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# Awareness and Knowledge of Medical Tourism Among Medical Practitioners in Tertiary Hospitals in the Federal Capital Territory (FCT), Nigeria

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***Abstract***

*The problem of low-level knowledge about medical tourism often makes medical practitioners and stakeholders ignorant of the eventual consequences of outbound medical tourism and the possible advantages of inbound medical tourism. This study assesses the awareness and knowledge of medical tourism among medical practitioners in tertiary hospitals in the Federal Capital Territory (FCT), Nigeria. This was a descriptive cross-sectional study carried out among 160 medical doctors who have made referrals for medical tourism in other countries. A multi-stage sampling technique was used and data was collected using an Interviewer-administered structured questionnaire. The Mean years of experience among the doctors was = 17.6±9.5 years; 48 (30.00%) had a work experience of 11 – 20 years, 42 (26.25%) 21 – 30 years, while 20 (12.50%) had worked for more than 30 years. About 148 (92.50%) of the doctors were aware of medical tourism. Of the proportion that were aware (n = 160), 34(21.25%) reported their colleagues as their source of information, and 65 (40.63%) indicated their workplace as their source. Outbound and inbound medical tourism were the most popular categories of medical tourism among the doctors, 56 (35.00%) and 51 (31.88%), respectively. In summary, 83 (51.9%) of the doctors had fair knowledge of medical tourism, while 43 (26.9%) had poor knowledge, and 34 (21.3%) had good knowledge. High awareness of medical tourism among Nigerian doctors is crucial for safeguarding public health, improving local healthcare services, and reducing medical tourism-related risks. It also positions Nigeria to potentially benefit from inbound medical tourism in the future.*

***Keywords:*** *Awareness, Inbound Medical Tourism, Knowledge, Outbound Medical Tourism.*

## Introduction

Knowledge and awareness about medical tourism are gradually increasing as the world experiences a much closer nature for trade in health services. Different studies [1-3] have shown different levels of knowledge on the subject matter. One description for medical tourism is planned travel away from one's home for medical treatment. Other names for it include offshore healthcare, cross-border care, medical travel, and health tourism. The practice of patients travelling outside of their nation to receive medical care, diagnostic testing, consulting, and other healthcare services and procedures is known as global healthcare. [4-7] The term was coined by travel agencies and mass media to publicize this new form of travel and medical services, but now it is no longer a jargon; it has become a common phrase that is widely acceptable to describe the rapidly-growing practice of travelling beyond international borders to access healthcare.[8-12] Although the whole range of health services is covered by medical tourism, the majority of trips are only allowed for a select few medical operations, such as organ and cell

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transplantation, orthopaedic surgery, heart surgery, cosmetic surgery, and fertility treatments.[4, 13] "Health tourism," "wellness tourism," and "spa tourism" are terms frequently used to describe travel to resorts, hot springs, and therapeutic retreats (spas). Generally speaking, travel that involves diagnostic tests and medical procedures is referred to as "medical tourism." [9, 12, 14].

The problem of lack of knowledge or low-level knowledge about medical tourism often makes the medical practitioners and stakeholders ignorant of the eventual consequences of the outbound medical tourism and the possible advantages of inbound medical tourism. With the increasing globalization of healthcare services, globalized learning opportunities, and huge travel traffic, knowledge and awareness of medical tourism are increasing. This advancing knowledge can be useful for developing countries to improve their infrastructure and standardize their care to attract foreign healthcare travelers [15-17].

