MEDICAL TOURISM AND NIGERIA-INDIA RELATIONS

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ABSTRACT

The paper examines the growing phenomenon of medical tourism in Nigeria-India relations. It discusses the evolving relationship between Nigeria and India and the growing presence of Indian investments in the Nigerian medical sector. The attraction of Nigerians to Indian hospitals is to seek quality and cost effective healthcare services. This has been necessitated by mismanagement resulting in the under-development of the health sector in Nigeria. India on the other hand has emerged as a major health provider because of its ability to offer 'first-class treatment at Third World prices'. While India gains from inflow of a large number of Nigerian medical tourists, Nigeria loses from the outflow medical tourists due to the resultant cash flight. The paper also discussed the challenges of medical tourism sector in India. These include complex visa procedures, lack of insurance covers, poor airport facilities to carter for patients who arrive with critical conditions and accommodation challenges. Nigeria and India relations can be further strengthened for mutual benefits by expanding the partnership in the medical sector. The recent inflow of Indian medical centres into Nigeria, such as the Apollo Clinics, Primus hospital, Vedic Lifecare Clinic, Mecure Healthcare Services Ltd, amongst others, provides the foundation for expanding partnership in this sector. That notwithstanding the number of Nigerians visiting Indian for medical tourism remains huge. Accordingly, the paper concludes by recommending an increased role on the part of the

Nigerian government in improving healthcare service delivery in the country. Considering the huge prospects in the health sector, the paper also recommends that Nigerian and Indian entrepreneurs should partner and invest massively in the provision of quality, affordable and accessible healthcare services in Nigeria.

Key Words: Medical, Tourism, Nigeria, India

INTRODUCTION

Medical tourism is a phrase that is commonly used to describe the phenomenon of foreign patients seeking healthcare in another country at better equipped hospitals and at medical fees comparatively cheaper than in their home countries. In other words, medical tourism refers to "visit by overseas patients for medical treatment and relaxation" (Shanmugam, 2013, p.1). The term medical tourism is an amalgamation of two distinct services - healthcare and tourism. The reality, however, is that it is difficult to associate the word tourism with chemotherapy, heart surgery, kidney transplant and other related treatment of cronic diseases. The World Tourism Organization (1999) defines tourists as people who "travel to and stay in places outside their usual environment for more than twenty-four (24) hours and not more than one consecutive year for leisure, business and other purposes not related to the exercise of an activity remunerated from within the place visited. From the above, it can be deduced that tourism involves particular activities selected by choice and undertaken outside the home. Accordingly, medical tourism has emerged as a form of travel activity undertaken for medical purposes and rest.

Compared to other forms of tourisms, namely leisure tourism, winter tourism, summer tourism and mass tourism; medical tourism, which is a form of adjectival tourism, is a recent phenomenon. Adjectival tourism refers to the numerous specialty travel forms of tourism that have emerged over the years, each with its own adjective. Many of these terms have come into common use by the tourism industry and academics. Apart from medical tourism, other examples of the more common emerging adjectival tourism markets include Agritourism, Culinary tourism, Cultural tourism, Ecotourism, Geotourism, Extreme tourism, Heritage tourism, Medical tourism, Nautical tourism, Pop-culture tourism, Religious tourism, Slum tourism, War tourism, Sex tourism, and Wildlife tourism (Gbadebo and Adedeji, 2013, p.13). Apart from these, other emerging forms of tourisms include sustainable tourism and space tourism, amongst others. It is beyond the scope of this paper to delve into these mentioned aspects of tourism in detail. That notwithstanding, it is pertinent to note that the medical tourism sector continues to grow at an increasingly fast rate and has emerged as a major force for the growth of services exports, not only in India, but worldwide. Apart from India, countries like the United Kingdom, Middle East, Japan, U.S., Canada, Belgium,

Costa Rica, Cuba, Dubai, Hungary, Israel, Jordan, Malaysia, Singapore, South Africa, Thailand and several others have emerged as active players in the medical tourism business.

India has emerged as major player in global medical tourism and has become the destination of choice for afflicted Nigerians who can afford to, or are compelled by fate of ill-health, to seek medical attention in that country. According to the Indian High Commission in Nigeria, 47 percent of Nigerians that visited India in the year 2012 did so to seek medical attention, while the remaining 53 percent did so for business, training, tourism and as students (Daily Independent Newspaper, June 6, 2014, p.3). The 47 percent of Nigerians that visited India for medical purposes amounted to 18,000 persons out of a total of 38,000 visas issued to Nigerians visiting India in 2012. The Nigerian medical tourists to India expended N41.6 billion (US$260 million) in foreign exchange in the process (Daily Independent Newspaper, June 6, 2014, p.3). The trend resulted from the inequality in access to healthcare and dearth of specialised medical facilities, which have remained a critical challenge to Nigeria's healthcare provision.

The article examines the growing phenomenon of medical tourism in Nigeria-India relations. It also discusses the evolving relationship between Nigeria and India and the growing presence of Indian investments in the Nigerian medical sector. It is evident that the attraction of Nigerians to Indian hospitals is hinge on the desire to seek quality and cost effective healthcare services. According to Modi (2011, p.125), India is emerging as a global healthcare provider because of its ability to offer world-class expertise at developing world costs. In addition to the public health care facilities maintained by the Indian government and long standing well equipped private healthcare centres, recently, there has been a proliferation of new private healthcare facilities in India. Government support and increased investment in medical infrastructure facilities are some of the factors that have contributed to the growth of the industry in India. Other underlying issues that define the growth medical tourism in India are air connections and access to visa facilities. The paper is divided into seven sections. Following the introduction, the second section examines the concept of medical tourism. The third section focuses on the history, character and dynamics of Nigeria-India relations. The fourth section looks at medical tourism and Nigeria-India cooperation. The challenges in medical tourism in India are discussed in the fifth section. Section six focuses on medical tourism and inflow of Indian investment in the medical sector. Section seven is the conclusion.

