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Cosmetic Tourism in Sub-Saharan Africa: Environmental Impact and Employee Sustainability in the 21st Century

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Abstract

An under-researched aspect of medical tourism in Sub-Saharan Africa (SSA) is cosmetic tourism, which involves traveling across national boundaries for cosmetic reasons. Scholarly focus has been on economic aspects, environmental and workforce sustainability are under-theorised. The present paper explores the environmental impact and staff sustainability in the cosmetic tourism industry of SSA within the framework of Sustainable Development Goals (SDGs). The paper employs LCA, workforce research and policy analysis to suggest that sectoral expansion leads to carbon emissions, plastic and medical waste, resource heavy energy consumption and to precarious labour conditions and healthcare worker burnout and migration. They hinder progress on good health and well-being (SDG 3), decent work and economic growth (SDG 8), responsible consumption and production (SDG 12) and climate action (SDG 13). The main thrust of the proposed argument is that, if left unchecked, the sector has the potential to create a new, unsustainable model of medical tourism, like that seen around the world. The results show that, in addition to the decent work gaps, there are substantial carbon emission costs associated with international travel, waste production, and resource use. Finally, the paper suggests a framework for cosmetic tourism governance that embeds environmental stewardship and decent work principles and provides a vision for the cosmetic tourism sector as a force for sustainable development, rather than a negative one.

Keywords: *Cosmetic tourism, medical tourism, Sub Saharan Africa, Environmental sustainability, Employee sustainability, Healthcare workforce, carbon footprint, Sustainable Development Goals, SDG 8, decent work.*

1. Introduction

Medical tourism is a multi-billion dollar industry that steps beyond international boundaries and is valued at more than USD 100 billion annually (Okereke & Oti, 2026; Awedoba et al, 2020). In this large industry, cosmetic tourism is creating a unique and rapidly growing niche (Goldie et al., 2025). In contrast to medical tourism, in which there are procedures that must be carried out, cosmetic tourism, on the other hand, is mainly about the desire for cosmetic enhancement, which includes procedures like rhinoplasty, liposuction, breast augmentation, and a variety of minimally invasive ones (Isa, 2025; Suwajee et al., 2025). South Africa, Kenya and Nigeria are becoming key destinations for cosmetic tourism in Sub-Saharan Africa, with these countries establishing themselves as regional centres for aesthetic medicine (Otieno, 2026; Çapar et al., 2025).

An analysis of the development of cosmetic tourism in Sub-Saharan Africa should take into account the severe systemic issues. Currently, the region is losing between USD 6 billion and USD 10 billion per annum to outbound

medical tourism, and Nigeria alone has the annual loss of around USD 1 billion (Okereke and Oti 2026; Macassa 2026). At the same time, the continent is projected to have over 6 million health workers shortage in 2035, while currently they have only an average of 1.5 health workers per 1,000 people, which is way below the minimum of 4.45 per 1,000 people recommended by the WHO (WHO, 2026; Otieno, 2026). These structural conditions define the opportunities and the contradictions of the development of cosmetic tourism.

Cosmetic surgery tourism (CST) is not a 'cold wars' narrative of 'West- to-East' or 'core-to-periphery' globalisation, as Holliday et al. (2015) maintain. Based on theories of flows, networks and assemblages, they show that CST takes place in complex, multidirectional flows of people, technologies, images on media, money and ideologies. They talk about "beauty scapes" (plural, non-isomorphic flows of beauty ideals and practices) and how patients pick up, contest and sometimes reject beauty ideals as they travel. This theory is a useful paradigm for understanding the complexity of cosmetic tourism in SSA: local and global dynamics intersect and create a complex set of outcomes, which vary in complexity and context. This paper focuses on two important yet little-explored aspects of cosmetic tourism in Sub-Saharan Africa: the environmental impact and the impact on employee sustainability. The environmental dimension focuses on the carbon emissions due to patient transportation, waste generated in surgeries and non-surgical interventions, and the use of resources in healthcare facilities (Smit et al., 2025; Goldie et al, 2025). The employee sustainability dimension evaluates the working environment, employee welfare and retention of health care workers and support staff involved in cosmetic tourism services (Isa, 2025; Okereke & Oti, 2026).