As popularity and awareness of medical tourism increase locally and globally, there will be a need for policies that direct and control the medical tourism sector, which were created by the World Health Organization [18].This is to regulate the operations of dishonest traffickers in human beings and organs for transplantation. Due to these associated problems, laws have been passed and international accrediting organizations such as Joint Commission International (JCI) and the National Accreditation Board for Hospitals and Health Care Providers (NABH) have been established to safeguard prospective medical tourists from deception and to help ensure that the host healthcare provider will provide the high-quality care that they have promised [7, 8, 18-23]. In order to help hospitals and governments worldwide establish patient safety policies and practices that can become especially pertinent while offering medical tourism services, the World Health Organization also established the World Alliance for Patient Safety. To restrict the various forms of illicit human organ trade for transplantation, the Declaration of Istanbul was also released in 2008 regarding the morally dubious notions of transplant tourism [8, 20, 23-25]. Patients are usually referred for medical tourism by medical experts in hospitals. that provide tertiary and highly specialized health services. Some patients decide to go on their own. In both rich and developing nations, medical tourism is intended to be regulated by the Medical Practitioners Licensing Council, national medical associations, and health ministries. This study objective is to assess awareness and knowledge of medical tourism among Medical Practitioners in Tertiary Hospitals in the Federal Capital Territory (FCT), Nigeria.

## Methodology

A descriptive cross-sectional study design was carried out among Medical Practitioners in Tertiary Hospitals in the Federal Capital Territory (FCT), Nigeria. Abuja-FCT. Abuja is a city in central Nigeria that serves as the country's capital and is located within the Federal Capital Territory (FCT). The Federal Capital City (FCC) occupies around 250 square kilometers of the landmass, with a population count of 778,567 for the Abuja Municipal Area Council. [26-28] Abuja was chosen for this study as it is now one of Nigeria's ten most populous cities and one of the world's fastest growing cities with an increasing number of the population with the representation of all tribes living in Nigeria, it has 3 major government-owned teaching hospitals. University of Abuja Teaching Hospital, Gwagwalada; National Hospital, Abuja, and Federal Medical Center, Jabi, Abuja, who have easy access to experts who can recommend treatment outside the country.

The study population for this study were fully licensed medical doctors practicing in Government-owned tertiary hospitals in Abuja City. The study was done in 2024 and carried out over six months. Data collection was carried

out over four months, while analysis and write-up of the study was done over a period of eight weeks.

The minimum sample size for medical doctors was calculated using Cochran's formula for minimum sample size determination in cross-sectional study:[29].

$$n = \frac{Z^2 pq}{d^2}$$

n= the desired sample size when the population is less than 10,000

z= standard normal deviate set at 1.96, corresponding to the 95% confidence level.

In a previous study conducted in India, UAE, Jordan, and China, 13.0% of patients were referred by their doctors [30].

p = 0.13

q= 1-p = 1- 0.13 = 0.87

d= degree of precision desired, which is set at 5 % (0.05).

Minimum sample size= $(1.96)^2 \times (0.13 \text{ X } 0.87) / (0.05)^2 = 173.8 = 174$

However, since the total number of medical doctors in Abuja City is less than 10,000, the final sample size *nf* will be determined using the formula [31, 32]:

$$nf = n/(1 + n/N) \quad nf = \frac{174}{1+\frac{174}{596}} = 134.7$$

Where, nf = the desired sample size when population is less than 10,000.

*n* = the desired sample size when population is more than 10,000.

*N* = the estimated population size.

Allowing for a non-response rate of 10%, i.e. (134.7 x 0.10), the minimum sample size will be approximately 134.7 + 13.5 = 148.2 ≈150.

A minimum of 160 questionnaires was used for data collection amongst the medical doctors.

A multi-stage sampling technique was used in selecting the respondents for this study. Data on Medical doctors' knowledge of medical tourism was collected using an interviewer-administered questionnaire. A structured, interviewer-administered questionnaire based on a simplified set of questions was used in this study. The first section contains information on the socio-demographic characteristics of the medical doctors, while the second section assesses the knowledge and awareness levels. These questions were adapted from medical tourism publications in Canada, the United States, Malaysia, and India. [1, 3, 33-35].

A one-week training program was conducted for 6 research assistants who were medical interns. Training covered the use of questionnaires on the research topic, ethical considerations, and quality control. Emphasis was laid on proper conduct during interviews and discussion as well as how to recognize the progression of interviews in line with themes.

