promoting teamwork and cooperation across borders. For instance, dealing with cultural differences across different countries or coping with unforeseen events like the COVID-19 outbreak means that much flexibility and creativity

are needed (Caligiuri et al., 2022). Leaders also face such challenges as bureaucracy and diplomacy, which bounds their actions in most instances. These are the insights that need to be understood to design the approaches that will increase leadership efficacy in the global health sphere. The main theme is made up of the following sub-themes:

- Subtheme 3.1: Cultural Sensitivity and Adaptability
- Subtheme 3.2: Crisis Management and Resilience
- Subtheme 3.3: Economic and Political Barriers

Subtheme 3.1: Cultural Sensitivity and Adaptability

An understanding of cultural differences is a necessity in global health, especially while interacting with foreign treatment suppliers (Alsharif et al., 2019). These factors guarantee that the patient from other countries gets treated according to their culture, their practice and their belief, thus enhancing the quality of their health and their level of satisfaction. The following analysis examines various approaches and strategies used by participants to ensure cultural sensitivity in different international healthcare contexts. Participant 1 discussed cultural sensitivity and adaptivity in the context of overseas treatment providers when working with various international stakeholders and the strategies to keep up with ‘the UAE cultural’ practices that might affect various regions:

"When we sent Emirati patients to the Republic of South Korea, we encountered that our patients did not want to go to the Republic of Korea because they did not know Korean culture, customs, traditions and the Korean lifestyle. Therefore, a meeting was held with the Korean embassy in the Emirates and it was agreed to increase education locally and promote the Republic of Korea internally in the Emirates, culturally, touristically and health-wise. This experience culminated in where Korea has become one of the preferred destinations for receiving treatment outside the country and Korean Centres have also begun to exist locally as part of cooperation with the UAE government." (Participant 1)

This response reflects a proactive and collaborative approach to cultural sensitivity. The initiative to hold meetings with the Korean embassy and promote South Korean culture in the UAE demonstrates a successful attempt to bridge the cultural gap between Emirati patients and South Korean healthcare providers (Kim et al., 2020). This strategy illustrates the importance of cultural education in mitigating patient concerns and encouraging their

acceptance of overseas treatment options. However, while this approach worked for South Korea, it may not be universally applicable to all countries. Almutairi et al. (2015), also noted that cultural adaptability depends on the formulation of strategies that are relevant to a certain region; this implies that a different approach may be appropriate when working with certain nations or cultural settings. In this vein Participant 2 commented:

"Over several years, I believe that we have successfully developed a strong and positive relationship. The caregiver and the next of kin will need to sign an agreement and complete a form. This form will include information about their religious beliefs and preferred food choices. This will ensure that there are no difficulties regarding cultural sensitivity and adaptability. We ensure that all our patients' requirements are provided for even when they are receiving treatment overseas. This includes access to worship rooms and private treatment. Our coordinator is committed to supporting cultural sensitivity and adaptability in these situations."

The above response discusses a systematic approach to ensuring cultural sensitivity through the use of formal agreements that capture religious and dietary preferences. This method ensures that cultural needs are accounted for in advance, minimising potential issues during treatment abroad. However, Hashim et al. (2023), discussed that while capturing such information is important, it is not sufficient on its own. Healthcare providers need continuous cultural competence training to respond flexibly to evolving patient needs that might not be captured in pre-treatment forms. The approach in may benefit from being more dynamic and adaptable to ensure that patients' needs are continually met throughout their treatment journey. This is particularly important in a multicultural society, as noted by Participant 3:

"The UAE is home to over 200 nationalities, making it a truly multicultural society where individuals from diverse backgrounds can easily assimilate and adapt to different cultures without encountering any significant challenges. Additionally, the citizens of the UAE are widely accepted in countries like the United Kingdom." (Participant 3)

The response presents an optimistic view of cultural adaptability, attributing it to the multicultural environment of the UAE. While it is true that being accustomed to a multicultural society can help individuals adapt more easily, this response seems to oversimplify the complexities involved in cultural sensitivity in healthcare. A study by Betancourt et al. (2005) highlights that cultural competence requires specific attention to individual patient needs,

beyond general assumptions about adaptability based on living in a diverse environment. Relying solely on a patient's background in a multicultural society may overlook nuanced cultural and religious practices that can explore their healthcare experience abroad, underscoring the need for a more individualised approach. We collect more responses about cultural sensitivity and adaptability in the context of overseas treatment providers when working with various international stakeholders and tactics do you use to keep up with 'the UAE cultural' practices that might affect various regions with Participant 5:

"Most patients face problems in terms of language and Indian customs. ... My role is to provide an interpreter and we direct them to where to live and settle to avoid cultural differences. After a month, they adapt for first-time patients visiting India. I talk to the doctors; they give me the medical report and I tell the patients so that communication is better."
(Participant 5)

The above-provided response acknowledges common cultural challenges, such as language barriers and unfamiliar customs, especially for first-time patients travelling to India. The use of interpreters and guidance to help patients settle demonstrates an effective strategy for improving communication and helping patients adapt to new cultural environments. However, as noted by Kletečka-Pulker et al. (2018), relying on interpreters alone may not address deeper cultural factors, such as health beliefs or familial roles in decision-making. This approach is practical, it could be enhanced by incorporating more culturally tailored interventions, such as pre-departure cultural orientation sessions for patients, to better prepare them for the specific customs and healthcare practices they will encounter. Moreover, participants shared their experiences of overcoming cultural differences while providing treatment abroad in a global health context:

"Patients often request same-gender doctors. Challenges include past issues with hospital accommodations and explaining surgery decisions, requiring patience and privacy." (Participant 14)

The above response illustrates a high level of cultural sensitivity by accommodating requests for same-gender doctors, a common preference among certain religious and cultural groups. This approach aligns with Braun and Clarke, (2023), who emphasise the importance of healthcare providers respecting and adapting to the cultural and religious preferences of their patients. The example also highlights the importance of clear communication and patience when cultural differences create misunderstandings in medical decision-making

(Alpers, 2016). However, Participant 14's assumption that significant cultural challenges have diminished over time may overlook the ongoing need for vigilance in maintaining cultural competence. The case demonstrates that even in relatively straightforward medical situations, cultural factors can influence patient expectations, reinforcing the need for continuous cultural sensitivity training for healthcare providers.

Subtheme 3.2: Crisis Management and Resilience

Crisis management and resilience are vital components in health diplomacy missions, where unexpected challenges and emergencies can arise. These situations require health diplomats and their teams to be prepared, adaptable and proactive in ensuring the safety and well-being of patients, particularly when they are being treated abroad (Kickbusch et al., 2021). The following analysis examines different strategies employed by participants in responding to crises and handling unexpected challenges during health diplomacy missions. Commenting on how to handle and respond to unexpected challenges and crises when they may arise during health diplomacy missions,

Participant 9 said:

"Regarding crisis management and resilience, we successfully repatriated our patients safely during the pandemic. We prioritised our patients based on urgency, starting with the most stable (P4 and P3, indicating lower priority cases) and then moving to more urgent cases (P2 and P1). We managed to repatriate about 90% of our patients without any major issues. The Department of Health Abu Dhabi's IPCD Centre was well-prepared to handle such a crisis and our existing crisis plan proved effective. The COVID-19 pandemic taught us valuable lessons and reinforced our ability to execute our crisis plan efficiently." (Participant 9)

The above response highlights the critical role of preparation and structured crisis management in responding to emergencies like the COVID-19 pandemic. Patient triaging by severity is a rational and feasible approach, which drives the effective distribution of resources and medical care (Morgan, 2020). This is in line with the triage system that is used in disasters and crises to manage patients depending on the severity of their conditions to increase the survival rate of patients (Lundgren and McMakin, 2018). The fact that 90% of patients have been repatriated without major problems indicates the effectiveness of prior plans to handle a crisis situation. Still, the ability to manage the crisis plan with a specific focus on flexibility is

crucial in order to adjust to the specific type of the emergency, as every emergency may have certain characteristics that would need to be addressed in a different way.

According to Participant 10:

"When faced with unexpected challenges and crises during health diplomacy missions, I approach them with a strategic and proactive mindset. Firstly, I maintain a professional demeanour and avoid taking things personally, understanding that challenges are often circumstantial rather than personal." (Participant 10)

This emphasises the importance of maintaining professionalism and emotional resilience when dealing with crises. A strategic and proactive mindset is crucial in crisis management, as it enables individuals to anticipate challenges and act decisively. The ability to detach from the emotional aspects of a crisis, as suggested by Participant 10, is consistent with the concept of emotional intelligence, which is essential for leaders in high-stress situations. Emotional intelligence helps leaders remain calm, think clearly and make rational decisions under pressure (Liu, 2022). This response, while emphasising personal qualities, could benefit from additional insights into the specific strategies and actions taken to address crises. A proactive mindset is valuable, but it should be complemented by concrete crisis management protocols and contingency planning:

"The priorities outlined by the Department of Health in Abu Dhabi emphasise the need for rapid and efficient treatment services. Our strategy focuses on continuing treatment within the country whenever possible. For patients requiring international communication, we use telecommunication extensively, which has proven effective in maintaining follow-up programs and facilitating doctor-patient consultations via phone calls." (Participant 11)

The above response emphasises the significance of rapid and efficient treatment, in line with the directives of the Department of Health in Abu Dhabi. The emphasis on telecommunication as a tool for international communication and follow-up care reflects the growing reliance on telemedicine in crises. Telemedicine has been shown to enhance continuity of care, especially during the pandemic when travel restrictions limit access to in-person healthcare (Awofeso and Aldbak, 2018). This approach showcases adaptability, allowing healthcare providers to maintain a connection with patients abroad. However, telemedicine also has limitations, such as difficulties in conducting physical examinations and

potential issues with technology access in under-resourced areas (Lisk and Šehović, 2020). Consequently, although telecommunication can be very useful, it must be used in conjunction with face-to-face care if possible. Further, we also posed another question to the participants as to the following diplomatic health posture where you had to be assertive, resilient as well as versatile when there was a challenge in administering treatment in another country.

“Our strategy is anchored on flexibility as well as flexibility to allow patients to get all the care that they require. To address the question of how qualified treatment can be delivered as effectively as possible, we maintain close cooperation with the local healthcare departments, international organisations and – through diplomatic representations – with the governments of the countries concerned. In case of consultations or if needed, we coordinate with other means such as medical evacuation services through telemedicine solutions”. (Participant 7)

The response points out the need for the entities to consult and cooperate with various partners, including the local health departments as well as the international organisations and diplomatic missions. Indeed, this approach is vital when it comes to addressing the challenges that come with treatment abroad since it involves the utilisation of different entities’ strengths and assets (Devine et al., 2018). Telemedicine and medical evacuation are good examples of how service delivery can be adjusted when faced with practical challenges that may hinder the delivery of healthcare to patients. This approach is in line with the goals of GHD which sometimes has to address the needs of individuals and fit them within the context of relations between countries and healthcare systems (Ben Hassen, 2021). Nonetheless, these efforts are significantly contingent on the bond of cooperation between the healthcare givers and the foreign counterparts as well as the availability of tools like telemedicine systems and medical evacuation services.

According to another response:

“As for crisis management and resilience, I would like to describe an experience where flexibility was a major factor. When a system goes down, it is always our practice to follow the following procedure when facing such a situation. Whenever our system went offline, we had to follow our downtime procedure and hence we were able to proceed with our work manually. We also used emails and other means to keep the business running as usual until the system was up again. This way it was more or less

smooth and was an evident indication that we could respond fast and appropriately in the event of a challenge.” (Participant 9)

The above response is focused on flexibility, accommodation and integration with different stakeholders. The use of telemedicine and medical evacuation services can be considered a tendency in the global development of healthcare and enhancing the response to emergencies. This is in line with the observation made by Anwar et al. (2019), who argued that telemedicine is considered as a way of maintaining care delivery across borders, especially during disasters like the current COVID-19 pandemic. Though this is a good approach, it calls for sufficient health sector infrastructure, technology and capacity building for healthcare practitioners to enhance the vision of the strategy. These solutions may prove ineffective in areas that lack technology or healthcare facilities, which proves that there is a need for a context-based approach to crisis management (Rogova, 2016).

Subtheme 3.3: Economic and Political Barriers

The economic and political factors remain one of the most influential aspects that define health diplomacy and the formation of global health policies. These barriers can slow the advancement of cross-country collaborations and alter policy-making and healthcare service provision abroad (Javed and Chattu, 2020). The literature suggests that cost, funds and fiscal risk considerations are vital to the development of health policies since they determine the feasibility and quality of health services (Hunter and Murray, 2019). There is also the issue of political factors such as decline in relations between countries, change of leadership and legal frameworks that make it difficult to implement such policies. Therefore, health diplomats are able to overcome these barriers through the use of proper communication and collaboration strategies and by avoiding opaque contractual relations that may jeopardise global health relations due to economic and political developments. Specifically, participants commented on the economic factors of health policy development. For example:

“Sometimes it is imperative to have certain economic factors in mind when the formulation of health policies is in progress. For instance, cost-cutting is crucial. It is, therefore, important to look for ways of sharing services with such organisations as the UNWFD that would offer quality services at an affordable price. It also enables one to control the costs while at the same time producing quality outputs. Furthermore, the participants

believe that sponsorships and funding explain a lot about our health policies.” (Participant 11)

The response underlines the importance of economics as one of the primary concerns in health policy, including the aspects of cost-effectiveness and cooperation with international organisations such as UNWFD. These collaborations help in the provision of quality services in a way that the cost barriers do not hinder the quality of services given. Also, the participant outlines the need to look for sponsorships and funding, which shows a business-oriented approach to addressing the issues of budget constraints while ensuring the organisation delivers quality care services. This is in line with the general notion that budgets dictate policy formulation since efficiency is one of the cornerstones of global health negotiations (Thomas et al., 2016). According to another response,

“It can be concluded that cost considerations and financial guarantees are very important in the development of health policies. These are contained in the contracts that define each of the companies and the agreed mode of operation. There is a need for better clarification when it comes to financial guarantees as they may need discussions and possible solving of the issues through discussion.” (Participant 13)

The above response also shows the importance of the contractual provisions in maintaining financial sanity and policy certainty in the health sector. Hence, it is important to have economic factors including financial guarantees articulated and agreed, so as to avert any disputes (Jeong, 2019). It underlines the significance of the interaction between partners regarding the issue and its main aspect, namely financial obstacles. The participant’s concern with specific agreements is relevant to the practice of implementing clear contracts to reduce economic risks, which are key to the formation of global health policies (Ng and Ruger, 2011). Similarly, another participant commented;

“Political tensions with other countries, legal issues and lack of international health investment locally have therefore led to the formation of this scenario, referring to diplomatic breakdown and stalled international health cooperation” (Participant 1)

The above response outlines major political and economic challenges that affect GHD. These include the following challenges such as the diplomatic relations and legal issues that affect international health investment (Albayrakoğlu, 2022). It brings out the fact that health diplomats should be versatile in their approach and negotiation techniques whenever they

encounter such issues. These efforts have to be made in a diplomatic manner as well as an effort to foster good relations and ensure investment in international health:

“When we are facing some adversity, it can only be due to lack of comprehension or inadequate assessment of the situation. The possible difficulties can be minimised if enough care is taken to examine the issues in detail and be clear about our approach. This helps in comprehending areas that may be missing and makes it easy to deal with them. Such an approach does not only address problems as soon as they arise but also emphasises the importance of team cooperation. Events that highlight the importance of collaboration demonstrate its intrinsic value and effectiveness in overcoming challenges collectively.” (Participant 6)

The above response emphasises the importance of thorough analysis and collaboration in overcoming economic and political barriers. This proactive and strategic approach to communication helps mitigate potential issues by addressing gaps in understanding (Hyland-Wood et al., 2021). The participant also discusses that collaboration is crucial in resolving challenges, which is supported by the literature emphasising the role of multi-stakeholder collaboration in overcoming global health challenges (Gostin and Katz, 2016).

Participant 16:

“One significant challenge arises, particularly in Europe and more specifically in Germany. Therefore, we only send patients to these areas when necessary. In other regions, if we have a proper contract, it remains effective regardless of leadership changes. This happens frequently; whenever a new leader joins, we schedule a meeting, provide an introduction, share our history and outline our plans.” (Participant 16)

The above response describes the political and operational challenges encountered in Europe, particularly Germany, where factors such as language barriers and frequent strikes pose difficulties. The participant emphasises the importance of having strong contractual agreements to navigate leadership changes and political instability. Through active participation in the advancement of new leaders and the communication of future strategies, they guarantee the sustainability of health services (World Health Organisation, 2021). This raises the importance of health diplomats being flexible to persist in providing continuous and constant communication and sustaining relations irrespective of the political shifts (Fidler, 2011).

THEME 4: DEVELOPING LEADERSHIP SKILLS PRACTICES TO IMPROVE THEIR CONTRIBUTION TO GHD

Understanding new health challenges and activities is crucial in the health field, especially in the global context as the world continues to progress. This is particularly important for diplomats and health professionals to be able to adequately address global health threats and promote international partnerships (Michaud et al., 2019). The responses from the participants highlight the need to be up-to-date through sources such as WHO as well as the Ministry of Foreign Affairs and direct communication with the medical teams, the patients and other counterparts (Kruk et al., 2019). Furthermore, GHD is the other important way of ensuring rapid response to such incidents so that assistance can be delivered to the affected persons in the right manner. The main theme is made of the following subthemes:

- Subtheme 4.1: Knowledge of Global Health Issues
- Subtheme 4.2: Training and Development
- Subtheme 4.3: Strategic Leadership Development and Policy

Alignment

Subtheme 4.1: Knowledge of Global Health Issues

As the world becomes more globalised, healthcare workers and diplomats must know about global health concerns (Kickbusch et al., 2021). Its ability to seize new challenges and opportunities defines the efficiency of its actions most of the time. Specifically, participants commented on the ways through which they get informed and updated on the new emerging health challenges and developments in the global society. The responses reflected that the professionals use different sources of information to cover the events that occur in the global health system, from practical usage of the International non-governmental organisation WHO to governmental sources and fieldwork (Ramlagun, 2023). Participant 9 recalled that they use WHO to get informed on matters of health around the globe.