2. THE CONCEPT OF MEDICAL TOURISM

Many scholars working on the subject have attempted to define medical tourism. Generally speaking, the term medical tourism is the act of travelling to other countries to obtain medical, dental and surgical care. According to Goodrich and Goodrich (1987), medical tourism is the

attempt to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular tourist amenities. Laws (1996) defined medical tourism as a travel from home to other destination to improve one's health condition as one type of leisure. This includes getting indigenous and alternative medical services, and any other form of tourism undertaken with the purpose of addressing a health concern. Connell (2006) describes medical tourism as a popular mass culture where people travel to overseas countries to obtain healthcare services and facilities such as medical, dental and surgical care whilst having the opportunity to visit the tourist spots of that country. Carrera and Bridges (2006) have defined medical tourism as travel which is systematically planned to maintain one's physical and mental health condition. According to the General Agreement on Trade and Services (GATS), medical tourism is the second mode of trade in health services. In this mode, customers (patients) leave their home country to obtain health care services with high quality and affordable prices.

Blouin et al., (2006) and Monica (2007) argue that medical tourism occurs when international patients travel across boundaries for their healthcare and medical needs. It can be understood as provision of cost effective private medical care in collaboration with the tourism industry for patients needing surgical and other forms of specialized treatment. Bookman & Bookman (2007) have defined medical tourism as travel with the aim of improving one's health, and also an economic activity that entails trade in services and represents two sectors - medicine and tourism. Dawn & Pal (2011) introduced an interesting dimension to the discourse on medical tourism. According to these authors, medical tourism is looking for available quality combined with cost effective and low price health services while offering a similar level of safety to the patient.

In the past, the majority of medical tourists visited the industrialized countries of the world especially Europe, the UK, Middle East, Japan, U.S. and Canada, where the cost of medical treatment has become very expensive and there are often long waiting times for treatments. Over the years, the increased number of medical tourists including government officials, elites and citizens, who can afford the cost of travel, treatment and accommodation, travel to emerging economies to receive medical care. Medical tourists from the less developed countries, such as Nigeria, travelled to other countries to receive medical care, for other reasons other than just cost. In most cases, the quality of medical care is poor or lacking due to the collapse of medical sector in their countries. For most ordinary citizens, tourism is hardly the attraction, but their main aim is usually to seek medical attention in well equipped hospitals in foreign countries (Olukotun, 2013, p.1). Other than India, emerging countries that are currently promoting medical tourism are Thailand, Malaysia, Singapore, South Korea, Bolivia, Brazil, Belgium, Cuba, Costa Rica, Hungary, and Jordan. Also in context, private sector development in emerging economies, such as India, Thailand, Singapore, and certain Latin American nations, attracts foreign patients for relatively cheaper care: the uninsured, the underinsured, or those who prefer not to wait for treatment under a national health insurance system.

The dynamics of globalization has had its impact on the medical tourism industry. This construct of globalization in relation to medical tourism highlights the importance of the reduction of fees that time and space impose, and should warrant particular attention to the extensive role of the internet. Over one billion individuals have access to the internet, and this number is growing daily. The internet is a truly global forum for information dissemination, advertisement as well as a medical information transport device which has virtually no boundaries. Patients and doctors are able to converse and share information instantaneously; the internet provides a practically free avenue to deliver medical history, X-rays, and other complex tests via email, in addition to video conferencing and free online chatting. The patients' primary care doctor at home can converse with their surgeons abroad at little more cost than the doctors' time.

Within the realm of the health sector, medical tourism is at the forefront of the globalization debate for various reasons. Firstly, most medical tourism sites exist within developing countries with high populations of poor and typically fewer healthcare professionals than demand requires. Secondly, many developing countries send hundreds or thousands of their citizens to the developed world for medical education, and these newly produced medical professionals remain in the developed world to practice. The combination of these two events leaves the developing world wanting more; hence the attraction of medical patients from the less developed countries to relatively more developed countries such as India.

3. THE HISTORY, CHARACTER AND DYNAMICS OF NIGERIA-INDIA RELATIONS

Historical exigencies, particularly, British colonialism brought the two countries into contact, with India becoming independent much earlier than Nigeria in 1947, while Nigeria became independent in 1960. The presence of a sizable number of Indians in Nigeria and Nigerians in India, which stood at about 35,000 and 5000 respectively in 2010, (Sachdev, 2011, p.1), is an attestation of this historical link. The Indian community has strong presence in Nigeria in the areas of trade and manufacturing, especially large departmental stores, textiles manufacturing, pharmaceuticals, paints, chemicals, engineering, banking, manufacturing, brewing, consumer goods and electronics. There are over 100 Indian companies that have established profitable technical and business ventures in Nigeria. These include Chellarams PLC, Bhojsons, Ranbaxy pharmaceutical company, Tata Automobiles, Reliance Communications, Airtel Barti Telecommunications, Bajaj, NIIT, Aptech, Indorama, Godrej, Primus hospital, Dana group, Stallion group, amongst others, which employ thousands of Indians and Nigerians. Their penetration of the Nigerian market has been facilitated by Nigeria's free economy as opposed to India's semi-closed economy.

Nigeria and India are important countries and both occupy strategic positions especially in their respective regions. This is apparently because of the sizes of their population, military, economic

endowments, and roles and contributions in the international system. For instance India accounts for 75 percent of the population of South Asia, 65 percent of its total area and 78 percent of its Gross Domestic Product (GDP) (Singh, 2007, p.25). India with a population of above 1.2 billion people is the second most populous country in the world next only to China (Government of India-Census of India, 2011). Economically, India has a dynamic and highly competitive private sector which accounts for over 75 percent of its GDP. Its GDP was estimated at US$2.1 trillion in 2014-2015 and its average annual GDP growth rate stood at 6.1 per cent during 2011-2012 (IMF, 2014, p.2).

Nigeria stands out not only in West Africa, but also in Africa. Historically, Nigeria has played prominent roles at sub-regional, continental and global levels. With a population of 140,003,542 million people (National Populations Commission, 2006), Nigeria is not only the most populous nation in Africa and ranking 8th in the world, but also has the largest population of black people in the world. Nigeria's annual Gross Domestic Product (GDP) in the year ending December 2013 was estimated at N80.3 trillion (US$509.9 billion), the highest in Africa, and the 26th largest economy in the world (Yemi, 2014, p.8). Nigeria's exports were worth US$98.364 billion in the fourth quarter of 2013 (Economy Watch, 2013), which was far higher than most countries on the continent. The country produces 1.8-2.3 million barrels of crude oil per day, a major commodity which account for 95 percent of Nigerian export earnings come from oil (Munyama, 2009, p.5), and 65 percent of total government revenue (Aribisala, 2013, p.1). Nigerian oil reserves are estimated at 32-36 billion barrels, and in addition the country is among the most richly endowed in the world in terms of natural gas, with an estimated 100-188 million cubic feet of reserves (Statistical Review of World Energy, 2009). Nigeria is rich in solid minerals, and its land is suitable for agricultural production of a variety of food and cash crops. Nigeria has the largest, best equipped and trained armed forces in the West Africa.

