

**Strategic Benevolence: India's Healthcare Diplomacy and
Cross-Border Health Systems with Bangladesh**

By

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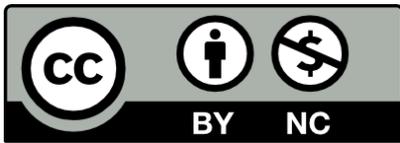
In partial fulfilment of the requirements for the degree of Bachelor of Arts in Philosophy,
Politics, and Economics

Supervisor: Judit Sandor

Vienna, Austria, 2025

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I, the undersigned, Kshitij Singh, candidate for the BA degree in Philosophy, Politics and Economics declare herewith that the present thesis titled “Strategic Benevolence: India’s Healthcare Diplomacy and Cross-Border Health Systems with Bangladesh” is exclusively my own work, based on my research and only such external information as properly credited in notes and bibliography. I declare that no unidentified and illegitimate use was made of the work of others, and no part of the thesis infringes on any person’s or institution’s copyright.

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Vienna, 24. 05. 2025

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ABSTRACT

This thesis attempts to answer the research question: In what ways has India employed healthcare diplomacy with Bangladesh to advance its economic and strategic standing, and how does the July Revolution reshape the trajectory of these efforts? The research explores the instruments of India's healthcare diplomacy— namely Medical Value Tourism (MVT), vaccine diplomacy, and traditional medicine frameworks— and their role in building cross-border solidarity. Combining descriptive qualitative and quantitative evidence grounded in neoliberal institutionalism and constructivism, the study identifies the projection of healthcare norms and institutional linkages as key to India's soft power strategy in South Asia. Ultimately, the analysis demonstrates that India's healthcare diplomacy has fostered cross-border solidarity whilst simultaneously providing economic and strategic benefits to India. However, with the July Revolution in Bangladesh, diplomatic channels with India have been disrupted, paving the way for China's expanding healthcare footprint. As such, the study exemplifies the impact of political and cultural dynamics in shaping health outcomes as well as geopolitical competition. In light of this, the thesis concludes with policy recommendations to develop regional infrastructure and ease visa restrictions, diversify healthcare centers, and institutionalize cross-border health flows to revive India's image as a benevolent partner.

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INTRODUCTION

Background & Context

India's healthcare system constitutes one of the largest and most diverse in the world, employing around 75 million people and providing care to more than a billion residents. Characterized by a combination of public and private cooperation, its quality and reputation have grown rapidly, especially in urban centers like Mumbai and Chennai. This has been critical in driving medical tourism into India, transforming the country into one of the world's top destinations for Medical Value Tourism (MVT). Earlier termed "medical tourism" to describe the "practice of travelling across international borders to seek healthcare services," further research saw an evolution of the name to account for the "growing patients" healthcare-seeking behaviour as well as the wider economic impact of such travel on nations hosting them" (Ministry of Tourism, 2022; Ministry of Tourism, n.d.). As of 2023, India received around 635,000 foreign arrivals for MVT, with most hailing from South and Southeast Asia and Africa (Press Information Bureau, 2024). This has not only served to transform India's healthcare economy but also significantly shaped its regional and global standing. By providing affordable and high-quality healthcare facilities, India has positioned itself as a trusted partner, especially in the regional landscape of South Asia. Nowhere has this been more visible than in its relations with its neighbour Bangladesh. In 2023, medical tourists from Bangladesh made up more than half of all MVT into India, and the two countries had established several partnerships to drive healthcare cooperation and collaboration on public health initiatives (Singh et al., 2022). Factors such as geographical and cultural proximity further accelerated this trend, enabling the sharing of medical expertise and high-quality healthcare training. However, as bilateral ties deepened, Bangladesh's domestic political climate grew increasingly unstable. In 2024, Prime Minister