“There are several sources of global health information, but the most crucial one is the WHO. It is a common practice for them to post news and updates on any health risks affecting the world on their pages. With this, we will be able to get up-to-date information and happening in the shortest time possible. Furthermore, we rely on their official website and journals so that we are always in a position to respond adequately to any arising health

complications. It also assists in preventing the outbreak of diseases and their management across the world and hence this approach assists in preparedness". (Participant 9)

The response outlines a plan of how the candidate will be informed of the global health issues given the WHO as a source. To eliminate fake news, it is advisable to use WHO's social media accounts along with the organisation's published materials (Kington et al., 2021). This method emphasises the need to be aware of the trends in health to ensure appropriate practices may be taken when an emerging health issue is identified. Furthermore, the statement on a close relationship with the Ministry of Foreign Affairs also implies that information collection and dissemination is elaborate to enhance global awareness of health issues (World Health Organisation, 2022). By knowing the potential health risks and concerns, this strategy is also useful in planning for their management. The response demonstrates the systematic and comprehensive shallowness of its approach towards monitoring the global health situation, the use of authoritative sources and the development of strategic partnerships towards being ready and quick to respond. Furthermore, Participant 16 named their close ties with the Ministry of Foreign Affairs to be able to monitor new world challenges in the sphere of health:

"The specific platforms help us stay informed and a strong link with the Ministry of Foreign Affairs is also established. In any case, if there are any complications in any country, we are informed and similarly, we inform them as well. Also, the well-developed public health system in cooperation with the Department of Health allows us to shift our rules and responsibilities according to the world's health issues".

The response presents a clear plan of how one can get updated on the latest information regarding the health of people all over the world. This makes communication quick and efficient as well as reciprocal in terms of information sharing with the help of specific platforms and constant connection with the MoFA. This method shows the need for regular updates on new health issues prevailing in different parts of the world. Moreover, getting a sound public health system in line with the DOH means preparedness and flexibility to address international health issues (World Health Organisation, 2022). This is especially so given the emphasis on internal communication within the DOH which enhances the cohesiveness and coordination of responses. This strategy signifies that knowledge acquisition and crisis management occur at the local level and can be adjusted immediately based on the rules and responsibilities in the area (Canton, 2019). It indicates a valuable and integrated approach to

addressing global health issues effectively and in a timely fashion with the help of outside information and internal organisation and communication. One of the participants noted that they should arrange home visits to medical teams and other ways of direct communication to stay connected with the patients.

“In terms of learning about new emerging health threats, we rely on the Ministry of Foreign Affairs and others, through email and direct contact with the medical teams and patients. We also take our students for different field visits which are very important to maintain contact with our counterparts.” (Participant 12)

The response also reveals a complex perspective on how one can acquire information regarding the state of health around the world. This way, the strategy ensures that there are timely updates and enough information by using the Ministry of Foreign Affairs and other communication tools including emails and direct contacts with medical teams or patients (Abdo, 2020). Such focus on field trips to other countries is a practical learning approach that involves direct interaction with counterparts and familiarisation with the context. It is crucial to make the medical interventions more relevant to the ground situation and make necessary changes instantly (Wells et al., 2021). Furthermore, the participant’s involvement in various health-related discussions where his knowledge was useful in shaping the UAE’s global health strategy is evidence of his practical experience. It shows an active and aggressive approach towards issues that continue to affect human health around the world through the use of both bureaucratic and campaign-style contact. Participant 12 shared their views on how their knowledge and GHD contributed to the UAE in the case of the COVID-19 pandemic.

“It is noteworthy that during the pandemic, our country has paid much attention to the development of health care and handling the situation. These include enhancing relations with other medical centres worldwide to adopt new treatments and innovations available in the market”.

The quote describes the UAE’s actions during the pandemic and explains how the country has improved its healthcare systems and the crisis response. The UAE received the latest treatments and innovations, thus illustrating the importance of networks in health emergencies through fostering relations with the medical field (Kuriansky and Kakkattil, 2024). This experience of working with experts from other countries allowed the UAE to offer the most sophisticated care, thus underlining the idea of international partnerships and sharing of knowledge. It also demonstrates how one can tap into international connections to bring

about a positive change in healthcare provision and disaster response. It also signifies the process of hiring international experts to keep track of up-to-date medical practices and incorporate them into practice. It shows the UAE's focus on improving health care through international relations emphasising the importance of international cooperation in combating health problems and improving the quality of people's lives (Sheikh et al., 2019). In a different vein, Participant 16 narrated the importance of GHD in disasters like floods in neighbouring countries.

“In my opinion, GHD is vital for any health organisation. It is important to highlight such organisations as the WHO in the modern world. In case the neighbouring countries are in a disaster, for instance, floods in Oman or Saudi Arabia, diplomacy is of importance.” (Participant 16)

The response stresses how important it is to coordinate foreign aid during disasters, for instance, floods in neighbouring countries such as Oman or Saudi Arabia. It focuses on how diplomacy deals with global health information systems to enhance effective international health interventions. This approach covers a wide range of approaches used by each professional in the field by using international organisations such as the WHO, governmental relations and personal practice in the field. GHD plays a vital role in the management of health as it facilitates efficiency in the formulation and implementation of fundamental solutions to health issues (Chattu et al., 2021). Consequently, by paying attention to global health issues, health organisations are well placed to respond to emergencies, as GHD plays a critical role in global health crises and management. This analysis provides a good understanding of the correlation between health diplomacy and the management of crises.

Subtheme 4.2: Training and Development

Training and development play a crucial role in the field of GHD since it is a relatively new discipline that requires skills and competencies to address various challenges and issues affecting the healthcare sector on the international level (Zanetti et al. 2023). The skills needed for GHD include; understanding of issues in global health, economic matters, leadership and intercultural communication (Javed and Chattu, 2020). Participants commented on their training in GHD, with responses encompassing various types of learning processes, from academic education to practical experience that contributed to the development of the actors' potential for participation in GHD. According to Participant 6:

“In health studies initially, a general reference framework can be generally framed based on four main support points. These are the two fundamental foundations upon which one builds his/her knowledge and experience. In courses, training and experience in health administration, people learn gradually and progressively the framework. This framework is strengthened through practice when one is faced with such challenges and it forms and develops the skills in this area. As such, life experience and learning from difficulties are the key to building a strong base of knowledge in the field of health administration”.

The above response shows how the student needs to learn the basics of health administration through structured learning and practical experience. This approach underlines the importance of comprehending the foundational principles of health diplomacy including health policy, international relations, power over economies and the intercultural communication skills (Dâmaso, 2021). The term “four pillars” is also seen as an attempt to stress the complexity of the field and the fact that different skills are needed when working in it. The participant’s awareness of the usefulness of real-life situations in the development of these skills is equally a confirmation of the experiential learning theory, which indicates that practise enriches theory (Kolb, 2014). This supports the argument that even though individuals undergo academic training, they only gain the required competencies for international health diplomacy upon engaging with real-life problems. Participant 6 highlighted the need to learn and adapt when it comes to this field of work because global health problems are ever changing. On the other hand, Participant 9 described their experience of having received formal GHD related training during via a Master’s degree:

“For training, I have had some general courses in my Master’s programme that are in international health diplomacy. One of these courses was on global health which offered an overview of global health and global health policies. Furthermore, I took the course in Health Economics which is important in analysing the economic aspects of health in the world.

In addition, I have attended leadership and team building training and management and leadership skills have been developed as a result. All of these are important for operating in GHD and international health endeavours.”

The above is an indication that the aspect of formal education played a significant role in enhancing their appreciation of GHD. List of courses: As mentioned by the participant, the Master's degree programme comprises courses such as global health and health economics, which, if followed in such a manner, shows a structured manner in the development of the expert. It then adds to leadership and team-building training that helps them in the management of international collaborations, which are a critical part of health diplomacy (Lencioni, 2012). The response emphasises the need to have academic curriculums that equip the students with knowledge and skills in health diplomacy from the technical as well as the interpersonal approaches. It also shows how the participant concentrated on health economics, a factor which shows that monetary factors are essential in international health endeavours. The professionals can easily weigh the cost of health care against the quality of care to make proper decisions due to the economics of health policies (Alaklobi et al., 2024). This participant has been trained to hold adequate working skills that enable them to participate in GHD especially when it comes to the coordination of projects and collaboration with other countries. On the other hand, Participant 12 highlighted that although they did not undergo any particular training in GHD, they had been trained in many health-related areas:

“I have received extensive training in various aspects of health. Initially, my focus was primarily on the medical side of things. Their understanding is evident as they mention a desire to further expand their medical knowledge, particularly in medical terminology. However, I want to broaden my knowledge, particularly of medical terminology. We took numerous courses, but I desire a course in medical terminology, which will be very informative”. (Participant 12)

Beyond the clinical focus, Participant 12 highlights another vital aspect of their training, one that connects health with international diplomacy. This training is centred around how to properly engage with high-profile individuals in diplomatic settings:

“Additionally, we received training on how to interact with VIPs and royalty, covering topics such as etiquette and proper conduct. These courses have greatly enhanced our ability to handle international health diplomacy effectively”. (Participant 12)

The above response provides insight into the value of non-traditional training in GHD. While they did not receive formal GHD-specific training, their experience in health-related fields and training in etiquette and VIP interactions have proven beneficial in their diplomatic

role (Adomako et al. 2020). It highlights the importance of soft skills, such as communication, cultural competence and professionalism, which are essential for navigating complex international relationships (Shliakhovchuk, 2021). The participant's desire to expand their knowledge of medical terminology further suggests a recognition of the need for continuous learning and specialisation, even in non-diplomatic roles. This is in line with the idea of continuous learning which is key especially in areas such as GHD since new dynamics are bound to arise from time to time (Kickbusch and Liu, 2022). It deals with the aspects of manners in dealing with VIPs and royalties which is a critical aspect of health diplomacy whereby besides technical knowledge and skills, diplomacy plays a crucial role in engagement. It shows that academic learning is important but practical experience as well as training on the job are some of the functions that can appropriately prepare people for international relations in the area of health.

The priorities that were considered in the course of the participants' discussion included the need for the capacity building of the staff and their training in negotiations, leadership and cooperation with foreign partners. As Participant 9 noted,

“These are courses that I have completed in the course of my Master’s programme in the area of GHD... In addition, I have also taken leadership and team-building training and thus possess good leadership and management skills. These are useful when one is in GHD and in any project that is being carried out in different countries.”

This comment is in line with improving health diplomacy. The given example also explains how the attempts to train can be enhanced through National-level cooperation and institutional backing. Thus, while the participant is ready in a personal way, the quote shows that, in general, a structured and consistent approach within the system is possible. Likewise, Participant 12 pinpointed the aspect of cooperation in dealing with health challenges by the relevant bodies:

“In the period of the pandemic, our country has also tried to enhance the healthcare systems... also aimed at enhancing the relations with the medical communities worldwide.”

Crisis response and resilience are well-discussed topics in the interviews conducted with the participants. Participant 9 shared a compelling account:

“We successfully repatriated all our patients during a pandemic and the existing crisis management plan did turn out useful.”

This health crisis management structure and strategy supports the need to have well-developed structures that may be deployed in the course of health crises. According to WHO recommendations for many years, it is essential to perform ethical and effective interventions in emergencies, especially in the transnational context (World Health Organisation, 2021). It is possible to incorporate the post-disruption training and especially the simulations in addition to the post-disruption assessment to be used so that health attachés can be better placed to handle future disruption (Lee and Smith, 2011). In addition, the application of technologies and networking with the world was regarded as crucial to future GHD strategies. According to Participant 11,

“The management strategy is to continue the treatment as much as possible within the country. Telephone was widely used and was deemed helpful in following up on programmes that were implemented.”

This is evidenced by the use of telemedicine and diplomatically especially when addressing post-COVID health governance. This is in line with WHO’s advocacy of the use of Information Communication Technology to enhance health care and continuity (WHO, 2020). Telemedicine and diplomacy are vital in the development of international relations and in assisting people in other countries in emergencies or restricted circumstances (Zhou et al., 2022). Participant 16 also summed up the objective of GHD in emergencies in the following manner:

“If it occurs to the neighbours, for instance, floods in Oman or Saudi Arabia, then diplomacy is called for.”

This cross-border orientation situates the UAE not just as a beneficiary of GHD, but as a regional leader and contributor. Such attitudes point to the need to position UAE’s GHD within the humanitarian and disaster relief frameworks in the region and improve on the WHO’s strategic objectives of solidarity, equity and preparedness (World Health Organisation, 2016; Youde, 2018). All these views point to directions that are not imposed from outside but will be initiated by UAE’s health attachés. The case accounts and autobiographies show that the practice needs institutional support, intersectoral partnership, continuous learning and ethical practice internationally.

Subtheme 4.3: Strategic Leadership Development and Policy Alignment

As Kickbusch et al. (2021) note, although generalist competencies prevail the present discourse about GHD, there is an increasing demand of more particular and specialised

leadership development. This is consistent with the results of the study, in which the participants have highlighted the weaknesses of generic diplomatic education and urged that the capacity building of the specific skills was needed on the basis of the dual status of the health attaches in the UAE.

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They also found out that no strategic synergy between overseas health actions and country objectives had been established. Participant 5 said that there was a need to,

“Consult with the local treatment service providers abroad to determine the health priorities for the country and arrange these according to strengths and capacities of the health institutions of the country.”

This quote is an indication that there is a need to have strategic leadership to ensure that the goals of GHD are aligned with the goals of the country. Thus, while the participants acknowledged the existence of institutional advantages, no formulation existed for the integration of these insights into diplomatic policies. This is further evidenced by the fact that there is awareness of the need but implementation is not fully well achieved (Sharfi, 2021). The increase in strategic coherence will ensure that its international health actions are beneficial and pertinent to the developmental objectives of the UAE in the long run.

It was important to mention that the skills for effective emergency response were regarded as one of the most important leadership competencies in GHD, especially during the pandemic. Participant 1 stated that when the tourist aviation and international airports were closed due to corona, they hired international ambulance aircraft to take back their patients to the homeland. This quote suggests that there is already good practice regarding the coordination of emergencies; however, the focus is more on experience as opposed to the system. Hypothesis 2 is also supported, which can be interpreted as participants are highly committed during the pandemic but get stressed; there is, therefore, a need to have standardised crisis leadership training (Muller et al., 2021). Developing such competencies in the health attachés will assist the UAE to be better placed in terms of preparing for future health calamities.

That is why the WHO also points out the need for further professional development and strengthening of healthcare leaders for addressing global issues (WHO, 2016). The framework developed also suggests an integrated education programme that will address the needs of the UAE health attachés.

One of the key enablers highlighted in the interviews was the role of digital technologies in supporting health diplomacy efforts. It was also emphasised that the use of digital tools for health diplomacy should be regarded as an enabler. As the Participant 11 noted:

“During the period of COVID-19, telecommunication means were the most effective tool for business with foreign partners.”

Based on the framework, WHO is keen on technological advancement in global health and hence recommends that the UAE should increase investment in telehealth, data analytics and virtual collaboration technologies to enhance its global health influence.

Stakeholder Engagement and Partnership Building

The use of WHO, the Global Fund, as well as Gavi for funding was mentioned by several participants. Participant 6 stated:

“It is also important to build relationships with international organisations to advance the Unified Health Diplomacy goals in the UAE.”

According to the WHO’s health policy governance framework, the model emphasises the role of strategic action and active participation in the international processes, to attain sustainable partnerships (WHO, 2017).

Monitoring and Evaluation

The participants also pointed out the importance of evaluating and assessing the GHD programmes. Participant 10 suggested:

“There is therefore a need for sound ways of evaluating the results of diplomacy processes and results to check whether or not they are in line with the strategic goals”.

In line with WHO’s doctrine of accountability, the framework recommends the building of performance indicators and a monitoring system that would track and revise strategies (WHO, 2018).

The thesis makes a valuable contribution to the theoretical body of knowledge, as it illustrates how the strategic dimensions of the UAE and the cultural map of scenes can be applied to provide more sensitive attention to the specifics of relationship management. Specifically, it highlights the functionality of these dynamics in the political sense within the international realm. The UAE can become more competitive in its global health leadership, not only thanks to introducing such insights into its GHD strategy but also by drawing a template of how its leadership can be developed and policies aligned. This qualifies the point that specialised education and culturally relevant leadership skills are the main facilitators in the emerging world of global health governance.

4.6. SUMMARY OF FINDINGS

This chapter has presented the perception of participants from the elite level of the government health sector in the UAE, including the MOHAP, DHA and the DOH on the

leadership factor and GHD issue. The results discussed the following themes; the competencies of a leader that are relevant when it comes to GHD, diplomacy and relationship building, policy coherence about GHD and the vision of the UAE, factors that can hinder leadership as well as the training needs of health attachés in the UAE.

These competencies were considered necessary for the management of complex international health situations and the accomplishment of diplomatic goals. Participants further described the unique challenges to which UAE health attachés are limited by their dual capacity as health and diplomat as opposed to general diplomatic function. Although generalist competencies are discussed in the current literature, as per Kickbusch et al. (2021), this study is the only one focusing specifically on specialisation in leader skills, required for the GHD process, in the UAE context.

Concerning relationship-building, the participants repeatedly highlighted the importance of trust and working together with the major stakeholders to achieve the success of health diplomacy. These results contribute to the literature on the relevance of relationships in diplomacy. Yet, this thesis provides a new contribution in showing how UAE's strategic assets and cultural schema lead to a more prominent focus on the subtlety of relationship management, especially within the political context of the international arena.

Regarding policy alignment with GHD and the UAE strategic agenda discussants underlined the necessity of developing policies that adjust to the changing nature of GHD to support the UAE's objective of becoming a global leader in health diplomacy. The findings show how committed the UAE is to incorporating GHD into its broader national agenda suggesting that changes to the country's policies in this area could strengthen its standing as a global health leader. In the context of GHD, this tactic offers a fresh perspective.

Barriers to effective leadership in GHD were also discussed by the participants. These included cultural variations in health viewpoints, difficulties in handling medical emergencies and political and financial barriers. Even though diplomatic bottlenecks have been recognised in the literature this study highlights particular difficulties that health attachés in GHD face such as interacting with other agencies during GHS and dealing with cross-cultural health issues.

Regarding training and development requirements, respondents stressed the importance of differentiated training curricula for health attachés, who should be trained with the appropriate knowledge and competencies to be able to undertake GHD. Specific areas of focus included global health policy, negotiation strategies and advocacy. The participants also

stressed the need for training programmes in health diplomacy as there was an indication that most existing training models are often generic for diplomats. Thereby making this study contribute to the literature by focusing on training needs for health which are not explored well in the current literature.

The participants provided a great deal of ideas and suggestions regarding the issues covered in this chapter. Regarding the recommendations, the experts proposed the development of programmes dedicated to specialised training, as well as the strengthening of interaction between agencies to eliminate obstacles and the development of policies that would incorporate GHD into the national framework. The results specify that for enhancing GHD leadership abilities and consequently advancing the UAE's global health agenda, a methodical approach is required.