Badejo (1990, p.88) notes that factors such as English language, governmental procedures, anti-colonial struggles as well as contemporary interests, necessarily brought the two countries into contact, interaction and cooperation. Both countries have diversities of religions, cultures, and languages. Both countries played active roles in the Commonwealth of Nations, as well as Group of 77 (G-77), Non-Aligned Movement (NAM), and Group of 15 (G-15). They are also members of the Asian-African Legal Consultative Organisation (AALCO), Afro-Asian Rural Development Organisation (AARDO). Both countries have demonstrated support for anti-colonial and anti-apartheid struggles and have been visible at multilateral platforms such as the United Nations (UN) and the World Trade Organization (WTO) and have actively supported the reform the world body and the demand of a new economic order. Both countries have demanded deeper participation of developing countries concerning critical issues on the global agenda such as climate change, the Doha rounds and the need to curb the spread of terrorism (The Guardian, October 15, 2007).

The relationship between the two countries has been strengthened at the political level through exchange of visits by political leaders. In the first 40 years of Nigeria's independence, there were two official visits from an Indian Prime Minister to Nigeria (Vasudevan, 2010, p.11). The first visit was by India's first Prime Minister Pandit Jawaharlal Nehru in September 1962, while the second was by Prime Minister Manmohan Singh in 2007 from October 14 -17, 2007 during which, the Abuja Declaration on strategic partnership between India and Nigeria and other Memoranda of Understanding were signed. Among the Nigerian leaders that have visited India are: President Shehu Shagari who was guest of honour at India's Republic Day Celebrations in January 1983; Brigadier Tunde Idiagbon and Commodore Augustus Aikhomu, on 2nd November, 1984 to attended the burial of former Prime Minister of India, Mrs Indira Gandhi; and President Olusegun Obasanjo who was a guest of honour at India's Republic Day Celebrations in January 2000. During Obasanjo's historic visit, he assured the Indians that Nigeria would soon be Africa's 'most lucrative market'; enabling India to access other West African markets as well (The Hindu Newspaper, 27 January 2000). Similarly, during the third India Africa Forum Summit held from October 23-29, 2015, President Muhammadu Buhari, who was among the 54 African leaders invited to the summit, assured heads of industries in Nigeria and prospective investors in New Delhi, that his administration will fight corruption and create a stable business environment for all businesses in Nigeria.

At the economic level, the two countries had been interacting even before Nigeria's independence in 1960. The Indian company known as Kishinchand-Chellarams (now Chellarams PLC) was established in Nigeria since 1923. Trade between the two countries was estimated to have reached US$16.3 billion in June, 2015. While exports from India stood at US$2.68 billion dollars, imports from Nigeria, which comprised mainly crude oil, stood at US$13.68 billion (Leadership News, June 6, 2015). Indian investment in Nigeria is estimated to be over ten billion dollars (Sachdev, 2014, p.181). It was also reported that India, with an investment of US$5 billion, was the largest investor in Nigeria in 2010 (The Punch, 12 August, 2011, p.20).

Indian entrepreneurs' presence in the Nigerian economy is well diversified and does not easily subject itself to stratification. However, Indian investment in Nigeria can be compartmentalised into three broad categories on the basis of the source of investments. These include: India-based (Tata and Airtel), by Nigeria-based Indians (Dana Group, Chanrais, and Chellerams) and by third country based Indians (Indorama). The current Indian entrepreneurial presence in Nigeria touches virtually all aspects of the Nigerian economy, even as its relative strengths are uneven. Although many of the Indian ventures are concentrated around Lagos, Indian enterprises are present in many Nigerian states as well. In terms of numbers, the pharmaceutical sector dominates with over 30 establishments, followed by healthcare, steel smelting (from scrap) and consumer products. In terms of size of investments, Airtel Nigeria currently has the highest investments with an estimate of about 4.5 billion US dollars. The major Indian investments in Nigeria comprise of Airtel,

Indorama, various groups of Channai family, Sterling Energy, Dana group, Stallion group, Mehtanis, Chellarams group, Bajaj, Tata, Godrej, NIIT, Ashok Leyland, Skipper, Simba and Primus amongst others.

Another meaningful and enduring relationship between Nigeria and India is in the area of military cooperation which dates back to 1961 (Kura, 2009). Over the years, the Nigerian armed forces have benefited from the various forms of military assistance by the Indian government. Particularly, the Indian government helped in the building of the military institutions, including the Nigerian Defense Academy (NDA) in Kaduna and the Command and Staff College (CSC) Jaji in Kaduna (Isa, 2008:59; Kura, 2009:14). The Indian government has also provided scholarships under the Special Commonwealth African Assistance Plan (SCAAP) (Pham, 2007a:53). The annual number of scholarships to Nigerian students for studies in India has also been increased from 50 to 75. In fact two former Nigerian Heads of State, General Olusegun Obasanjo and Ibrahim Babangida received military training in India. In 1997, 10 out of the 36 Military administrators received military training in India (Isa, 2008:59).

Notwithstanding some commonalities between them such as historical experiences of underdevelopment under British colonialism as well as diversities of religions, cultures, and languages, India's determination to break away from underdevelopment and dependency has led her to emerge as a developed and a destination country for medical tourism. It is within this context that we can understand India's quest for increased engagement of countries with resource endowment and large markets such as Nigeria.

After it introduced an economic liberalization programme in 1991, India's foreign policy shifted from Gandhian and Nehruvian principles and rhetoric of south-south, nonalignment etc to focus on pragmatic economic diplomacy. This shaped its relations with African countries as well. India began to view Africa through a strategic lens and realized that economic engagement with African countries could serve its national interests. Africa's rich energy resources were attractive for a rapidly industrialising India. India has since then used economic diplomacy as a method of engaging African countries, including Nigeria. In 1993, the Indian government stated that, 'in the future, new relationships based on concrete economic, technological, educational cooperation will assume significance' (MEA, Annual Report, 1992-1993, 55). Indian officials also emphasised that the orientation of India's foreign policy is designed to promote 'enlightened national interest' (Beri, 2011, 1). At the same time, Indian policy makers pointed out clearly that energy security is an important element of India's foreign policy, particularly in the context of the developing world. According to the Indian Prime Minister, Manmohan Singh, 'our concern for energy security has become an important element of our diplomacy and is shaping our relations with range of countries across the global, Africa, West Asia, and Latin America' (Beri, 2011, 1).

