LUND UNIVERSITY

FACULTY OF MEDICINE

MASTER'S PROGRAMME IN PUBLIC HEALTH

Medical Diplomacy in the Persian Gulf

Could health collaboration improve intergovernmental relations and public health in the Gulf-region?

A Grounded Theory study

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June 2022

Abstract

Introduction: International cooperation is essential for public health, as countries need to access medical equipment, combat health crises, and strengthen health capacities. Medical Diplomacy is a concept and practices that combines the goals of improving intergovernmental relations *and* health, by initiating and facilitating intergovernmental health cooperation.

Objectives: This study specifically investigates whether the practice of Medical Diplomacy could be useful for improving relations and public health in the Persian Gulf. The geographical area of interest is relevant both from a public health and diplomatic perspective. As tensions run high in the region, cooperate on health issues might help to improve both regional relations, and public health.

Method: A Constructivists Grounded Theory approach was applied. Data consisted of expert-interviews with relevant professionals (n=11) from countries (n=7) in the Gulf region.

Results: The study shows that Medical Diplomacy could potentially play an important role in improving intergovernmental relations and public health among the Gulf countries. Medical Diplomacy could provide a platform for dialogue, initiate interaction and reduce suspicion. Multiple areas of possible health collaboration were identified. However, there are also impediments to the application of Medical Diplomacy in the Gulf. Some of these are related to the complex and troubled history of the region, international politics, and lack of common medical standards and practices. A framework for clarification, which maps Gulf-specific opportunities, challenges, and important approaches to consider in relation to Medical Diplomacy, was developed.

Conclusion: This study presents both the promise, as well as challenges of Medical Diplomacy in the Gulf region. Although possibly limited by endogenous and exogenous factors, Medical Diplomacy could improve health and relations among the Gulf countries.

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1. Introduction

War and conflict are direct threats to human health. So are also international disputes and political instability, as they impede health collaboration and joint medical efforts. Functioning relations between nations and cross-border cooperation are key to ensure access to medical equipment, combat health crises and strengthen health capacities. Therefore, measures to improve international relations are crucial from a health perspective (McKee et al., 2005). A concept and practice that combines the goals of improving intergovernmental relations *and* health is *Medical Diplomacy* (MD), the subject of this thesis.

MD as a concept refers to international political measures that aim to both strengthen relations between nations, improve health, and put public health on the foreign policy agenda. In practice, MD is a political and diplomatic method for enabling and promoting good relations between countries by providing tools for dialogue and cooperation on health issues. Countries sending doctors and medical supplies to help other nations, as well as engaging in the development of international health policies, are examples of forms MD can take (Brown et al., 2016; Novotny et al., 2013).

The geographical area of interest for this thesis is the countries around the Persian Gulf: Iran, Iraq, Kuwait, Kingdom of Saudi Arabia, Qatar, Bahrain, The United Arab Emirates and Oman. While "The Persian Gulf" is the historically correct name of the body of water located between the Iranian and Arabian Peninsula (Bosworth, 1997), the politically more neutral name "The Gulf" will be used in this thesis.

When delving into the existing research on MD, I identified a research gap, as there is a lack of literature focusing on MD *among* the countries in this region. However, the Gulf has several features of relevance to MD in terms of intergovernmental relations (often rocky and bad) and health (the countries border each other, and many of them share the same public health issues). The aim of this study is therefore to bring clarity to whether MD would be a useful method employed in improving intergovernmental relations and public health among the Gulf countries. Further, the aim is to investigate what need be considered in the design and implementation of MD in order to increase the probability of success. [1]

[1] My interest in the Gulf region is derived from my involvement in an organisation called EMERG (European Middle Eastern Research Group), that facilitates peace building projects in the Gulf. In preparation for a conference that I helped organise in Muscat, 2021, I developed an interest in Medical Diplomacy.

1.1 Research Questions and Aims

Through a Constructivist Grounded Theory study and the analysis of expert-interviews, the aims are to develop a framework for increased clarification and understanding of the potential of MD to improve relations and public health in the Gulf. Furthermore, the aim is to investigate what issues are relevant to consider in the design and implementation of MD in this region. The overall research question is as follows:

What is the potential for medical diplomacy to promote intergovernmental relations and public health among the countries in the Gulf region?

To investigate MD in the Gulf, it is crucial to understand the breadth of the concept and how it is understood by people with relevant expertise in the region. Therefore, the first sub-question is:

a. How is MD understood as a concept and practice in the region? How do these understandings relate to the existing literature?

I further analyse the potential of MD to improve relations and health through two sub-questions:

b. What are the opportunities and challenges for medical diplomacy to achieve the double purpose of improving intergovernmental relations and public health among the Gulf countries?

From this follows that it is crucial to examine and imagine how MD should be practised and designed to be successful:

c. What would be important to consider in the implementation of medical diplomacy among the Gulf countries?

The thesis is structured as follows: Chapter two contains a research background, describing the Gulf region, and the research field of MD. Chapter three describes the methodological research design, ethical considerations, and descriptions of participants. Chapter four presents the results of the study. The discussion in chapter five contains a summary of the study, comparisons with existing literature, methodological considerations, and a conclusion.

2. Research Background

This chapter contains a brief presentation of the Gulf countries, their regional and global political relations, as well as a short overview of the public health situation in the region. This is followed by a description of what Medical Diplomacy is, and the current state of the research field.

2.1 The Gulf Region

The Gulf region refers to the countries along the coastline of the Gulf: Iran, Iraq, Kuwait, Kingdom of Saudi Arabia (K.S.A.), Qatar, Bahrain, The United Arab Emirates (U.A.E.) and Oman. While having a lot in common in terms of culture, religion, and language (Arabic is the official language in all but Iran), the Gulf countries differ in terms of history, financial resources, and political status in the global community. In this chapter, most attention will be paid to Iran and Iraq, as their political, economic, and health situations are the most troubled.

A majority of the countries surrounding the Gulf were not internationally recognised as sovereign states until the latter half of the 20th century. Iraq and K.S.A. gained independence in 1932. Oman was under British control until 1951, Kuwait until 1961, Bahrain, Qatar and U.A.E. until 1971. Iran is the nation with the longest history as a sovereign state in the region, existing as an independent entity in various forms since 200 CE (Cleveland, 2004).

Nationalism has played an important role in the region over the years, and in this regards, *ontological security* is a relevant concept. Ontological security in international relations refer to a sense of order and historical continuity in a nations experience of possessing its place in the existing world order. Ontological security for nations consists of having a strong national identity and self-image. Inversely, critical situations that breach and challenge routines, or publicly calls the existence of a country into question, creates *ontological insecurity* (Steele, 2008; Roberts, 2020).

2.1.1 Financial Capabilities and International Relations

The Gulf countries can be divided into two blocks based on their financial capacities. The World Bank (2022) ranks Kuwait, K.S.A., Qatar, Bahrain, U.A.E. and Oman as high-income countries, while Iran and Iraq are classified as lower-middle income and upper-middle income countries respectively. All Gulf countries have access to natural resources, such as oil and

natural gas, although with differing reserves. Yet, although geographically similar, due to political crises, revolutions, war and conflicts, the countries have developed in different directions.

Kuwait, K.S.A., Qatar, Bahrain, U.A.E., and Oman, are all governed through autocratic monarchies, have functional international relations and are well integrated in the global community, mainly through trade and other investment activities (Abdelal, et al., 2008; Cleveland & Bunton, 2016).

The Islamic republic of Iran has been governed through a religious autocracy since the revolution of 1978-1979. The country is currently under heavy U.S. sanctions which, among other things, has led to grave financial difficulties. The sanctions increased in intensity under the Trump administration, and the poverty rate is estimated to have risen to 46-48 % in 2021. The sanctions have also adversely affected all other international interactions, as financial actors all over the world shied anyway from Iran, for fear of being punished by the U.S. (Cleveland & Bunton, 2016; Bootwala, 2020; Kahalzadeh, 2021).

Iraq is governed through a federal parliamentary republic. Since the 1980s the country has been involved in several conflicts, under U.S. occupation and the target of UN sanctions. Due to this, Iraq has struggled to build and sustain functioning institutions, and societal infrastructures of high quality. This has severely affected the country's population and resulted in insufficient healthcare and poor development (Cleveland & Bunton, 2016).

2.1.2 Conflicts and Cooperation in the Gulf Region

The Gulf region has a history coloured by war and political strife. A recent example would be the blockade of Qatar by a coalition of K.S.A., the U.A.E., and Bahrain, which created serious complications in terms of trade, travel, import and export (Roberts, 2020). However, the conflict that takes centre-stage in the region concerns the two largest countries, K.S.A., and Iran. The countries adhere to different branches of Islam (Iran is predominantly Shia, K.S.A. is predominantly Sunni). While this is important, the conflict is not primarily religious. Riyadh and Tehran are regional power rivals, and the conflict between the two is sometimes referred to as “The Middle Eastern Cold War” (Gause, 2014). Three different years can help us illustrate their mutual mistrust and subsequent confrontations.