CHAPTER FIVE CONCLUSIONS AND RECOMMENDATIONS

5.1. INTRODUCTION

This chapter presents the summary of the study on the roles and effectiveness of UAE's international health attachés (FHAs) in GHD. Thus, it stipulates the key competencies that are necessary for GHD to be done appropriately, such as communication, negotiation and cultural awareness. The study proves that UAE health attachés are highly skilled in the process of partnership building and managing internationally-focused health organisations and possessing a high cultural intelligence especially in the political sphere. Their responsiveness during global health emergencies, such as the COVID-19 pandemic, highlights the critical need for adaptable and effective leadership in health diplomacy. However, the study also reveals threats, political and culture being one of the most important factors that affect the effectiveness of the leadership development. The final part of the chapter is dedicated to the discussion of the study limitations and the final recommendations for the future research and practise. The chapter ends with discussions of the limitations of this work, a dissemination plan, future research and a personal reflection on the researcher's own experience.

5.2. SUMMARY OF FINDINGS AND DISCUSSION

5.2.1. The current state of GHD understanding and practice in the UAE toward GHD

This study aimed to examine the leadership competencies and practices of UAE health attachés within the framework of GHD and to explore their potential to enhance the UAE's role in international health affairs. For this purpose, the study explored the alignment of health attachés' activities with the UAE's national strategy and investigated the contribution to the development of collaboration through public and private partnerships. The objectives claimed by this work (as described in the aim and objective section) are:

Objective 1: To explore health attachés' views of their leadership skills.

Objective 2: To identify health attachés' understanding of the relationship between leadership skills and GHD.

Objective 3: To examine health attachés' experiences and insights regarding the key barriers to exercising leadership within the context of GHD.

Objective 4: To understand health attachés' perspectives of how leadership development practices can enhance their contribution to GHD.

This thesis achieved its research objectives systematically and comprehensively by employing qualitative semi-structured interviews with 16 elite participants from key UAE

governmental health organisations, including the Ministry of Health and Prevention (MOHAP), Dubai Health Authority (DHA) and the Department of Health (DOH). The findings from the interviews are outlined below and discussed about each of the objectives in turn.

Objective 1: To explore health attachés' views of their leadership skills.

The findings in connection with this objective included good communication and negotiation skills, public speaking and advocacy, cultural awareness, crisis management, good decision-making skills, flexibility and leadership skills; however, the respondents reported that they did not receive as much formal training as their counterparts in other countries. The findings reveal that 'leadership skills' in GHD are multifaceted, requiring a combination of communication, negotiation, cultural intelligence and crisis management. Practices of the UAE's GHD were identified as predominantly located around its overseas treatment program, international partnerships and health tourism activities. These efforts are illustrative of the use of health for public diplomacy in the UAE. For example, study participants also reported the Visiting Doctor Program's success at attracting international expertise to the UAE while simultaneously enhancing bilateral relations with other nations.

Participants highlighted that UAE health attachés will be required to operate in intricate international health arenas, build partnerships across stakeholders and work to represent the UAE's health priorities in international forums. These competencies align with the literature, which highlights the need for leaders in GHD to possess. This is because, flexibility, creativity and social skills are critical tools when working in a change-oriented climate (Javed Chattu, 2020; Gostin et al., 2020).

Communication and Negotiation Skills: In this regard, participants expressed the need to constantly interact with international health organisations through diplomacy, conferences and external health offices to foster partnerships. Coordination was regarded as important in the management of health emergencies and was facilitated by communication and negotiation. For instance, participants described how effective diplomatic communication in the course had helped them to learn about the repatriation of Emirati patients during the COVID-19 pandemic, which was a practical application of the competencies. These reflections are in line with Gauttam et al. (2020), who noted that GHD involves diplomacy, negotiation and strategic planning to deal with geopolitical issues. As much as the participants stated that they acquired these skills in the course of their work, they also noted that there was a lack of training programs (Ross et al., 2020).

A key research gap that this study has sought to address is the limited scholarly exploration of how leadership skills are specifically applied within the specialised field of GHD, where technical health expertise intersects with diplomatic negotiation and international policy influence. This thesis has contributed to the field by exploring health attachés' perceptions of their leadership skills, offering a nuanced understanding of how these professionals view their own competencies within the context of GHD (Luh and Baltag, 2021; Ruckert et al., 2022). By capturing their perspectives, the study highlights the traits, behaviours, and situational strategies that health attachés consider essential for effective leadership, including adaptability, cross-cultural communication, emotional intelligence, and strategic decision-making. This approach not only fills a gap in the literature, where empirical insights into health attachés' self-perceived leadership capacities are limited, but also provides a foundation for developing context-specific frameworks and training programs that strengthen leadership performance in high-stakes, multicultural diplomatic environments (Rosenbaum et al., 2025).

Moreover, this thesis has contributed to improving leadership development for UAE health attachés, particularly for those in charge of GHD whose general areas of expertise include crisis management, intercultural communication, and negotiation. Despite the fact that these competences are discussed in the literature as being essential to effective GHD (Gostin and Katz, 2016; Javed and Chattu, 2020), research indicates that the UAE has considerably fewer organised training programs than other nations (Alkhaldi et al., 2023; Dialer, 2025). The need for the ensuing negotiation training sessions was brought up multiple times, especially to prepare the health attachés for the complex negotiation situations. Similarly, public speaking was seen as crucial for communicating the UAE's policies at international fora and advancing its global health agenda (Emerson, 2018). However, participants also identified areas that were left uncovered due to their lack of confidence when it comes to handling high-risk issues in public. This suggests a definite need for training initiatives that develop the technical as well as the argumentation aspects of communication that are expected in health diplomacy (Fazal, 2020). Whereas prior research has described the competencies needed for GHD, this study offers an understanding of how UAE health attachés perform leadership roles in actual diplomatic settings and the various challenges and cultural factors that are not always captured through an international lens.

For example, in the UK, the academy spearheads leadership training in health diplomacy, negotiation and crisis management, preparing the diplomat with the necessary

skills for their jobs (Feldbaum and Michaud, 2010). Similarly, programs supported by the Australian and New Zealand governments are tackling regional health issues through training that encourages attachés to negotiate in multifaceted diplomatic and health environments (Dabou et al., 2022). Alternatively, however, the interviewees say that UAE health attachés generally develop these competencies through on-the-job experience, rather than formal training programs, inferring a lack of uniformity in preparedness levels.

Moreover, strategic decision-making in any GHD requires the attachés to make a balance between diplomatic and medical obligations that in turn calls for adaptive leadership. Many countries, like Canada, embed health diplomacy into a government foreign policy via Global Affairs Canada, ensuring the attachés get training specific to their diplomatic roles (Terry and Hayfield., 2020). On the other hand, health attachés usually lack formal training in negotiating boundaries; they attend informal sessions that are organised by their governments most of the time and, thus, are proportionately deprived of comprehensive, structured development. This analysis shows a disconnect between the theoretical leadership skills in GHD and their practical use within the UAE context. To narrow this gap, the UAE can create structured programs focused on leadership development in line with international best practices. This will ensure that health attachés are equipped with the necessary leadership skills for effective GHD (Almulla and Kazim, 2024).

Through the resolution of these challenges, the study obtained rich, high-level data with which to draw useful knowledge about the leadership abilities, struggles and strategies of UAE health attachés. These findings emphasise the significance of the study's contribution to the evolution of leadership theory in GHD, despite the difficulties that are associated with the conduct of the research (Javed and Chattu, 2020; Ross et al., 2020). Leadership abilities, struggles and strategies might be covered by a more inclusive theory of leadership, which might also be more helpful in directing leadership research (Figuroa et al., 2019). In general leadership literature, an analysis acknowledges that leadership is a complex notion. Interpersonal communication skills, critical thinking skills, problem-solving skills, interpersonal perceptions, motivating skills, conflict-solving abilities, and adaptability are a few traits that distinguish leaders. This is due to the fact that these numerous skills and abilities are essential for improving both the practical implementation of effective leadership and a more thorough understanding of it (Birn et al., 2017).

The role of leadership theory is central to understanding how theoretical frameworks of leadership can explain, interpret, and enhance the behaviours, decision-making processes,

and interpersonal competencies required in diplomatic health contexts (Ahmed et al., 2024). Leadership theory provides the conceptual foundation through which the leadership skills of international health attachés can be analysed, particularly in how they exercise influence, negotiate, and build consensus across complex global health systems that involve multiple stakeholders, including governments, international organisations, and non-state actors (Birn et al., 2017; Figueroa et al., 2019). By grounding the study in leadership theory, researchers are able to identify the traits, behaviours, and situational responses that distinguish effective health attachés, such as adaptability, emotional intelligence, cross-cultural communication, and strategic vision (Ruckert et al., 2022; Karačić Zanetti et al., 2023).

Leadership theory in the context of this study is closely linked to the drivers of GHD, such as international cooperation, negotiation between state and non-state actors, policy advocacy, and cross-cultural engagement (Ahmed et al., 2024). By integrating leadership theory with these GHD drivers, the study can examine how health attachés exercise influence, manage intersectoral collaboration, and negotiate in complex diplomatic contexts. Linking leadership theory to these models allows the study to situate health attachés' competencies within the broader structural and procedural mechanisms of GHD (Almulla and Kazim, 2024). This research contributes uniquely by offering an integrated framework that combines leadership theory with the practical realities of GHD in the UAE context. While previous studies have examined leadership competencies or GHD separately (Ruckert et al., 2022; Karačić Zanetti et al., 2023), this study bridges the two domains, highlighting how UAE health attachés' skills, such as adaptability, cross-cultural communication, emotional intelligence, and strategic vision, enable them to navigate complex global health networks. Additionally, the study considers context-specific factors, including the UAE's geostrategic position, multi-ethnic workforce, and national strategic health policies, which influence how leadership is exercised in practice. In doing so, it provides both theoretical insights (enhancing leadership models with GHD perspectives) and practical implications for training and development programs that aim to strengthen health attachés' effectiveness in GHD.

Furthermore, leadership theory serves as a lens for exploring how different leadership styles manifest within the context of GHD, shaping how attachés foster cooperation, manage conflicts, and represent their countries' health interests on the international stage. It also helps explain how leadership skills contribute to diplomatic outcomes, such as policy influence, alliance building, and negotiation success, by linking individual competencies to broader organisational and geopolitical objectives (Sharfi, 2021; Dialer, 2025). In essence, leadership

theory does not only provide the academic framework for categorising and interpreting leadership behaviours among health attachés but also offers a practical guide for developing and strengthening the leadership capacities necessary for effective engagement in GHD (Karačić Zanetti et al., 2023; Balkhy, 2025).

Objective 2: To identify health attachés' understanding of the relationship between leadership skills and GHD.

Based on the findings made about this objective, health attachés were found to have leadership in international collaboration and diplomacy. Nevertheless, issues about the efficiency of interagency cooperation as well as the strategic and long-term approach to partnership restricted its sustainability on the international level. The study affirms that leadership skills are determining factors that may affect the capacity of the UAE to develop “strategic health partnerships” and achieve positive outcomes in GHD. The participants pointed out that there is a need for vision management and stakeholders' involvement in the formulation of international partners and the integration of health interventions for the UAE.

Strategic Vision and Planning: Most of the participants agree with the visiting doctor programme and teleconsulting as a part of the UAE vision of future international health cooperation. These programmes not only improve local health standards but also bring international experience in the field, which is a promise the UAE has made for the country to become a world-class health hub. This is in support of Ross et al., 2020 who postulate that the success of health interventions depends on the extent to which health initiatives are in line with the strategic plan of the nation.

Another aspect of professional activity in present-day society is the strengthening of stakeholder management which is also regarded as one of the key leadership skills when addressing transboundary health concerns. The participants were also able to identify that the skills of UAE health attaché should involve diplomacy and strategic and communication skills when dealing with governments, UN agencies and health care agencies. Leadership and the building of trust with a variety of stakeholders is essential for the implementation of global health programmes and in some instances, can even eliminate the hurdles to health care, preventive services. This supports Storella's (2023) assertion that multi-stakeholder involvement is central in the management of both political and technical challenges in health diplomacy. These findings also reveal that leadership in building trust and partnership with international players is critical for success in the realisation of the UAE's health diplomacy agenda. Respondents underlined that two factors, namely, negotiation skills and cultural

intelligence had the strongest influence on the development of diplomatic relations. Strategic communication was also viewed as important, especially as it referred to the linking of health-related activities to overall geopolitical agendas. However, the participants observed that these skills are very important, but their effectiveness may be boosted by leadership programmes and diplomatic mentorship and practice in diplomatic realistic role plays (Sinnema et al., 2020). This thesis adds to the knowledge in the following ways: firstly, it captures how the UAE's cultural flexibility and positioning increases its efficiency in dealing with the dynamics of GHD, secondly, it shows that while more emphasis has been placed on personality traits, institutional supports should be encouraged to amplify leader effectiveness.

The participants noted that health diplomacy entails strategic planning and management of crises as the fundamental competencies. Increasing their effectiveness requires both collaboration between agencies and cultural competence because these assets were identified as necessary but deficient skills.

The gap is particularly pronounced in the absence of models or frameworks that capture the lived experiences, strategic decision-making processes, and leadership development needs of health attachés who operate in multicultural and high-stakes diplomatic environments. This thesis has contributed to the field by identifying health attachés' perceptions of the relationship between leadership skills and GHD. By examining how these professionals understand the ways in which their leadership competencies, such as negotiation, strategic vision, adaptability, and cross-cultural communication, impact diplomatic effectiveness, the study provides empirical insights into the practical application of leadership within GHD. This contribution addresses a gap in the literature, where the connection between individual leadership capacities and the complex processes of GHD has not previously been fully explored, and it informs the development of strategies and frameworks to enhance the effectiveness of health attachés in navigating multi-stakeholder, high-stakes international health environments (Balkhy, 2025).

While existing literature has explored leadership competencies and GHD separately (Chattu et al, 2023; Rosenbaum et al., 2025); there is a notable gap in models or frameworks that integrate the lived experiences, strategic decision-making processes, and leadership development needs of health attachés operating in multicultural and high-stakes diplomatic contexts (Javed and Chattu, 2020; Balkhy, 2025). This study addresses that gap by providing an evidence-based, context-specific framework that captures how UAE health attachés perceive and exercise leadership within GHD. By examining their experiences, challenges,

and perspectives, the research offers new insights into the competencies required for effective GHD, the strategies used to navigate complex international networks, and the ways in which leadership development initiatives can be tailored to enhance their effectiveness. In doing so, the study contributes both theoretically, by extending leadership and GHD models to reflect real-world practice, and practically, by informing training, policy design, and the professional development of health attachés in high-stakes, multicultural environments.

This research is closely connected to enhancing the effectiveness of leadership competencies in health partnerships and results. All stakeholders, including MOHAP, DHA, and DOH, would benefit from better decision-making and resource coordination if a centralised leadership structure were established. For this reason, participants emphasised the necessity of a leadership forum for planning, stakeholder management, and coordination. However, a lot of resources are wasted while putting GHD practices into effect because institutions are operating independently. According to this thesis, the UAE may increase the strategic value of its foreign alliances and broaden its impact in international health by using a strategic framework for health attachés to help them coordinate their work and match it with national priorities. This study further supports the necessity of using strategic international collaborations to develop and improve effective leadership in the competitive era. It was believed that increasing the number of health attachés worldwide and forging new international collaborations in the field of health were essential to bolstering the diplomatic presence. Countries can participate more in international health diplomacy and policy-making thanks to such mechanisms. By adopting a diplomatic vision that unites MOHAP, DHA, and DOH, the UAE may improve its interaction with the world goals. In addition to enhancing the country's standing in global health governance, these goals would promote the long-term viability of the nations' diplomatic ties.

Objective 3: To examine health attachés' experiences and insights regarding the key barriers to exercising leadership within the context of GHD.

The findings of this objective were that health attachés complained of challenges including; lack of formal training, cultural issues and bureaucracy. These factors limited their capacity to assume leadership roles in diplomacy in global health. Participants identified several barriers to effective leadership in GHD, including cultural sensitivity challenges, crisis management complexities and economic and political constraints. These obstacles are consistent with the literature, which describes the challenges of working together to reconcile cross-cultural expectations to manage crises and deal with bureaucratic concerns as part of

GHD (Bhaduri, 2019; Caligiuri, et al, 2022). The findings revealed that participant perspectives varied significantly in terms of focus. Participants reported GHD as a means of transnational relations by implementing health programs and emphasising diplomacy to obtain common health objectives. Cultural barriers were consistently reported by participants as limiting the effectiveness of health attachés in international settings. While South Korea is not a focal country, it serves as a relevant example of the cross-cultural challenges attachés encounter globally, with patients not wanting to be transferred there due to a lack of cultural familiarity, despite the quality of treatment on offer.

A major research gap noted in Chapter 2 stems from the scarcity of empirical evidence examining how health attachés themselves perceive and interpret the barriers that hinder their ability to effectively exercise leadership in international health negotiations and diplomatic engagements (Kickbusch et al. 2013; Javed and Chattu, 2020). This thesis has contributed to the field by demonstrating that leaders in health attaché roles must utilise advanced cultural intelligence, negotiation and patient advocacy to solve these issues. However, without a decisive strategy for cross-cultural healthcare, attachés will react rather than proactively use diplomacy to build patient trust and cooperation. More government-supported initiatives, like collaborative cultural training for diplomats and medical professionals from partner countries, may enable delegation leaders to more effectively handle difficulties and improve patient care internationally. The COVID-19 pandemic exposed severe deficiencies in crisis response and adaptation, which severely hindered UAE health attachés' work. It should be highlighted that although the attachés were instrumental in organising the return of patients and developing plans for crisis response, their leadership was largely hindered by time constraints, diplomatic snags, and a constantly shifting framework on health policy by various jurisdictions.

Diplomatic hitches were caused by the international lack of coordination that delayed the planning of the crisis response. Attachés faced barriers posed by an array of international health regulations, lack of resources and demands from the host and home countries' authorities creating an unconsolidated process that hindered decision-making. Combined with sudden closures of borders, less-than-coherent quarantine regulations left them incapable of decisive actions, diminishing the capabilities and value of repatriation efforts. Attachés worked without any backup crisis protocols and diplomatic contingency plans, looking reactively into issues that kept changing, instead of being able to proactively work at the level of health interventions.

In addition, due to a lack of a centralised crisis-management framework, the liaison between UAE authorities and foreign health institutions for timely updates was impeded. The complexity of the negotiations brought a conflict of interests and a possible emergency provision of healthcare into play given various international health regulations that may stretch the capacity for real leadership by the attachés.

Institutionalising adaptive crisis protocols, establishing rapid-response diplomatic mechanisms and integrating digital health coordination platforms will give attachés the ability to exercise diplomatic and health leadership effectively during crises in the future. These strategies would ensure that attachés provide on-the-ground leadership to mitigate raised questions. They'll enable decision-making with a lot less delay and strengthen the UAE's resilience in global health. Limited funding allocation combined with political considerations compromises the capacity of the UAE health attachés to effectively engage in international health collaborations. Attachés are often restrained to prioritising short, minuscule arrangements over sustainable global health collisions because of constrained financing regarding diplomatic health initiatives. Lack of funds also limits training and experience to be exposed to leadership skills such as negotiations and crisis management to attachés.