The main argument is that the current development of cosmetic tourism in Sub-Saharan Africa is environmentally unsustainable and socially precarious, thus restricting the progress on the attainment of important Sustainable Development Goals, including decent work and economic growth (SDG 8) and good health and well-being (SDG 3) (Çapar et al., 2025; Macassa, 2026). Without deliberate and timely policy intervention, the sector risks replicating the parasitic and disproportionate patterns that characterise much of the global medical tourism industry (Okereke & Oti, 2026). The paper identifies four objectives: First, it puts cosmetic tourism into the context of medical tourism in Sub-Saharan Africa and its connection with the SDGs; Second, it examines, in the light of life cycle assessment (LCA), the environmental impact of cosmetic tourism in relation to SDG 12 and SDG 13; Third, it analyses, in the light of SDG 8, the challenges for employee sustainability in the field of cosmetic tourism; Fourth, it proposes an integrated framework for sustainable cosmetic tourism governance, which advances multiple SDGs simultaneously.

2. Cosmetic Tourism in Sub-Saharan Africa: Context, Drivers, and SDG Linkages

2.1 The Regional Landscape

Cosmetic tourism is in its dual nature in Sub-Saharan Africa. It is a source market for outbound medical tourists/visitors and a destination market for inbound medical tourists/visitors (Otieno, 2026; Okereke & Oti, 2026). Patients from all over the continent travel to South Africa for cosmetic surgery, as it offers much lower prices than in Europe or North America and is the oldest destination of choice (Goldie et al, 2025; Suwajee et al, 2025). Nigeria and Kenya are in a developmental phase of their aesthetic medicine skills and stakeholders urge regulation and professional standards within the expanding sector (Çapar et al., 2025; Macassa, 2026).

The attraction for cosmetic tourism in Sub-Saharan Africa can be many. The increasing availability of cosmetic procedures, the shift in body image norms fostered by social media, and the notion of cosmetic surgery as a sign of modernity all drive this demand for plastic surgery (Goldie et al., 2025; Awedoba et al., 2020). The business is on the rise on the supply end because there are one or two private aesthetic clinics, and surgeons who are trained in other countries are available, with the cost of procedures being lower than that of western markets (Isa, 2025; Otieno, 2026).

Contrary to popular belief, cosmetic surgery tourists are not necessarily rich and powerful individuals, they are just “ordinary people with low incomes who can no longer afford treatments domestically” (Holliday et al., 2015, p. 219). It is one of the main motivators and many go abroad for surgery on loan. The discovery is important for SSA because out-of-pocket payments are the primary way people finance healthcare, and where to draw the boundaries between medical necessity and aesthetic desire is often muddied by economic necessity.

2.2 The Economic Paradox of Decent Work and Economic Growth (SDG 8)

The economic rationale behind cosmetic tourism in Sub-Saharan Africa is highly contradictory and also has a direct effect on SDG 8 – Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all (Çapar et al., 2025). On the other hand, the sector will help save foreign exchange from going abroad to the providers and provide employment of different skill levels ranging from highly

skilled medical workers to vocational beauty workers (Macassa, 2026). The promotion of development-oriented policies that support productive activities, job creation, entrepreneurship, creativity and innovation, and encourage the formal growth of micro, small and medium sized enterprises (MSMEs) is directly stated in SDG 8. This specifically promotes development-oriented policies that support productive activities, job creation, entrepreneurship, creativity and innovation and encourage the formal growth of micro, small and medium sized enterprises (MSMEs) (Okereke & Oti, 2026). Because cosmetic tourism is a labour intensive service industry, it has the potential to achieve these goals in practice.

On the other hand, the region's broader medical tourism trajectory reveals a troubling pattern that brings to the fore a substantial outflow of patients and spending. According to the African Export-Import Bank, Nigeria alone loses an estimated USD 1.1 billion annually to medical tourism, while the entire African continent collectively forfeits approximately USD 7 billion yearly (Awedoba et al., 2020; Okereke & Oti, 2026). The irony of this matter is that every dollar spent abroad is a dollar not invested in building domestic healthcare capacity (Macassa, 2026). The expansion of medical tourism can contract the domestic healthcare services sector, causing lower labour productivity and crowding out medical facilities in the public sector (Otieno, 2026; Isa, 2025).

Recent empirical research critically examined the relationship between SDGs and medical tourism across 34 countries and found that while sustainable practices in medical tourism are deepened by quality education, gender equality, clean water and sanitation, industry and innovation, sustainable cities, responsible consumption and production, and climate action, the relationship between decent work and economic growth (SDG 8) and medical tourism was found to be neutral (Çapar et al., 2025). This suggests that the mere presence of SDG 8 rhetoric does not automatically translate into decent work outcomes in the medical tourism sector (Çapar et al., 2025; Macassa, 2026). This finding underscores the need for deliberate policy interventions that ensure cosmetic tourism development genuinely advances decent work rather than merely generating economic activity that benefits the elites (Okereke & Oti, 2026).