The first event is the outbreak of the Iranian revolution in 1979. K.S.A. is the birthplace of Islam and sees itself as the natural leader of the Muslim world, but the Iranian revolutionaries questioned this leadership and rejected Saudi rulers due to their close ties to the U.S. The

following year, Iraq attacked Iran, with K.S.A. supporting Iraq financially. Riyadh aimed to contain Iranian revolutionary fervour and circumscribe Iran's regional influence. Worth noting is that Kuwait and several other states, among them the U.S., also supported Iraq through weapon supplies, and by campaigning for an embargo on Iranian oil. The third important event in Iranian-Saudi relations occurred in 2003, when Riyadh again feared that a power shift in Iraq would favour Iran. This time, the issue concerned the overthrow of the Iraqi Sunni leader Saddam Hussain by the U.S. He was a strong opponent of Iran and his removal allowed for a democratically elected Shia-led government and thereby increased Iranian influence. Today, Iran and K.S.A. support opposing sides in the Yemen conflict, all the while accusing each other of supporting terrorism (Cleveland & Bunton, 2016; Gause, 2014).

Despite existing tensions and conflict in the Gulf, there are established structures for cooperation, at least among the rich countries of the region. K.S.A., Qatar, Kuwait, Bahrain, Oman and the U.A.E. are all part of the Gulf Cooperation Council (GCC), established 1981. The GCC (2022) has a set of objectives they want to achieve, such as harmonizing regulations and legislation, increase integration and strengthen relations between the countries. According to the GCC's website the organisation has instituted some health-related collaborations, such as agreements on proper disposal of medical waste at health centres, and a common customs tariff on tobacco.

In addition to the GCC, there is a health focused council, established in 1976, called the "Gulf Health Council" (GHC). The GHC (2022) works to achieve sustainable and good health for all GCC citizens. Nonetheless, Iran and Iraq are not included in this council. All Gulf countries are however part of the Regional East Mediterranean WHO Office (EMRO). EMRO (2022) comprises 21 member states, with a population of nearly 745 million people, and works for improved public health in the region.

Although tensions in the region are severe, especially between Iran and K.S.A., there are signs of possible openings and improved relations between Iran and its neighbours (Vatanka, 2022). Some important conditions have already been met, there is for example a recognized key mediator in the region, Oman (Worrall, 2021).

2.1.3 Public Health in the Gulf Region

K.S.A., Qatar, Kuwait, Bahrain, U.A.E., and Oman, mainly struggle with so-called diseases of affluence, and rank among the highest in the world on mortality rates due to non-communicable diseases related to unhealthy lifestyle factors. Physical inactivity, high-calorie diets, but also

inadequate health promotion and disease management have led to diabetes, obesity and cardiovascular conditions being a major problem in their populations. However, the GCC countries generally have well developed healthcare systems and provide free high-quality care to their citizens. That said, as most of the GCC countries are small, with small populations, they are dependent on external workforces in their healthcare sectors (Rawaf el al., 2014; Khoja et al., 2017).

In Iran and Iraq, the health situation is significantly different. Non-communicable diseases, car accidents and drug abuse are among the leading causes of illness and mortality in Iran today. While everyone has the right to basic healthcare, quality varies. Sanitation levels are lower in rural areas which means that the country still struggles with, for example, waterborne diseases. However, Iran has invested heavily in different health programs, as well as medical expertise, and is almost self-sufficient in pharmaceutical production. Given the circumstances of the country (regional conflicts, war, and sanctions), these public health achievements are considered impressive (Danaei et al., 2019; Dolatabadi & Kamrava, 2021, B).

Iraq's healthcare system has not recovered since the conflicts described above, and the country struggles with severe public health issues. Lack of medical staff, medical supplies, clean water, food, and vaccination programs are among the greatest health problems in Iraq today (Iraqi Ministry of Health, 2021; Lami, et al., 2021).

2.2 Medical Diplomacy

Medical Diplomacy, also called *health diplomacy, public health diplomacy* or g*lobal health diplomacy,* is a concept with a set of different understandings and definitions. In its broadest sense, it refers to international political actions that aim to strengthen relations between nations, improve health, and put public health on the foreign policy agenda. Within the research community, the assessment is that MD can provide a platform for dialogue, bridge the divide when negotiations are hard to come by, and help alleviate tensions between countries through cross-border health initiatives and cooperation. At the same time, MD is a tool for creating a positive image of one's own country and improve one's standing in the international community (Dolatabadi & Kamrava, 2021, A; Dolatabadi & Kamrava, 2021, B; Lee & Smith, 2011; Feldbaum & Michaud, 2010; Brown, et al, 2016). For this thesis, I am interested in MD as a political and diplomatic practice which aims to promote health as well as good relations

between nations by providing tools for dialogue and cooperation within the area of health collaboration and integration.

To better understand what MD can look like in practice, the case of Cuba provides a good example. Having not much in the way of natural resources, other than sugar cane, but a highly developed healthcare sector, the island nation has sent doctors to other countries in need of healthcare support since the 1960s. Furthermore, Cuba has provided free medical education to tens of thousands of foreign students, thereby improving its relationships with other nations, and bolstering the countries humanitarian image (Feinsilver, 2010).

Important to note is that MD is a multi-stakeholder activity, that engages different actors at different times. Not only diplomats, but also the medical community, researchers, NGOs, and international organisations such as the World Health Organisation participate in MD. What form MD takes depends on contextual factors, such as needs and interests. Managing infectious disease outbreaks, sharing medical supplies, or joint research funding are other examples (Bertorelli et al., 2013).

2.2.1 The History of Medical Diplomacy

The modern history of MD begins in 1851, when European nations gathered to discuss cooperation on cholera, plague, and yellow fever at the first *International Sanitary Conference* (Fidler, 2001). It was, however, not until 1978 that the concept was formally articulated, by then U.S. presidential assistant Peter Bourne, who stated that "some humanitarian issues, especially health, can provide a platform for dialogue and the removal of diplomatic barriers because they transcend traditional and more volatile and emotional concerns." (Bourne, 1978). Initially, the concept was employed as a foreign policy tool for improving health, human rights, and developing relations between nations. But a new strategy has gradually emerged, using MD to improve the self-image of the nation, gain international prestige, power, and influence, while also achieving foreign policy goals (Dolatabadi & Kamrava, 2021, A).

2.2.2 Current Research Paradigm

While increasingly a popular term that has started to appear quite frequently in journals and health conferences around the world, the existing research on MD is relatively limited. Criticism has been expressed for the lack of models to guide and inform relevant professionals in how to practice MD (Brown et al., 2016). Katz et al., (2011) writes that:

> Expanding demands on global health diplomacy require a delicate combination of technical expertise, legal knowledge, and diplomatic skills that have not been systematically cultivated among either foreign service or global health professionals.

In "The Guide to Global Health Diplomacy", Nikogosian et al., (2021) provide a holistic description of features and practical aspects of conducting *Global Health Diplomacy* (which focuses on *global* policy environment and actions for health), and define seven dimensions under the following headlines:

1. Negotiating to promote health and well-being in the face of other interests.
2. Establishing new governance mechanisms in support of health and well-being.
3. Creating alliances in support of health and well-being outcomes.
4. Building and managing donor and stakeholder relations.
5. Responding to public health crises.
6. Improving relations between countries through health and well-being.
7. Contributing to peace and security.

They further touch upon the complexity of MD, as it "has to deal with several complexities at the same time", and refer to the international system, interaction between different actors operating in the field, and their connection to social, political, and economic determinants (Nikogosian et al., 2021).

As mentioned earlier, the definition and meaning of MD varies, however, Katz et al., (2011) describe how all the definitions fall into three different categories of public health interaction:

1. Core diplomacy: formal negotiations between nations.
2. Multistakeholder diplomacy: negotiations between nations and different state-actors that do not necessarily lead to binding agreements.
3. Informal diplomacy: various forms of interaction between different actors, such as health professionals, NGOs, the private sector, and the public.

Further, different tools are available within the different levels of diplomacy. These are 1. Formal negotiations, agreements, and treaties between nations (core diplomacy). 2. Negotiations and partnerships between Government Agencies and other actors from different countries that do not necessarily intend to lead to binding agreements (multi-stakeholder diplomacy). 3. Interactions between nations through engaging health professionals, NGOs, the private sector, the public through, for example, different health programs (informal diplomacy) (Katz, et al., 2011).

People from a range of professions must be involved to successfully practice and implement MD (Katz et al., 2011). See Figure 1, Appendix 1, for a visualisation of the different levels and professions, and what tools they have.

In the field of international relations and diplomacy, "soft" and "hard" power are two important and frequently used concepts. They refer to different kinds of political tools. Hard-power tools are of a cohesive character, where the threat or actual use of military power is often on the table. Soft-power is instead a persuasive approach, where economic and cultural influences are used (Marrogi & al-Dulaimi, 2014). Generally, hard-security issues are viewed as urgent and dangerous, characterised by the outbreak of war or disputes of a similar magnitude. Soft-security issues, on the other hand, refer to less immediate and sensitive issues such as health (Fatić, 2002).

In terms of diplomacy, MD can be seen is a form of *confidence-building measure*, a concept that refers to actions taken to "introduce trust and stability into regions of tension" (Fisher, 1991). Multiple confidence-building measures have been taken to improve relations in the Gulf over the last couple of decades (Parsi & Esfandiari, 2020; Narbone & Divsallar, 2021), however, MD is not one of them.