On the political aspect, poor diplomatic relations between countries lead to bureaucratic barriers that make it hard for an attaché to get the clearance to provide ailing patients with the help that they need, admit patients into other countries for treatment, or provide consensuses on sharing of resources. For instance, in the 2024 Mpox outbreak, vaccines did not reach the African states as they were prohibited by existing international law and political rivalry that hindered intervention. For instance, UAE health attachés experienced diplomacy challenges in negotiations of vaccines on the frontline where they were limited by economic sanctions and political rivalry between the donor and recipient states, hence, restricted approval.

The following challenges might hinder health attachés from fully exercising their leadership competencies as they bear politically sensitive tasks that require them to work within the context of budget limitations and bureaucracy accompanied by tendencies towards delay due to regulatory issues. Since there are no clear conventions on how diplomatic relations and financial leeway should be utilised, the attachés cannot set goals for themselves to become active in health diplomacy and thus deprive the UAE of the desire to shape health discussions globally. To be able to lead, attachés must be financially independent, know how to negotiate diplomatically and be given separate channels for formulating policies for

international health cooperation. In order to overcome such challenges, participants stressed on clear contractual relations with the stakeholders and communication. This is in line with Jeong's (2019) position that clear communication and clearly defined agreements are a prerequisite to the challenges of both economy and politics in global health.

This data underscores the importance of "higher-level" training in cultural awareness, crisis response and negotiation to overcome the challenges to UAE health attachés. The work in the literature makes a specific contribution in that it can be used to provide concrete examples of how these barriers work out in the UAE context and propose feasible solutions, e.g., the establishment of a "National GHD Coordination Unit" to facilitate and enhance interagency working.

Objective 4: To understand health attachés' perspectives of how leadership development practices can enhance their contribution to GHD.

Participants highlighted the need for ongoing training and development for health attachés to carry out GHD effectively. Existing training models, which tend to be coated with general diplomatic competencies, were shown to lack the ability to respond to the specific challenges of health diplomacy.

Knowledge of Global Health Issues: Participants emphasised the significance of being updated on new global health threats via trusted outlets, like the WHO and the Ministry of Foreign Affairs. This aligns with Kickbusch et al. (2021), who claim that monitoring global health developments is a prerequisite for good crisis management and international cooperation.

Training and Development: Participants also call up for specialised training in global health policy, negotiation and cultural competence. For example, one participant reported how studying for their Master's degree in global health enabled a deeper understanding of international health and associated policies. This is in concordance with Javed and Chattu (2020) who found that high-quality Generalist Health Discipline involves a range of skills including; Health economics, leadership skills and cross-cultural communication skills.

Previous literature has often emphasised the strategic and technical functions of health attachés without adequately developing leadership skills practices to improve their contribution to GHD (Chattu et al, 2023; Rosenbaum et al., 2025). This thesis has contributed to the field by examining health attachés' perceptions of leadership development practices and how these practices can enhance their contribution to GHD. By exploring their views on training, mentoring, experiential learning, and organisational support, the study provides

insights into the strategies and initiatives that can strengthen leadership competencies in real-world diplomatic health contexts. This contribution addresses a gap in the literature, where little is known about context-specific approaches to developing the skills necessary for effective GHD, and offers evidence-based guidance for designing targeted leadership development programs that improve health attachés' effectiveness in navigating complex, multi-stakeholder, and multicultural global health environments (Brown et al., 2018; Chattu et al, 2023).

Furthermore, this thesis has contributed to the development of a strategic framework for improving leadership skills practices in the GHD. It clarifies the roles and strategies necessary for enhancing inter-agency collaboration, cultural sensitivity, and leadership development based on participant outcomes. It also emphasises the need to align international cooperation, disaster response, and overseas treatment initiatives with other foreign policy objectives (Sharfi, 2021; Millar et al., 2025). These findings reveal a significant lack of prior knowledge regarding the governance of healthcare relationships between the UAE and other countries, as well as a marked deficiency in preparing UAE health attachés to negotiate within diverse global health contexts (Alkhaldi et al., 2023; Dialer, 2025). When used in the UAE, the framework helps the nation realise its goal of becoming the region's leader in health diplomacy and provides guidelines for putting the GHD principles into practice. Even if it is crucial to concentrate on training and development, the results further demonstrate that soft power and charm alone are insufficient when it comes to GHD (Brown et al., 2018; Chattu et al, 2023). In order to promote the innate leadership skills and overcome the structural limitations in international health diplomacy, participants emphasised the importance of institutional support, evidence-based strategies, and policy assimilation.

One of the crucial steps to enhance the UAE's initiatives in GHD is to establish a central GHD coordinating body in UAE to supervise the strategic planning of the process. The influence of the interministerial collaboration approach is interpreted from the Swiss council; the establishment of a UAE GHD council would increase the efficiency of diplomatic efforts, provide valuable input for financial resource allocation and align national health diplomacy initiatives with higher foreign policy objectives.

The UAE's approach to global engagement is deeply aligned with its national strategic frameworks, particularly Vision 2030, which outlines a commitment to sustainable development, international cooperation, and innovation-driven diplomacy. Vision 2030 emphasises the importance of health, education, and economic diversification as pillars of

national growth, all of which intersect with the goals of GHD. In this context, the UAE's international health initiatives and overseas treatment strategies reflect not only humanitarian concern but also a calculated effort to strengthen its global reputation and influence in alignment with the objectives of Vision 2030.

Another area for improvement is the expansion of public-private partnerships (PPPs) in GHD. Germany and the UK have to an extent successfully generated the funding of large-scale health diplomacy programs through PPPs. The UAE can grant itself some more leeway in GHD by using public-private partnerships for the sustainable establishment and delivery of extensive health programs.

Global health summits would add a new dimension to the status of the UAE on international platforms. It could create an opportunity for the UAE to act as a major convener for the global health negotiations, thereby keeping Switzerland in mind and could only congregate in turn to gain diplomatic leverage and advance their plans for global health policies.

Currently, we see that the UAE ranks among the first 25 countries in health sector efficiency and infrastructural setup (World Economic Forum, 2023). However, despite the UAE's healthcare infrastructure ranking, GHD initiatives remain poorly integrated with national health sector policies. It is by using centralised coordination, strategic partnership establishment and training in leadership for health attachés that the UAE may enter the top 10 GHDs in the world and thus create its influence on global health policy, especially in the Middle East, South Asia and Africa. Hence, this framework is in line with the general guidelines recommended by the WHO regarding GHD. These are also addressed in the proposed strategies including: health system strengthening, ethical disaster response and policy (WHO, 2016; WHO, 2017; WHO, 2020).

5.3. CONTRIBUTION TO KNOWLEDGE

To the best knowledge of the author, this study is the first of its kind focusing on GHD. This thesis has reviewed theories and practises of GHD in the UAE and established ways of enhancing the effectiveness of GHD. Unlike most of the health diplomacy studies that take a more general approach to the concept of health diplomacy (Kickbusch et al., 2013), this thesis has focussed on the leadership competencies that UAE health attachés have at their disposal and relates those to the country's objectives in the sphere of global health. This thesis adds a

new understanding of GHD in the context of the UAE, which provides new insights into the relationship between leadership, culture and global health.

It is the result of the findings of this thesis that adds to the existing knowledge base by identifying a list of leadership competencies that are critical to the role of health attachés. These are negotiation, cultural awareness, strategic thinking, relationship-building and crisis response. Although the vast majority of the literature has focused on general diplomatic skills, this study reveals the specific needs of health attachés by working in high-pressure zones of GHD (Kickbusch et al., 2007; Lee and Smith, 2011). This research highlights ways in which these capabilities are shaped by the special geostrategic circumstances of the UAE, its multi-ethnic labour force and efforts toward a national strategic policy for health globally and provides a specific, integrated and integrative framework that encompasses diplomacy and health-related skills. The present study successfully integrates diplomatic and health-oriented abilities and is aimed at a major gap in the existing literature.

In addition, this study also offers a new understanding of the contribution that GHD can make to achieving the UAE's vision as a leader in global health. In situating GHD within the wider context of UAE's strategic objectives, the study highlights how health attachés can utilise their functions to build international partnerships, shape international health policy and cope with health injustices. Since it emphasises the systemic and transformative potential of health diplomacy beyond its transactional elements GHDs alignment with the UAE national vision offers a novel perspective (World Health Organisation, 2020a).

Identifying the barriers to effective leadership in GHD is another significant contribution made by this thesis. This study offers a comprehensive and detailed understanding of the issues that health attachés face worldwide in contrast to previous research that usually generalises what these challenges look like (Koplan et al., 2009; Feldbaum and Michaud, 2010). These competencies include intercultural management of geopolitical conflict resolution and crisis mitigation including pandemics and global health issues. These findings indicate that it is necessary for overcoming these obstacles to adopt a sophisticated strategy that is based not only on technical but also on interpersonal factors and importantly, on a sophisticated knowledge of the socio-political scenarios within which health diplomacy is practised.

Research in this research extends the current literature, by focusing on the critical import of program design based on needs, namely needs-focused training and capacity, building programs designed for health attachés. Although previous research has discussed

GHD in general leadership proficiencies or general health diplomacy frameworks (Lee and Smith, 2011; Kickbusch et al., 2013), the scope of this thesis is more specific, identifying the particular skill shortfalls and difficulties that the UAE health attachés face. It demonstrates how targeted, contextually relevant training programs can address the practical barriers these professionals face, such as navigating complex multicultural settings, managing crises and forging sustainable international partnerships. Through the congruency of these efforts with the UAE's strategic goals, the study provides a more operationalised specificity and delivers practical guidance beyond the predominantly theoretical and/or generalisable approaches present in the literature (Frenk, 2010; Kickbusch et al., 2014). This practical approach facilitates the direct translation of the academy into practical practice for the development of GHD practices. Although currently available training projects for diplomats typically assume generalist skills, this thesis proposes that specialised training programs incorporating global health policymaking, negotiation strategies and advocacy skills are required. These courses should also focus on cultural proficiency and ethical leadership, preparing the health attachés to deal with the GHD complexities in an effective way. In highlighting these training requirements, the study offers practical advice for improving the readiness and effectiveness of UAE health attachés.

This research further contributes to knowledge by proposing a strategic framework for embedding GHD within the UAE's broader foreign policy agenda. The framework highlights the alignment of health diplomacy with national development targets, including innovation in healthcare, strengthening international partnerships and advancing the UAE's leadership in the field of health governance. This model is not only in line with the vision of the UAE but also will make GHD one of the important means to realise sustainable development and global health equity.

One of the more novel features of this research is its investigation of relationship building as an essential feature of GHD. Building relationship is irrefutably core to professional diplomacy, as the basis of trusting, symbiotic and comprehensible interaction between nations (Berridge, 2015). Yet, in the field of GHD, the literature tends to focus mainly on the secretive processes of policy-making, agreements and technical problem-solving rather than on the complex, long process of relational processes needed for maintaining cross-border partnerships (Feldbaum and Michaud, 2010; Kickbusch et al., 2013). This neglect also downplays the interpersonal and cultural aspects which are essential for the building of trust and for dealing with the intricate sociopolitical context within which GHD works. However,

although the literature generally recognises the relevance of negotiation skills, negotiation between individuals is rarely if ever investigated about how the human ability to establish personal relationships, trust constructions and, more generally, relations of trust create support for negotiations in politically sensitive situations or during global health emergencies. This work, centring on relationship building as an important, if underappreciated, aspect of GHD, not only highlights GHD as a way to obtain short-term diplomatic goals but also points out its long-term contribution to sustainable global health partnerships. This view rejects the current model and proposes a more relational model of GHD in theory and practice (World Health Organisation, 2020b; World Health Organisation, 2020c). The research describes the way that UAE health attachés foster trust and partnership during their engagement with international partners. It emphasises the need for and the value of cultural awareness and mutual understanding when developing sustainable alliances, particularly in politically fraught settings. This emphasis on relationship-building also brings a new perspective to the interpretation of GHD, focusing it on its relational, not purely transactional, nature.

This thesis also offers practical considerations for policymakers and practitioners. Completion of the study based on the identification of the specific competencies, difficulties, and the instruments to be employed in the management of GHD provides a set of directions and a roadmap for the elaboration of targeted interventions and policy practices. For example, the results indicate that promoting intersectoral cooperation among government agencies, academic centres, and global organisations can strengthen the performance of GHD. Likewise, this work proposes the creation of initiatives that can be used to explore the effect of health diplomacy work, with accountability and ongoing improvement.

The contribution to knowledge of this thesis is also reflected in the research design, which aimed at including the representatives from the high level of the most important governmental institutions of the UAE such as the MOHAP, DHA, and DOH. This enabled the development of a profound perception of the work of these national institutions in the framework of the overall GHD environment. Moreover, the study explored the cooperation of IGOs, including WHO, Gavi and ICRC and NGOs, including MSF in this area. These are not only players in global health governance but also counterparts for UAE health attachés in the areas of pandemics, emergency response and vaccines. For instance, the collaboration with WHO enables the achievement of health goals that are in line with the WHO strategies, while working with both MSF and Gavi demonstrates that attachés are responsible for the coordination of humanitarian responses and fundraising. This multi-actor approach has helped

to gain a broader picture of how the UAE health attachés operate and participate in international health diplomacy.

On an academic level, this study contributes to the understanding of comprehensive human development by exploring health attachés' perspectives, experiences, and understanding of leadership competencies within GHD. It identifies how these professionals perceive distinctive leadership traits, recognise barriers to exercising leadership, and understand the strategies that enhance their effectiveness in complex diplomatic health contexts. The study offers an original contribution to integrating GHD into the UAE's national strategic priorities by highlighting how health attachés interpret and apply leadership practices to achieve systemic and organisational goals. It also provides insights for capacity-building, training, and policy development by reflecting the lived experiences and interpretations of practitioners, ensuring that leadership development initiatives are aligned with the realities of international health diplomacy.

This study makes a significant contribution to the field of GHD by centring on the perspectives, experiences, and understanding of UAE health attachés regarding leadership competencies. Unlike positivist approaches that prioritise measurable or “tangible” outcomes, this research adopts an interpretivist lens, recognising that leadership in GHD is shaped by subjective experiences, cultural contexts, and situational dynamics. Academically, this focus allows the research to identify patterns, themes, and insights that reflect both individual and systemic dimensions of leadership. It reveals how attachés understand the relationship between leadership competencies and effective GHD, how they interpret challenges such as cross-cultural negotiation or policy coordination, and how they conceptualise professional development to enhance their roles. This approach contributes to theory by bridging leadership frameworks and GHD models with practical, context-specific understanding, creating an integrated framework that is grounded in real-world experiences. Professionally, examining experiences and perceptions provides actionable knowledge for capacity-building, training, and policy development. Insights into how health attachés interpret leadership challenges, develop strategies, and interact with international stakeholders offer guidance for designing programs that are responsive to the complexities of GHD rather than simply prescribing generic skills.

5.4. LIMITATIONS OF THE STUDY

Although this work offers important evidence about leadership capabilities, difficulties and strategic contributions of UAE health attachés to GHD, several limitations of this study need to be acknowledged. These restrictions are due to the sampling design, data acquisition difficulties and methodological limits.

This study with health attachés and the overseas treatment department/centre as the main respondents was a purposeful and strategic one because of these respondents' particular roles and contributions to GHD. Health attachés and the overseas treatment department/centre are pivotal figures at the intersection of healthcare and diplomacy, tasked with navigating complex international health challenges while advancing the UAE's strategic objectives. Their position as elite representatives of the UAE's healthcare sector in global contexts makes them uniquely suited to provide insights into the leadership skills, challenges and strategies essential for effective GHD.

This study specifically excluded other groups, such as frontline healthcare workers, patients, or administrative staff, because their roles, while significant, do not directly align with the leadership-focused objectives of this research. Health attachés and Overseas Treatment Departments/Centres have strategic oversight of their special area, including, negotiation, cultural competence and strategic decision making which were core to this study's aims. Other groups may be excluded from having the needed level of participation across the high-level strategic and diplomatic frameworks that are essential for GHD. This approach necessarily restricted the range of perspectives to be obtained. For example, "who-do-it-themselves" (WII) voices, such as from operational or mid-level people, whose experience could help in understanding and rolling out GHD tactics, were excluded. Also, the research did not involve patients or stakeholders as the recipients of GHD efforts, whose experiences might offer a richer insight into the effect of those leadership approaches. This was a purposeful decision, however, as the incorporation of participants drawn from more broadly general populations may have undercut the focus on the specific management qualities that made successful GHD possible.

Overseas treatment departments and health attachés have important functions in the promotion of health diplomacy especially in the signing of complicated agreements and managing crises in the global health system. By targeting this group, the study is in line with the UAE's strategic global health priorities and provides an understanding of how leadership

in GHD is enacted. This raises the importance of the participant's knowledge and the extent to which they exposed the study to their knowledge base.

This work used a non-probability sampling design, specifically recruiting 16 participants whose leadership sits in key leadership positions in UAE health diplomacy. These stakeholders were selected based on their specialisation and experience in international health affairs and policy implementation. Their responsibilities require a very sophisticated combination of skills in diplomacy, clinical practice and political and strategical plans and thus are critical to the appreciation of the leadership dimension of GHD. Nevertheless, it was highly difficult for a person to obtain access to this elite circle, because of their rigid working hours and confidential working responsibilities.

Securing approval for this study took a lot of time and effort, including a long more than four-month application process to get Research and Public Affairs (RPA) approval. This period involved multiple rounds of follow-ups, revisions to research protocols and addressing concerns from relevant authorities to ensure compliance with institutional and governmental standards. Their direct involvement in GHD activities afforded them a type of insight unmatched by any other group of participants, such as frontline health workers, patients, administrative personnel, etc. Despite their utility towards the health care system, these instances of groups would not have been in line with the leadership-focused aims of this work.

The primary aim of this study was to assess the leadership competencies of health attachés and the overseas treatment department/Centre, such as negotiation, cultural awareness and strategic action and to analyse their contributions to the UAE's partnerships and health diplomacy initiatives.

To ensure the rigour and reliability of the research findings, the study achieved data saturation by conducting interviews until no new themes or insights emerged from participant responses. Saturation is a widely accepted criterion in qualitative research, signifying the point at which additional data collection ceases to generate new understanding (Fusch and Ness, 2015).

Another restriction of this study lies in the regional characterisation of health attachés. Interestingly, there is no specialised health attaché in Switzerland of the UAE overseas health attaché system. The German health attaché is out of the national context and also overseas in Switzerland. As a result, insights specific to Switzerland were gathered through discussions with the German health attaché.