2.3 SDG 3, Health Equity, and the Two-Tier System

Cosmetic tourism in Sub-Saharan Africa intersects critically with SDG 3, which seeks to ensure healthy lives and promote well-being for all ages (Otieno, 2026). Target 3.c of SDG 3 specifically calls for a substantial increase in health financing, recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries (WHO, 2026). Therefore, the growth of a private cosmetic tourism sector that competes for scarce healthcare personnel with under-resourced public health systems directly threatens this target (Okereke & Oti, 2026; Macassa, 2026).

The same challenges faced by the traditional healthcare system are still embedded in African countries; that is, the two-tier healthcare system that characterises many Sub-Saharan African countries, in which private facilities cater to wealthy domestic and foreign patients while leaving the public healthcare under-resourced, is reproduced and intensified by the cosmetic tourism industry (Isa, 2025; Otieno, 2026). A 2026 review of medical tourism in emerging markets found that without deliberate policy to safeguard the industry, medical tourism may inadvertently undermine progress toward universal health coverage (UHC), with potential crowding out of local patients, workforce migration toward private international facilities, and widening inequities in access to care (Macassa, 2026; Okereke & Oti, 2026). This dynamic directly contradicts SDG 3's commitment to UHC and the principle that everyone has a fair and just opportunity to attain their full health potential (Çapar et al., 2025).

Otieno (2026) further notes that in contemporary Africa, health is no longer treated as a fundamental human right but as a commodity traded in the marketplace, subject to forces of demand and supply. Medical tourism is increasingly embraced by the privileged in national governments to meet their health needs, while the majority of citizens rely on underfunded public systems. This commodification of healthcare raises profound ethical questions about distributive justice and healthcare resource allocation, which are central to the sustainability of cosmetic tourism in the region.

3. Environmental Impact of Cosmetic Tourism: Aligning with SDG 12 and SDG 13

3.1 Carbon Emissions from Patient Travel

The carbon emissions associated with international patient travel have the most significant environmental impact of cosmetic tourism in Sub-Saharan Africa (Smit et al., 2025; Suwajee et al., 2025). This directly affects the actualisation of SDG 13 on climate action (Macassa, 2026). A research study on the life cycle assessment of a clinical malaria trial conducted in Mali, one of the few studies to quantify the environmental footprint of health-related activities in the region, found that the trial conduct resulted in approximately 20.5 metric tons of CO_2-equivalent emissions (Smit et al., 2025). Of these, 50% was contributed by international travel, electricity in Mali (28%), and air transportation of materials (14%) (Smit et al., 2025). Although this study examined clinical research

rather than cosmetic tourism, its findings are instructive: the carbon-intensive nature of cross-border health-related travel is a structural feature of the industry (Smit et al., 2025; Goldie et al., 2025).

In another study, estimates of CO_2 emissions from international medical electives give further insights (Coakham et al., 2025). These show that for some applications, the per-person emission of 1,185 kg of CO_2 equivalents can exceed 1,705 kg of CO_2 equivalents for trips to South Africa (Coakham et al., 2025). The emissions were relatively high when compared to the average annual CO_2 emissions in the UK per person of 7,000kg/year (Coakham et al., 2025).

Therefore, for cosmetic tourism specifically, the emissions profile is likely to be similar or even greater, as cosmetic patients usually travel for elective treatments and treatments often require several appointments for consultation, surgery and follow-up care (Goldie et al., 2025; Suwajee et al., 2025). However, the irony is acute in that Sub-Saharan Africa, which contributes only approximately 3% of global carbon emissions, is bearing the environmental burden of a carbon-intensive industry serving predominantly elite travellers (Smit et al., 2025; Macassa, 2026).

Recently of note, research has begun to develop strategic models for carbon-neutral medical tourism (Suwajee et al., 2025). In Thailand, the C.A.R.E.-M.E.D. model, developed through research, proposes seven strategic dimensions for achieving carbon neutrality in wellness tourism (Suwajee et al., 2025). These are Certified Infrastructure, Accessible Low-Carbon Travel, Recovery Integrated Experiences, Engagement in Carbon Reduction, Medical-Tourism Partnership, Exact Needs Communication, and Diverse Activities (Suwajee et al., 2025). For a necessary and feasible alignment with SDG 13, this model provides a concrete framework that could be adapted for Sub-Saharan African contexts (Suwajee et al., 2025; Macassa, 2026).