During the literature review for this study, no research was found on MD *among* the Gulf countries. Some of them have health-collaborations with countries *outside* the region, often in the form of so called "medical tourism" (Thirarath, 2020), and Iran has a history of practicing MD through for example building hospitals in Lebanon, Iraq, Afghanistan, and Syria (Dolatabadi & Kamrava, 2021, A). Further, as described earlier, some cooperation within the medical field among the rich countries in the Gulf exists. However, for this study, I'm interested in the practice of MD among *all* countries within the Gulf region.

3. Methodological Approach

In this chapter, the methodological research design applied in this study is presented. Thereafter follows a description of the sampling strategies, data collection process and characteristics of participants. Lastly, a description of the data analysis and ethical considerations is given.

3.1 Research Design

As the aim of this study is to create an increased understanding and clarify the potential of MD to improve relations and public health in the Gulf region, conducting a qualitative study was chosen as the most appropriate method.

By interviewing experts from within fields relevant for MD, we can understand the complexity of the subject matter from their perspective. A semi-structured interview guide with open-ended questions was used (see Appendix 3). This was to create an open and interactive environment, which enables the participants to express themselves freely, while also letting the researcher ask questions and follow up on areas of inquiry, that could clarify the participants perspectives (Charmaz, 2014). Further, MD is a relatively new concept, and a majority of the interviewees are not experts on MD per se, but are rather professionals in different fields relevant to MD. It was therefore considered important to define how I use the concept in this thesis at the start of the interviews, in order to provide a framework from where to begin the discussion.

Who is an expert? In *Interviewing Experts,* Bogner et al., (2009) describe an expert as someone who possesses knowledge that can be distinguished "from other forms of knowledge like everyday knowledge and common-sense". In addition, the person should have an institutionalised authority to construct reality, with the position to structure conditions of actions in a relevant way. The people I interviewed are highly knowledgeable within their different fields through years of studying and working within their professions, but also possess institutionalised authority in some form through their work-positions.

Interviewing experts can have some drawbacks (such as the power imbalance between the researcher and the expert), however, it is considered a good strategy in exploratory and theory-building research. Experts can be seen as "crystallisation points" that can provide substantial, in-depth knowledge on the topic of their expertise. Experts are also considered a good source of information since they have a professional connection and general curiosity concerning the topic (Bogner, 2009).

Characteristics of study participants A total of 11 interviews were conducted for this study, where all the Gulf countries except Iraq were represented. The interview participants either live in, or are from, the Gulf. Their expertise ranges from the field of international relations, politics, diplomacy, and conflict resolution (7 people) to medicine and public health (4 people). The participants are associate professors, professors or doctors at different

universities, experts at different health or peace-building organisations, or ministries. They all focus on the region in their work. The participants represent a broad variety in terms of age, gender, and country of origin (see appendix 4).

Methodological approach Grounded Theory (GT) was considered the most suitable method to achieve the aims of the study. GT is most frequently a method designed to build new theories when there are no existing theories to understand the concept or process of interest. However, GT does not always have to result in a new theory. It can also be used to develop frameworks for improved clarification, or to increase the understanding of a phenomenon in a specific context that existing theories and models do not cover. In this sense, we can say that GT is useful to increase clarity and developing existing theories, which is the aim of this study (Creswell & Ploth, 2017; Timonen et al., 2018).

As the name indicates, an important aspect of GT is that the understanding of the phenomena being investigated must be firmly grounded in the data. It is useful for understanding and studying processes, behaviours, actions, and the context in which they develop. GT is therefore an inductive process where new theories and clarifying frameworks arise through the researcher comparing, contrasting, and contextualising the data in an iterative manner. This iterative process, entails going *beyond* the descriptions in the data and systematically transforming it into more generalisable concepts (Charmaz, 2014; Dahlgren et al., 2019).

Constructivist Grounded Theory Different variants of GT, with different ontological and epistemological perspectives have been developed over time. For this study, the Constructivist Grounded Theory (CGT) developed by Kathy Charmaz is used. CGT can be seen as an extension of the original GT and differs in its epistemological approach. CGT adheres to a constructivist and interpretative perspective, where knowledge is seen as something that is constructed both by the research participants and the researcher. Within CGT, the researcher is recognized as part of the world that is being studied, were data is collected, and analysis carried out (Charmaz, 2014).

A CGT approach was chosen as my position and active role in the data collection, interpretation of data and the decisions made during the process were considered important for the study results.

3.2 Sampling Strategies and Inclusion Criterions

Sampling in GT is a continuous process with different stages. I used several strategies and started with *initial sampling*. During this stage, I established the sampling criteria for the participants, planned how to access them, and conducted a Letter of Invitation (see Appendix 2). I wanted to interview people with a spatial connection to the region, as well as expertise relevant to MD in the Gulf. Hence, the participants needed to either be from, or live in, the region, as well as have expertise within international relations, politics, conflict resolution, diplomacy, public health, or medicine from a Gulf-perspective. These fields were considered relevant as they constitute important elements of MD. Furthermore, experts within these fields would be actors inhabiting crucial roles in the potential implementation of MD in the region.

I started to contact people by email. The organisation EMERG functioned as a gateway, as I was already acquainted with several experts that met the inclusion criteria through my work within the organisation. To find additional participants, I applied snowball sampling (Dahlgren et al., 2019), and asked the interviewees if they could suggest people within their network that would be relevant for me to interview.

Further, I applied *theoretical sampling*, a selection strategy where the researcher recruits participants who contribute to the emerging theory. In practice, this meant that, when I had reached a point in the data collection and analysis process where some categories could be identified in the interviews that were promising but tentative, I gathered more data to be able to strengthen and refine these categories (Timonen et al., 2018). Snowball sampling helped me find additional interviewees, but I also emailed people from different universities and health organisations with relevant work experience and expertise that I found online.

3.3 Preparation and Data Collection

Due to the Covid-19 pandemic and unpredictability regarding travel, most of the interviews were conducted via video calls using Zoom, between the end of December 2021, and March 2022. However, I had an understanding of the region, thanks to a work trip with EMERG to U.A.E. and Oman in November 2021. During this visit, I met some of the people I later contacted for an interview. A second trip could be made in mid-March 2022, this time to U.A.E. and Bahrain. During both visits in the region, I participated in meetings with people from different ministries and fields of relevance for this study. These experiences gave me an

understanding of the region as such, the relations between the countries, as well as an insight into how the societies and institutions function in the region.

In addition to the field trips, I did a lot of reading on the region. This increased my understanding of the complexity of the political situation, as well as potential openings for cooperation.

All interviews, except one, were recorded and transcribed (one participant preferred not to be recorded). During transcription repetitive words and sequences were removed (for example, when interviewees said: "it is, it is") and prepositions were corrected to improve readability of the transcripts.

3.4 Data Analysis

In GT, data collection and data analysis take place simultaneously, where analysis consists of coding and processing the data through different steps. Through coding, the researcher defines what is happening in the data, and starts to grapple with what it means. The coding process shapes the analytical frame and is a pivotal link between collecting data and developing a theory to explain it (Charmaz, 2014). The coding/analysis process and vocabulary differs between different types of GT. I applied Charmaz constructivist approach as described below and used the coding programme NVivo for sorting codes and categories (see Appendix 6 for compilation of codes and categories).

The coding process consists of at least two phases: *initial coding* and *focused coding.* Initial coding involves a close reading of the data and naming each bit of data according to what it indicates. This is an interactive process, where the researcher actively selects, separate and sort data. However, it is important to remain open to the data and all different theoretical directions that may appear during this stage of the process (Charmaz, 2014).

Focused coding follows and entails sifting the initial codes and creating focused codes based upon the most frequent initial codes, or codes of particular significance. During focused coding, the analytical directions of the work advance as the process also involves going from codes to tentative categories. This is done by further synthesizing, analysing, and conceptualizing the data (Charmaz, 2014).

Theoretical sampling and theoretical sorting When the researcher has arrived at some preliminary, tentative categories, more data needs to be gathered to build better substantiated and more robust categories. To achieve this, the researcher moves on to the next important step in GT, namely *theoretical sampling (*se chapter 3.2) (Charmaz, 2014). Through theoretical

sampling, the data reaches *saturation*, which means that new data no longer contributes to new theoretical insights. When saturation has been reached, the categories that have emerged from the data are robust and well substantiated. The researcher has been able to move from tentative categories to theoretical categories, and it is time to start the *theoretical sorting.*

Theoretical sorting means comparing the categories with memos taken along the way (see next paragraph), while integrating the categories on an abstract level. Sorting generates an initial analytic frame, and the theoretical development takes form (Charmaz, 2014). See Appendix 5 for an example of the coding process.

Memos A fundamental concept and practice within CGT is memo-writing. For this study, memos were written during and after each interview, as well as during the coding process, field trips and reading of the literature. Memo-writing supports the integration of categories and the generation of theory, as the memos consist of ideas and thoughts that emerge during the research process (Charmaz, 2014).

3.5 Ethical Considerations

Several measures have been taken to ensure that research ethics are complied with in this study. While I concluded that the study itself would not cause any harm to the participants or anyone else, politics is a sensitive topic. Therefore, I asked broad questions which supported the participants ability to formulate themselves in ways that felt safe and comfortable.