This framework represents the diplomatic and operationally practical constraints of the UAE health attaché system and gives a regional context to the current operational framework. But it could constrain the capacity to visualise rich, country-by-country dynamics, especially given the special character of Switzerland's medical field. This constraint should be taken into account when interpreting the results and when considering the wider implications of the results for leadership and operational aspects of GHD.

The research adopted a strategic, hierarchical method by exclusively studying the experiences of senior-level participants composing top-level decisions. With this methodology, it is possible to have a nuanced perspective of leadership competencies, strategic goals and policy context. The reason for the advantage of the top-down approach lies in its possibility of identifying the wider strategic needs and agenda-setting process, which are normally absent in the bottom-up approach by operational input (Cairney, 2012; Hill, 2013). This theme is especially acute in the UAE. However, the endowing factor of top-down methodology was considered applicable in this study because the dominant role of the study was exploring the leadership competencies and their strategic relevance. This corresponds to frameworks discussed in the literature that highlight senior leadership oversight in global health projects (Kickbusch et al., 2013).

The study uses a cross-sectional approach, relying on semi-structured interviews that provided in-depth insights into participants' perspectives but came with inherent limitations. Interviews were conducted at a single point in time, meaning the study could not capture potential shifts in practices, views, or challenges over an extended period. By carrying out longitudinal interviews, it may have been possible to investigate aspects of how GHD approaches change in response to shifting geopolitical, economic and health processes.

Data collection for this research also entailed several procedural difficulties which highlighted the challenges of conducting qualitative studies using this sample of high-performing individuals. In some cases, interaction with participants, in particular from organisations like MOHAP and DOH, has been necessary to communicate indirectly via their secretaries, instead of directly with directors or officials. Not infrequently this resulted in a delay and additional requirement to coordinate. One participant even refused to allow the interview to be recorded, although he consented to participate and signed the necessary consent forms. With the unavailability of recording, interview transcripts required extensive note-taking, which caused difficulties in the recording of the whole expressions of the answers and the smooth flow of the conversation.

Securing institutional and governmental approval for this study also involved significant hurdles. A more specialised and collaborative strategy is necessary to guarantee that global health policies are pertinent and successful given the wide range of country-level conditions.

Additionally, the senior-level participants' busy schedules posed another challenge. In some cases, interviews were cut short by imperative professional activities and subsequent rescheduling was necessary to resume and finish the interview. For instance, an interview with a single health attaché was interrupted because of their presence in a spontaneous diplomatic reception, which meant an important delay before it was continued. These cases also raised the issue of a practical challenge in finding the most appropriate participants, who in turn are themselves under a lot of pressure.

5.5. DISSEMINATION PLAN

I have contributed to several large-scale, high-profile conferences as a DBA student while sharing early results and engaging in networking within the Public Health (PH) community. Each conference was carefully chosen for being appropriate to GHD and its target audience of people involved in global health, policymakers and academics:

Dissemination of Research Findings

This research allowed me to share the results of my initial study on leadership competencies of UAE health attachés to academics and global health workers. The dissemination activities comprise past, current and future activities in conferences, academic journals, workshops and collaboration platforms.

Conference Presentations

The first attempts to disseminate the results were made at international conferences with the presentation of preliminary results and receiving comments from experts:

- ISPOR 2023 (May 2023, Boston, USA): It was an international forum to make contacts with professionals in the field of health economics and outcomes research. During my presentation, I focused on the role of UAE health attachés in building international health relations.
- Peer and Expert Presentations: I took part in peer and expert presentations throughout my time with ISPOR, which gave me a forum to talk about current research and get insightful criticism from audiences that were both academic and professional. To further share my findings with a larger worldwide

audience, I have also been invited to present at the Global Health 2025 conference, which will be held in November. I have used the insights I gained from presenting at these events into continuing research projects, and several of my works have already been published Almulla, and Kazim, (2024).

Further dissemination will be made through other occasions at global health forums:

GLOBAL HEALTH 2025 – The Fourteenth International Conference on Global Health Challenges: This conference shall provide the platform through which I can present new research findings as well as disseminate information on the challenges of GHD and the leadership skills on cross-border partnerships. These forums are important in promoting cross-sectoral, long-term approaches to addressing global health issues. These forums not only help in disseminating my work output but also in engaging in more meaningful discussions and exchanges on GHD.

Academic Publications

Publishing in peer-reviewed journals is thus one of the major components of a longer-term plan of academic and policy relevance:

Global Health Governance: A paper that addresses a literature gap has already been jointly written by the present author (Almulla and Kazim, 2024) concerning the leadership competencies of UAE health attachés, negotiation skills, cultural awareness and crisis management.

Journal of Health Diplomacy: Almulla and Kazim, (2024) explain the difficulties faced in the process of institutionalising GHD and provides policy suggestions concerning training and decision-making.

Harvard Business Review (under review): A manuscript that makes a cross-disciplinary connection to the concept of diplomacy and leadership in global health and economic diplomacy is under consideration, based on which an attempt has been made to enrich the debate on diplomatic competence.

An article in the Journal of Political Science: An article that is yet to be published will explore the geopolitical effect of GHD in the UAE, and this study will be used as the basis of the article.

International Relations: This paper will also analyse how the UAE's utilisation of GHD fosters cooperation and represents health globally.

The choice of journals is based on the focus and the purpose of the research to target the audience of academics and policymakers. A list of the submitted and active projects is presented in Appendices 1 and 7.

Workshops, Training and Collaboration

I have participated in specific workshops and training sessions like "Defending Your PhD Thesis" and received specialist training in GHD from WHO EMRO and the GHD Network in order to improve my capacity for dissemination. Additionally, I took part in workshops hosted by the UK Data Service events team, such as Introduction to Effective and Practical Research Data Management (8 April 2025) and Introduction to Copyright: Copyright and Publishing (24 April 2025), as well as the UEA Online Training Series for PGRs 2024–25 on Comparison of Qualitative Methods (13 March 2025). Additionally, a number of academic conferences approved my work for presentation, including the JUSWA PGR Conference at Harvard (UK) (22–23 June 2025) and the PGR Annual Conference 2025 (UK) (21–22 May 2025) with a poster presentation.

These experiences helped me in presenting and defending research findings in academic and professional settings. I have developed a professional working relationship with academic institutions, policy-making bodies, and global health organisations as a result of these events and publications taken together. These collaborations raise my work's profile, credibility, and applicability while establishing the UAE as a proactive leader in GHD.

5.6. AREAS FOR FUTURE RESEARCH

Although this work offers valuable insights into the leadership traits and activities of health attachés in UAE in GHD) many new research pathways also need to be explored. These fields hold promise to increase the knowledge base and enhance GHD practice on a regional and global level. It is recommended that the contributions of other GHD stakeholders be investigated to advance this research. Private healthcare facilities, international missions and national health authorities are all part of the broader GHD system. As such, future studies could examine how these organisations work together to achieve shared health diplomacy objectives with UAE wellness ambassadors. Further, the vicarious/patients' perspective on GHD program effectiveness, which is included, may contribute important insights into the effectiveness of GHD programs, supplementing the policy knowledge of this study.

Further broadening the geographical scope of research could also add to the knowledge gained. For example, while the UAE enhances relations with countries such as Korea or China, a study of GHD practices of these countries may reveal how cultural and political climates influence styles of leadership. Additionally, by exploring areas that have different healthcare challenges, for instance, Africa, one may discover how UAE health attachés modify their approach by working in places featuring inadequate healthcare infrastructure. Such understanding would feed into a richer understanding of the function of GHD in different global settings.

In the UAE, further research has the potential to target other healthcare centres that are relevant to GHD actions. Other organisations aside from the Overseas Treatment Department, such as the Ministry of Health and Prevention's International Cooperation Division, the Dubai Health Authority's International Relations Office and the Department of Health Abu Dhabi's Global Partnerships Unit may also be examined. These departments are central to the development of UAE-based international health agreements, responsiveness to global health projects and the creation of partnerships that support the UAE's strategic health goals. Examining their work will give a more contextual understanding of the role of GHD on the UAE's diverse healthcare landscape and how global health is investigated.

Methodically, mixed methods can be used in future work to bring richer and more profound features of the GHD practices. Quantitative techniques, for example, surveys, have the potential to capture general trends and patterns whereas qualitative techniques, including longitudinal interviews, thematic analysis and ethnography can focus on the lived experiences of health attachés and collaborators. In particular, a longitudinal design, could follow the changes in GHD practices over an interval, as well as at the time of time of emerging global health crises or geopolitical changes.

This work also points out the lack of a distinguished health attaché for specific countries, e.g., Switzerland, whose function is currently fulfilled by a German health attaché covering a wide European area. Future studies could examine the effects of these regional representation models and explore how well they perform in comparison to those that are country-specific. A closer look at the feasibility of establishing specialised health attaché positions in key nations could result in useful suggestions for improving the UAE GHD even more.

In addition, the following areas of other healthcare sectors in the UAE, such as medical research pharmaceutical trade or the development of telemedicine, may also be included in

prospective research to understand their involvement in GHD endeavours. These industries are now taking on a significant role as the UAE advances toward the position of a global hub for health innovation. Understanding their roles and how they may play a part in GHD would go a long way in giving an all-round view on the position of the UAE's healthcare system with regards to the global healthcare systems.

Therefore, in future research, efforts should be made to gain a more holistic view of GHD, to expand the research focus and to examine overlapping with new health technologies. These exercises will help advance and advance the GHD as a key strategy of the UAE in tackling global health issues.

5.7. RECOMMENDATIONS

Based on the findings, several recommendations are offered, which could be applied to improve the practice of GHD by the UAE health attachés. In particular, they may also contribute to the design and implementation of a leadership model, aimed at improving the leadership capabilities of the UAE at the global level. The following critical recommendations contribute to the UAE's GHD promotion: creating an independent GHD training centre, establishing UAE's coherent national GHD strategy, engaging UAE health attachés in international forums and outlining specific goals for UAE's multilateral GHD activities and partnerships.

1. Building a clear and strong leadership: the creation of a GHD Coordination Unit

The proposal to set up a GHD Coordination Unit means creating an organisation that unit would be responsible for UAE foreign policy in the sphere of health. This unit would work with MOHAP, DHA and DOH to set an annual calendar of events, international participation, communication and health missions overseas. It would also function as the source of data and information, thus providing the basis for decisions and swift action in cases of global health threats. Coordinating the efforts that are often uncoordinated, the unit maintains the coherence of the messages and enhances the role of the UAE in the sphere of health diplomacy.

2. Building a Leadership Focused National GHD Strategy

A National GHD strategy would act as a policy framework through which the global health agenda is aligned with the UAE's strategic interests and development plan. It would set out goals and targets and the metrics or indicators for the achievement of health attachés and

the partner agencies. This approach would be based on the multistakeholder process involving policymakers, public health specialists and international cooperating partners. This would be done through annual evaluations to allow the strategy to be flexible and in response to changing environments globally about health. This would help in achieving the strategic alignment which will enable the health attachés to operate with certainty and direction in diplomatic terrains.

3. Enhancing Leadership Training Programs

Leadership training should be made in a way that incorporates modular training programs based on competencies that include theory and practical. These would include crisis negotiation, transcultural communication, health governance and emotional intelligence offered in partnership with health diplomacy institutes. The realistic aspects like the simulation of meetings, secondment to global organisations like the WHO or Gavi or other similar organisations, or shadowing by senior diplomats would provide more practical experiences. To enhance professionalism, there should be a clear certification process training programs and refresher courses after every few years to keep the professionals up to date. This investment would develop a new generation of UAE health attachés that would be capable of managing crucial negotiations and enhancing the national interests internationally.

To achieve the goal of developing a national GHD strategy, financial, human and technological resources are crucial. Funding is needed to put in place organisational structures such as the GHD Coordination Unit, online means of communication among GHD members, as well as leadership development and training. Human resources should comprise diplomatic, healthcare, policy and technology experts with academia, NGOs and global health organisations. Investing in technology should go to telemedicine, data analysis and centralisation of processes and communications. Last but not least, it is crucial to have a sound Monitoring and Evaluation framework to assess the sustainability of the GHD activities as well as the extent of achievement of its goals.

5.8. PERSONAL REFLECTION

This study entailed a lot of endeavours to understand the UAE healthcare and diplomacy given my position in the organisation. The biggest hurdle was to arrange and interview the senior health attachés which are diplomats working in the esteemed health institutions in the UAE. Creswell and Poth (2018) also pointed out that it is not always easy to gather the elites and may involve negotiation, compromise and how to get through the

organisational structure. This was apparent when I had to undergo several forms of approval, establish relationships and accommodate the time constraints and changes. Both Kvale (2002) and Finlay (2002) stress that to interview elites, one has to deal with power relations, which influenced how each meeting was conducted.)

As someone who was not a representative of the health attachés and was academically affiliated with a British university, I brought an external critique to the analysis of UAE health diplomacy. This extrinsic viewpoint is consonant with the idea that researchers having an externally oriented perspective on such practices can provide novel, objective information (Berger, 2015). But, at the same time, it also brought restrictions because, the subtle level of understanding of, organisational culture and internal structures– the kind of information that, usually, can only be gained by insiders–continues to be opaque (Kvale, 2002; Alvesson Sköldberg, 2017). Reflexivity, therefore, was important, helping me to critically reflect on how my positionality informed the process of research activity. With a reflective journal, I recorded difficulties and modified my method to maintain consistency with participants' professional environments (Guba Lincoln, 1989; Finlay, 2002).

The interview process also required strategic adaptability. To prompt participants to direct the discussion toward topics that they felt were worthy, even topics that went beyond the pre-set questions, active listening and flexible questioning methods were used. This approach is congruent with best practices in qualitative research, in which the benefit to participants, of being empowered and thus able to generate insightful data can be realised (Charmaz, 2014). Overall, the duality of having an organisational outsider status presented opportunities and burdens. Although this role afforded the possibility of taking a step back from the phenomena under investigation, it required an enormous reflexive effort to represent accurately the lived experience of the participants. As noted by Alvesson and Sköldberg (2017), the nuances of qualitative research may demand maintaining a tightrope walk between distance and rich, detailed contextual immersion, a relationship I aimed to achieve throughout the study. Since this is a sector where male leadership is more dominant, my presence as a female researcher may have slightly influenced some participant reactions, especially on questions asked for leadership and decision-making. Being aware of this, I reduced the possibility of gender biases and prepared for the interviews carefully. My deep understanding of the Overseas Treatment Department/Centre and UAE healthcare, along with my knowledge of data collection policies, enhanced my professionalism. The criterion of this preparation, along with a considerate and culturally aware attitude facilitated me to create

trust, to have sincere communication and to maintain the sense of validity of my work. Studying this from a UK academic perspective expanded my understanding of GHD because it made me consider paradigms of health diplomacy and leadership beyond the confines of the United Kingdom. This turned out to be an academic emphasis that promoted the best methodologies and critical analytical skills on GHD in the international context. It also forced me to open my mind beyond regional health diplomacy in UAE and look at the global perspective concerning health.

5.9. SUMMARY

This thesis has provided a comprehensive analysis of the structural, operational, and competency-related dimensions shaping the performance of the UAE's overseas treatment offices and health attachés within the broader GHD landscape. By reviewing existing literature, policy frameworks, and international best practices, the thesis has clarified the conceptual foundations of GHD while identifying the key institutional elements required for effective diplomatic engagement in global health arenas. The theoretical discussion contributed academically by delineating the intersection between health governance, diplomacy, and professional competency frameworks, thereby positioning the UAE case within a rapidly evolving global field that places increasing emphasis on specialised health diplomacy expertise.

To meet the requirements of a professional doctorate, the thesis has translated academic insights into a set of structured considerations relevant to policymakers, institutional leaders, and practitioners working in international health engagement. It has demonstrated how effective performance in GHD depends not only on technical health knowledge but also on diplomatic skillsets, cross-cultural negotiation capacities, and organisational coherence across governmental sectors. By situating the UAE overseas treatment offices and health attachés within this multidimensional context, the chapter has highlighted practical gaps in coordination, leadership development, and competency standardisation, offering conceptual tools that can inform policy reform, capacity-building initiatives, and institutional restructuring. These contributions bridge the divide between theoretical constructs and real-world application, ensuring that the study carries meaningful professional relevance.

Importantly, the thesis has addressed and filled the identified knowledge gap by developing a structured analytical lens that had previously been absent in the literature and

policy discourse. Whereas previous studies focussed either on generic diplomatic functions or on health system operations, this thesis has brought these domains into dialogue, creating an academic space that connects both within the context of global health diplomacy and situates the UAE case within this integrated perspective. By doing so, it has directly responded to the absence of empirical insights into how leadership competencies, institutional mandates, and inter-sectoral coordination shape the effectiveness of UAE health attachés and overseas treatment departments. This thesis therefore advances academic understanding of GHD practice while simultaneously offering a foundational reference for designing more coherent, strategically aligned, and competency-driven policies in the UAE's international health engagement system.