3.2 Waste Generation and Resource Consumption: SDG 12 in Focus

Against the backdrop of SDG 12, which advocates for responsible consumption and production, cosmetic tourism generates substantial quantities of medical and plastic waste, directly implicating SDG 12 (Goldie et al., 2025; Macassa, 2026). Therefore, environmentally sound management of chemicals and all wastes throughout their life cycle, to significantly reduce air, water, and soil pollution, and actively promote prevention and reduction in waste generation, encouraging waste recycling and reuse, is a must for all (Çapar et al., 2025).

Globally, healthcare contributes an estimated 4.4% to global carbon emissions and generates vast volumes of plastic waste, though the environmental burden of aesthetic healthcare specifically remains under-quantified (Goldie et al., 2025; Macassa, 2026).

In a recent study published in 2025, researchers analyzed sustainability in aesthetic and surgical clinics and identified various clinic operations and materials that have a significant impact on the environment, such as energy consumption, transportation, personal protective equipment, surgical supplies, and waste management (Goldie et al., 2025). The environmental footprint of aesthetic healthcare is estimated at 4.4% of global carbon emissions and significant amount of plastic waste, although the environmental footprint specific to aesthetic healthcare remains poorly quantified (Goldie et al., 2025; Macassa, 2026).

In the total medical waste, plastic surgery practices generate 20% to 30% of the waste (Goldie et al., 2025). This is an out-of-ordinary proportion given that this is a specialty field in medicine (Goldie et al., 2025; Macassa, 2026). Later, the global medical tourism sector has been found to be responsible for rising carbon emissions, over consumption of resources, and high medical and plastic waste (Suwajee et al., 2025; Goldie et al., 2025). In sub-Saharan Africa, waste management infrastructure is often unmet and 90% of waste is being dumped in unregulated sites with open-air incineration, which releases toxic gases and worsens the existing environmental health threat of cosmetics tourism (Macassa, 2026; Okereke & Oti, 2026).

Environmental pressures from the use of resources by cosmetic tourism facilities are further exacerbated (Goldie et al., 2025). Aesthetic clinics are generally very energy intensive, with reliable electricity power supplies being required for surgical suites, sterilisation equipment, and climate control (Goldie et al., 2025; Macassa, 2026). The life cycle assessment in Mali revealed that electricity use was a significant source of carbon emissions and ecosystem impacts, such as the formation of fine particulate matter (PM2.5) which has health impacts (Smit et al., 2025). The significant potential for mitigation is demonstrated, such as 2,179 kg of CO_2 per year for retrofit with LED bulbs and 16,023 kg of CO_2 per year for solar panels (Goldie et al., 2025). Up to 97% of emissions could be reduced by using reusable surgical instruments like tungsten carbide tools, and 62% of beauty consumers are now prioritising sustainability, with this pressure building the market, responsible production and consumption practices (Goldie et al., 2025; Suwajee et al., 2025).

3.3 Environmental Governance Gaps and Certification

The environmental governance system for cosmetic tourism in Sub Saharan Africa is still not complete and

effective (Macassa, 2026; Okereke & Oti, 2026). Although there are various countries that have already established environmental management legislation, none of these were developed with the specific environmental issues associated with medical and cosmetic tourism in mind (Macassa, 2026).

In many jurisdictions, EIAs are required for tourism investments, but there are inconsistencies in enforcement; and the cumulative environmental effects of several small-scale cosmetic tourism operations are not always considered (Okereke & Oti, 2026; Macassa, 2026).

Kimengsi and Fogwe (2017) also report such governance challenges in Bamenda, Cameroon for urban green development planning. They highlight that the urban green projects in Sub-Saharan Africa are facing challenges from other land users, poor management of urban space due to poor implementation of development controls and lack of political will. The results are consistent with the cases of cosmetic tourism that have been found in the environmental governance space, where weak regulation and enforcement of the codes of conduct are allowing unsustainable tourism practices to continue.

Emerging sustainability certification schemes provide some answers to SDG 12's requirement for sustainable procurement and responsible production patterns (Macassa, 2026). Egypt has unveiled the first ever programme for the African Eco Mark for Sustainable Medical Tourism, gathering momentum to boost quality and sustainability in medical and logistical services in Africa (Macassa, 2026). The initiative aims to harmonise the national standards with the standards in Africa and elsewhere, including ISO 22525 and ARS-4, in order to provide high-quality services that are efficient, sustainable and transparent (Macassa, 2026). The medical tourism framework is shifting from growth oriented to regenerative and equitable, where integration of the principles of the circular economy – reusable or reprocessed instruments, reusable or recyclable packaging, repairable devices, zero waste can benefit people and the planet.