Secondly, all participants received the Letter of Invitation (see Appendix 2), containing information about the purpose of the study, and their rights as participants', such as voluntary participation, their right *not* to answer questions or to withdraw from participation at any point. It was stated in the invitation letter that, no one except my supervisors and I would have access to the interview material, their participation would be anonymous, and all material would be destroyed after the thesis-course. Lastly, the invitation letter clarified that I would like to record the interviews for later analysis. At the beginning of each interview, I repeated this information and asked if they had any questions, to ensure that they had understood everything and could give informed consent to participate.

The participants' confidentiality and anonymity were ensured by removing all names and identifying information. That being said, the software used to conduct the online interviews (Zoom) opens up the potential risk of surveillance beyond the researcher's control. It is possible that Zoom for example, is monitored by external actors such as governments.

To ensure that differing perspectives and approaches were represented in the study, I aimed to include participants from a broad spectrum of professions, from all countries in the Gulf region. Further, I worked to find people of different ages and genders. However, it is important to remember that this is a qualitative interview study, with no aspiration of being representative of all potential views of the subject matter.

4. Results

This chapter contains a presentation of the study result and the categories that emerged from the coding and analysis process. Quotes from the interviews will be used to support the findings.

4.1 Medical Diplomacy from a Gulf Perspective

It was considered important to present how I define MD in this thesis at the start of the interviews, in order to provide a framework from where to begin the discussions. However, as I was interested in what MD means in this specific region and did not want to project my understanding on participants, I also asked the interviewees to describe their own understanding of the concept. They were encouraged to express themselves freely and add or remove elements from the definition I had provided.

All agreed with the definition I presented, while a few wanted to add two elements which they described as particularly important dimensions of MD in the Gulf: transparency and sharing of best practices. These participants expressed that MD could contribute with and should aim towards strengthening the regional health capacitates among the countries (e.g., by sharing of medical best practises), as well as build trust. Yet, for this to be successful MD must be conducted in a transparent manner.

Although at a principal level the definition was accepted, the interviews revealed how the concept inhabits both a spatial, as well as a contextual dimension, grounded in the lived reality of the region and its particular histories. This in turn helped me flesh out the definition of the concept itself.

4.2 Description of Categories

Various perspectives, subjects and thoughts were expressed by the interviewees which resulted in one core-category: "MD in the Gulf: great potential, unrealistic expectations?", and three main-categories: "A vital soft-security tool: Opportunities of MD in the Gulf", "Lack of order and a lot of bad blood: Challenges to MD in the Gulf", and, "By the region for the region: Approaches to succeed with MD in the Gulf". The main-categories are in turn built up by sub-categories that describe different aspects and characteristics of them.

4.2.1 Medical Diplomacy: Great Potential, Unrealistic Expectations?

The core-category emerged as about half of the participants expressed great enthusiasm and optimism regarding the potential of MD for improving relations and public health among the Gulf countries. However, the second half were critical and expressed little belief in the potential of MD. The contradictory result displays the complexity of the research field, and the need for a nuanced understanding. The main-categories, *opportunities* and *challenges,* of the core-category will be described below.

4.2.2 *A vital soft security tool*: Opportunities of MD in the Gulf

This main-category emerged from how participants described MD as a useful and potentially successful tool for improving intergovernmental relations and public health in the region. The category will be described through subcategories that exhibit the different dimensions and characteristics.

An avenue for dialogue that can build trust

A majority of the participants spoke of the importance for dialogue in improving regional relations. Without dialogue, any relation or collaboration is impossible to develop. In this regard, most participants elaborated that medical issues are seen as less sensitive and less complicated to discuss in comparison with more traditional hard-security topics in the region. Therefore, MD could be a platform for dialogue even in times of conflict, or during disputes, that can provide a peaceful avenue of interaction. MD could build bridges between the Gulf countries and reduce suspicion:

> It would be a vital soft security track and it would get people used to seeing each other, […] talking to each other. Over time that inevitably decreases tensions and creates friendships, which means it's easier to pick up the phone and talk to one another and not be wary of talking to one another or suspicious of it. (Middle East expert, focusing on conflict-resolution)

Medical diplomacy: a soft-security tool with an edge

Many participants described MD as a form of *soft-power* and health as a *soft-security issue*, perceived as less important and less urgent than hard-security issues. This was considered a good thing, as it can open doors towards other issues:

> There are more opportunities [with discussing health issues] because it's a lot less hostile in terms of how to speak to another country or what sort of relations you want to build. That can open a door towards harder politics or more difficult topics. (Expert in international relations)

Further, several participants described how health has been given a higher priority because of the Covid-19 pandemic, and the realisation of how severe health problems can affect countries. This has given MD an "edge" that other soft security issues lack. MD could bridge the divide where other soft-security tools cannot, and therefore have a greater impact:

> So up until the outbreak of the pandemic, I would say, you know, it's hard to find a soft security issue that's important enough that the countries want to engage on it. [...] The pandemic has really shown them that, you know, viruses know no borders [...]. It's not like it's going to stop at the U.A.E., Saudi Arabia's border, right? And so, that has frightened a lot of people and it's given them a sense of urgency, that there are other issues than the hard security conflicts that they have to talk about, that they have to resolve, and they can only resolve together. Because closing your border is not an option. So, I actually think that medical diplomacy has been boosted, its importance has been boosted by the outbreak of the pandemic. (Middle Eastern expert, focusing on conflict-resolution)

A tool to practice compartmentalization: MD as one track among many

The complexity of the Gulf region in terms of political disputes and instability was emphasised in most of the interviews. However, focusing on one specific issue at a time, rather than bringing all difficulties to the table at once (i.e., *compartmentalize*), was described as a fruitful strategy to overcome these barriers:

> Simplicity helps. To say you know "we're not here to talk about Cyber Security we're here to talk about health, and we're all concerned about health", establishing a trust that way, trust, and exchange [...]. (Academic specialising in political science).

Further, participants explained that engagement on several levels is needed to build political improvements, and in this multi-level engagement, MD could be one track among many:

> The way that I envisage dialogue in the Gulf region generally is that it's such a complicated issue, and there are so many varying levels of tensions that, the only way that you overcome them is a long term, sustained engagement on multiple fronts. And medical diplomacy would sit in that long term sustained multi-level engagement. So, it would be one track amongst many. (Middle Eastern expert, focusing on conflict-resolution)

Several areas of potential cooperation exist

Participants with a background in diplomacy, international relations or political science mainly focused on MD as a political tool and its potential in this regard. The health experts, on the other hand, talked about the need for, and potential of, collaborating on various health issues. Some participants expressed that MD could be used to improve cooperation in medical education, research, treatment, and policy development, while others articulated health collaboration in terms of *security*. They described how collaborating on health issues in the Gulf is crucial in order to, for example, track the spread of disease during pandemics. Further, collaboration was described as a way for securing medical supplies in the region:

> I do think that there are opportunities in terms of being able to collaborate, and to use the resources of each country in a way that would make the region more secure in terms of medical items and pharmaceuticals. (Expert in international relations)

Shared culture: a unifying factor

While cultural differences in the region were proclaimed to be potential obstacles to MD by some participants, several explained that cultural similarities, such as religion and values, can be unifying factors. Some interviewees stated that the region struggles with similar health problems emanating from cultural values and habits. Lifestyle factors, like diet and physical exercise, but also how diseases such as HIV are dealt with, were given as examples. Due to these shared, culturally connected health issues, the countries in the Gulf would benefit from cooperating, exchanging knowledge and expertise on tackling them:

> […] In a way that is attuned to the context of the Middle East because a lot of health issues are linked with social issues and with cultural values and religious values. So, it would be important to have a view where you can share knowledge, health related knowledge that is now more relevant to your population. I think that adding these dimensions given where we are today would be interesting avenues to explore. (Academic specialising in Public Health)

4.2.3 *The lack of order and a lot of bad blood*: Challenges to MD in the Gulf

This main-category emerged from the scepticism expressed towards MD in the interviews. The sub-categories that detail different dimensions of this main-category will be described and exemplified with quotes below.