Sheikh Hasina's government attempted to restructure government job quotas to provide allocation for the descendants of freedom fighters. The approval of this policy by the Supreme Court eventually triggered large-scale student protests, transforming into the July Revolution which ousted Sheikh Hasina and her party (Ahmad, 2025). The perception that India had legitimized and supported Hasina's regime raised several questions regarding India's involvement in the country's politics and its collaborative efforts. With this shift in sentiment, relations in the healthcare sector were also detrimentally impacted, as visa restrictions and political instability caused a sharp decline in MVT and disrupted established channels of cooperation. As such, India needs to carefully navigate its healthcare diplomacy with Bangladesh— understanding the economic and political factors that shape it, and adapting its approach to ensure the continued success of its healthcare initiatives.

Research Focus

As India evaluates its relationship with Bangladesh, the role of healthcare diplomacy in shaping bilateral ties has become increasingly prominent. Although bilateral healthcare cooperation is universal, what makes this particular issue timely is the convergence of two unique developments: first, Bangladesh's increasing and total dependence on India in the healthcare sector; and second, the political rupture caused by the July Revolution and its disruption of India's established relations with the Hasina government. These shifts demand an assessment of the role healthcare has played in India's diplomatic toolkit— its strengths, instruments, and vulnerability to political shifts. Thus, the central research question guiding this study is: In what ways has India employed healthcare diplomacy with Bangladesh to advance its economic and strategic standing, and how does the July Revolution reshape the trajectory of these efforts? This study is temporally delimited to the period post-2014 and concentrated on the instruments of medical value tourism, vaccine diplomacy and development aid, and traditional Indian medicine.

Ultimately, this thesis argues that India has instrumentalized MVT, vaccine diplomacy and development aid, and traditional Indian medicine as a tool of healthcare diplomacy with Bangladesh to bolster its economic and strategic position. Despite political transitions in Bangladesh, India's healthcare sector remains a critical channel for diplomacy, and with a greater focus on healthcare and cultural cooperation, India can enhance its influence in the region and further solidify its role as a South Asian leader. This investigation contributes to the growing literature on international relations, healthcare policy, and India-Bangladesh ties. Most importantly, however, it fills a gap in understanding how healthcare, as a form of non-coercive diplomacy, can serve as a political and economic tool to shape narratives. This is especially unique in the South Asian context between India and Bangladesh—neighbouring countries with established flows of medical value tourism. Furthermore, it also highlights the ways in which cross-border healthcare systems and diplomacy are impacted by political upheaval.

By analyzing the economic and strategic dimensions, this study will also provide policy recommendations, shedding light on how India can adapt its healthcare and foreign policy to better achieve its objectives in response to the political transitions within Bangladesh. This research will also be significant for healthcare investors and international development agencies, as it offers actionable insight into building resilient healthcare ecosystems and driving healthcare-driven economic and political transformations.

Theoretical Framework

This inquiry will predominantly focus on the period post-2014, which marked a strategic recalibration of India's foreign policy under Prime Minister Narendra Modi. It was during this time that important policy measures such as Heal in India and Vaccine Maitri were implemented,

and healthcare diplomacy emerged as a critical component of power projection in South Asia. In order to understand India's approach with Bangladesh, its foreign policy strategy must also be mentioned. Under Modi's administration, India pivoted towards the Neighbourhood First policy, emphasizing active engagement with its South Asian neighbours (Ministry of External Affairs, n.d.). This involved greater economic cooperation, provision of humanitarian or developmental aid, and collaboration on education and health initiatives. This policy has been instrumentalized in tandem with the Act East policy— focused on Southeast Asia— to counter growing Chinese influence. In discussing this, while realist approaches may explain India's strategic interest in Bangladesh, they fail to account for the non-coercive, narrative-shaping role of healthcare through institutions and educational initiatives. As such, the neoliberal institutionalist and constructivist viewpoint will help better understand the symbolic dimensions of India's actions. Before turning to these two main theoretical approaches, it is worth noting the concept of soft power, which Nye (2004) defines as the power of culture, policies, and values in achieving political outcomes. This form of power seeks to co-opt rather than coerce. India's projection of itself as a benevolent provider of affordable, high-quality healthcare tools through initiatives like Vaccine Maitri and Heal in India embodies this idea. In this investigation, although soft power does not function as a standalone methodological theory, it anchors the analysis by aptly describing India's healthcare efforts in Bangladesh, especially with educational and traditional health initiatives.