Sustainable transformation (Macassa, 2026; Goldie et al., 2025), which is so central to waste sterilisation in clinical settings.

These however are still in their infancy and use is limited at sub-Saharan level (Macassa, 2026; Okereke & Oti, 2026). Furthermore, there are no mandatory environmental reporting requirements for the cosmetic tourism industry, which means that the environmental impact of the sector is not well known by both regulators and consumers and will not support SDG 12 and SDG 13 targets (Macassa, 2026; Çapar et al., 2025).

4. Employee Sustainability in Cosmetic Tourism: Framing through SDG 8

4.1 The future healthcare workforce crisis is upon us (SDG 8)

The issue of employee sustainability in the cosmetic tourism sector needs to be considered in the context of the healthcare sector in Sub-Saharan Africa which has a problem of employee sustainability (Okereke & Oti, 2026; Macassa, 2026). By 2030, the health workforce shortage in the region is projected to be 6.1 million, threatening to prevent realization of universal health coverage, Sustainable Development Goals (SDGs) (WHO, 2026; Otieno, 2026). The total number of registered cardiologists in Africa is 2000 and the population is over 1.2 billion, which translates to one registered cardiologist for every 600,000 people. In Africa there are approximately 2000 registered cardiologists to serve a population of over 1.2 billion, or about 1 cardiologist per 600,000 people. The demand for health workers in Africa is still significantly higher than the number of health workers that are available to train, hire and retain by 2035 (WHO, 2026; Otieno, 2026).

SDG 8 focuses on achieving full and productive employment and decent jobs for all women and men, particularly for young women and men and persons with disabilities, and on equal pay for work of equal value (Çapar et al., 2025).

The WHO Commission on Health Employment and Economic Growth has clearly identified that investment in the health workforce is linked to SDGs 8, 1 (ending poverty), 4 (quality education), 5 (gender equality), 10 (reducing inequalities) and 17 (cross-sectoral partnerships) and called on all to invest in the health workforce, for national governments to create intersectoral action plans that identify and budget for transformative education, skills and job creation in the health sector (WHO, 2016; Okereke & Oti, 2026).

In this limited labour market, cosmetic tourism may forfeit skilled workers with low wages, such as surgeons, anaesthetists, nurses, and aesthetic practitioners, to public health (Okereke & Oti, 2026; Isa, 2025). The growth of medical tourism has been correlated with increased compensation of medical tourism workers, and, thereby retaining skilled medical workers who might otherwise emigrate (Otieno, 2026; Macassa, 2026). However, this retention effect operates primarily in the private sector and does not address the systemic underfunding of public healthcare (Okereke & Oti, 2026; Isa, 2025). The WHO has emphasised the need for evidence-based policy formulation prioritising health worker retention, fair and ethical migration practices, and promoting decent work

and social protection for health workers (WHO, 2026; Otieno, 2026).

4.2 Working Conditions and Burnout: The Decent Work Deficit

The working conditions in cosmetic tourism facilities in Sub-Saharan Africa present significant challenges to employee sustainability and directly undermine SDG 8's decent work agenda (Isa, 2025; Okereke & Oti, 2026). Healthcare professionals across the region face substantial mental health challenges (Bizuneh et al., 2025; Macassa, 2026). In the high disease burden and resource-constrained contexts of Sub Saharan Africa, health workers experience a range of psychosocial stressors that leave them vulnerable to developing burnout, which can reduce service quality and negatively impact their own health and wellbeing (Bizuneh et al., 2025; Okereke & Oti, 2026). Burnout rates are alarmingly high: 81% among physicians in South African rural district hospitals, 65.2% among physicians in southern Ethiopia, and 64.8% among nephrology and hemodialysis workers in Burkina Faso (Bizuneh et al., 2025; Macassa, 2026). In Nigeria, the prevalence of burnout among physicians is also elevated (Isa, 2025; Okereke & Oti, 2026). A study conducted during the COVID-19 pandemic found that the prevalence of high burnout in the emotional exhaustion domain was 35.1%, with overall burnout at 40.4% among Nigerian physicians providing specialized and critical care (Okereke & Oti, 2026). The CHARTING II study revealed that over 60% of Nigerian early-career doctors experience high emotional exhaustion and poor work-life balance, linked mainly to workload (Okereke & Oti, 2026; Isa, 2025).