A lack of order makes it difficult to improve intergovernmental relations and create health cooperation in the Gulf

A "lack of order", globally and regionally, was considered one of the largest obstacles to MD. Current wars and conflicts *in other parts* of the world, complicates peaceful development among the Gulf countries. One participant expressed the following:

> The main reason behind those crises is not lack of cooperation. It's not lack of understanding, it's not lack of interest and stability. The main driving force in my evaluation of these crises, the expansionism of Iran, the expansionism of Turkey et cetera, et cetera, is that the regional order is up for grabs. It's not settled yet, it's still in the making and everyone is doing their best to shape it and reshape it in a way that serves their own interests. It's not settled. Why is it not settled? For a long list of reasons. Number one is that the international order itself is in transformation, and the international order reflects upon regional orders. (Academic specialising in political science and international relations)

Global politics makes it difficult to improve intergovernmental relations and create health cooperation in the Gulf

Whilst the region itself has problems, several interviewees emphasised that global politics as well as global market mechanisms pose a threat to the development of the region, both in terms of intergovernmental relations and health. The sanctions on Iran were purportedly impediments, since these structural barriers make any interaction, or collaboration difficult. It was also expressed that countries outside of the region have their own agenda in how the situation develops in the Gulf. Financial incentives, such as arms trade, and political power were given as examples:

> I mean, when there are tensions, you can sell weapons. Who else would the Americans sell weapons to? And every year, according to the Stockholm Peace Research Institute, there are records, there's a new record set of weapon sales. So, they absolutely love it because you know… So long as these tensions don't result in war. So, one of the things we see is that the Americans like managed tensions because it provides an opportunity for them not just to sell weapons, but to be the outside security guarantor, and so it gives them a foothold in the region. (Academic specialising in politics of the Middle East)

A competitive environment makes it difficult to improve intergovernmental relations and health in the Gulf

Even though global politics plays a crucial role, the current tensions and conflicts among the Gulf countries are also due to regional history and context. There is a reluctance to work together, based on past and present experiences. One participant described how the current tensions stem from an insecurity among the states and connected this to the fact that the majority of them have relatively recently gained independence. The Gulf countries work hard to claim and maintain their individual roles and power regionally and internationally, which leaves little room left to consider cooperating with each other:

> One analogy is they're like teenagers. And as teenagers they are deeply insecure. And so, it's how teenagers easily get into fights at the schoolyard, throwing punches and undermining each other. And we saw the most examples of this in 2017 to 2020. [...] And there's not like yester-years that we're talking about, these are contemporary historical processes. These are states that continue to be in the process of formation in terms of their identity, their heritage. And the breakneck speed with which they are developing, giving them added competition, and so MD is something far off in everybody's mind… (Academic specialising in politics of the Middle East)

Furthermore, several participants explained that there seems to be a *lack of will* to collaborate with the aim of strengthening health regionally. The GCC countries have the financial resources to buy what they need, and they would rather turn to the global market than improve national capacities or look to cooperation within the region:

> So you know it's quite tricky because it's one thing to sort of ideally say that it would be nice to cooperate and collaborate, but on the one hand you need the capacities inside countries, you also need desire inside countries to want to be self-sufficient and to want to produce their own science or knowledge, and not just rely upon you know whatever that is handed to them. And that is a big challenge. (Academic specialising in Public Health)

Pride makes it difficult to improve intergovernmental relations and create health cooperation in the Gulf

Related to the competitive mindset in the region, *pride* was also mentioned as an obstacle to practising MD. Several participants remarked that there is a general reluctance to accept help and/or collaborate within the region due to this:

> I also sense that there is a lot of pride on, you know, all sides and it's yeah… I think that first there needs to be an icebreaker that makes everyone willing to talk about their problems, but

> then also talk about their successes and learn from each other. (Academic specialising in Public Health)

Another participant reasoned in similar ways on this topic:

> Pride is a major issue in the civilizations and cultures around the world, one of which is the Arabian civilization and culture. Pride is a major thing, as it is the case in Iran. One thing when I talk with my Iranian friends is that it is difficult for Iran to admit that there is a development gap, that there is a management efficiency gap, there is a problem of chronic corruption, et cetera et cetera. So, accepting it provokes so many other things. (Academic specialising in political science and international relations)

Historical conflicts and disputes make it difficult to improve intergovernmental relations and create health cooperation in the Gulf

While some participants were sceptical towards the success and functioning of the GCC, some interviewees highlighted that collaboration between GCC countries is good. The most difficult collaboration to build in the Gulf region was viewed to be between the GCC countries and Iran, and more specifically between K.S.A. and Iran. The relation between those two countries was a sensitive topic that some interviewees preferred not to talk about at all. However, one participant stated that there is a lot of "bad blood" which makes cooperation between them especially difficult:

> What can I say? It's not as simple as a lot of researchers or people outside of the region perceive it [...]. Fact of the matter is, there's a lot of bad blood that makes it very difficult. Iraq is on the border, it's easier. The GCC countries are GCC countries, so either way they're inseparable. That collaboration happens even without us knowing that it happens, it's sort of automatic, but our friends across the pond. That is a little bit more difficult. Because there's just a lot of complicated history. I guess… I mean, honestly, the Persians and the Arabs have been fighting for thousands of years. That's a lot of bad blood. (Expert in international relations)

Moreover, some risks could be associated with practising MD. These were not many, and the interviewees explained that the positives would outweigh the risks. Yet, medical cooperation may be circumscribed by other political tensions. As an example: if country A relies on country B for a specific medical supply, this could become a pawn in B exerting pressure during a dispute. This could in turn expose people in country A to health risks, as elaborated by one participant:

> If you don't make progress on other areas of tension between them, the risk is that this will be frozen and arguably, this is probably not more important than political tensions or wars

> that they're fighting, but at least has the potential to affect people directly and very quickly, and so this could be held hostage to, for example, a lack of political dialogue or a worsening of tensions or an outbreak of violence. And that for me is a drawback of this kind of cooperation. (Middle East expert with a focus conflict-resolution)

Moreover, it was noted that MD might risk being used to *mainly* favour foreign policy objectives, and therefore be disappointing from a health perspective.

Lack of common health policies and practices

When asked about the impediments to MD from a purely medical perspective, several participants answered that lack of common health policies and practices in the region are severe obstacles to cooperation. One participant described conducting a study, which showed the lack of common medical standards in the region:

> […] we brought in experts, medical experts, and experts in public health, from a bunch of places. And we realised that there's not even a baseline you know, […] we don't even have primary data. One of the interesting findings was that because of the nature of demography of the region, you bring in an Indian doctor and he's trained in an Indian medical school, and then you have a Syrian doctor trained in Syrian medical school and an American, and they come with different kinds of medical training. They're used to different medicines and different medical practices. The infrastructure here, to develop national medical standards, doesn't exist yet. […] So, you know, this is a real issue. […] We really have to go back to the basics when it comes to this region because many of these common denominators don't even exist in terms of standards, national standards of pharma. (Academic specialising in politics of the Middle East)

4.2.4 *By the region for the region*: Approaches to Succeed with MD in the Gulf

To incorporate a discussion focusing on practical dimensions and not just theory, I asked interviewees what they saw as important to keep in mind for ways forward, regardless of their optimism or scepticism of MD as such. What would they, based on their expertise and experience, consider to be important steps, approaches, or perspectives in order to implement MD in the Gulf, and increase the probability of success?

The third main-category emerged from how the interviewees reasoned on this topic, and their answers were coded into sub-categories. I was able to identify an order in *when* different approaches and important steps would be needed, as described below:

Introducing the concept

Most interviewees remarked that MD is an unfamiliar concept in many circles. Its introduction would require that relevant actors at different levels learn about MD and how it should be practised. This was described as important, not only to increase awareness and develop practical skills among different professions, but also to create a common understanding of what MD means across the region and avoid misunderstandings.

Framing the practice correctly

It would be important to ensure that MD is framed correctly, in order to be well received as a practice in the region. This means taking a diplomatic approach and emphasising that MD is a joint project, where all parties give and take. It would be important to ensure that MD is not seen simply as a form of charity, as this could be viewed as paternalistic, something countries would be unwilling to participate in:

> The way of presenting things, it matters so much. If I am presenting coffee to you, I would present it in a way that suggests please do me the favour of accepting it, and I would be very grateful. So, it's as if you are the party who's giving me coffee, not the other way around. Presenting things matters a lot, the way to talk about them. (Academic specialising in political science and international relations)

Ensure regional ownership

Another important aspect was that of *regional ownership and agency*. MD must be designed by the region, for the region, and not imposed by those outside. Think-tanks, institutes, or lobbyists from outside the region dictating what and how to do it, would be perceived as imperialistic and paternalistic in the Gulf-countries:

> We have a tendency to say: Okey, we [outsiders] think we should design it in this particular way and then kind of present it as a prepared package and be like you guys take what we're giving you and what we think you should do and do it. I think there's a lot of, um, kind of not ill will… But people in the region don't take well to that, so [...] I think the first and most important step will be to ensure that it's kind of designed by the region for the region and isn't something that's imposed from people outside. (Middle East expert, focusing on conflict resolution)

Ensure multi-level engagement

Many emphasised that it is crucial actors from different professions and levels are involved. NGOs, healthcare professionals, politicians, diplomats, and academics were mentioned as examples of important actors to include:

> You'd have to engage everybody, right. Because the healthcare professionals will tell you what they need in terms of pure substance of conversations on public health issues and what's more urgent and what kind of transparency they can afford to have […]. But then, at the official, Ministry of foreign affairs or politician level, they'll tell you what's feasible, just in terms of general engagement of the other. And that's where protocol and stuff like that is going to come in. So where can we have the meeting and how what format will it take and how public will it be? And is it going to be just technical? Or do we have some political level representation as well? And they're the guys that are going to be able to tell you that. So, when one engages with the countries in the region in order to discuss and understand what they need. You'd have to do it at multiple levels. (Middle East expert, focusing on conflict-resolution)