India has, in recent times, made several efforts to engage Nigeria and other African countries, with an interest motivated by geo-economics, especially in terms of resources. While some have interpreted the phenomenon of India's increased engagement of Nigeria in the light of a new scramble for Africa's resources and markets, others see it as a continuity of a relationship in the light of old ties such as in the days of the Nonaligned Movement, anti-colonial struggle and in the spirit of South-South cooperation. The first was held in New Delhi in April 2008, and the second was held in Addis Ababa in 2011 and the third was held in 2015. The first two summits witnessed a serious strategic push from the Indian government to strengthen its ties with African nations. The cooperation framework adopted at the 2008 Summit outlines the priority areas of future cooperation which ranged from capacity building, agriculture, infrastructure development, health food security, energy security and technology cooperation.

The 2011 Summit sought to enhance partnership between Africa and India for the mutual benefits. Both partners agreed to assist each other to achieve inclusive growth, socio-economic development and self-reliance. Areas for such cooperation outlined included sharing strategies for sustainable development, poverty alleviation, healthcare and universal education, and sharing appropriate technologies. Although several issues were highlighted during these summits, however, the desire to ensure energy security is seen as the dominant interest in India's policy towards Africa today. From October 26 to 29, 2015, India hosted the third India-Africa Forum Summit (IAFS III), which had in attendance representatives of 54 countries, with 40 Heads of State or government. Originally scheduled for December 2014 but postponed because of the Ebola crisis, IAFS III was a spectacular event. African Heads of state as well as representatives from the African Union (AU) and continental bodies like the New Partnership for Africa's Development (NEPAD) agency were in attendance at the meeting in New Delhi.

In lined with the theme of the IAFS III, which is 'Invigorated Partnership: Shared Vision' the Indian government offered additional concessional credit of 10 billion US dollars under concessional lines of credit (LOC) over the next five years. That was double the US$5 billion announced at the 2011 summit. This is an addition to the ongoing credit programme. It also offered a grant assistance of 600 million US dollars, which includes an India-Africa Development Fund of 100 million US dollars and an India-Africa Health Fund of 10 million US dollars. It also included 50, 000 scholarships in India over the next five years. In addition, India pledged to support the expansion of the Pan African E-Network and institutions of skilling, training and learning across Africa. The problems with the LOCs are well documented including a widening gap between sanctions and disbursements. In a pre-summit media briefing in New Delhi on October 17, Secretary (West) in the Ministry of External Affairs, Navtej singh Sarna, gave an update on LOCs. On the US7.4 billion offered before 2015 summit, US6.8 was approved and only US3.5 billion had been disbursed. In effect most African countries were unable to access the LOCs promised. Both India and recipient African countries are responsible for the low disbursement of the LOCs. In India, a multi-tiered and

multi-agency framework for sanctioning and disbursing these loans creates delays. Additionally, a non-transparent process engenders attendant distortions. Exim Bank, which finally disburses the loans, has complained to the Prime Minister of India's office about malpractices (Singhal, 2015: 3). On the African side, capacity gaps in drawing up detailed project reports essentially for the Indian side to conduct a proper appraisal and assessment caused enormous delays. Nigeria is one of the countries that have not been able to access the US$100 LOCs promised during the visit of Indian Prime Minister, Manmohan Singh to Nigeria in 2007. The complaint from the Indian side has been lack of transparency and accountability. On the Nigerian side, there have been complains of lack of cooperation from the Indian government. That notwithstanding, during the IAFS III in 2015, the Indian government promised to review the implementation of, and progress, areas of cooperation and identified projects.

There are many dynamic considerations why the Indian government is increasing its engagement of key African countries such as Nigeria. At the forefront of India's foreign policy priorities as from the 1990s is energy security (Obi, 2010, p.187). The Indian economy has grown rapidly from the 1990s, and securing cheap energy and other strategic raw materials as well as markets on a long-term basis has become an economic and political imperative. It is projected that by 2030, India will be the world's third-largest consumer of energy. Currently, 75 percent of India's oil imports come from the politically volatile Middle East. Notably, because India possesses few proven oil reserves, diversifying the sources of its energy supply by developing stronger economic ties with the African continent tops the political agenda. With projections suggesting that India will depend on oil for almost 90 percent of its energy needs by the end of this decade, it is little wonder that energy security through the diversification of supplies is a key priority. Given Africa's position as the last oil frontier, and Nigeria as Africa's largest producer of oil, it is only strategic that India engages the continent, and Nigeria, in particular, in the pursuit of her energy security interests. This urgency is further elevated by the increasing scramble for African resources and markets by India, China and the industrialised countries of Europe and America. Nigeria has also become a major attraction to Indian oil companies in recent years because its oil is of high quality, being low in sulphur.

Secondly, Nigeria, given its huge population and the strategic size of its economy now the largest in Africa, has emerged as an important market for Indian goods and services, as well as tourism industry of which medical tourism is currently a major attraction for Nigerians. In this regard, the Indian private sector, with sufficient government support, has been active in expanding trade and investment in Nigeria to capture its market potential. Indian hospitals either directly or through agents have reached out to Nigerians promising 'first-class treatment at Third World prices'. Similarly, as a developing country, Nigeria is also interested in drawing lessons from the Indian experience, having moved up from an industrially underdeveloped state. It is also interested in drawing lessons from India's experience in the areas of information and communications

technology, agriculture, pharmaceutical and medical sector, as well as small and medium scale enterprises, with its huge potential for employment generation in Nigeria (Ashiru, 2012, p.3).

While acknowledging the fact that India has its own share of development problems including, high rates of poverty, unemployment and corruption, there is no denying the fact that India has moved up the development ladder. India has made achievements in the areas of industrialisation, scientific and technological capabilities, advances in information and communications technology (ICT), as well as medical sector from which Nigeria could benefit immensely. Strengthening relations between the two countries becomes even more imperative since both nations are looking for avenues to promote their interests in an increasingly changing and interdependent global environment.