These pressures may be worsened by the particular dynamics of cosmetic tourism (Goldie et al., 2025; Macassa, 2026). Aesthetic clinics may work with commercial interests, with a greater focus on patient. This can impact on volume and profitability, at the same time as potentially impacting on the well-being of staff (Goldie et al., 2025). Unlike public healthcare facilities where staffing ratios are regulated (however inadequately), some private cosmetic tourism facilities may be staffed with less people to deal with higher workload (Isa, 2025); Macassa, 2026). The outcome is a workforce that is expected to provide high quality, to offer patient-centred care to paying customers and to deal with the emotional toll of aesthetic service, communication, patient expectations, body image concerns, and the delivery work that involves navigating patient expectations, body image concerns, and the delivery of the product or service, and the satisfaction and expectations of the customer or user.

Possible psychological challenges associated with cosmetic procedures (Goldie et al., 2025; Isa, 2025). This scenario is a clear decent working opportunity gap in SDG 8, to promote safe and secure working opportunities. All workers must be provided with working environments that are suited to them (Çapar et al., 2025).

A study on Green Human Resource Management by Sharma and Gupta (2014) states that HRM plays a crucial role in promoting HR practices that align with environmental sustainability.

There are practices that organizations can implement to combine environmental sustainability and employee wellbeing exempt from such things as green staffing, training and development, performance appraisal and compensation, employee involvement and empowerment. Their case study on HCL Technologies shows that tying staff involvement and participation in environmental management programmes to better outcomes.

An area of potential future research is organizational environmental performance. This framework has relevance for cosmetic tourism facilities, which could adopt Green HRM practices to simultaneously enhance environmental sustainability and employee welfare.

4.3 Brain Drain and Retention Challenges

The sustainability of the cosmetic tourism workforce is further threatened by the persistent brain drain of skilled healthcare professionals from Sub-Saharan Africa (Isa, 2025; Okereke & Oti, 2026). Migration, the phenomenon where healthcare professionals relocate across national boundaries in search of enhanced career opportunities, increased remuneration, improved working conditions, or access to cutting-edge technology and training, is especially significant when professionals leave lower income or developing countries to wealthier nations, thereby worsening pre-existing healthcare difficulties in their countries of origin (Macassa, 2026; Okereke & Oti, 2026). The scale of the problem is stark. About 70% of African doctors who leave for specialist training abroad never return (Okereke & Oti, 2026). More than 60% of Nigeria's qualified radiographers now practise abroad (Isa, 2025). The ongoing exodus of healthcare professionals is closely linked to the exodus of patients, creating a vicious cycle: doctors leave because they are underpaid and lack the environment they need to practise, and patients leave because they do not believe they can get the care they need at home (Okereke & Oti, 2026; Isa, 2025).

WHO Commission recommended to create an international platform on health worker mobility to achieve the maximum benefit from health worker mobility while minimising health worker vulnerabilities from international migration in developing countries (WHO, 2016; WHO, 2026). This platform should take into

consideration, the global trends towards improved mobility, such as the development of the African Union passport and other regional agreements on freedom of movement (WHO, 2026; Otieno, 2026). The retention challenge is even more pronounced with cosmetic tourism as the skills involved are advanced aesthetic medicine, surgical techniques and patient-centred services are all easily transferable and are widely sought after across the world (Goldie et al., 2025; Isa, 2025). Surgeons who were trained in a cosmetic tourism clinic in Sub Saharan Africa may be recruited by clinics in the Middle East, Europe, or Asia where working conditions and pay is more favorable (Isa, 2025; Macassa, 2026).

The feedback from industry players and health professionals has reinforced the need to prioritize the wellness of healthcare workers as a retention measure (Okereke & Oti, 2026; Isa, 2025). Better remuneration, enhanced workplace safety, expanded training opportunities, and effective retention strategies have been identified as essential to reducing medical tourism and reversing the migration of skilled healthcare professionals (Okereke & Oti, 2026). The National Policy on Health Workforce Retention has been highlighted as a critical framework whose full implementation would be sufficient to retain healthcare professionals and improve retention rates (Isa, 2025; Okereke & Oti, 2026). The WHO has also emphasised the need for targeted, catalytic investment in health workforce planning, governance, decent work and data systems to deliver measurable results (WHO, 2026; Otieno, 2026).