The study instruments were pretested among medical doctors in Federal Medical Center Keffi, Nasarawa State, located about 120km away from the study area. All ambiguous questions were reviewed to reduce the possibility of information bias. Questions were rewritten or deleted to reflect specific aspects of medical tourism related to the study objectives. Questionnaires was screened for completeness, coded and entered by the researcher into the Statistical package for scientific solutions (SPSS) version 22.0 software for analysis. Discrete data was presented as proportions (percentages) while continuous variables such as age were expressed as means ± standard deviation. Where continuous data are skewed, median values were stated as well.

A self-designed scoring system was used to categorize knowledge as poor, fair, and good. Questions 13 a-g, 14a-g was used to assess respondents' knowledge of medical tourism. There are a total of 14 items. These items were subjected to the Chronbach's reliability test. Only a resultant alpha value >0.7; demonstrated internal consistency. Responses were graded as 'Yes=1'; and 'No=0'; giving a cumulative grade score of 14. This total score of correct responses was converted to a percentage and used to categorise respondents' knowledge of medical tourism as follows:

### Knowledge Scores

1- 6= (Poor knowledge): ≤49%;

7 - 9= (Fair knowledge): 50-69%;

≥10= (Good knowledge): ≥70%.

Ethical clearance to conduct this research was sought and obtained from the Bingham University Teaching Hospital Research Ethics Committee before the commencement of the study. Permission to conduct this study was sought from all the Health facilities that were used in this study. Written informed consent was obtained from each respondent before the conduct of interviews after adequate information must have been given to the respondents by the interviewers concerning (i) the identity of the researcher and the university; (ii) the purpose of the research; (iii) the nature of the questions; (iv) the approximate length of time required to complete the survey; and (v) advice on how to make a complaint to the university if desired.

Confidentiality and privacy were respected during the interview. Participants will be treated with dignity and respect. All data shall be kept secure and made available only to the researcher. Findings from this research will be made public and will contribute to the knowledge of the scientific community.

## Results

### Distribution of Work Characteristics of the Doctors

Table 1 shows that the Mean years of experience among the doctors was = 17.6±9.5 years, 84 (52.50%) of the doctors had memberships, while 56(35%) had fellowships as their highest qualification. Junior residents comprised the largest group in the study, 56 (35.0%), while 52 (32.50%) were consultants.

Forty eight 48 (30.00%) had a work experience of 11 – 20 years, 42 (26.25%) 21 – 30 years, while 20 (12.50%) had worked for more than 30 years.

Two hundred and twenty-eight 82 (51.25%) of the doctors practiced privately on part time basis, 68 (42.50%) had no other practice, while 10 (6.25%) practiced in public hospitals on part time basis.

### Awareness, Sources of Information, Knowledge and Types of Medical Tourism Among the Doctors

Table 2 shows that 148 (92.50%) of the doctors were aware of medical tourism, while 12 (7.50%) claimed they were not aware (Figure 1) . Of the proportion that were aware (n = 160), 34(21.25%) reported their colleagues as their source of information, 65 (40.63%) indicated their workplace as their source, while 8 (5.00%) reported television.

135 (84.38%) could correctly define medical tourism, while 25 (15.63%) could not define medical tourism. Health tourism was the most popular synonym of medical tourism as indicated by 52 (32.50%) and 46 (28.75%) who indicated medical travels. Outbound and inbound medical tourism were the most popular categories of medical tourism among the doctors 56 (35.00%) and 51 (31.88%) respectively]. Similarly, 38(23.75.% %) indicated reproductive and transplant tourism as popular types of tourism, 24 (15.00%) indicated cosmetic surgery tourism, while 21(13.13%) stated dental tourism.

### Summary of Level of Knowledge on Medical Tourism Among Medical Doctors

Table 3 shows that 83 (51.9%) had fair knowledge of medical tourism, while 43 (26.9%) had poor knowledge, and 34 (21.3%) had good knowledge.