Nye's and Keohane's theory of neoliberal institutionalism offers a comprehensive insight into the dynamics between India and Bangladesh. This theory holds that cooperation between states takes place through channels of institutions, which create systems of mutual economic benefit, ultimately establishing better relations (Keohane & Nye, 2011). Developing on this, Ikenberry (2001) argues that regardless of changing governments, institutions remain durable

because of several factors, including but not limited to: coalition-building impact, high cost of setting up challenging institutions, and spillovers into other institutions. India's healthcare employment can thus be viewed through this framework as a strategy of institutional entrenchment, wherein diplomatic and developmental partnerships are constructed in such a way that they outlast temporary political shifts. The signing of multiple bilateral Memoranda of Understanding (MoUs), training programs, and AYUSH centers leave an impact that is difficult to erase with political transitions, since they focus on people-to-people ties and knowledge diplomacy. Yet, it must be noted that while India undoubtedly holds structural advantages, it does not possess unilateral control. Bangladesh has already shown a willingness to step up cooperation with China, undermining India's Neighbourhood First Policy. As such, in understanding India's healthcare diplomacy, neoliberal institutionalism carries certain assumptions of entrenched institutional resilience that might not hold with ideational shifts, thereby necessitating the use of constructivist theory.

The constructivist theory complements this analysis by placing emphasis on the role of ideational factors in state interactions and international relations. While neoliberal institutionalism explains the foundation that enables healthcare cooperation through institutions, it assumes largely rational and interest-driven behavior. Constructivism challenges this materialist bias by arguing that state preferences are defined by socially constructed and context-dependent identity and ideology. As Alexander Wendt (1992) asserts, even core concepts like "power politics" are not static, but subject to historical relationships and changing ideas. Norms— which are defined by Chayes (1994) as "a broad class of prescriptive statements...carrying an obligation"— are central to this process. According to Finnemore and Sikkink (1998), the success of these norms is contingent on factors like history and universality. This is especially relevant in India's institutional links to Bangladesh, where normative guidelines of healthcare rooted in

historical memory are propagated by India to foster collaboration with its neighbour. Within this context, constructivism also helps unpack the religious divide between the two countries as a salient ideational component. Although India may frame its initiatives through an inclusive ethos, how well a Muslim-majority country like Bangladesh perceives this is influenced by its historical perspective and norms. As such, this thesis also employs a constructivist lens to explain the interpretation and reception of Indian healthcare initiatives in Bangladesh, particularly during moments of political and ideological transitions.

Methodology

This thesis investigates India's healthcare diplomacy with Bangladesh from 2014 onward, a period marked by a strategic recalibration under Prime Minister Narendra Modi. This period is chosen precisely because it coincides with the development of a definitive diplomatic approach by the Indian government involving instruments of healthcare, as well as a greater level of economic and political engagement between India and Bangladesh. This study adopts a mixed-methods approach grounded in neoliberal institutionalism and constructivism. Neoliberal institutionalism helps trace the formal agreements and institutional structures that define the India-Bangladesh relationship, whereas constructivism allows an understanding of firsthand accounts describing how stakeholders perceive and internalize India's healthcare outreach. The single-case design of this investigation is justified given the healthcare-driven and historically amicable nature of India-Bangladesh relations, as well as the availability of data because of this high level of engagement. Alternative cases such as Nepal and Sri Lanka were considered but eventually excluded given their lack of comparability in healthcare reliance and geopolitical instability.