Institutionalise MD as a practice

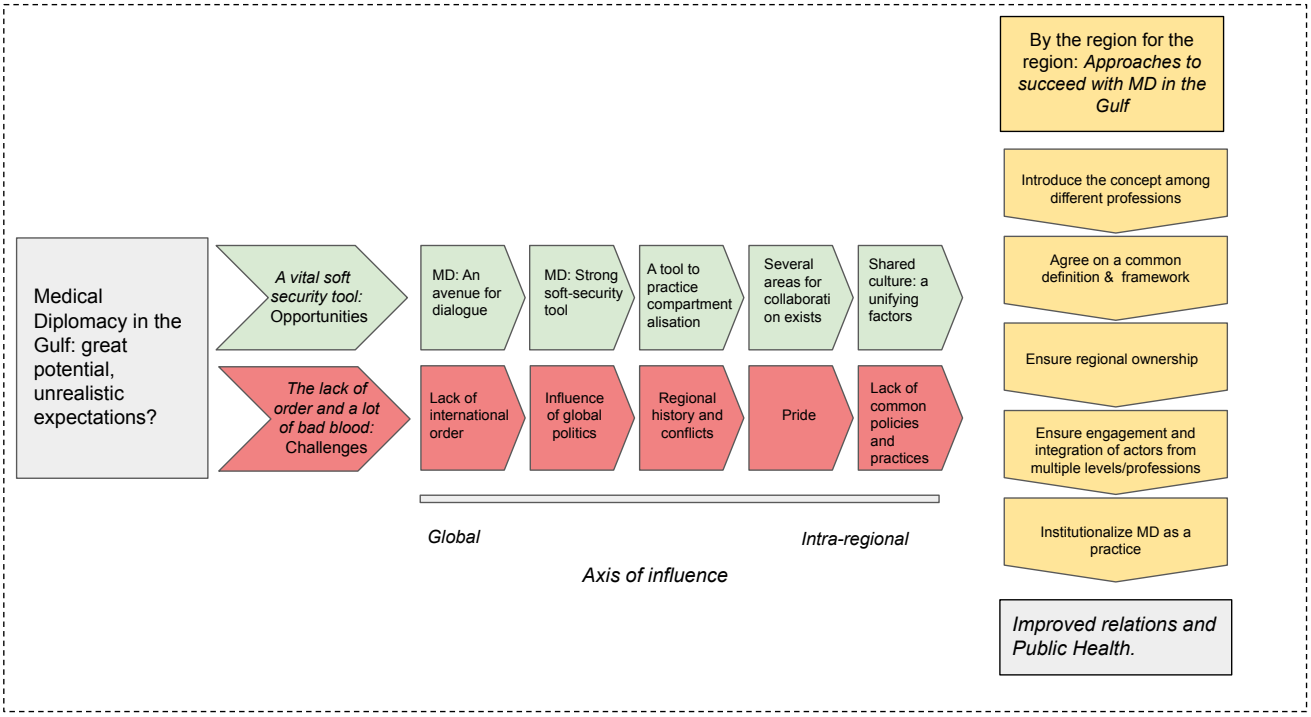
Finally, several interviewees highlighted the importance of *institutionalising* MD. The practice must be conducted on a solid basis of sustained interaction, have a long-term perspective and be systematic in its approach and implementation:

> What I think would be important is to maintain the momentum. And how do you maintain the momentum? It's by a kind of institutionalising some of the exchanges that you've had in dealing with one particular crisis and ensuring that you have it set up on a more permanent basis. (Middle East expert, focusing on conflict resolution)

4.3 Framework for Clarification

The aim of a GT study is to develop a new theory, or, as in this case, a framework for clarification of the subject matter. Figure 2 visualises the potential of MD in the Gulf by conceptualizing and mapping out what was coded as opportunities, challenges, and approaches for MD to succeed. Further, the figure captures the process of how one can work to understand MDs potential in a new context. First, how the concept is understood must be investigated, and what different opportunities and challenges exist. Thereafter, what approaches to consider, and what factors that must be in place for an implementation need be scrutinized.

Figure 2, *Framework for clarification*



In the grey box to the left, capturing the interviewees answers and mixed opinions on MD in the Gulf, is the core-category. The small green boxes are sub-categories, which describe different Gulf-specific factors and circumstances that were coded as opportunities and strengths, that speak for the potential of MD in the region. The small red boxes are sub-categories that describe Gulf-specific factors that were coded as challenges to MD in the Gulf. Some of them are of a global character, while others are regionally situated.

During the process, a chronology was identified in the participant's reasoning regarding what steps need be taken, and approaches to apply. For example, as MD is relatively unknown in the region, it would be important to start by introducing the concept. This is visualised by the yellow boxes to the right.

5. Discussion

In this chapter, the findings of the study will be summarised and discussed in relation to the existing literature. I will reflect over the methodology, trustworthiness, and limitations of the study. Thereafter follows a conclusion.

5.1 Overview of Findings

About half of the interviewees were optimistic and described MD as a tool with great potential to improve intergovernmental relations and public health in the region. Health is less politicised than other issues and can therefore provide an avenue for dialogue, while building trust.

The other half were cautious about the potential positive effects of MD (both in terms of political and medical improvements) and remarked that it would be limited by politics and encounter challenges due to existing conflicts, pride, and a general unwillingness to cooperate. A lack of common health policies, practices and standards within the region may also be an obstacle.

With regards to how MD should be designed and conducted to succeed in its objectives, five main points could be identified in the interviews. These range from introducing MD among different professions, to working for institutionalisation and a systematic long-term implementation of the practice.

While the result of the study may seem contradictory, it reflects the complexity of the Gulf, and contributes some interesting new facets to MD, with a Gulf-perspective.

The different examples of potential health collaborations, raised by the participants, further prove the public health relevance of MD. That being said, the challenges should not be underestimated, they require a contextual understanding and specific adaptations in the application of MD.

5.2 Engaging with the Literature

Most of the findings correspond well to the existing literature. The prevailing view in the interviews was that MD could function as a platform for dialogue, which in turn could facilitate interaction and ease tensions between countries. This resembles how MD is described by Dolatabadi & Kamrava, (2021, A), Lee & Smith, (2011), Feldbaum & Michaud (2010) and Brown, et al (2016). In addition, the interviews correspond well with Nokogosian et al (2021), and the seven dimensions of Global health Diplomacy that they map out. Many of these dimensions of MD were discussed by the participants.

The result strongly points to MD's complexity and challenges being based on financial, political, and social determinants, as well as the global world order, which Nikogosian et al. (2021) also mention. Further, the study resembles Katz et al. (2011) by emphasising the

importance of practicing MD through a multi-level engagement; including and integrating people from different professions.

In relation to the literature on the regional context, the study confirms that Iran is the country that the others, mainly K.S.A., have the most difficulty cooperating with. However, Iran has a lot of medical expertise that other Gulf countries lack, which implies that everyone could benefit from a complementary cooperation in order to strengthen regional health capacities.

Furthermore, influences from foreign powers and international politics were considered obstacles to improved relations in the Gulf. From the literature on the region, it is clear that this is not a new situation. Rather, it is part of deep-rooted tensions among the Gulf countries, which inevitably also affects the ability to practice MD.

This thesis brings some new perspectives to the research field, primarily by shedding light on MD from a Gulf-perspective, but also generally. Firstly, the study shows that having a deep contextual understanding is a prerequisite for being able to design and implement MD to suit the countries involved. Multiple Gulf-specific factors were identified, and many of them are interlinked. For example, I see a connection between the historical conflicts, the fact that most Gulf countries are still young independent states, their pride, and the competitive climate in the region. The countries are invested in nationalist projects of building and strengthening their identity and power, which affects their regional ability and willingness to cooperate. This points to an *ontological insecurity* among the states, which becomes a hindrance to MD. Moreover, the study shows that paternalistic attitudes and tutelage expressions from external actors are not well received in the region. This is important to understand for external actors interested in working with the Gulf.

Secondly, the challenges that lie ahead of MD are deeply rooted and partly concern an internal developmental approach taken by the Gulf countries where a willingness to work regionally is limited. As the practice of MD is dependent on political will, this indicates a need to nuance existing understandings of MDs potential. Although health may be less sensitive than many other issues, this study has made it clear that health *is* politicised and does not exist in a vacuum. Although vaccines, for instance, may be easier to discuss than the war in Yemen, one should not be naïve in one's expectations. However, I consider the fact that health was described as a *security-issue,* essential for understanding what MD *could* achieve in the region. When a problem is labelled as a security-issue, it is often given higher priority which indicates that MD may be seen as a useful health-security tool by the Gulf states.

Thirdly, given the sensitive political situation in the Gulf, it seems important to focus on the *medical* dimensions of MD. To avoid historical and current conflicts, pride, and controversies, one must ensure that the activity is separated from other issues and the general political competition.

Fourthly, while the willingness and possibility for cooperation may vary (some issues may be too difficult or sore to approach even if there is a desire for improved relations), health issues are everyone's concern. They sometimes require cross-border efforts, *forcing* countries to cooperate. This thesis implies that the interaction this inevitably entails, can have positive trickle-down effects and lead to improved relationships. MD can therefore be a fruitful tool even if the will, or possibility, to cooperate is initially lacking.

Fifthly, this study indicates that MD could function as a confidence-building measure in the region. Several suggestions for potential health collaboration were given in the interviews, and some initiatives and organizations are already in place (EMRO, GCC, GHC). This shows that there is at least some willingness to improve relationships. Taking advantage of the will and initiatives that exist, as well as covid-related realisations regarding the importance of regional health and joint health efforts, could be a way of circumventing political challenges.