**Table 1.** Distribution of Work Characteristics of the Doctors

| **Work Characteristics** | **Frequency (n = 160)** | **Percent** |
|---|---|---|
| **Facility** | | |
| Surgery | 40 | 25 |
| Internal Medicine | 28 | 17.5 |
| General outpatient | 26 | 16.25 |
| Paediatrics | 20 | 12.5 |
| Obs &Gyn | 18 | 11.25 |
| Dentistry | 18 | 11.25 |
| Pathology | 10 | 6.25 |
| **Highest Qualification** | | |
| MBBS | 20 | 12.5 |
| Membership | 84 | 52.5 |
| Fellowship | 56 | 35 |
| **Rank in Hospital** | | |
| Medical officer | 20 | 12.5 |
| Junior resident | 56 | 35 |
| Senior resident | 32 | 20 |
| Consultant | 52 | 32.5 |
| **Work Experience (years)** | | |
| ≤ 10 | 50 | 31.25 |
| 11 – 20 | 48 | 30 |
| 21 – 30 | 42 | 26.25 |
| ≥ 31 | 20 | 12.5 |
| **Other Places of Practice** | | |
| Full time Public | 68 | 42.5 |
| Part time Public | 10 | 6.25 |
| Part time Private | 82 | 51.25 |

*Mean experience = 17.6±9.5 years*

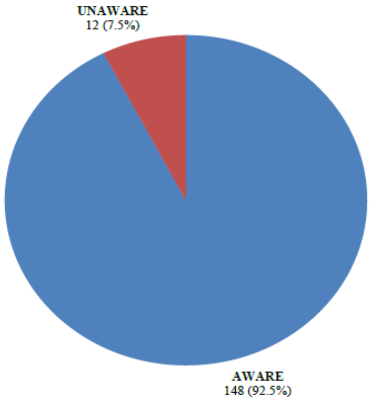


**Figure 1.** Awareness of Medical Tourism Among Medical Doctors

One hundred and Forty eight 148 (92.3%) of the doctors were aware of medical tourism.

**Table 2.** Awareness, Sources of Information, Knowledge and Types of Medical Tourism Among the Doctors

| Variable | Frequency (n = 160) | Percent |
|---|---|---|
| **Awareness of Medical Tourism (n = 160)** | | |
| Aware | 148 | 92.50 |
| Not aware | 12 | 7.50 |
| **Sources of Information*** | | |
| Colleague | 34 | 21.25 |
| Workplace | 65 | 40.63 |
| Television | 8 | 5.00 |
| Newspaper | 4 | 2.50 |
| Internet | 38 | 23.75 |
| Radio | 8 | 5.00 |
| Books | 3 | 1.88 |
| **Knowledge of the Definition** | | |
| Correct | 135 | 84.38 |
| Incorrect | 25 | 15.63 |
| **Knowledge of Synonyms*** | | |
| Health tourism | 52 | 32.50 |
| Medical travels | 46 | 28.75 |
| Oversea travels | 16 | 10.00 |
| Holiday tourism | 13 | 8.13 |
| Offshore healthcare | 11 | 6.88 |
| Cross border care | 10 | 6.25 |
| Leisure tourism | 12 | 7.50 |
| **Categories of Medical Tourism*** | | |
| Outbound medical tourism | 56 | 35.00 |
| Inbound medical tourism | 51 | 31.88 |
| Intrabound medical tourism | 29 | 18.13 |
| Offbound medical tourism | 24 | 15.00 |
| **Knowledge of Types*** | | |
| Reproductive tourism | 38 | 23.75 |
| Transplant tourism | 38 | 23.75 |
| Cosmetic surgery tourism | 24 | 15.00 |
| Dental tourism | 21 | 13.13 |
| Lipotourism | 19 | 11.88 |
| Suicide tourism | 10 | 6.25 |
| Abortion tourism | 10 | 6.25 |