4. MEDICAL TOURISM AND NIGERIA-INDIA COOPERATION

The reasons for the increase of Nigerians going for medical tourism in India are many. First, years of systemic decay by a lack of political commitment, corruption and mismanagement of the national economy has also affected the health sector. The political leaders inclusive lack confidence in healthcare facilities established by them and prefer to go abroad for treatment. Aside the lack of confidence in the health sector, the then President of NMA, Dr Osahon Enabulele, argued that the major reason for the medical pilgrimage, includes persistent negligence and under-development of the health sector, especially under the military era; poor funding and out-of-pocket financing of the sector; declining quality of medical personnel occasioned by dwindling standards of education. Secondly, with the Nigerians preference for anything foreign, it is not surprising that over 5,000 citizens fly out on a monthly basis, seeking medical treatment in India and other countries. According to the Nigeria Medical Association (NMA), while Nigeria loses over US$500 million annually, India gains about US$260 million of the resultant cash flight. Buoyed by the boom of its medical tourism due ostensibly to Nigerians' patronage, India's projection for the year 2014 was to realize a huge sum of between US$1bn and US$2bn from a medical tourism market worth over US$20bn (Shanmugam, 2013).

At all levels of government, local, state and federal, there are many contributing factors. These factors make subjecting result to treatment in any Nigerian hospital an avoidable risk. The late activist, Gani Fawehinmi was diagnosed in Nigeria of Malaria was treated of same several times, only to discover that it was cancer, when he travelled for treatment abroad (The Punch, June 26th, 2014). Unfortunately the right diagnosis was made too late to save him. The same fates that befall several Nigerians go unreported in the country. The irony is that most of those Nigerians who can afford to spend between US$20,000 and US$50,000 on an average trip abroad for medical

treatment may end up being treated by fellow Nigerians, who back home, would not have been as efficient and prominent as they have become in a foreign land.

The main reasons for the growing popularity of medical tourism in India include the long waiting lists in the developed countries; low cost of medical treatments in India as compared to other developed countries. Table 1 provides Cost Comparison between India, USA, Thailand, and Singapore US dollars.

Table 1: Cost Comparison between India, USA, Thailand, and Singapore (approximate figures in US$)

Procedure	US	India	Thailand	Singapore
Heart bypass	1,30,000	10,000	11,000	18,500
Heart valve replacement	1,60,000	9,000	10,000	12,500
Angioplasty	57,000	11,000	13,000	13,000
Hip replacement	43,000	9,000	12,000	12,000
Hysterectomy	20,000	3,000	4,000	6,000
Knee replacement	40,000	8,500	10,000	13,000
Spinal fusion	62,000	5,500	7,000	9,000

International Figures Based on Hospital Quotes in Named Countries

Source: http://www.docstoc.com/docs/12163631/MEDICAL-TOURISM/P/36

From the table above, there is no doubt that India provides relatively cheaper fees compared to the USA, Thailand, and Singapore. Apart from cheaper cost, the attraction to India has been facilitated by increased use of the internet to communicate with prospective hospitals and increase in air travels. With the development of information and communications technologies (ICT), new

tourism companies have emerged that act as middlemen between international patients and hospital networks, giving patients easy access to information, prices and options. Other reasons for the increased popularity of medical tourism in India are the state-of-art technology, specialist doctors, nurses and para-medical staffs that have been adopted by the big hospitals and diagnostics centres in India. In India, the medical education system also caters to the ever increasing demand for the delivery of the quality health care services all over the country (Suthin et al., 2007).

Table 2: Trends in the Performance Indicators in the Indian Tourism Industry

Year	Foreign Tourist Arrivals (in Million)	Foreign Exchange Earnings from Tourism					Visits to States and Union Territories		Out Bound Tourism (Million)
		India (Rs. crore)	World (US$ Billion)	India (US$ Billion)	India's Share (%)	India's Rank	Domestic (in Million)	Foreign (in Million)	
1991	1.68	4318	276.9	1.9	0.67	-	66.67	3.15	1.94
1992	1.87	5951	315.4	2.1	0.67	-	81.46	3.10	2.16
1993	1.76	6611	321.9	2.1	0.66	-	105.81	3.54	2.73
1994	1.89	7129	354.9	2.3	0.64	-	127.12	4.03	2.73
1995	2.12	8430	405.3	2.6	0.64	-	136.64	4.64	3.06
1996	2.29	10046	438.7	2.8	0.65	-	140.12	5.03	3.46
1997	2.37	10511	442.8	2.9	0.65	-	159.88	5.50	3.73
1998	2.36	12150	444.8	2.9	0.66	34th	168.20	5.54	3.81
1999	2.48	12951	458.2	3.0	0.66	35th	190.67	5.83	4.11
2000	2.65	15626	475.3	3.5	0.73	36th	220.11	5.89	4.42
2001	2.54	15083	463.8	3.2	0.69	36th	236.47	5.44	4.56
2002	2.38	15064	481.9	3.1	0.64	37th	269.60	5.16	4.94
2003	2.73	20729	529.3	4.5	0.84	37th	309.04	6.71	5.35
2004	3.46	27944	633.2	6.2	0.97	26th	366.27	8.36	6.21
2005	3.92	33123	679.6	7.5	1.10	22nd	392.01	9.95	7.18
2006	4.45	39025	744.0	8.6	1.16	22nd	462.32	11.74	8.34
2007	5.08	44360	857.0	10.7	1.25	22nd	526.56	13.26	9.78
2008	5.28	51294	939.0	11.8	1.26	22nd	563.03	14.38	10.87
2009	5.17	54960	851.0	11.4	1.34	22nd	668.80	14.37	11.07
2010	5.78	64889	919.0	14.2	1.54	17th	747.70	17.91	12.99
2011	6.29	77591	n.a	16.6	n.a	n.a	850.86	19.95	n.a.
Average Annual Growth Rates (%)									
1992-2002	4.35	14.64	5.68	8.24	-	-	13.87	6.98	8.99
2003-2011	11.63	20.32	8.71*	21.23	-	-	13.70	16.56	12.97*

Source: Government of India (2011); * till 2010.

With the growth of medical tourism in India, the tourism industry in the country as a whole which has witnessed significant growth since the 1990s has also emerged as a major income earner for India. Table 2 captures the growth of the tourism industry in India from 1991 to 2011.