In terms of qualitative discussion, this case study relies on discourse analysis using primary sources such as official documents from the Indian Ministry of External Affairs (MEA), the Indian Ministry of Health, the Press Information Bureau, and Bangladesh's Ministry of Health and Family Welfare. These archival documents include memoranda of understanding, government press releases, policy white papers, and joint health agreements. These were selected primarily for their insight into formal healthcare engagement tools and institutional networks that have been deployed to develop the India-Bangladesh relationship. These sources are analyzed through the neoliberal institutionalist framework to trace the impact and durability of cooperative structures like bilateral health MoUs and institutional training programs. Simultaneously, secondary sources are utilized to highlight the impact of formal engagement tools across individual experiences and narratives. Among these are academic studies evidencing Bangladeshi perceptions of Indian traditional medicine and healthcare infrastructure, and news articles focusing on MVT flow and India-Bangladesh relations. The constructivist lens is applied here to assess how Indian initiatives function within the framework of political identity and shape Bangladesh's identity and perspectives of Indian healthcare. In this assessment, the efficacy of India's healthcare diplomacy will be measured in accordance with the response it elicits from Bangladeshi stakeholders such as bureaucrats, medical professionals and patients. Additionally, the research is also supported by a recorded single interview featuring two participants: Dr. Kiron Khan— an Assistant Professor and medical tourist from Bangladesh with firsthand experience of India's healthcare system, and Dr. Reeta Sharma—an Indian doctor of Ayurveda. These interviewees were chosen in order to provide anecdotal, complementary perspectives from both sides of the healthcare diplomacy scene.

The quantitative aspect of this research employs a descriptive analysis of statistical trends in MVT, pharmaceutical trade volumes and medical aid flows, and health-sector investment and

profit using Indian government sources, pharmaceutical trade volumes from national trade databases, and reports on Indian development aid. These datasets are used predominantly to contextualize the economic dimensions of India's healthcare diplomacy, and evaluate the outcomes of India-Bangladesh cooperation on the financial front. While third-party datasets were available, this study prioritizes official or affiliated Indian and Bangladeshi sources to maintain consistency and relevance to policy frameworks. The data is not utilized for statistical modeling, but is interpreted descriptively to showcase economic patterns, especially in studying the appeal of the Indian healthcare model.

CHAPTER I: LITERATURE REVIEW

1.1 New Era of Healthcare Diplomacy

Previous research on India-Bangladesh relations had focused extensively on the political frontier, where healthcare studies mostly concentrated on economic and MVT-oriented results. However, with the COVID-19 pandemic, research intensified into what was deemed an era dominated by healthcare, as opposed to trade, military, or culture-driven bilateral relations (Singh & Chaudhuri, 2024). This form of diplomatic engagement and influence, through the use of health initiatives such as the provision of medical assistance, vaccinations, and healthcare infrastructure, can be termed healthcare diplomacy. Observing the transforming landscape, India's Ministry of Health and Family Welfare (MoHFW) and the Ministry of AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy) launched the Heal in India campaign, streamlining MVT by setting up a dedicated platform for foreigners to directly connect with medical facilitators and access relevant information (Press Information Bureau, 2023). Yet, the development of such systems has been a relatively recent phenomenon. While health committees and institutes were established as early as the 1990s and 2000s, attempts to internationalize them emerged later under Modi's administration. Under Modi, the Ministry of AYUSH became part of the WHO's 'Traditional Medicine Strategy 2014–2023 and Indian diplomats began playing a greater role in disseminating the country's health agenda abroad (World Health Organization, 2023). During the COVID-19 pandemic, India launched its 'Vaccine Maitri' initiative, supplying vaccines to around 75 countries and receiving unanimous praise for its efforts (Sharma, 2025). This was visibly exemplified in the case of Bangladesh. A study by Mondal (2024) evaluated the success of India's vaccine diplomacy with Bangladesh during the COVID-19 pandemic, where it provided 2 million doses within four days of starting its own vaccination program. The research concluded that this “not only strengthen[ed] political