Lastly, the study emphasises the importance of *institutionalizing* MD, rather than viewing and practising MD as an emergency tool. While this study mainly contributes to the research field by bringing clarity to MD from a Gulf-perspective, I perceive this finding particularly, to be of universal relevance.

5.3 Methodological Considerations

Individual interviews with experts from different relevant fields, in combination with a CGT approach enabled the development of a framework for clarifying the potential of MD to improve relations and public health in the Gulf.

The data consists of eleven interviews. As the participants, possessing expertise and many years of experience in their fields, provided long answers that made possible an in-depth analysis, this was considered adequate for a study of this size. It was not feasible to analytical separate intergovernmental relations and public health in this thesis, however, different aspects of these two aims of MD were discussed and investigated in the analysis.

A limitation of the study is that relevant perspectives might have been missed since participants from Iraq were not found. Also, future studies should consider a larger sample size,

including additional sectors, such as professionals working in policy making at the governmental level.

Another interesting aspect that should be considered for future studies is how online-interviewing affected the results. Would the answers have been different if the interviews had been conducted on site? This is no doubt a relevant methodological question for researchers to grapple with, as the future becomes more digital.

Within an interview process, it is important to consider the bias and subjective experience of the interviewees. I sometimes experienced that the participants acted as representatives of their own nations and presented the best sides of their countries. However, I found that the bias I was able to discern reflected the problems in the region in an interesting manner.

Trustworthiness A set of actions have been taken during the study process to ensure the *credibility, transferability, dependability,* and *confirmability* of this study.

Credibility (the researcher's ability to capture the multiple realities described by the informants) is increased by activities that bring the researcher closer to the study-participants and enables a dialogue between the participants and researcher (Dahlgren et al., 2019). The combination of my literature review of MD, the Gulf countries, as well as personal field studies in the region increased my understanding of the geographical context and the participants perspectives.

Further, multiple realities were captured by interviewing experts from different fields and countries. Follow-up questions were asked throughout the interviews to ensure that the answers given by the interviewees were correctly understood. In cases where the data felt unclear during the coding process, informants were contacted again for clarifications.

A goal in qualitative research is to generate *analytical generalisations*, and the *transferability* of a study is important. The transferability of this study has been ensured through *thick descriptions*. Detailed information about the research process and context enables other researchers to make informed decisions about the transferability of the results to other settings (Dahlgren et al., 2019).

Dependability refers to the *consistency* of the study findings, meaning that other researchers should be able to come to similar conclusions if analysing the same data (Dahlgren et al., 2019). The descriptions of the methodology, context and research process provided in this study create dependability by explaining circumstances of importance for the study findings. Further, interview quotes show that the results are grounded in and emerged from the data.

In CGT, the researcher's active role in creating and constructing knowledge is recognized, and *confirmability* refers to neutrality of the data rather than neutrality of the researcher (Dahlgren et al., 2019). The following actions have been taken during the process to ensure the confirmability of this study:

Peer-debriefing was conducted through regular meetings with the supervisors, where the analysis process and interpretations of the data were discussed. These discussions contributed with helpful perspectives and strengthened the credibility of the study. I also discussed my interpretations with a peer student to receive and measure the perspective from someone outside of the study process, which also strengthened the credibility of the thesis.

One of my supervisors is from the region, and an expert in the history and politics of the Gulf. His feedback was very helpful and contributed to my understanding of the geographical context.

I have followed the advice given by Charmaz (2006) and kept a research diary throughout the process. I have reflected on my role as a researcher, my starting point, standing points and position in the society studied, as well as in relation to the research topic and informants.

I entered the field with a fairly basic understanding of MD, based on the literature I had read. However, I started with some knowledge of the Gulf region through previous work and field trips to the region. That said, I grew up in Sweden, with no personal connection to the Gulf. Perhaps, that has allowed greater analytical distance. On the other hand, people with stronger attachment and longer experience in the region may more keenly understand the underlying tensions stewing between the countries.

5.4 Conclusion

This study shows that MD could potentially play an important role in improving intergovernmental relations as well as public health among the Gulf countries. It is a soft-security tool inhabiting a position of unique relevance and urgency. Further, there are many areas for potential health collaboration of great health importance in the region. MD's potential, however, depends on the existence of political will, as any effort would encounter numerous obstacles mainly of a political character. International politics and regional conflicts that span centuries have also led to bad blood in the region. This in combination with an uncertainty in the ontological security of the countries, their pride, and an unwillingness to cooperate regionally are major challenges.

This study indicates that MD can be more politically sensitive than previous literature implies. Although health issues are less sensitive than many other topics, the regional and political context have a decisive impact and should not be underestimated. This study shows the importance of understanding the contextual factors in the implementation MD. Identifying the opportunities and taking advantage of them, can increase the likelihood of success. Correspondingly, there are several measures that can be taken and approaches to apply to increase the likelihood of success with an implementation of MD. They range from introducing the concept to people in different professions in the region, ensuring regional ownership and working for sustainable health integration and cooperation.

Although the situation is complex, and flourishing relations between the countries around the Gulf are probably far away, one must try to move in that direction, not least for the sake of improving and securing regional health. Multiple tracks and strategies are needed to build the trust and goodwill that is now lacking. In this long-term multi-level engagement, MD can be an important tool in a toolbox of many different resources.[2]

[2] First of all, I want to thank the interview participants who took the time to participate in this study. It has been extremely interesting to talk to you and take part of your experience and expertise! Furthermore, I would like to extend a big warm thank you to my supervisors Maria Andréa Nardi and Rouzbeh Parsi for invaluable guidance. I have learned an incredible amount from you! A special thank you to Dylan Pashley for proofreading and support throughout this process. You all made this thesis possible!

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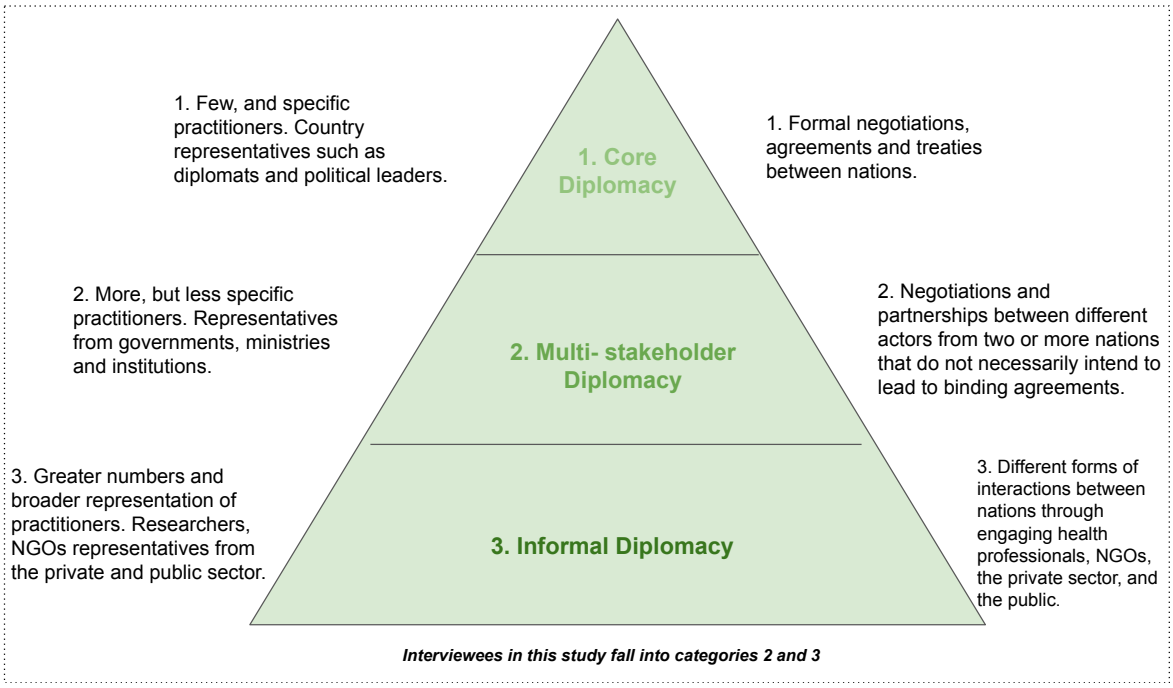
Appendix

Appendix 1.

Figure 1. *Authors own model based on adaptation of Katz et al (2011*).



Appendix 2.

MA Programme in Public Health

Letter of Invitation

My name is Louise and I am a master's student from the Public Health Programme at Lund University. I am currently writing my master thesis on Medical Diplomacy in the Gulf region. The aim is to examine the role of medical diplomacy as a tool in intergovernmental relations and public health cooperation between the Gulf countries. To collect data, I am conducting interviews with experts on issues related to **international relations and public health in the Gulf countries**.

Considering your expertise and experiences within this field I am writing to ask if I could interview you as part of this project. The interview will be held in English, either over zoom or in person. It will take around one hour, and I would like to record the session for later analysis.

The interview will be conducted according to Lund University's guidelines for research ethics. Participation is voluntary and at any time during the interview process, you are free to decide if there are questions you would not like to answer, or if you want to discontinue the interview.

Please feel free to ask questions regarding the project at any point before, during, or after the interview.