Foreign tourist arrivals to India increased from 1.68 million people in 1991 to 6.29 million people in 2011. India's earning from tourism also increased from US$ 1.9 million to US$ 16.6 million within the same period, with India also ranking as the 17th highest earner in world in tourism in 2010. According to the Confederation of Indian Industry (CII), the industry's earning potential of medical tourism sector was estimated at Rs.5000-10000 Cores by 2012 (CII-Mckinsey, 2002, p.2). The major service providers in Indian medical tourism include: the Apollo Hospitals, Escorts Hospital, Fortis Hospitals, Breach Candy, Hinduja, Mumbai's Asian Heart Institute, Arvind Eye Hospitals, Manipal Hospitals, Mallya Hospital, Shankara Nethralaya and AIIMs, a public sector hospital. In terms of locations, New Delhi, Chennai, Bangalore and Mumbai cater to the maximum number of health tourists and are fast emerging as medical tourism hubs. It also visualizes high-end healthcare services through Indian BPO firms like Hinduja TMT, Apollo Heart Street, Comat Technologies, Datamatics and Lapiz that work in the areas of claim adjudication, billing and coding, transcriptions and form processing. One-stop centres in key international markets to facilitate patient flow and stream lining immigration for healthcare are envisaged. The CII, along with Indian Health Care Federation (IHCF), wants to establish an Indian healthcare brand synonymous with safety, trust and excellence. Therefore, it is clear that the opportunities and challenges for growth in the health sector are seen primarily within the private/corporate sector, not in the public sector. Nowadays medical tourism in India includes advanced and life savings health care services like open transplants, cardiovascular surgery, eye treatment, knee/hip different cosmetic surgeries and alternate systems of medicine. Also leisure aspect medical travelling/wellness tourism may be included on such medical travel trips. India provides a variety of medical services to overseas patients. The reality, however, is that 'medical tourisms' are hardly tourisms in the true sense. For instance there is nothing tourism about chemotherapy, heart surgery, kidney transplant and other related treatment of cronic diseases. Medical tourism in India is not without challenges.

5. THE CHALLENGES IN MEDICAL TOURISM IN INDIA

There are several challenges involved in medical tourism in India. Like many developing countries, though better off than many, some parts of India suffers from lack of adequate infrastructural facilities including poor power supply, poor water supply, lack of connectivity, and lack of coordinating system (Dawn and Pal, 2011, p.193). Major challenges that impact on medical tourism sector in India include poor accessibility, lack of, or insufficient capital, lack of community participation and awareness, lack of concern for sustainability, complex visa procedures, lack of good language translators, accommodation challenges and poor airport facilities to carter for patients who arrive with critical conditions. Most Indian hospitals are also face problems such lack of trust from the foreign patients. Some Nigerians, whose patients or family members have either suffered complications after being treated or died in Indian hospitals, have complained of the medical treatment in India and observed that the medical treatment in India falls below their expectations (The Punch Newspaper, April 21, 2014). The Indians on the other hand have blamed

Nigerians of bringing patients to Indian only when they are in critical conditions and often too late to save them. The Indians have also pointed out that some Nigerians visiting the country for medical treatment lack medical insurance to cover medical bills and some lack adequate resources to cater for their stay including payment of accommodation or hotels (The Punch Newspaper, April 21, 2014). Some Indian hospitals have been criticised for observing poor hygiene, especially among the medical attendants; unhygienic food handling; and lack of proper hospitality services; heterogeneous pricing of services and no industry standards (Dawn and Pal, 2011, p.193).

A strong case has also been made on the need for the Indian government to be more involved in medical tourism in India, rather than leaving it in the hands of the private sector that are currently more involved in the medical tourism business. Problems facing medical tourism industry in India, which are perceived as caused by the government include- poor regulations, taxation anomalies, bureaucratic bottlenecs, lack of land reforms, lack of long-term investor friendly policies and instability with respect to terrorism and communal tensions (Dawn and Pal, 2011, p.193). On the part of insurance and allied services, the medical tourism industry in India is also facing some serious bottlenecks. These include inadequate insurance cover, underdeveloped insurance market in India, insurance frauds and overseas companies refusing reimbursement to customers (patients). Apart from these, there are some specific issues that have to do with quality of personnel. They includes quality accreditations to the Indian hospitals and service providers, training and development to the Doctors, Nurses and Para medical staffs, lack of customer oriented approach.

There is no doubt that medical tourism to India involves high costs and many other challenges encountered on the part of afflicted Nigerians travelling to access medical care in India. These issues are further exacerbated by the lack of direct air travels between Nigeria and India. Travellers to India have to connect flights in Addis Ababa, South Africa, Dubai, Nairobi, Cairo, Doha, Frankfurt or London. Movements of patients during emergencies have proved to be very uncomfortable and also difficult on account of lack of direct flights between the two countries. Processing visa for medical purposes to India involves complex procedures of uploading personal data through an online system, printing and submission, and in most cases, appearing in person for interview, documents and medical report citing and biometric capturing. These procedures, no doubt are cumbersome for patients seeking medical attention in India. As part of the new National Tourism Policy (Government of India, 2002), the Eleventh Five Year Plan (Planning Commission, 2008), the Indian government took various steps to promote tourism in India. One of the major steps was the introduction of Visa-on Arrival scheme was introduced for tourists from Singapore, Finland, New Zealand, Luxembourg, and Japan on a pilot basis from January 2010 and was extended to many other nations in 2011 (Shanmugam, 2013, p.10). So far, the Visa-on Arrival scheme has not been extended to medical tourists from Nigeria. Given the large number of Nigerians visiting India for medical tourism, the government of India should consider extending the Visa-on Arrival scheme to

Nigerians visiting India for medical purpose. This should be done, in addition to reducing the difficulties faced by patients and accompanying relatives in processing visa from Nigeria for medical purposes in India. The Indian government, in turn, stands to benefit as indicated in the Draft Approach to the 12th Five Year (Planning Commission, 2011) reports which highlighted the importance of the tourism sector in terms of its contribution to GDP and employment generation. Against this backdrop, medical tourism has provided a new platform for partnership between Nigeria and India in the provision of state of the art medical care by Indian professionals locally through the establishment of Indian managed hospitals in Nigeria.