ties with neighboring and global countries but also interact[ed] with religious value systems, influencing public acceptance of vaccines” (Mondal, 2024) This implied the role of healthcare in transcending religious boundaries, ultimately creating people-to-people connections that bolstered relations and positioned India as a leader on the global stage (Singh and Chaudhuri 2024). At the same time, it traced the roots of India’s healthcare diplomacy to its civilizational ethos of ‘Vasudhaiva Kutumbakam’ or ‘the world is one family’ (2024). In these studies, a strong healthcare narrative grounded in cultural values was emphasized, suggesting that India's healthcare diplomacy is not solely driven by political or economic motives, but also deeply embedded in its cultural and philosophical outlook. Having established its reputation as a trusted medical partner, India has further used this position to advocate for traditional Indian medicine systems like Ayurveda, Unani, Yoga and Homoeopathy. Historically, Pal (1997) finds that the majority of people in South Asia have been “looking up to” Ayurvedic treatment for curing various illnesses. While it is difficult to draw a causal relationship, India’s push for adoption of such traditional medicine systems has coincided with a significant rise in the use of Ayurvedic medicine in Bangladesh. The Ministry of AYUSH has been actively involved in deputing experts to foreign countries, including Bangladesh, “for promotion and propagation of AYUSH Systems” (Ministry of AYUSH, n.d.). A significant portion of the healthcare budget has also been allocated for the “strengthening of health centers/institutions in a foreign host country” since 2020 (Press Information Bureau, 2021).

However, while this literature explores India’s healthcare outreach and decision-making, few studies analyze the role of such initiatives as diplomatic tools embedded in soft power and structural dependence, particularly with Bangladesh. Even fewer offer any insight into how these systems function or falter in the face of political transitions. Moreover, existing research tends to universalize frameworks of healthcare diplomacy without adequately considering the cultural and historical dynamics in the context of South Asia. In the case of India and Bangladesh, healthcare

diplomacy cannot be purely understood through a strategic lens, but through linguistic and cultural solidarities. This thesis addresses this dimension by exploring how India's healthcare initiatives are projected as well as received across the border in Bangladesh, and how their effectiveness is shaped by cultural linkages and political transitions.

1.2 Regional Centers and Policy Shifts

India's independent think tank – Observer Research Foundation (ORF) – has been conducting greater research into the factors driving healthcare collaboration between Bangladesh and India. It identified several challenges facing Bangladesh's healthcare sector: corruption, poor quality of infrastructure, shortage of medical professionals, lack of hygiene, and dearth in rural areas (Bose, 2025). These factors were largely responsible for driving a patient exodus into India, where treatment was more reliable and affordable, avenues for leisure were present in abundance, and connectivity was of little concern. Kolkata – the capital of India's West Bengal province – was the most attractive destination, being home to prestigious hospitals like the Apollo Multi-Speciality Hospital, the Narayana Super Specialty Hospital, and the Rabindranath Tagore International Institute of Cardiac Sciences (2025). This offered some insight into not only the importance of proximate urban centers but also historic and cultural bonds in shaping healthcare relations. Kolkata and West Bengal in general are home to most of India's Bengali population, thereby having strong family and linguistic ties to Bangladesh. This region thus becomes crucial to understanding India's healthcare diplomacy with Bangladesh.