REFERENCES

- Abbas Zaher, W., Ahamed, F., Ganesan, S., Warren, K. and Koshy, A., 2021. COVID-19 crisis management: lessons from the UAE leaders. *Frontiers in Public Health*, 9, p.724494.
- Abdo, B., 2020. Social Media Channels in Medical Departments in Hospitals and Other Healthcare (Doctoral dissertation, University of Phoenix).
- Adomako, M., Kamiar, A., Alshaikh, A., Baines, L.S., Benson, D., Bettcher, D.W., Cheema, B., Corijn, L., Fountain, E., Gdaniec, B.G. and Garonzik, E., 2020. The burgeoning role of global health diplomacy to alleviate suffering of cancer patients in low-and middle-income countries. *International Health*, 12(3), pp.231-233.
- Ahmed, G., Al Amiri, N. and Abudaqa, A., 2024. Strategic leadership and economic transformation: The UAE (UAE) model. *Journal of Global Business Research and Practice*, 1(1).
- Al Kurdi, O.F., 2021. A critical comparative review of emergency and disaster management in the Arab world. *Journal of Business and Socio-economic Development*, 1(1), pp.24-46.
- Alameri, H., Hamdy, H. and Sims, D., 2021. Medical education in the UAE: Challenges and opportunities. *Medical Teacher*, 43(6), pp.625-632.
- Alameri, H.F., McMahan, G.T., Al Jenaibi, F.H. and Husseiny, A.M., 2023. Abu Dhabi's Journey Towards Excellence in Continuing Medical Education. *Journal of CME*, 12(1), p.2285381.
- Alkaabi, A. and ElSORI, D., 2025. Navigating digital frontiers in UAE healthcare: A qualitative exploration of healthcare professionals' and patients' experiences with AI and telemedicine. *PLOS Digital Health*, 4(4), p.e0000586.
- Alkhalidi, M., Moonesar, I.A., Issa, S.T., Ghach, W., Okasha, A., Albada, M., Chelli, S. and Takshe, A.A., 2023. Analysis of the UAE' contribution to the sustainable development goals with a focus on global health and climate change. *International Journal of Health Governance*, 28(4), pp.357-367.
- Almulla, N. and Kazim, Y., 2024. Analysis of Leadership Skills in Global Health Diplomacy: A Study of International Health Attachés at the Dubai Health

- Authority in the UAE. *International Journal of Leadership and Governance*, 4(4), pp.1-10.
- Alotaibi, F.M., Almazam, A.A., Alotaibi, M., Emam, A.M., Alqahtani, N.S., Alheggi, A.I., Alharbi, K.K., Alhamed, A.A., Ali, E.I.A., Alnemer, M.J., Almussa, N.A., Aldosari, M.A., Alghamdi, M.S. and Alharbi, N.H.M. 2022. Anticipating future global health crises. *International journal of health sciences*, [online] 6(S10), pp.1743–1754.
- Alpers, L.-M. 2016. Distrust and patients in intercultural healthcare: A qualitative interview study. *Nursing Ethics*, 25(3), pp.313–323.
- Alsharif, N.Z., Brennan, L., Abrons, J.P. and Chahine, E.B., 2019. An introduction to cultural sensitivity and global pharmacy engagement. *American journal of pharmaceutical education*, 83(4), p.7221.
- Alvesson, M. and Sköldbberg, K. 2017. Reflexive Methodology: New Vistas for Qualitative Research. *SAGE Publications*.
- Alzaabi, J. 2023. Research | *UCLan - University of Central Lancashire*.
- Antwi-Boateng, O. and Alhashmi, A.A. 2021. The emergence of the UAE as a global soft power: current strategies and future challenges. *Economic and Political Studies*, 10(2), pp.1–20.
- Antwi-Boateng, O. and Alhashmi, A.A., 2022. The emergence of the UAE as a global soft power: current strategies and future challenges. *Economic and Political Studies*, 10(2), pp.208-227.
- Anwar, S., Prasad, R., Chowdhary, B.S. and Anjum, M.R. 2019. A Telemedicine Platform for Disaster Management and Emergency Care. *Wireless Personal Communications*, 106(1), pp.191–204.
- Artaman, A., Bekele, H.T. and Millar, R., 2025. Strengthening global health education in the UAE: assessing the current landscape and future directions. *Frontiers in Public Health*, 13, p.1584880.
- Asadi-Lari, M., Ahmadi Teymurlouy, A., Maleki, M., Eslambolchi, L. and Afshari, M., 2021. Challenges and opportunities for Iranian global health diplomacy: lessons learned from action for prevention and control of noncommunicable diseases. *Health Research Policy and Systems*, 19(1), p.152.
- Ayotte, K., Gerberding, J. and Morrison, J.S., 2020. Ending the Cycle of Crisis and Complacency in US Global Health Security: A Report of the CSIS

Commission on Strengthening America's Health Security. *Centre for Strategic and International Studies*.

- Balkhy, H., 2025. An initiative to leverage health diplomacy and leadership to urgently address threats to healthcare in the Eastern Mediterranean Region. *Eastern Mediterranean Health Journal*, 31(3), 157-159.
- Bandola-Gill, J., Grek, S., and Tichenor, M., 2023. The rise of the reflexive expert? Epistemic, care-ful and instrumental reflexivity in global public policy. *Global Social Policy*, 23(3), 481-498.
- Barhem, B., Younies, H. and Younis, M. 2010. Employee Satisfaction in the Health Care Sector. *Journal of Health Management*, 12(1), pp.19–38.
- Berger, R. 2015. Now I See It, Now I Don't: Researcher's Position and Reflexivity in Qualitative Research. *Qualitative Research*, 15(2), 219–234.
- Berridge, G.R. 2015. *Diplomacy: Theory and Practice*. 5th ed. London: Palgrave Macmillan.
- Berry, L.L., Yadav, M.S. and Hole, M.K., 2024. Reclaiming healthcare's healing mission for a sustainable future. *Journal of Service Research*, 27(1), pp.6-27.
- Bhaduri, R.M., 2019. Leveraging culture and leadership in crisis management. *European Journal of Training and Development*, 43(5/6), pp.554-569.
- Bonner, C., Tuckerman, J., Kaufman, J., Costa, D., Durrheim, D. N., Trevena, L., ... and Danchin, M. 2021. Comparing inductive and deductive analysis techniques to understand health service implementation problems: a case study of childhood vaccination barriers. *Implementation science communications*, 2(1), 100.
- Braun, V. and Clarke, V. 2023. Thematic Analysis. *Springer eBooks*, [online] pp.7187–7193.
- Braun, V. and Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), pp.77-101.
- Brown, M.D., Bergmann, J.N., Novotny, T.E. and Mackey, T.K., 2018. Applied global health diplomacy: profile of health diplomats accredited to the UNITED STATES and foreign governments. *Globalisation and health*, 14, pp.1-11.
- Bruno, P., Calimeri, F., Filice, F., Marte, C., and Perri, S. (2024). IDADA: A Blended Inductive-Deductive Approach for Data Augmentation. In *International Conference of the Italian Association for Artificial Intelligence* (pp. 79-91). Cham: Springer Nature Switzerland.
- Bryman, A., 2016. *Social Research Methods*. 5th ed. *Oxford University Press*.

- Burkle, F.M., Martone, G. and Greenough, P.G., 2015 'The changing face of humanitarian crises', *Prehospital and Disaster Medicine*, 30(1), pp. 3-7.
- Burns, M., Bally, J., Burles, M., Holtslander, L. and Peacock, S. 2022. Constructivist grounded theory or interpretive phenomenology? Methodological choices within specific study contexts. *International Journal of Qualitative Methods*, [online] 21(21), pp.1–13.
- Cairney, P., 2012. *Understanding Public Policy: Theories and Issues*. Palgrave Macmillan.
- Caligiuri, P., De Cieri, H., Minbaeva, D., Verbeke, A. and Zimmermann, A., 2022. International HRM insights for navigating the COVID-19 pandemic: Implications for future research and practice. In *Crises and Disruptions in International Business: How Multinational Enterprises Respond to Crises* (pp. 417-454). Cham: *Springer International Publishing*.
- Campbell, C. 2019. Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalised settings. *Social Science & Medicine*, 257.
- Canton, L.G., 2019. *Emergency management: Concepts and strategies for effective programs*. *John Wiley and Sons*.
- Carey, M.A., 1993. The group effect in focus groups: Planning, implementing and interpreting focus group research. In: Morgan, D.L., ed. *Successful focus groups: Advancing the state of the art*. Newbury Park, CA: *Sage*.
- Charmaz, K., 2014. *Constructing Grounded Theory*. London: *SAGE Publications*.
- Chattu, V. K., Singh, B., Kajal, F., Chatla, C., Chattu, S. K., Pattanshetty, S., and Reddy, K. S., 2023. The rise of India's global health diplomacy amid COVID-19 pandemic. *Health promotion perspectives*, 13(4), 290.
- Chattu, V.K. and Chami, G., 2020. Global health diplomacy amid the COVID-19 pandemic: a strategic opportunity for improving health, peace and well-being in the CARICOM Region—a systematic review. *Social Sciences*, 9(5), p.88.
- Chattu, V.K., Knight, W.A., Adisesh, A., Yaya, S., Reddy, K.S., Di Ruggiero, E., Aginam, O., Aslanyan, G., Clarke, M., Massoud, M.R. and Jha, A., 2021. Politics of disease control in Africa and the critical role of global health diplomacy: A systematic review. *Health Promotion Perspectives*, 11(1), p.20.
- Christou, P.A. 2022. How to Use Thematic Analysis in Qualitative Research. *Journal of Qualitative Research in Tourism*, [online] 3(2), pp.79–95.

- Cochrane, L. 2021. The UAE as a global donor: what a decade of foreign aid data transparency reveals. *Development Studies Research*, 8(1), pp.49–62.
- Collett, C., 2024. The hustle: How struggling to access elites for qualitative interviews alters research and the researcher. *Qualitative Inquiry*, 30(7), pp.555-567.
- Corlett, S., and Mavin, S., 2018. Reflexivity and researcher positionality. *The SAGE handbook of qualitative business and management research methods*, 377-399.
- Creswell, J. W. and Poth, C. N., 2018. Qualitative Inquiry and Research Design: Choosing Among Five Approaches. *SAGE Publications*.
- Creswell, J.W., 2003. Research design: Qualitative, quantitative and mixed methods approaches. 2nd ed. Thousand Oaks, CA: Sage.
- Dar, H. and Kashyap, K., 2023. Smart healthcare system (SHS): medical tourism delivering, consumption and elevating tool in the ages of smart technologies. *Tourism Planning and Development*, 20(3), pp.397-415.
- Davies, S.E., Kamradt-Scott, A. and Rushton, S., 2015. Disease diplomacy: International norms and global health security. *JHU Press*.
- Devine, F., Edwards, T. and Feldman, S.R. 2018. Barriers to treatment: describing them from a different perspective. *Patient Preference and Adherence*, [online] Volume 12, pp.129–133.
- Dhatt, R., Theobald, S., Buzuzi, S., Ros, B., Vong, S., Muraya, K., Molyneux, S., Hawkins, K., González-Beiras, C., Ronsin, K., Lichtenstein, D., Wilkins, K., Thompson, K., Davis, K. and Jackson, C. 2017. The role of women’s leadership and gender equity in leadership and health system strengthening. *Global Health, Epidemiology and Genomics*.
- Dialer, D., 2025. Introduction: Public and Global Health Strategies. In *The Future of African-European Relations: Towards an Equitable Global Society?* (pp. 281-285). Cham: Springer Nature Switzerland.
- Dutta, A., 2025. Incorporating Evidence-Based Medicine into health diplomacy: A strategic imperative for equitable global health. *Ethics, Medicine and Public Health*, 33, 101175.
- Esapebong-Ray, F.E., 2024. Defining Global Health Diplomacy in a Post-COVID Era: Investigating the Knowledge, Skills and Core Competencies Required by Us

- Global Health Diplomacy Actors (Doctoral dissertation, The George Washington University).
- Esping-Andersen, G. 1990. *The three worlds of welfare capitalism*. Princeton, NJ: Princeton University Press.
- EY 2024. *The UAE health care ecosystem Future trends and insights Contents*. [online] EY. Available at: <https://www.ey.com/content/dam/ey-unified-site/ey-com/en-ae/industries/health/documents/ey-ae-future-of-health-05-2024.pdf> [Accessed 27 Jun. 2025].
- Fazal, T.M., 2020. Health diplomacy in pandemical times. *International Organisation*, 74(S1), pp.E78-E97.
- Feldbaum, H. and Michaud, J., 2010. Health diplomacy and the enduring relevance of foreign policy interests. *PLoS Medicine*, 7(4), pp.1–5.
- Figueroa, C.A., Harrison, R., Chauhan, A. and Meyer, L. 2019. Priorities and challenges for health leadership and workforce management globally: A rapid review. *BMC Health Services Research*, 19(1), pp.1–11.
- Finlay, L. 2021. Thematic analysis: the ‘good’, the ‘bad’ and the ‘ugly’. *European Journal for Qualitative Research in Psychotherapy*, [online] 11(1756-7599), pp.103–116.
- Finlay, L., 2002. Negotiating the Swamp: The Opportunity and Challenge of Reflexivity in Research Practice. *Qualitative Research*, 2(2), 209–230.
- Freeman, E. E., Padovese, V., Singal, A., Yotsu, R., Oyesiku, L., James, A. J., ... and Mosam, A., 2023. The BJD’s approach to global health and equity in publishing: adding author reflexivity statements. *British Journal of Dermatology*, 188(5), 583-585.
- Frenk, J., Chen, L., Bhutta, Z.A., Cohen, J., Crisp, N., Evans, T., Fineberg, H., Garcia, P., Ke, Y., Kelley, P. and Kistnasamy, B., 2010. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The lancet*, 376(9756), pp.1923-1958.
- Fusch, P. I. and Ness, L. R., 2015. Are we there yet? Data saturation in qualitative research. *The Qualitative Report*, 20(9), pp.1408-1416.
- Gauttam, P., Singh, B. and Kaur, J., 2020. COVID-19 and Chinese global health diplomacy: Geopolitical opportunity for China’s hegemony?. *Millennial Asia*, 11(3), pp.318-340.

- Gilson, L., and Grandsoult, V., 2025. Health systems as human systems: reflexivity, relationships, and resilience in the pursuit of the SDGs. *Frontiers in Public Health*, 13, 1653839.
- Gökalp, D., 2020. *The UAE's humanitarian diplomacy: Claiming state sovereignty, regional leverage and international recognition*. Chr. Michelsen Institute.
- Goldstein, K., 2002. Getting in the Door: Sampling and Completing Elite Interviews. *PS: Political Science and Politics*, 35(4), 669-672.
- Gostin, L. O. and Katz, R., 2016. The International Health Regulations: The Governing Framework for Global Health Security. *The Milbank Quarterly*, 94(2), 264-313.
- Goundar, P. R., 2025. Researcher Positionality: ways to include it in a qualitative research design. *International Journal of Qualitative Methods*, 24, 16094069251321251.
- Guba, E. G. and Lincoln, Y. S., 1989. *Fourth Generation Evaluation*. SAGE Publications.
- Guba, E.G. and Lincoln, Y.S., 1994. Competing paradigms in qualitative research. In: Denzin, N.K. and Lincoln, Y.S., eds. *Handbook of qualitative research*. Thousand Oaks, CA: Sage, pp.105-117.
- Guest, G., Bunce, A. and Johnson, L., 2006. How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), pp.59-82.
- Harring, N., Jagers, S.C. and Löfgren, Å. 2020. COVID-19: Large-scale collective action, government intervention, and the importance of trust. *World Development*, 138, p.105236.
- Harvey, W. S., 2011. Strategies for Conducting Elite Interviews. *Qualitative Research*, 11(4), 431-441.
- Hassenteufel, P. and Palier, B. 2007. Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms in Bismarckian Welfare Systems. *Social Policy & Administration*, 41(6), pp.574–596.
- Hill, M., 2013. *The Public Policy Process*. Routledge.
- Honig, D. and Weaver, C. 2019. A Race to the Top? The Aid Transparency Index and the Social Power of Global Performance Indicators. *International Organisation*, 73(03), pp.579–610.

- Hoskins, K., 2015. Researching female professors: the difficulties of representation, positionality and power in feminist research. *Gender and Education*, 27(4), 393-411.
- Hunter, B.M. and Murray, S.F., 2019. Deconstructing the financialisation of healthcare. *Development and Change*, 50(5), pp.1263-1287.
- Hyland-Wood, B., Gardner, J., Leask, J. and Ecker, U.K., 2021. Toward effective government communication strategies in the era of COVID-19. *Humanities and Social Sciences Communications*, 8(1), pp.1-11.
- Inglehart, R. and Norris, P., 2003. *Rising tide: Gender equality and cultural change around the world*. Cambridge University Press.
- Ismail, D. A. I., Basthomi, Y., and Karmina, S., 2023. Students' perceptions and experiences about the combined inductive-deductive approach in intermediate grammar class. *International Journal of Education and Learning*, 5(1), 66-78.
- Javed, S. and Chattu, V.K., 2020. Strengthening the COVID-19 pandemic response, global leadership and international cooperation through global health diplomacy. *Health promotion perspectives*, 10(4), p.300.
- Jindal, R.M., Baines, L.S. and Mehjabeen, D., 2023. Reimagining diaspora diplomacy during the COVID-19 crisis in India. *International Health*, 15(1), pp.93-100.
- Kalaitzi, S., Czabanowska, K., Azzopardi-Muscat, N., Cuschieri, L., Petelos, E., Papadakaki, M. and Babich, S. 2019. Women, healthcare leadership and societal culture: A qualitative study. *Journal of Healthcare Leadership*, Volume 11, pp.43–59.
- Kandel, N., Chungong, S., Omaar, A. and Xing, J. 2020. Health security capacities in the context of COVID-19 outbreak: an analysis of International Health Regulations annual report data from 182 countries. *The Lancet*, [online] 395(10229), pp.1047–1053.
- Karačić Zanetti, J., Brown, M., Viđak, M. and Marušić, A., 2023. Diplomatic response to global health challenges in recognising patient needs: A qualitative interview study. *Frontiers in public health*, 11, 1164940.
- Karmakar, A. and Sahib, U., 2017. Smart Dubai: Accelerating innovation and leapfrogging E-democracy. *E-democracy for smart cities*, pp.197-257.
- Kickbusch, I. and Liu, A., 2022. Global health diplomacy—reconstructing power and governance. *The Lancet*.

- Kickbusch, I., Gleicher, D. and Erk, C., 2019. A conceptual model of the implications of top-down versus bottom-up leadership on the function of health systems. [online] Available at: https://www.researchgate.net/figure/A-conceptual-model-of-the-implications-of-top-down-versus-bottom-up-leadership-on-the_fig1_337987073 [Accessed 20 December 2024].
- Kickbusch, I., Lister, G., Told, M. and Drager, N., 2016. Global Health Diplomacy: Concepts, Issues, Actors, Instruments, Fora and Cases. 2nd ed. *Springer*.
- Kickbusch, I., Nikogosian, H., Kazatchkine, M. and Kökény, M., 2021. A guide to global health diplomacy: better health–improved global solidarity–more equity.
- Kickbusch, I., Silberschmidt, G. and Buss, P. 2007. Global Health Diplomacy: The Need for New Perspectives, Strategic Approaches and Skills in Global Health. *PLOS Medicine*.
- Kickbusch, I., Silberschmidt, G. and Buss, P., 2013. Global health diplomacy: The need for new perspectives, strategic approaches and skills in global health. *Bulletin of the World Health organisation*, 85(3), pp.230–232.
- Kim, H.L. and Hyun, S.S., 2022. The future of medical tourism for individuals’ health and well-being: a case study of the relationship improvement between the UAE (UAE) and South Korea. *International Journal of Environmental Research and Public Health*, 19(9), p.5735.
- Kim, J., Lee, S. and Kim, H. 2020. South Korea’s COVID-19 Response: Lessons for Global Health Diplomacy. *Journal of Global Health*, 10(2), 123-135.
- Kington, R.S., Arnesen, S., Chou, W.Y.S., Curry, S.J., Lazer, D. and Villarruel, A.M., 2021. Identifying credible sources of health information in social media: principles and attributes. *NAM perspectives*, 2021.
- Kletečka-Pulker, M., Parrag, S., Droždek, B. and Wenzel, T. 2018. Language Barriers and the Role of Interpreters: A Challenge in the Work with Migrants and Refugees. *An Uncertain Safety*, [online] pp.345–361.
- Koornneef, E., Robben, P. and Blair, I. 2017. Progress and outcomes of health systems reform in the UAE: a systematic review. *BMC Health Services Research*, 17(1).
- Koplan, J. P., Bond, T. C., Merson, M. H., et al. 2009. Towards a common definition of global health. *The Lancet*, 373(9679), 1993–1995.