6. MEDICAL TOURISM AND INFLOW OF INDIAN INVESTMENTS IN THE NIGERIAN MEDICAL SECTOR

Recently, Nigeria witnessed the entry of Indian hospitals, a development, which the Nigerian government under President Goodluck Ebele Jonathan had argued will curb medical tourism and reduce capital flight to India. The Chennai-based Apollo Group of Hospitals, with an extensive network of hospitals in India and abroad, was the first private hospital group to offer its consultancy services to hospitals in West Africa, in Ghana and Nigeria in 2003/2004. In 2004, Apollo partnered with Hygeia Nigeria, which owns the largest Health Maintenance Organization (HMO), with over two hundred hospitals and clinics in the country (Modi, 2010, p.128). Since 2000, Apollo has been the largest provider of telemedicine in India. In Nigeria, Apollo, which is located at Wuse II in Abuja, has assisted in capacity-building through upgrading the skills of medical personnel and has introduced state-of-the-art techniques that are used by the Apollo chain of hospitals in India (www.apollohospitals.com). It has also worked to improve the clinical and administrative process and also train doctors in super specialty disciplines and provide telemedicine support. Another leading Indian hospital in Nigeria is Primus hospital located at Karu in Abuja. The hospital, which began with capacity of 120 beds, before expanding to 250 beds in 2012, conducts major surgeries in Nigeria. The hospital also has state of the art advanced technology.

Evidently buoyed by the huge returns on investments, the Indian High Commissioner to Nigeria noted that Indian investors have expressed readiness to establish Indian hospitals across the six geopolitical zones of the country. This was followed by the entry of Vedic Lifecare Clinic in 2013 (http://www.vediclifecare.com/home.html). The hospital which was established at a cost of N20 billion, is supported by clinical, technological and management support from Manipal Hospitals based in India. Manipal Hospitals is one of the most patronized hospitals by Nigerians on medical tourism to India and is part of the Manipal Educational and Medical Group (MEMG), which pioneers in the field of education and healthcare delivery in India. The setting up of the Indian hospital in Nigeria is therefore to be accessible to more Nigerians that would have hitherto

travelled to India for treatment. The hospital, located at Lekki, Lagos, offers multi-specialty tertiary healthcare and seeks to expand the concept to Abuja, Port Harcourt and Warri.

There is no doubt that particularly, the public health infrastructure in Nigeria, is in shambles owing mainly to poor funding, shortage of medical facilities and personnel and poor medical service delivery. These inadequacies have created immense opportunities for the Indian medical sector's marketing line of 'first-class treatment at Third World prices'. Having the medical facilities closer to home is undoubtedly advantageous, particularly, in terms of immediate access to medical facilities and regular follow-ups. To overcome the shortage of healthcare facilities, the Nigerian government explored the possibility of Indian investments in hospitals and export of medical skills in the form of public-private-partnerships (PPP) in the country. There is no doubt that this arrangement, whether in form of medical tourism or the incursion of Indian hospitals, gives India an edge and offers huge gains from the Nigerian economy. So far, the entry of a few Indian investments in the medical sector has not curbed the outflow of medical tourists to India. The complex interdependent nature of Nigeria's relations with India in the medical sector is such that both countries cannot just walk away from the relations. While India depends on the Nigerian market for medical tourists or customers (patients) for the Indian hospitals, Nigeria on the other hand depends on Indian expertise in the health sector and has to pay the huge cost of health services offered by the Indian hospitals.

7. CONCLUSION

Promoted by the Indian government, the medical sector and tourism industries, India is increasingly seen as the favoured destination of 'medical tourists' from developing countries such as Nigeria, who seek better treatment at relatively cheaper cost than is obtained in the developed countries. Thus, both the public and private hospitals in India are experiencing an influx of patients from Nigeria, who can afford to pay the bills or are compelled by fate of ill health to travel to India for treatment. The key selling points of the Indian medical tourism industry to Nigerians and other patients from developing countries are the combination of high quality facilities, competent, English-speaking medical professionals, cost effectiveness and the attractions of tourism. As noted earlier, the term medical tourism has been subjected to various interpretations. For some, there is nothing to suggest leisure or tourism about chemotherapy, heart surgery, kidney transplant and other related treatment of cronic diseases. Rather, it is the long wait and poor attention often given, lack of professionals/specialists in these areas, and also, lack of specialised medical facilities in Nigerian hospitals that have compelled some people to travel to India to seek medical care. There is a need to improve the quality of healthcare delivery in the country; restore the confidence of citizens in the health sector, and, more importantly, create the enabling environment for the Nigerian medical practitioners in the diaspora to return home and also boost Nigeria's medical

tourism. An improved health sector will, no doubt, reduce the huge cash flight which the current exodus to India for medical treatment represents and go a long way to boost the ailing economy. The conclusion of this article is that medical tourism provides a basis for partnership between Nigeria and India. In this regard, the paper recommends that the Indian example could be replicated in Nigeria by encouraging Nigerian and Indian entrepreneurs to partner and invest massively in the provision of quality, affordable and accessible healthcare services in Nigeria.

References/ Bibliography

Aribisala, F. (2013), The future of nigeria's oil economy. Retrieved from

https://www.stratfor.com/the-hub/future-nigerias-oil-economy

Ashiru, O. (2012), *Dynamics of indo-africa relations: the critical role of nigeria.* Keynote address Presented at the 2nd India-Africa Academic Conference, Organised by the Nigerian Institute of International Affairs (NIIA), in collaboration with the Indian Council on World Affairs (ICWA), at NIIA, Lagos, 14-15, March, 2012.

Badejo, B. A. (1990), Nigeria's economic relationship with brazil and india: An assessment of south-south co-operation. *Nigerian Journal of International Affairs*, *16 (1)* 73–89.

Beri, R. ed. (2014), India and africa enhancing mutual engagement. New Delhi: Institute for Defence Studies & Analyses and Pentagon Press.

Beri, R. (2011), *Evolving india-africa relations: Continuity and change* (Ocassional Paper No 76). South African Institute of International Affairs, Emerging Powers and Global Challenges Prorgramme.

Blouin C. Drager, N. & Smith, R. (2006), "*International trade in health services and GATS: current issues and debates"*, Washington DC: World Bank.

Bookman, M. & Bookman, K. (2007), *Medical tourism in developing countries*, New York: Palgrave Macmillan

Carrera, P.M. & Bridges J.F.P (2006). "Globalisation and healthcare: Understanding health and medical tourism", *Expert review of Pharmacoeconomics and Outcomes Research*, 6(4), pp.447-454.

CII-McKinsey (2002), "*Health care in india: The road ahead*", New Delhi: CII, McKinsey and Company and Indian Healthcare Federation.