Despite the aforementioned advancement in diplomatic relations, the July Revolution of 2024 had immediate repercussions on the healthcare ties. As reported by Das (2025), ongoing instability has caused a significant decline in MVT, as the Indian government has drastically cut back on visa provisions. This has paved the way for China to expand its footprint and influence in Bangladesh, pursuing deeper economic and healthcare cooperation. In March 2025,

Bangladesh's interim Prime Minister Mohammad Yunus informed Chinese Ambassador Yao Wen that the country was gearing up to open its market further to Chinese firms and investment (Dhaka Tribune, 2025). In fact, since the interim government took office, Chinese companies have “invested more than \$230 million in Bangladesh, the most of any country in that period” (Das, Patel, & Paul, 2025). Meanwhile, many Bangladeshi patients have opted for Thailand or China as their alternative destination for treatment. In this climate, the existing literature, despite offering descriptive contributions and statistical trends, provides little in the way of strategic guidance for India. This thesis fills this gap by discussing the policy measures through which India can preserve and enhance its instruments of healthcare diplomacy—building an actionable framework rather than a mere enumeration of trends.

CHAPTER II: THE INSTRUMENTS OF INDIA'S HEALTHCARE DIPLOMACY

2.1 Medical Value Tourism (MVT) as a Vehicle of Strategic Power

India has instrumentalized MVT as a tool of soft power with Bangladesh to bolster its strategic and economic position. An essential step in positioning India as the leading destination for MVT has been the institutionalization of such tourism. While many countries experience an inflow of MVT, few have developed direct digital and bureaucratic infrastructures like the Heal in India platform through which foreign patients can seamlessly access treatment, compare hospitals, and even arrange travel. Even before this institutionalization during Modi's rule, Indian hospitals and networks were facilitating MVT. The impact of this was observed in successfully communicating India's intentions as a 'Vishwamitra' or a *friend of the world*, by enabling the well-being of foreign populations (Singh, 2024). A study by Nabi, Khan, Misbauddin, and Fatema (2023) confirmed the resulting favorable perception, finding that Bangladeshi patients strongly associated Indian medical services with procedural fairness, respectful interpersonal treatment, and clear communication. These three dimensions of perceived justice – procedural, interpersonal, and informational – had a significant influence in shaping these positive views (2023). This means that Bangladeshi patients not only valued medical outcomes or affordability, but also the transparency, dignity and humane treatment they encountered. As such, Indian healthcare actors transcended their roles as service providers, as they fostered a layer of people-to-people diplomacy that operated independently of official state narratives. Even though the Indian state laid the foundation for these interactions through its initiatives, the ultimate manifestation of soft power was observed at the grassroots level. The creation of positive word-of-mouth ecosystems thus became essential in shaping positive emotions towards Indian healthcare as well as India in general. This was also made explicit with a study published in 2023

by Zakaria et al. (2023), which surveyed 388 Bangladeshi tourists and discovered that “interpersonal channels” involving family or friends were the source of information about healthcare in India for 77% of the participants. Most of the surveyed participants also expressed positive perceptions about India’s cultural offerings and country image. These interactions illustrated a broader normative process. From the constructivist lens, it can be said that the preferences and behaviors of patients were not merely determined by material outcomes, but rather socially constructed notions of India as a benevolent regional entity. The use of community networks and familial bonds demonstrates this diffusion of norms about what constitutes ethical and dignified care across borders. At the same time, this points to the success of the neoliberal institutionalist framework to some extent. Indian hospitals have served as informal diplomatic posts, building trust and familiarity with patients from Bangladesh and transforming them into ambassadors of goodwill. In this sense, India’s healthcare infrastructure functions as proof that diplomacy can be conducted through daily human encounters within hospital walls as opposed to government offices.