- Kruk, M.E., Gage, A.D., Arsenault, C., Jordan, K., Leslie, H.H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S.V., English, M., Elorrio, E.G., Guanais, F., Gureje, O., Hirschhorn, L.R., Jiang, L., Kelley, E., Lemango, E.T., Liljestrand, J. and Malata, A., 2019. High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet Global Health*, [online] 6(11), pp.e1196–e1252. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7734391/>.
- Kujala, J., Sachs, S., Leinonen, H., Heikkinen, A. and Laude, D. 2022. Stakeholder Engagement: Past, Present, and Future. *Business & Society*, [online] 61(5), pp.1136–1196.
- Kumar, M., 2021. Development of National and Sub-national Electronic Health Records to Enable Health Data Exchange for Improved Maternal Health Service Delivery and Program: The Case of a Tertiary Care State Government Hospital in India (Doctoral dissertation, The University of North Carolina at Chapel Hill).
- Kuriansky, J. and Kakkattil, P., 2024. Introduction to the volume on resilient health systems leveraging technology and social innovation to transform healthcare for pandemic recovery and beyond. In *Resilient Health* (pp. 3-17). Academic Press.
- Kvale, S. 2002. *Interviews: An Introduction to Qualitative Research Interviewing*. SAGE Publications.
- Lal, A., 2025. Towards a coherent global health architecture: perspectives on integrating global health security and universal health coverage through diplomacy and governance reforms. *Health Policy and Planning*, czaf086.
- Lawson, M.L. and Morgenstern, E.M., 2020, April. Foreign assistance: An introduction to US programs and policy. LIBRARY OF CONGRESS WASHINGTON DC.
- Lee, K. and Smith, R. 2011. What is ‘global health diplomacy’? A conceptual review. *Global Health Governance*, 5(1), 1–12.
- Lim, W.M. 2024. What Is Qualitative research? an Overview and Guidelines. *Australasian Marketing Journal (AMJ)*, [online] 33(2), pp.1–31.
- Lo, W.Y.W. 2011. Soft power, university rankings and knowledge production: distinctions between hegemony and self-determination in higher education. *Comparative Education*, 47(2), pp.209–222.

- Loney, T., Aw, T.-C., Handysides, D.G., Ali, R., Blair, I., Grivna, M., Shah, S.M., Sheek-Hussein, M., El-Sadig, M., Sharif, A.A. and El-Obaid, Y. 2013. An analysis of the health status of the UAE: the 'Big 4' public health issues. *Global Health Action*, [online] 6(1), p.20100.
- Luh, S., and Baltag, D., 2021. The role of EU health attachés for global health diplomacy in times of COVID-19. *Global Affairs*, 7(6), 903-920.
- Mattingly, J.E., Harrast, S.A. and Olsen, L. 2009. Governance implications of the effects of stakeholder management on financial reporting. *Corporate Governance: The international journal of business in society*, 9(3), pp.271–282.
- Mehrajunnisa, M. and Jabeen, F. 2019. Ranking the enablers promoting female empowerment in the UAE health care sector. *International Journal of Gender and Entrepreneurship*.
- Michaud, J., Moss, K., Licina, D., Waldman, R., Kamradt-Scott, A., Bartee, M., Lim, M., Williamson, J., Burkle, F., Polyak, C.S. and Thomson, N., 2019. Militaries and global health: peace, conflict and disaster response. *The Lancet*, 393(10168), pp.276-286.
- Millar, R., Abu-Agla, A., and Badr, E., 2025. Building capacity and capability for science diplomacy: challenges in decolonising the curriculum for Global Health System Leadership. *Frontiers in public health*, 13, 1441351.
- Miller, R.M., Chan, C.D. and Farmer, L.B. 2018. Interpretative Phenomenological Analysis: A Contemporary Qualitative Approach. *Counselor Education and Supervision*, [online] 57(4), pp.240–254.
- Ng, N.Y. and Ruger, J.P. 2011. Global Health Governance at a Crossroads. *Global health governance: the scholarly journal for the new health security paradigm*, 3(2), p.1.
- Nyimbili, F. and Nyimbili, L., 2024. Types of purposive sampling techniques with their examples and application in qualitative research studies. *British Journal of Multidisciplinary and Advanced Studies*, 5(1), pp.90-99.
- Ollenschläger, G., Marshall, C., Qureshi, S., Rosenbrand, K., Burgers, J., Mäkelä, M. and Slutsky, J., 2004. Improving the quality of health care: using international collaboration to inform guideline programmes by founding the Guidelines International Network (GIN). *BMJ Quality and Safety*, 13(6), pp.455-460.

- Olukotun, O., Mkandawire, E., Antilla, J., Alfaifa, F., Weitzel, J., Scheer, V., ... and Mkandawire-Valhmu, L., 2021. An analysis of reflections on researcher positionality.
- Panikar, G. and Morozov, V., 2025. The role of state economic policy in the implementation of new technologies and innovations: The case of public-private partnerships in EU countries. *Actual Problems of International Relations*, 1(162), pp.83-100.
- Park, C., Lee, J. and Wilding, M., 2017. Distorted policy transfer? South Korea's adaptation of UK social enterprise policy. *Policy Studies*, 38(1), pp.39-58.
- Park, C., Wilding, M. and Chung, C., 2014. The importance of feedback: Policy transfer, translation and the role of communication. *Policy Studies*, 35(4), pp.397-412.
- Proudfoot, K., 2023. Inductive/deductive hybrid thematic analysis in mixed methods research. *Journal of mixed methods research*, 17(3), 308-326.
- Ramlagun, L., 2023. Institutional field-level change in Global Health: logic evolution in health initiatives (Doctoral dissertation, Anglia Ruskin Research Online (ARRO)).
- Regmi, K., Naidoo, J. and Pilkington, P., 2010. Understanding the processes of translation and transliteration in qualitative research. *International Journal of Qualitative Methods*, 9(1), pp.16–26. <https://doi.org/10.1177/160940691000900103>
- Rogova, G.L. 2016. Crisis Management and Context. *Springer eBooks*, pp.107–119.
- Rosenbaum, P., Rehn, C., Wennberg, K., Nordström, A. Alfvén, T., 2025. Navigating global health diplomacy: challenges and opportunities in building a community of practice. *Globalisation and Health*, 21(1), 1-13.
- Ruckert, A., Almeida, C., Ramírez, J., Guerra, G., Salgado de Snyder, V. N., Orozco, E., ... and Labonté, R., 2022. Global Health Diplomacy (GHD) and the integration of health into foreign policy: Towards a conceptual approach. *Global public health*, 17(6), 1041-1054.
- Ruckert, A., Almeida, C., Ramírez, J., Guerra, G., Salgado, N., Orozco, E., Alexandre Andrade Alvarenga, De, N., Santos, Sepúlveda, D., Del, E., Santos, S., Doriani, K. and Labonté, R. 2021. Global Health Diplomacy (GHD) and the integration of health into foreign policy: Towards a conceptual approach. *Global Public Health*, 17(6), pp.1041–1054.

- Ruckert, A., Labonté, R., Lencucha, R., Runnels, V. and Gagnon, M. 2016. Global health diplomacy: A critical review of the literature. *Social Science & Medicine*, [online] 155, pp.61–72.
- Ryan, G. 2018. Introduction to Positivism, Interpretivism and Critical Theory. *Nurse Researcher*, [online] 25(4), pp.41–49.
- Sabatier, P.A. 1986. Top-Down and Bottom-Up Approaches to Implementation Research: a Critical Analysis and Suggested Synthesis. *Journal of Public Policy*, 6(01), pp.21–48.
- Sharfi, M., 2021. The GCC and global health diplomacy: the new drive towards artificial intelligence. In *Artificial Intelligence in the Gulf: Challenges and Opportunities* (pp. 117-139). Singapore: Springer Singapore.
- Sharifi, A., Pathak, M., Joshi, C. and He, B.J., 2021. A systematic review of the health co-benefits of urban climate change adaptation. *Sustainable Cities and Society*, 74, p.103190.
- Shliakhovchuk, E., 2021. After cultural literacy: New models of intercultural competency for life and work in a VUCA world. *Educational Review*, 73(2), pp.229-250.
- Smith, J.A., 1983. *Qualitative psychology: A practical guide to research methods*. 1st ed. London: Sage.
- Soherwordi, S.H.S., Qayyum, S. and Qayyum, F. 2022. Multilateralism and Human Security: Situating the Nature and Scope of ‘Global Health Diplomacy’ (GHD) in the context of COVID19. *NUST Journal of International Peace & Stability*.
- Stainton Rogers, W. 2017. The SAGE Handbook of Qualitative Research in Psychology. *The SAGE Handbook of Qualitative Research in Psychology*, [online] pp.1–664.
- Strong, G.R. 2025. *Cross-Cultural Competence in Transnational Medical Education Partnership*. [online] Fisher Digital Publications.
- Surmiak, A.D. 2018. Confidentiality in Qualitative Research Involving Vulnerable Participants: Researchers’ Perspectives. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, [online] 19(3).
- Theile, C. M., and Beall, A. L., 2024. Narrative Reviews of the Literature: An overview. *Journal of Dental Hygiene*, 98(1).

- Toth, J. 2018. National identity in the UAE and its capacity for social transformation. *Routledge eBooks*, pp.127–149.
- UN 2009. *Achieving the Global Public Health Agenda Dialogues at the Economic and Social Council*. [online] Available at: https://www.un.org/en/ecosoc/docs/pdfs/achieving_global_public_health_agenda.pdf [Accessed 22 Jun. 2025].
- UN 2023. *Financing Sustainable Transformations Financing for Sustainable Development Report 2023 Inter-agency Task Force on Financing for Development*. [online] Available at: https://www.taxexpenditures.org/wp-content/uploads/2023/10/FSDR_2023_0.pdf [Accessed 22 Jun. 2025].
- UNDP 2023. *The promise of health for all | United Nations Development Programme*. [online] UNDP. Available at: <https://www.undp.org/stories/promise-health-all> [Accessed 29 Jun. 2025].
- Union Atlas 2025. *UAE Union Atlas*. [online] Fgic.gov.ae. Available at: <https://atlas.fgic.gov.ae/ueaatlas/Health/HealthcareJourney?lang=en> [Accessed 28 Jun. 2025].
- United Nations 2022. *World Population Prospects 2022: Summary of Results*. [online] Available at: https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/wpp2022_summary_of_results.pdf [Accessed 29 Jun. 2025].
- Vehovar, V., Toepoel, V. and Steinmetz, S., 2016. Non-probability sampling. *The Sage handbook of survey methods*, 1(2016), pp.329-345.
- WAM., 2025. Ahmed bin Mohammed opens landmark 50th edition of Arab Health://www.wam.ae/en/article/aq76v75-arab-health-congress-announces-partnership-with
- Wang, Y., Kung, L., Gupta, S. and Ozdemir, S., 2019. Leveraging big data analytics to improve quality of care in healthcare organisations: A configurational perspective. *British Journal of Management*, 30(2), pp.362-388.
- Warren, A.E., Wyss, K., Shakarishvili, G., Atun, R. and de Savigny, D., 2013. Global health initiative investments and health systems strengthening: a content analysis of global fund investments. *Globalisation and health*, 9, pp.1-14.
- Wells, E.M., Cummings, C.L., Klasa, K., Trump, B.D., Cegan, J.C. and Linkov, I., 2021. Real-time anticipatory response to COVID-19: A novel methodological

- approach. In *COVID-19: Systemic Risk and Resilience* (pp. 35-59). Cham: Springer International Publishing.
- World Bank 2023. *Population, Total - UAE | Data*. [online] [data.worldbank.org](https://data.worldbank.org/indicator/SP.POP.TOTL?locations=AE). Available at: <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=AE> [Accessed 29 Jun. 2025].
- World Health Organisation (WHO), 2014. *Health in All Policies: Framework for Country Action*. Geneva: WHO.
- World Health organisation (WHO), 2016. *Global Strategy on Human Resources for Health: Workforce 2030*. Geneva: WHO.
- World Health organisation (WHO), 2018. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: WHO.
- World Health organisation (WHO), 2020a. *Rapid Response to Public Health Emergencies: A WHO Perspective*. Geneva: WHO.
- World Health Organisation, 2020b. *Health and well-being profile of the Eastern Mediterranean Region: an overview of the health situation in the Region and its countries in 2019*.
- World Health Organisation, 2021. *Health service continuity planning for public health emergencies: a handbook for health facilities: interim version for field testing*.
- World Health Organisation, 2022. *Health systems resilience toolkit: a WHO global public health good to support building and strengthening of sustainable health systems resilience in countries with various contexts*.
- World Health organisation. 2020c. *Global health diplomacy: Strengthening health and foreign policy coordination in a changing world*. Geneva: WHO
- Yasin, E., 2007. *Modernisation and society*. *Voprosy ekonomiki*, 5, pp.4-29.
- Youde, J., 2018. *Global Health Governance in International Relations*. Routledge.

APPENDICES

Appendix (1): Training and development

Date	Title	Place	Key Learning Aim
23–24/05/2022	Introduction to Dissertations	UCLan	Learning basic activity of writing dissertations
12/03/2023	Understanding Academic Integrity	UCLan	Meeting ethical approval criteria
02/04/2023	Making Your Writing More Critical	UCLan	Learning advanced skills in academic writing with interactive programs
22/05/2024	Artificial Intelligence and What It Means for Us	UCLan	In-depth understanding of AI principles and technologies for innovative solutions in academic teaching
23/05/2024	Understanding the Academic Regulations Teams	UCLan	Essential insights into university policies and guidelines
24/05/2024	Assessment and Feedback, Practical Skills Teams	UCLan	Ability to design effective assessments and provide constructive feedback

Workshop Sessions

Date	Title	Place	Key Learning Aim
20/03/2022	Global Health Diplomacy	The State University of New York	Comprehensive understanding of the GHD concept
06/03/2023	Diplomacy in the Modern World	University of London	Understanding general modern diplomacy
01/12/2024	Defending Your PhD Thesis	Research Graduate	Focus on what to do and what not to do during VIVA defense

Appendix (2): Theme & Subtheme participants examples

Theme	Subtheme	Examples of Participant Insights
Theme 1: Leadership Skills in Global Health Diplomacy (GHD)	Subtheme 1.1: Communication and Negotiation Skills	"Negotiation is not just transactional but relational." Participant 3
	Subtheme 1.2: Public Speaking and Advocacy	"Advocating for UAE health diplomacy agenda in global platforms is integral." Participant 16
	Subtheme 1.3: Leadership and Team Management	"Leadership requires managing teams across different countries and time zones." Participant 13
Theme 2: The Perceived Relationship Between Leadership Skills And GHD	Subtheme 2.1: Strategic Vision and Planning	"Strategic alignment with Vision 2030 helps focus on long-term GHD priorities." Participant 10, Participant 4
	Subtheme 2.2: Stakeholder Engagement	"Interagency collaboration is key to achieving health diplomacy goals." Participant 1 participant 12
Theme 3: Key Barriers To Using Their Leadership Roles With GHD	Subtheme 3.1: Cultural Sensitivity and Adaptability	"Adapting to cultural nuances is critical in building trust." Participant 6, Participant 9
	Subtheme 3.2: Crisis Management and Resilience	"The COVID-19 pandemic tested our adaptability in unprecedented ways." Participant 5, Participant 15
	Subtheme 3.3: Economic and Political Barriers	"Bureaucratic delays often impact decision-making at crucial stages." Participant 7

Theme 4: Developing Leadership Skills Practices To Improve Their Contribution To GHD	Subtheme 4.1: Knowledge of Global Health Issues	"We must understand how global health systems work to be effective diplomats." Participant 14
	Subtheme 4.2: Training and Development	"We need continuous training to keep up with global health challenges." Participant 2, Participant 11
	Subtheme 4.3: Strategic Leadership Development and Policy Alignment	"A unified approach to leadership would streamline our diplomatic efforts." Participant 8

Data Description

The interviews involved 16 participants, comprising key stakeholders and officials from the Ministry of Health and Prevention (MOHAP), Dubai Health Authority (DHA) and the Department of Health - Abu Dhabi (DOH). The participants were selected for their roles as health attachés or leadership positions in overseas treatment and international health policy implementation. The data were analysed using thematic coding to identify patterns and insights relevant to the study's focus on Global Health Diplomacy (GHD).

Participants demographic description

- **Gender:** 10 males, 6 females.
- **Nationality:** 14 UAE nationals, 2 non-UAE nationals.
- **Positions:** Roles ranged from consultants and medical attachés to directors of international health divisions.
- **Education:** Majority held advanced degrees (Masters or PhD) in health-related fields or international relations.

Appendix (3): Participants' Information Sheet

Participant Information Sheet

1. Title of Study

An Analysis of Leadership Skills Associated with the Global Health Diplomacy of international health attachés of the UAE

2. Version Number and Date

V1.0 11.10.2023

3. Invitation Paragraph

My name is Noora Abdulrahman Almulla and I am currently pursuing a research project titled "An Analysis of Leadership Skills Associated with the Global Health Diplomacy of International Health Attachés of the UAE." Please accept my invitation to participate in my research study, which will interview outstanding leaders such as yourself.

You have the right to withdraw from this research at any point in time; however, please note that if you withdraw after 14 days from the time of the interview, your data will not be withdrawn from the study as the data anonymised after 14 days from the date of interview. You may refuse to answer any question without giving justification. By agreeing to this interview, you acknowledge that you have understood and participated in this research of your own free will. The

primary objective of my research is to gain insights into the leadership skills and strategies employed by international health attachés from the UAE (UAE) in the context of global health diplomacy. This online (through MS Teams platform) video conference interview is expected 45 to 60 minutes.

Thank you for your participation.

4. What is the purpose of the study?

Research Context and Background

This study will be used to analyse GHD related leadership skills in the Offices of UAE Health Attachés across four different countries. The Dubai Health Authority, the Abu Dhabi Department of Health and the Ministry of Health are responsible for managing the healthcare system in the UAE and also to act as the lead in external Health Attachés Offices. It has been shown that the leadership skills possessed by a Health Attaché are essential to the maintenance of international relationships with the UK, US, Republic of India and Switzerland (Javed and Chattu, 2020).

The motivation behind this study is to identify the leadership skills which are most essential for the Health Attachés to promote GHD in UAE effectively.

Through an examination of the leadership skills for four international health attachés, the research will provide better insights into the core characteristics which contribute to effective leadership in the GHD context.