I can reassure you that your confidentiality will be maintained throughout the data collection and analysis process, as well as in the presentation of the results. Your name will be removed from the interview material, and only my supervisors and I will have access to the material during the work process. The recordings and transcriptions of the interviews will be destroyed at the end of the thesis course in May 2022.

If you have any further questions, please feel free to reach out!

Contact information

Name: Louise Burenby

Phone Number: ###

Email: xyz

Appendix 3.

Semi Structured Interview Guide

Start

- *Present myself, my study and the research ethics for informed consent.*
- *Ask if they have any further questions.*
- *Turn on recording.*
- *Ask if they can give informed consent to participate.*

Kick of question

- Ask participants to say a few words about themselves, their background and profession.

Present my working definition of Medical diplomacy

The topic of my thesis is medical diplomacy, and before I start to ask the more specific questions, I will give you the definition I use of the concept. You will soon have the opportunity to add to or remove from that definition, or describe your understanding of the concept, because I know that it has several different definitions.

However, I approach medical diplomacy as a form of diplomatic relations which is intended to promote good relations between nations, support foreign-policy objectives, while also providing needed health services. It is believed that medical diplomacy can help to ease tensions between countries, and at the same time create a positive image of the nation giving medical support.

Cuba is for example well known for practicing medical diplomacy. They have been sending doctors to other countries in need of health care support since the 1960, but they have also provided free medical education for tens of thousands of foreign students in an effort to contribute and give medical assistance to the world.

And just to make sure that we are on the same track, I'm not only focusing on the GCC countries, but all countries around the Gulf. So, Iraq, Iran, Qatar, Kuwait, Bahrain, Saudi Arabia, Oman, United Arab Emirates.

Questions

What does medical diplomacy mean to you/ How would you define this concept and practice*?*

Within your field of expertise, would you say that medical diplomacy is a well-known concept?

Potential/strengths/possibilities

If any, what potential/strengths/possibilities do you see with medical diplomacy among the countries in the Gulf?

Why and how could medical diplomacy possibly play an important role for improved intergovernmental relations in the Gulf region?

Risks/drawbacks/impediments?

If any, what kind of risks, drawbacks or difficulties do you see with practicing medical diplomacy among the Gulf countries?

Impact on relations among the countries in the region

How do you think that Medical Diplomacy can affect the relations between the countries in the region?

MD potential effects and impact on public health among the countries in the region

How do you think that Medical Diplomacy can affect the public health development in the region?

Potential spin-off effects

Do you think that MD could have any possible synergy effects if practiced in the Gulf region?

Transformational Potential

What potential/ability/power do you see with medical diplomacy in the Gulf?

Ways forward/methods for success

Based on your expertise and profession, how would you suggest that Medical Diplomacy was performed and used to be a useful tool to improve the intergovernmental relations in the region and help to improve public health? What methods and approaches do you think would be important for medical diplomacy in order to be practiced successfully?

Ending

Is there anything you want to add or elaborate a bit more on before we end this interview? Before we say goodbye, I wonder if you know anyone else within your network that you think would suit this study? → Ask for contact details.

Appendix 4.

Table 1. *Anonymised list of participants*

# Of interviews	Profession/work	Subject of expertise	Country of origin/work	Gender
1	Academic	Public Health	Iran	Female
2	Medical doctor/academic	Medicine/Global Health	Oman	Male
3	Academic/NGO	International relations	Iran	Female
4	Academic	International relations	Iran/Qatar	Male
5	Medical doctor/hospital	Medicine	Iran	Male
6	Academic	International Relations	K.S.A.	Male
7	Medical doctor/academic/NGO	Public Health/Policy	Bahrain	Female
8	Academic	International relations/diplomacy	U.A.E.	Male
9	Academic/Ministry	International relations	K.S.A.	Female
10	Academic	International relations	Kuwait	Female
11	Academic	History and politics in the Gulf	Qatar	Male

Appendix 5.

Table 2. *Analysis process, from raw data to categories*

Segments of text	Code	Tentative Category	Category
"The way that I envisage dialogue in the Gulf region generally is that it's such a complicated issue, and there are so many varying levels of tensions that the only way that you overcome them is a long term, sustained engagement on multiple fronts and medical diplomacy would sit in that long term sustained multi-level engagement. So, it would be one track amongst many. It would be a track which is likely to make more progress, because again it's something that's urgent. It's something that's important and it's something that's not political, particularly at a time of a pandemic. So, it would be a vital soft security track and it would get people used to seeing each other. It would get people used to talking to each other and over time that inevitably decreases tensions, creates friendships which means it's easier to pick up the phone and talk to one another and not be wary of talking to one another or suspicious of it. And so, I think it's a key component of just a multi-level engagement."	Dialogue is complicated, varying levels of tensions. Tensions require long-term engagement on multiple fronts to be over-come. MD would be one track amongst many. MD likely to make more progress for intergovernmental relations and health than other tools. MD would be a vital soft security track. Through practicing MD, people would interact regionally and get to know each other. MD could decrease tension and suspicion.	**MD could be a vital soft-security tool to ease tensions and improve relations in the Gulf.**	**MD: Strong soft-security tool**

Appendix 6

Table 3. *Coding process, from codes to categories*

Codes	Sub-categories	Main-categories	Core-category
- Health is ever one's concern. - MD: good platform that opens doors. - MD can be used to create interaction and build relations. - Health not politicised.	MD: An avenue for dialogue	***A vital soft security tool*: Opportunities**	Medical Diplomacy in the Gulf: great potential, unrealistic expectations?
- MD: not political, yet important. - Health is important "enough" to not be ignored. - MD can increase trust and build relations. - Covid-19 has given health higher priority.	MD: Strong soft-security tool		
- Start small, focus on different topics separately. - Engagement on multiple fronts needed. - MD can be one component amongst many others.	A tool to practice compartmentalization: MD as one track amongst many		
- Collaborate through exchange of recourses. - Common research fund. - Collaborate on difficult cases. - Share culturally sensitive knowledge. - Implement regional health policies.	Several areas for collaboration exist		
- Similar health issues in the region. - Same religion. - Similar values.	Shared culture: a unifying factors		

- Lack of regional and international order. - Insecurities in the world (conflicts). - Global order is in transformation. - Global order reflects region order.	Lack of international order	***The lack of order and a lot of bad blood:*** **Challenges**	
- Sanctions are impediments to collaboration and interaction in the region. - Intellectual property rights and other global political factors are impediments to MD in the region. - Countries outside the region have interest in how the region develops.	Influence of global politics		
- Gulf-situation not as easy as people from the outside perceive it. - A lot of bad blood in the region. - Complicated, long history of conflicts. - Iraq and GCC countries: OK relations. - Relations between especially K.S.A. and Iran very difficult.	Regional history and conflicts		
- There is a lot of: - Pride in the region. - Insecurity in the region. - A competitive environment among the Gulf.	Pride		
- No medical baseline. - No infrastructure to develop medical standards. - Common denominators in terms of pharma needed in the region.	Lack of common policies and practices in the region		
- MD: not a well-known concept. - Introduce MD to people. - Multi-level engagement needed.	Introduce the concept among different professions		

- Risks of miscommunication and misunderstandings. - Important to be transparent and communicate clearly. - MD must be done in a dynamic way where everyone needs to be involved. - MD must be based upon everyone's interest. - Everyone involved should feel that they own in.	Agree on a common definition & framework	***By the region for the region*: Approaches to succeed with MD in the Gulf**	
- "Outsiders" tend to apply their own ideas on the region. The region doesn't take well to that. - MD must be designed by the region for the region.	Ensure regional ownership		
-MD requires different knowledge → different people must be engaged: - Health care professionals must be engaged. - State officials must be engaged. - Political representative must be engaged.	Ensure engagement and integration of actors from multiple levels/professions		
- Maintain the momentum of the priority health has been given in the wake of Covid-19. - MD need a permanent basis. - MD should be built on a strong base of collaboration. - Institutionalise MD.	Institutionalize MD as a practice		

Appendix 7.

Popular science summary

Medical Diplomacy in the Persian Gulf: Could health collaboration improve intergovernmental relations and public health in the region?

Functioning relations between nations and cross-border cooperation are key to ensure access to medical equipment, combat health crises and strengthen health capacities. Therefore, measures to improve international relations are crucial from a health perspective. Medical Diplomacy is a concept and practice that combines the goals of improving intergovernmental relations *and* health by initiating intergovernmental health initiatives and cooperation. This study focuses on whether Medical Diplomacy could be useful as a method to improve relations and public health in the Persian Gulf.

The study shows that medical diplomacy could have the potential to play an important role in improving intergovernmental relations and public health within the Gulf region. There is a need for trust building between the countries, and medical diplomacy could play an important role by providing a platform for dialogue.

Medical diplomacy is extra relevant now, as health has been given increased priority due to the Covid-19 pandemic. Many areas for potential health collaboration among the Gulf countries could be found in this study, and it is possible that those could be of great public health importance.

Yet, all of this depends on political will. According to this study, medical diplomacy would encounter obstacles related to the complex and troubled history of the region, international politics and lack of regional medical standards and practices.

The study emphasises that before employing Medical Diplomacy, a deep contextual understanding is needed of the countries that one aims to engage. Further, while Medical Diplomacy is a soft-security tool, and health is less political and sensitive than other issues, one should not underestimate the extent to which politics could affect the use and success of the practice.