2.2 Vaccine Diplomacy and Development Aid: India’s Regional Strategy

During the COVID-19 pandemic, India’s vaccine diplomacy emerged as a definitive feature of its regional and global soft power outreach. Through Vaccine Maitri (Vaccine Friendship), India provided millions of COVID-19 vaccines to countries all over the world. With Bangladesh in particular, these efforts were swift and effective, as demonstrated by Indian External Affairs Minister S. Jaishankar’s tweet that “#VaccineMaitri reaffirms the highest priority accorded by India to relations with Bangladesh”(Jaishankar, 2021). India’s provision of 2 million vaccine doses and medical equipment to Bangladesh under this initiative marked a high point in

India-Bangladesh relations. These sentiments were expressed by both parties involved. During the pandemic, Bangladesh's Prime Minister Sheikh Hasina thanked PM Modi, calling Vaccine Maitri a "prudent initiative" that reiterated India's position as a "tested" friend which stood by Bangladesh in all times of need (NDTV, 2022). Not only this, she expressed that Modi had "won the hearts and minds of people" by supporting Bangladesh during this crisis (2022). Domestically in India, the role of Vaccine Maitri was also recognized by former diplomat and politician Dr. Shashi Tharoor, who said it "considerably augmented India's soft power, projecting across the developing world that India could prioritise humanitarian aid, reinforcing its image as a benevolent and reliable partner on the global stage" (Tharoor, 2025). This widespread political as well as public approval showcases the effectiveness of India's healthcare diplomacy through the Vaccine Maitri project. Bangladesh's recognition of India as a tested friend demonstrated a level of relational trust-building rooted in solidarity and compassion, as opposed to a commercially-driven partnership.

India's vaccine initiative was also not simply an isolated gesture, but a broader continuum of India's role in Bangladesh's healthcare ecosystem. This has been demonstrated on several instances, most notably with the 'Aid to Bangladesh' program, which involved Indian government funding for the construction of 36 community clinics in Bangladesh (Partners in Population and Development, 2017). Under this programme by 2018, the Government of India had completed 29 grant projects focused on the development of medical facilities in Bangladesh, particularly in rural regions. Again, this was met with applause from the other side of the border. Bangladesh's High Commissioner to India Syed Muazzem Ali declared that Bangladesh-India relations "reached to a newer height, thanks to the commitment and able leadership of our Prime Ministers"(Ali, 2018). He also emphasized the need to keep expanding bilateral cooperation in the healthcare sector. The deepening of this relationship was then observed during the

COVID-19 pandemic, when Bangladesh reciprocated India's early support by sending consignments of medical equipment— a reminder that healthcare diplomacy had matured into a two-way channel of cooperation.

2.3 Harnessing Tradition: The Role of AYUSH and Traditional Systems

Possibly the most recent development in Indian healthcare diplomacy has been the push to propagate ancient systems of healing. Private companies have been central to this strategy. Through participation in the South Asian Free Trade Area (SAFTA), the two countries bolstered trade relations, as Indian goods came to account for 12% of all Bangladeshi imports (India Brand Equity Foundation, n.d.). In the traditional medicine scene, Indian companies dominated. The impact of this was exemplified with the rapid growth of the herbal medicine market, which stood at a value of 2.5 billion Taka, in 2023, largely driven by Indian companies such as Dabur and Patanjali (Chakma, 2023). In fact, nearly all of the high-demand Ayurvedic products sold in Bangladesh were either manufactured in India or closely modeled after Indian formulations. This market penetration serves to embed Indian medical diplomacy in everyday health practices, taking advantage of soft infrastructure: cultural familiarity, linguistic accessibility, and reputational prestige. In addition to commercial gains, this soft power strategy also functions as a civilizational assertion of India's regional identity as a custodian of holistic healing systems. Even the branding of popular Indian companies such as *Patanjali* is a subtle nod to this civilizational continuity. The name *Patanjali* itself refers to the ancient Indian sage who founded Yoga and advanced traditional systems in the subcontinent. Such invocations of a shared past tend to resonate with Bangladeshis, who despite their distinct Muslim identity, still remain inextricably linked to Hindu or Buddhist-influenced traditional practices. The popularization of Indian traditional medicine in Bangladesh cannot be thus perceived in economic terms, but as a shift in

epistemic norms perceived through the constructivist lens. This process can be understood through Finnemore and Sikkink's (1998) notion of 'norm entrepreneurs'—actors and agencies that construct and promote norms in the international sphere. The Ministry of AYUSH and brands like Patanjali function not solely as exporters of products, but a normative agenda of what counts as legitimate healthcare methods, rooted in historical memory. As such, the Indian traditional medicine framework blurs the line between public health outreach and civilizational storytelling, generating soft power through the evocation of shared historical consciousness.