***Multiple responses***

**Table 3.** Level of Knowledge on Medical Tourism Among Medical Doctors

| Knowledge of medical tourism | Frequency (n = 160) | Percent |
|---|---|---|
| Poor | 43 | 26.9 |
| Fair | 83 | 51.9 |
| Good | 34 | 21.3 |
| Total | 160 | 100 |

## Discussion

Almost all the doctors were aware of medical tourism as it was a common discussion among colleagues and in the workplace. In terms of definition, over 80% could define medical tourism. A third could state health tourism as a synonym of medical tourism, others called it medical travel. This contrasts with a study done in Iran where 91% had not heard about medical tourism in the past. [2] This may be due to the closed health system in Iran or low formal utilization of the term "medical tourism". Such low levels of knowledge were also observed in a study done in Egypt [1]. This level of knowledge is useful in building a medical tourism market for Nigeria, but, in this case, it is "inbound Medical tourism". This will be helpful for our health system. The task is to make our health system attractive and create an agency under the Federal Ministry of Health that will fast-track the achievement of this task of global competitiveness.

A third knew about outbound and inbound medical tourism as the main categories of medical tourism. Other popular types were reproductive and transplant tourism, cosmetic surgery tourism, and dental tourism. With this categorization, 21% of the doctors had good knowledge of medical tourism, 27% had poor knowledge, and half of the doctors had fair knowledge of medical tourism. This finding shows that despite the high level of awareness about medical tourism, only a few had in-depth knowledge of medical tourism.

Doctors with high awareness of medical tourism can better educate patients on the risks and benefits of seeking healthcare abroad. This ensures that patients make informed decisions based on quality, cost, and potential complications [36, 37]. Furthermore, this level of knowledge will make stakeholders to work towards strengthening the Local Healthcare System. When doctors understand why patients seek medical care abroad, they can advocate for improvements in local healthcare services, such as better infrastructure, specialized training, and policy reforms to reduce medical brain drain. Good knowledge of medical tourisms will enable doctors to discuss ethical concerns with patients, such as the credibility of foreign healthcare providers, post-surgical complications, and the risks of unregulated procedures in some countries [38, 39].

It also important to note that patients returning from medical tourism may carry infections, complications, or antibiotic-resistant bacteria. Doctors with strong knowledge of medical tourism can take the necessary precautions and provide appropriate follow-up care. When practitioners have insights into medical tourism trends, it can help policymakers address the factors driving medical tourism, such as high costs of care, long waiting times, or lack of specialized treatments in Nigeria [16, 40, 41].

High awareness of medical tourism among Nigerian doctors is crucial for safeguarding public health, improving local healthcare services, and reducing medical tourism-related

risks. It also positions Nigeria to potentially benefit from inbound medical tourism in the future.

## Conclusion

There was high awareness about medical tourism, and most doctors had fair knowledge of medical tourism. Most medical practitioners felt out outbound medical tourism was not good for the Nigerian health system. One hundred and forty-eight (92.50%) of the doctors were aware of medical tourism, mainly from their colleagues and workplace as their source of information. (84.38%) could correctly define medical tourism. In summary, 21.3% had good knowledge, 51.9% had fair knowledge of medical tourism, and 26.9% had poor knowledge.

## Recommendations

### To Governments

There is a need to sustain the current level of awareness and work towards improving the local healthcare infrastructure and workforce retention.

There is a great need to strengthening Nigeria's Medical Tourism Sector, rather than losing patients to other countries, high awareness among doctors can contribute to developing Nigeria as a medical tourism destination by improving the quality of care and marketing available medical services.

### To Medical Associations and Medical Tourism Stakeholders

To work towards sustaining the level of awareness and improving knowledge of medical doctors and other health workers towards medical tourism, this will be essential to develop a more robust health care delivery system to increase inbound medical tourism.

## Conflict of Interest

No conflict of interest.


## Acknowledgements

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