5. Toward an Integrated Sustainability Framework:

5.1 A Multi-SDG Approach

The Green, Circular, Responsible, and Regenerative (GCRR) framework, developed for medical tourism more broadly, offers a comprehensive starting point for addressing the environmental and workforce sustainability challenges of cosmetic tourism in Sub-Saharan Africa (Macassa, 2026; Goldie et al., 2025).

This strategy will combine environmental sustainability, resource circularity and corporate social responsibility, to foster economic sustainability, social justice and planetary health (Macassa, 2026). It provides guidelines and principles for the development of medical tourism systems grounded in circular economy and UN Sustainable Development Goals, and suggests how policy makers, healthcare providers and tourism stakeholders can work together to improve the medical tourism systems for equitable, sustainable and regenerative development (Macassa, 2026; Çapar et al., 2025).

The GCRR would be applied to cosmetic tourism by ensuring facilities implement circular economy principles (minimising waste, maximizing resource use efficiency, and designing out pollution) and/or decent work standards (including the wellbeing of the people employed) in their employment practices (Macassa, 2026; Goldie et al., 2025). The framework places healthcare equity at the heart of the outcome as the principle that every person has a fair and just chance at achieving their health potential, and one that demands the elimination of unnecessary physical, social and economic obstacles to health (Macassa, 2026; Otieno, 2026). This positioning is directly connected to SDG 3 - the commitment to provide universal health coverage and SDG 10 - the target to reduce inequalities (Çapar et al., 2025; Macassa, 2026).

In their study Future of Work in a Changing Natural Environment, Montt, Fraga and Harsdorff (2018) call for a new development model that incorporates social, environmental and economic outcomes into the equation. They prove that decent work and job creation are not incompatible with environmental sustainability and that a shift to a green economy can lead to the generation of 18 million net jobs in the world by 2030, if the energy sector is decarbonized (Montt et al., 2018). Their policy recommendations encompassed an expanded national accounts framework that also accounts for natural capital, environmentally-friendly structural transformation, the integration of negative externalities into price, skills development for a green transition, social protection schemes, social dialogue and a just transition of rights, which can be adapted for cosmetic tourism governance (Montt et al., 2018).

5.2 Policy Recommendations Aligned with the SDGs

To integrate sustainability into cosmetic tourism development in Sub-Saharan Africa, several policy interventions are needed that will bring the cosmetic tourism sector to the SDGs (Macassa, 2026; Okereke & Oti, 2026):

Mandatory environmental reporting, as part of SDG 12 and SDG 13 (Goldie et al., 2025; Macassa, 2026). All cosmetic tourism service providers must be able to measure and disclose their carbon emissions, waste output and resource usage (Goldie et al., 2025). This would lead to evidence-based policy making, consumer choice, and would contribute to SDG 12 (Sustainable production patterns) and SDG 13 (Climate action) targets (Çapar et al., 2025; Macassa, 2026).

Second, some environmental certification schemes based on SDG 12 (Macassa, 2026; Goldie et al., 2025). There is a need for customized certification programs for medical and cosmetic tourism, with the African Eco Mark for Sustainable Medical Tourism as an example, and the GCRR framework which focuses on the reuse of

instruments, recyclable packaging and no waste, sterilisation (Macassa, 2026; Goldie et al., 2025).

Third, labour standards that support SDG 8 (Çapar et al., 2025; Okereke & Oti, 2026). Labour standards should be drawn up for the cosmetic tourism sector, such as maximum working hours, requirements for support of mental health, fair compensation benchmarks and safe working environments etc., which can support SDG 8 target 8.8 – decent work and fair and equitable labour practices directly.

Fourth, SDG 3 (WHO, 2026; Okereke & Oti, 2026) – Investment in the health workforce in alignment with SDG 3. There should be a linkage of investment in domestic healthcare workforce development with the requirements for cosmetic tourism licensing, so as to contribute to the healthcare capacity in the region, not be absorbed by the sector (Otieno, 2026; Okereke & Oti, 2026). It is in line with SDG 3 Target 3.c, which calls for more investment in health financing and the recruitment, development, training and retention of the health workforce in developing countries (WHO, 2026; Çapar et al., 2025).

Fifth, a platform for international cooperation on health worker mobility (WHO Commission, 2016, 2026) to support the retention and equitable distribution of health workers in the region, not to worsen brain drainage as a consequence of the development of cosmetic tourism.