Connell, J. (2006), "Medical tourism: Sea, sun, sand and surgery", *Tourism Management* , 27 (6), pp. 1093-1100.

Dawn, S. K. & Pal, S. (2011), Medical tourism in india: Issues, opportunities and designing strategies for growth and development. *International Journal of Multidisciplinary Research, 1(3)*, 185-202. p.185

Economy Watch (2013), Nigeria trade, exports and imports. Retrieved from http://www.economywatch.com/world_economy/nigeria/export-import.html

Gas: Proven Reserves, *Statistical Review of World Energy 2009*,

Gbadebo, A.M and Adedeji, O.H. (2013), Tourism and recreation (EMT 508), lecture notes on Environmental Management and Toxicology. Retrieved from www.unnaab.edu.ng/attachements/464_508_Notes.pdf

Goodrich, G.& Goodrich J. (1987). "Healthcare tourism-An exploration study", *Tourism Management*, September, pp.217-222

Government of India (2011a), India tourism statistics 2010 at a glance: Incredible india. Ministry of Tourism, July 2011.

Government of India (2011b), India tourism statistics 2010: Incredible india. Ministry of Tourism, November 2011.

Government of India (2002), National Tourism Policy 2002, Ministry of Tourism, New Delhi.

Government of India- Census of India, 2011

IMF (2014), *World outlook database- report for selected countries and subjects.* Retrieved from www.imf.org/external/pubs/ft/weo/2014/02.

Indian Ministry of External Affairs, Annual Report, 1993, p.55)

Isa, A.A.M. (2008), Nigeria-india military relations: issues and challenges. *Nigerian Journal of International Affairs,* 34(1), 53-64.

Kale, Y. (2014), *Measuring better: Rebasing / re-benchmarking of nigeria's gross domestic product,* Abuja: National Bureau of Statistics, p.

Kura, S. B. (2009), Nigeria-india economic, political and socio-economic relations: Critical reflections for continuous mutual cooperation. *International Journal of Asia-Pacific Studies (IJAPS), 5(1),* 1-31.

Laws, E. (1996), "Health tourism: A business opportunity approach. In S. Clift and S.J. page (Eds.) Health and the International Tourist (pp. 199-214), London and New York: Routledge.

Leadership News, June 6, 2015

Medical tourism: what nigeria must learn from india (July 6, 2014), *Daily Independent.*

Modi, R. (2010), The role of India's private sector in the health and agricultural sectors of Africa. In F. Cheru & C. Obi (Eds), *The rise of china and india in africa* (pp.120-130) London and Uppsala, Zed Books & The Nordic Africa Institute.

Modi, R. (2011), Offshore healthcare management: medical tourism between Kenya, Tanzania and India. In Emma Mawdsley & Gerard McCann, *India in africa: Changing geographies of power* (pp.125-139) Oxford, Pambazuka Press.

Munyama V, (2009), *Nigeria: Annual economic outlook.* Johannesburg: Standard Bank. p.5

National populations commission (2006) Population Distribution by Age and Sex: 2006 Census Priority Tables (Vol 4) Retrieved from http://www.population.gov.ng/index.php/publications/141-population-distribution-by-age-and-sex-2006-census-priority-tables-vol-4

News Agency of Nigeria, NAN (2015), Nigeria, India trade volume hits $16.36 bn, Leadership News, June 6, 2015

News Agency of Nigeria, NAN (2015), Nigeria, India trade volume hits $16.36 bn, Leadership News, June 6, 2015

Obi, C. (2010), African oil in the security calculations of china and india. In F. Cheru & C. Obi (Eds), *The rise of china and india in africa* (pp.181–192) London and Uppsala, Zed Books & The Nordic Africa Institute.

Olukotun, A. (2013), Our growing medical tourism to India. Retrieved from http://www.nigeriaintel.com/wp-content/uploads/2013/07/Medical tourism in Nigeria india relations/Our growing medical tourism to India _ Nigeria Intel.htm

Pham, P. J (2007a), India's expanding relations with africa and their implications for us interests. *American Foreign Policy Interests*, 29 (5), 341–352.

Pham, P. J (2007b), The indian tiger africa safari', *World Defense Review,* July, 45-67.

Planning Commission (2011), Faster, sustainable and more inclusive growth: an approach to the 12th five year plan (Draft), Government of India, August 2011.

Sachdev, M. (2011, July), *Highlights of nigeria-india ties, a diplomatic briefing.* Presented by the Indian High Commissioner at the Nigerian Institute of International Affairs, Lagos.

Sachdev, M. (2012, March), *Remarks by High Commissioner to Nigeria.* Presented at the 2nd India-Africa Academic Conference, Organised by the Nigerian Institute of International Affairs (NIIIA), in collaboration with the Indian Council on World Affairs (ICWA), at NIIA, Lagos.

Sachdev, M. (2014), *Nigeria: A business manual*. New Delhi: M/s Eco-Diplomacy & Strategy.

Shanmugam, K.R. (2013), Medical tourism in india: Progress, opportunities and challenges, Monograph 26, Madras School of Economics, Chennai, India, p.1. Retrieved from www.mse.ac.in.

Singh, S. K. (2007), *India and west africa: A burgeoning relationship* (Briefing Paper, AFP/ASP BP 07/01, April 2007). Chatham House. p.25

Singhal, R. (2015), *India Resets Africa Strategy.* Retrieved from www.gatewayhouse.in/india-resets-africa-strategy

Suthin, K., Assenov, I., & Tirasatayapitak, A. (2007), Medical Tourism: Can supply keep up with the demand. Proceedings, *APac-CHRIE & Asia Pacific Tourism Association Joint Conference 2007*, May 23-27 May, 2007, Beijing, China

The Guardian (Nigeria), Monday, October 15, 2007. P9

The Hindu Newspaper, 27 January 2000

The Punch (2014), Editorial: Medical tourism: Healing Nigeria's health sector, April 21, 2014

The Punch, 12 August, 2011, p.20

Vasudevan, P. (2010), *The changing nature of nigeria-india relations* (Programme Paper, AFP2010/02), London: Royal Institute of International Affairs, December. p.11

Vedic Lifecare (2014), Vedic Lifecare Clinic offers the wide range of advanced healthcare services. Retrieved From http://www.vediclifecare.com/home.html

WTO (1999), Global Code of Ethics for Tourism in 1999. Retrieved from http://www.world-tourism.org/frameset/frame_project_ethics.html