The study will also identify the areas where existing health attachés need to improve or enhance their leadership skills in promoting health initiatives as there maybe gaps and challenges identified as the needs within global health challenges emerge and the need for immediate and long-term responses required.

The findings of the research will form the basis of recommendations for public health professionals and policy makers to improve GHD related leadership skills both internally as UAE policy standards as well externally to the UAE into the attachés operating in the fore aforementioned countries.

Understanding the key leadership skills for GHD can also inform the development of training programs to improve leadership skills and the recruitment of effective Health Attachés with strong leadership skills, which can assist international partners in coordinating and collaborating to address complex public health issues as and when they emerge.

5. Why have I been invited to take part?

You have been selected because the interview aims to explore your experiences, challenges and successes as an international health attaché, with a particular focus on your leadership role in advancing global health diplomacy objectives on behalf of the UAE.

6. Do I have to take part?

You do not have to participate and have the free will to refuse participation. You may also choose to take part and are free to withdraw from this research at any point in time.

7. What will happen if I take part?

Suppose you specified to take part in the interview. In that case, the data collected from the interview will be anonymised and combined with the data collected from other participants in this research. You will have a period of 2 weeks (14 days) to withdraw from this research even after completion of the interview. Any later requests for withdrawal will not be entertained, as your data will no longer be identifiable. Please also note that you will not receive monetary compensation for your participation. This research is purely for academic purposes. Your online interview will be scheduled at your convenience through the MS Teams platform.

8. How will my data be used?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of ‘public task’ and in accordance with the University’s purpose of “advancing education, learning and research for the public benefit”. Both the Director of Studies and the Student Researcher have access to the data. Have access to the pre-anonymised personal data.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University’s research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

Further information on how your data will be used can be found in the table below.

How will my data be collected? Interviews

How will my data be stored?

Confidentiality of data and maintaining it can be assured by saving them in a secured and password-protected folder within UCLan’s network.

How long will my data be stored for?

The data will be stored for 14 days from the interview's completion date; then, it will be anonymised and stored within UCLan’s password-protected network for seven years.

What measures are in place to protect the security and confidentiality of my data?
Confidentiality of data and maintaining it can be assured by saving them in a secured and password-protected folder within UCLan's network.

Will my data be anonymised?

Yes, this will be done 14 days after the data collection date.

How will my data be used?

Your data will be used to reach meaningful conclusions and is vital for the research outcome.

Who will have access to my data?

The researcher will have exclusive access to your data.

Will my data be archived for use in other research projects in the future?

No

How will my data be destroyed?

The data will be destroyed by destroying the folder which holds the personal data.

9. Are there any risks in taking part?

There are no known risks involved in this research.

10. Are there any benefits from taking part?

The research findings could be shared with participants to utilise the benefits.

11. Expenses and / or payments

There will not be any payments handed to the participants for this research and the researcher will not be liable for any expenses incurred.

12. What will happen to the results of the study?

The study results will be shared with participants and will remain anonymous and cannot be identified. Saved Confidentiality all data and maintaining it can be assured by saving them in a secured and password-protected folder within UCLan's network.

13. What will happen if I want to stop taking part?

You have the right to stop taking part at any time before, during or after the interview. Suppose the participant decides to stop taking part after the interview. In that case, the researcher must be informed of this within 14 days after the completion of the interview, as the data will be anonymised on the 15th day.

14. What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Mrs. Noora Almulla, Email: naaalmulla@uclan.ac.uk and we will try to help. If you remain

unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Ethics, Integrity and Governance Unit at OfficerForEthics@uclan.ac.uk.

The University strives to maintain the highest standards of rigor in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling +44(0) 303 123 1113.

15. Who can I contact if I have further questions?

If you have any further questions, please contact the Principal Investigator on the following:

<p>Research Student: Noora Almulla Email: naaalmulla@uclan.ac.uk Contact no. +971 50 903 9229</p>	<p>Director of study: Dr. Iftikhar Bokhari Contact number: +44(0) 1772 201 201 Email: ibokhari3@uclan.ac.uk</p>	<p>Co-supervisor: Dr Mark Wilding Contact number: +44(0) 1772 201 201 Email: MWilding2@uclan.ac.uk</p>
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Appendix (4): Participant Consent Form



Interview Consent Form

Research Project Title: An analysis of leadership skills associated with the Global Health Diplomacy of international health attachés of the United Arab Emirates

Research Supervisor:

Name: Iftikhar Bokhari -position: Director of Studies

Name: Mark Wilding -position: Project supervisor

Research Student:

Name: Noora Almulla - Email: naaalmulla@uclan.ac.uk

Contact no. +971 50 903 9229

The purpose of the study:

The purpose of this study is to involve developing a conceptual framework that is based on evidence from literature sources, and collecting primary interview data. As there is a lack of research in this area, this study will both make a meaningful contribution to the academic literature, and make recommendations for improving global health Diplomacy leadership in practice

The study methodology:

A primary qualitative methodology will be used in this study to collect data. Qualitative research methodologies will be useful in gathering data regarding the overseas treatment department's experiences as well as the health attaché offices' activities. It is appropriate to use a qualitative methodology for this study because it allows for the researcher to understand the perspectives and understanding of events of participants who are experts in their fields, thereby allowing the researcher to examine the role of leadership skills in the context of GHD of UAE.

- I voluntarily consent to participate in this research project.
- I understand that I may revoke permission to use my interview data within two weeks of the interview, at which point the content will be deleted.
- I am aware that I will not personally benefit from my participation in this research project.
- I consent to having my interview recorded in video form MS team.
- I am aware that any information I provide for this research will be kept strictly confidential. And my identity will remain anonymous in any writing on the results of this research.
- This will be accomplished by altering my name and concealing any details of my interview that could disclose my identity or the identities of the individuals I discuss.
- I am aware that masked excerpts of my interview may be included in the dissertation.

The duration of the interview 45 to 60 minutes. We will appreciate your participation in the aforementioned study by conducting an interview with you. In accordance with universities' ethical protocols for academic research, respondents must provide their informed consent to both being interviewed and having their responses used in study. To make sure you know why you're helping and that you agree with the terms, we need you to sign this permission form.

Participants Name/ Signature

Date

Appendix (5): Interview Questions

Interview Questions:

Demographic information:		
1	Sex	Male
		Female
2	Nationality	UAE National
		Non- UAE National. Please specify:
3	Job title	
4	Location	United Kingdom (UK)
		United States of America (US)
		Republic of India
		Switzerland
		Department of health Abu Dhabi
		Dubai Health Authorities
		Ministry of Health and Prevention
5	Education	Bachelor's Degree which subject:
		Master's Degree which subject:
		Ph.D. which subject and what is your thesis about:
		Other (member of specialist organisation):
1- General question:		
1	What is your understanding of the phrase Global Health Diplomacy	
2	What are the priorities of GHD from your perspective	
Communication and Negotiation Skills:		

1	To advance the UAE's global health agenda, how do you communicate and negotiate? How did you achieve a successful diplomatic outcome related to health?
2	When it comes to global alliances and partnerships, what are the most effective ways and key strategies and how do they differ based on the health issues and environments of the countries involved?
2- Cultural Sensitivity and Adaptability:	
1	How can you ensure cultural sensitivity and adaptability in the context of overseas treatment provider when working with various international stakeholders and what tactics do you use to keep up with "the UAE cultural" practices that might affect various regions?
2	Share your experience where you had to overcome cultural differences while providing treatment abroad in a global health context.
3- Strategic Vision and Planning:	
1	How do you align your initiatives with the UAE's long-term strategic vision for global health cooperation?
2	How do you prioritise and plan your activities to maximise the impact of the UAE's health diplomacy efforts?
4- Crisis Management and Resilience:	
1	How do you handle and respond to unexpected challenges and crises that may arise during health diplomacy missions?
2	Share a diplomatic health stance in which you demonstrated flexibility and adaptability in the face of difficulty in providing treatment abroad
5- Public Speaking and Advocacy:	
1	How do you effectively defend the UAE's global health priorities in public forums, international conferences or media platforms?
2	Describe a notable instance where your public speaking skills positively impacted the perception of the UAE's global health efforts.
6- Knowledge of Global Health Issues:	

1	How do you stay informed and updated on emerging global health challenges and opportunities?
2	Have you recently discussed a health-related issue where your knowledge played a critical role in guiding the UAE's global health response?
7- Leadership and Team Management	
1	Could you please describe how you motivate and lead the overseas treatment team for the global health agenda? Kindly share an example of successful projects that have learned from the collective efforts of a global scale?
2	In the field of global health diplomacy, might resource needs be identified and actually applied to deal with urgent health crises? How will leadership respond when faced with new global health challenges?
8- Training:	
1	What specific GHD-related training have you received? If yes , elaborate on the nature and impact of the training. If No , What training programs or knowledge/skills would enhance your understanding and practice of Global Health Diplomacy? Please provide your suggestions
9- Economic	
1	What economic factors are considered in the development of health policies?
10- Stakeholder	
1	How do you tackle global health concerns with a stakeholder in global health diplomacy And how you overcome obstacles in international healthcare relations and get the results you want?
3	In light of such difficulties, how have you adjusted your communication style with stakeholders to maintain global health diplomatic relations? How have you demonstrated influence through your capacity? **This is especially important when dealing with changing leaders and

	international health coordinators who assist in providing services for overseas treatment.
11-	Recommendations:
<p>-----</p> <p>-----</p> <p>-----</p> <p style="text-align: center;">-----</p>	

Appendix (6): A copy of the ethical approval letters

Ministry of Health and Prevention-Research Ethics Committee



**Ministry of Health and Prevention
Research Ethics Committee**

Study Title: An analysis of leadership skills associated with the Global Health Diplomacy of international health attachés of the United Arab Emirates

Subject: Approval Reference No: **MOHAP/DXB-REC/M.M.M /No. 63/ 2024.**

**Dear Dr Iftikhar Bokhari,
Noora Almulla,**

Regarding to the above-mentioned Study protocol, this is to confirm that on the meeting dated (26/ 03/ 2024) the Ministry of Health and Prevention Research Ethics Committee has reviewed the study protocol as well as all the documents submitted in the submission file from the ethical point of view and has approved the conduct of above-mentioned study.

Opinion: Approval.

Committee members:

Name	Designation	Role in committee
Dr. Suad Hannawi	Consultant Rheumatologist	Chairman
Dr. Haifa Hannawi	Consultant Dentist	Deputy chairman
Dr Nabeel Humod	Consultant prosthodontics	Member
Yusra Swaidat	Senior charge technician	Coordinator
Khawla Salem	Administrator	Lay person
Janet Saldhana	Nursing informatics	member
Maryam Yaslam	Training officer	Member
Dr Mohamed Badawi	Consultant intensivist	Member
Dr Linda Saif Eldein	General Practitioner	Member
Dr Alaa Abu Quta	General Practitioner	Member



2. Please note that it is the Principal Investigator's responsibilities, to immediately inform the Committee of any changes in the research protocol and/or the research Methodologies, should the need for those changes arise prior to or during the conduct of this research study.
3. The approval is valid for up to **1year** from the date of approval. If the study extends beyond this date, a progress report must be sent to the research ethics committee to renew the approval 30 days prior the expiry date.
4. The research ethics committee must be informed when the research has been completed and a copy of the final research report must be submitted for our records.

A handwritten signature in black ink, appearing to read 'A. Al Khayat'.

Dr Abdulla AL Khayat
Chairman- Research Ethics Committee
Ministry of Health and Prevention

Date:26/ 03/2024

Dubai Health Authority - Research Ethics Committee



DUBAI SCIENTIFIC RESEARCH ETHICS COMMITTEE APPROVAL LETTER



From:	Dubai Scientific Research Ethics Committee (DSREC) Dubai Health Authority	Date:	29 FEB 2024
To:	Noora Abdulrahman Almulla, Doctorate of Business Administration, University of Central Lancashire, UK	Ref:	DSREC-SR-02/2024_05
Study Site	Emirates of Dubai		

Subject: Approval for the research proposal, *"An analysis of leadership skills associated with the Global Health Diplomacy of international health attachés of the United Arab Emirates"*

Dear Student Researcher,

Thank you for submitting the above-mentioned study proposal to Dubai Scientific Research Ethics Committee, DHA. The Dubai Scientific Research Ethics Committee has been organized and operates in accordance with the ICH/GCP and the committee is registered with the Office for Human Research Protection (OHRP).

Your request was discussed during an expedited review held on **27 FEB 2024**. Upon review the committee issued some queries for your response.

Since the final response received is satisfactory, we are pleased to advise you that the committee has granted ethical approval for following documents and above-mentioned site.

No.	Documents
1	DSREC Application form
2	Study Proposal
3	Participant information sheet and consent form_English_Final version received on 29 FEB 2024
4	Data collection tool Interview Questions_English
5	PGR-interview ppt_English
6	DHA Confidentiality agreement: Patient information form_Signed by student researcher
7	CV of the PI_Noora Abdulrahman Almulla

Please note that it is DSREC's policy that the principal investigator should report to the committee of the following:

- Anything which might warrant review of ethical approval of the project in the specified format, including:
 - any serious or unexpected adverse events and
 - unforeseen events that might affect continued ethical acceptability of the project
- Any proposed changes to the research protocol or study team or to the conduct of research
- Any new information that may affect adversely the safety of the subjects
- If the project is discontinued before the expected date of completion (reason to be specified)



Page 1 of 2

COPIES: The researcher must submit One (1) copy to his/her reporting higher Authority and one (1) copy to the study site higher Authority.

DSREC@dha.gov.ae

5. Annual report to DSREC about the progress of the study
6. A final report of the finding on completion of the study

The DSREC approval validity for the study expires on **28 FEB 2025** and continuing approval of the research will be subject to the principal investigator submitting an annual report. If you wish to continue, please submit an application for renewal together with the Annual Study site progress report **no later than 30 days** prior to the expiry date.

The DSREC wishes you every success in your research.

Yours faithfully,



Prof. Dr. Wadeia Mohammad Sharief
Chairperson, Dubai Scientific Research Ethics Committee (DSREC)
Dubai Health Authority
Dubai, UAE.



Ministry of Health and Prevention-Research Ethics Committee



Ref : DOH/ADHRTC/2024/1075

Date : 29th, March, 2024

Noora Abdulrahman Almulla
Researcher
Anglia Ruskin University - UK

Subject: Abu Dhabi Health Research and Technology Ethics Committee – Approval Letter

Study title:

An Analysis of Leadership Skills Associated with the Global Health Diplomacy of International Health Attachés of the United Arab Emirates

Thank you for submitting all required documents. The request has been carefully reviewed by the committee and we are pleased to inform you that the committee, after deliberation, has granted you ethical approval for the documents submitted.

Please note that this approval is considered as an official approval and it overrides the local committee's approval; however, you need to report to the local Research Ethics Committee in the desired institutions mentioned in the study protocol in order for us to receive the following:

1. Local REC feedback in case of anything that might warrant the review of the ethical approval given
2. Any proposed changes to the research protocol/the conduct of research
3. Any information that might affect the safety of the Human Subjects
4. Annual report to Medical Research Department about the progress of the study
5. Pre-publication request

The ADHRTC approval validity for the study **expires on 28 March 2025** and continuing approval of the research will be subject to the principal investigator submitting an annual report along with renewal application later than 30 days prior to the expiry date.

The composition of Ethics Committee participating in the study review is compliant with GCP terms and none of the members who voted in favour of this study were part of the site study team.

ADHRTC wishes you all the best in your research endeavors

Yours Sincerely,

Dr. Habiba Alsafar
Committee Chair

Cc:



ص.ب: 5674 أبوظبي، الإمارات العربية المتحدة PO Box 5674 Abu Dhabi, United Arab Emirates

+971 2 4493333 +971 2 4449822 haad.ae

Appendix (7): A list of Publication and conferences attendance

#	Research Status	Contribution	Year	research projects titles
1	Published edited book	Main author	2025	"Analysis of Leadership Skills in Global Health Diplomacy: A Study of International Health Attachés at the Dubai Health Authority in the UAE"
2	Published	Main author	2024	"Analysis of Leadership Skills in Global Health Diplomacy: A Study of International Health Attachés at the Dubai Health Authority in the UAE"
3	Ongoing	Main author	2024	Utilisation of telemedicine services among diabetic patients in Dubai Health Authority during COVID-19 pandemic.
4	Published	Main author	2024	<u>Analysis of Leadership Skills in Global Health Diplomacy: A Study of International Health Attachés at the Dubai Health Authority in the UAE</u>
5	Published	Author	2023	<u>Doctor for Every Citizen: Telehealth Visits at Dubai Health Authority during COVID-19 Pandemic in Dubai, UAE</u>
	Published	Author	2023	<u>Who is More Likely to Complete the Appointments and What Factors Determine the Appointment Wait Time?</u>
7	Accepted as a presenter at the conferences	Poster presenter	2022	IHF conference 45th – UAE-Dubai Title: Doctor for Every Citizen: Telehealth Visits at Dubai Health Authority during COVID-19 Pandemic in Dubai, UAE
	Accepted as a presenter at the conferences	Poster presenter	2023	ISPOR 2023- U.S, Boston Title: Patient Experience of Using Telehealth Services during COVID-19 in Dubai Health

				Authority: A Retrospective Cross-Sectional Electronic Survey
	Conference attendance	Attendance	2024	Annual postgraduate Research Conference-UK, UCLAN

Appendix [8]: Participants Characteristics - Professional Backgrounds

Participant Code	Title/Role	Years of Experience
Participant 1	Senior-level official at government health organisation	10–15 years
Participant 2	Mid-level diplomat in international health	5–10 years
Participant 3	Consultant in public health sector	10–15 years
Participant 4	Health Attache	5–10 years
Participant 5	Manager in cross-border health coordination	15–20 years
Participant 6	Senior medical officer in diplomatic role	10–15 years
Participant 7	Consultant in health systems development	10–15 years
Participant 8	Strategic health partnerships advisor	15–20 years
Participant 9	Senior advisor in health diplomacy	15–20 years
Participant 10	Deputy official in international relations	10–15 years
Participant 11	Medical attaché with coordination role	5–10 years
Participant 12	Global health strategy advisor	15–20 years
Participant 13	Consultant in emergency health programs	10–15 years
Participant 14	Health attaché	5–10 years
Participant 15	Policy analyst in healthcare	5–10 years
Participant 16	Health policy advisor and trainer	10–15 years

Summary:

- **Average Years of Experience:** 12.5 years
- **Fields of Expertise:** Includes medical specialised, Strategic Planning, Public Health, Crisis Management and International Relations.

- **Roles Distribution:** Participants hold a variety of roles, ranging from junior attachés to senior advisors, reflecting diverse perspectives and expertise in overseas treatment.

This appendix highlights the elite nature of the participant group, emphasising their extensive experience and specialised knowledge in health diplomacy and international collaboration.