In their special issue on sustainability in tourism policy and planning in Sub-Saharan Africa (SSA), Adu-Ampong and Kimbu (2019) highlight the critical need for a more responsible and inclusive approach to formulating and implementing tourism policy in emerging destinations in SSA. They highlight that although tourism has been promoted as a means to economic development, employment creation and poverty alleviation, the results have been disappointing.

However, the picture is not consistent and implications at the local level are not yet clear (Adu-Ampong &Kimbu, 2019). Their demand for concrete integration of ‘sustainability' into the economic, social and environmental aspects of tourism is in line with the policy recommendations presented here for ‘cosmetic tourism governance'.

The students will identify the role of industry and consumers within the food system.

However, industry stakeholders (medical tourism facilitators, clinic owners and professional associations) must voluntarily implement sustainable practices, even if it is not required by law, to meet their responsibility (Goldie et al., 2025; Macassa, 2026). This encompasses investments in renewables for the clinic, waste reduction and recycling initiatives, and a focus on employee wellbeing as a key performance indicator (KPI) of the business (Goldie et al., 2025). LED bulb retrofit studies have shown that LED lights can be used to replace standard light bulbs in clinics.

The adoption of and solar panels can provide substantial emission reductions and cost savings, and the replacement of surgical instruments with reusables can reduce emissions by up to 97% (Goldie et al., 2025; Smit et al., 2025). Consumer demand for sustainability is also strong and it is reported that 62% of beauty consumers consider sustainability a product attribute they look for - so market pressure can be a real motivator for change in the beauty industry (Goldie et al, 2025; Suwajee et al, 2025).

Consumers of cosmetic tourism products, especially those from high-income countries, can impact their purchasing choices, opting for providers that have a strong environmental and social responsibility ethos (Suwajee et al., 2025; Goldie et al., 2025). But, change by consumers is not enough (Macassa, 2026). The drivers of unsustainability: carbon intensive travel, resource intensive clinical operations and precarious labour require systemic solutions which can only be achieved through coordinated policy action (Macassa, 2026; Okereke & Oti, 2026). The SDG framework offers the normative framework for such intervention but will need to be implemented through specific governance mechanisms, independent auditing and accountability mechanisms that make industry actors accountable for both environmental and social performance. et al., 2025; Macassa, 2026).

6. Conclusion

The phenomenon of cosmetic tourism in Sub Saharan Africa is both an opportunity and a challenge, with significant impacts on the region's sustainable development future (Okereke & Oti, 2026; Macassa, 2026).

The growth of the sector provides an opportunity to achieve economic diversification, job creation and a reduction in the cost of health care seeking for outbound tourism (SDG 8's vision for inclusive economic growth and decent work) (Çapar et al., 2025; Otieno, 2026). These advantages, however, are dependent on solving environmental and work force sustainability issues that exist today describe the industry (Macassa, 2026; Goldie et al., 2025).

International patient travel and the carbon footprint, waste from surgical procedures and from clinic operations, are incompatible with SDG 12 and SDG 13 (climate action) and the ecological vulnerabilities of the region (Smit et al., 2025; Goldie et al., 2025). At the same time, the work conditions, the potential for burnout and the lack of decent

working conditions for people working in the cosmetic tourism industry pose risks to the long-term sustainability of the industry and are contrary to SDG 8's decent work agenda (Bizuneh et al., 2025; Okereke & Oti, 2026). The struggle for limited healthcare professionals between the private cosmetic tourism sector and under-resourced public health systems compounds SDG 3's pledge to achieving health system coverage (Okereke & Oti, 2026; Macassa, 2026).

The transition to sustainable cosmetic tourism in Sub-Saharan Africa should involve a paradigm shift in the logic of the tourism sector, moving from a growth-at-any-cost approach to one that is regenerative in nature and focuses on ecological integrity and human wellbeing, in line with the interrelated and integrated nature of the SDGs (Macassa, 2026; Çapar et al., 2025). This is not only an ethical, but also a strategic requirement (Goldie et al., 2025). In a health care resource poor area of the country, tssshe declining resources and cosmetic tourism that consumes them are ultimately self-defeating (Okereke & Oti, 2026; Macassa, 2026). This is the challenge policy makers, industry leaders and health system stewards must address, in order to establish frameworks that harmonize the commercial aspects of cosmetic tourism with the greater vision of planetary health, decent work and health equity (Çapar et al., 2025; Macassa, 2026). The success or failure of this alignment will be crucial for the sustainability of the development path of Sub-Saharan Africa in the 21st century, as well as the resilience of its health systems and the future of its 'cosmetic tourism' business (Otieno, 2026; Okereke & Oti, 2026).

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