On the other hand, public sector initiatives have also spearheaded India's healthcare diplomacy in Bangladesh by establishing cross-border educational systems. In 2014, India and Bangladesh signed a memorandum of understanding (MoU) to boost cooperation in the field of traditional medicine. Since then, the Ministry of AYUSH has set up an academic chair at Hamdard University in Bangladesh to develop research and facilitate exchange, an information cell to "disseminate authentic information", and allocated 104 seats for annual student fellowships in the areas of Ayurveda, Yoga, and Unani (Press Information Bureau, 2025). This cultivates a cross-border exchange of ideas alongside a new generation of healthcare professionals who are trained in Indian knowledge systems, and can contribute to local healthcare ecosystems in Bangladesh. In the long run, this creates a layer of epistemic influence that transcends market transactions, integrating India's healthcare vision into Bangladesh's intellectual framework. Most importantly, the reception of such initiatives has also been extremely warm in Bangladesh. Bangladesh became one of the few countries to have formally recognized all types of Indian traditional medicine as an official system of medicine by 2021 (Press Information Bureau, 2021). Not only this, a study conducted in Dhaka found that at the local level, around 96% of selected Bangladeshi participants believed that Ayurvedic treatment "was effective in both males and females" (Yoshida et al., 2016). What was even more revealing,

however, was the perception of doctors in Bangladesh. As far back as 2015, 62.0% of interviewed MDs in Bangladesh had treated their patients using Ayurvedic medicine (Yoshida et al., 2017). This established that Indian traditional medicine was not merely perceived as a remedy by rural populations and the government, but also the medical authorities. Given the fact that the traditional medicine industry has grown substantially in Bangladesh, so much so that 70% of the population relied on some traditional remedy in 2024, it would be reasonable to claim that efforts to integrate Indian traditional medicine into Bangladesh's healthcare ecosystem have found both cultural resonance and greater institutional viability (Nahar et al., 2024).

CHAPTER III: ECONOMIC AND POLITICAL IMPLICATIONS

From an economic standpoint, healthcare diplomacy has provided India with substantial benefits. In 2020 alone, the MVT industry generated 167,000 jobs and revenues of \$8 billion (Dave, 2023). While other countries experience MVT as well, India's infrastructural development as a component of healthcare diplomacy enabled a predicted annual growth rate of 21.1% in the industry until 2024 (Federation of Indian Chambers of Commerce and Industry, n.d.). The ease of access and dignified treatment that patients from Bangladesh experienced has been instrumental in driving up revenues of Indian private hospitals like Max Healthcare and Apollo, and it is reported that Bangladeshi medical tourists constitute at least 3-7% of these figures (CNBCTV18.com, 2024). Some also argue that this has rendered Bangladesh complacent, relying on external options rather than pursuing domestic healthcare reform (Chakma, 2024). As of 2019, Bangladesh's government health expenditure was the lowest of all South Asian countries, and out-of-pocket expenses for citizens were second-highest (Huq, Al-Amin, Howlader, & Kabir, 2015). This leaves Bangladeshi patients from poorer backgrounds with very few options to pursue high-quality healthcare, and has thus proved beneficial for Indian healthcare providers, with MVT comprising around \$6 billion of the industry in 2022, and expected to rise to \$13 billion by 2026 (Federation of Indian Chambers of Commerce and Industry, n.d.). Moreover, this economic inflow has not been limited to the healthcare sector. This tourism has generated broader multiplier effects in sectors of hospitality, transportation, artisan crafts, and retail. In Indian cities, Bangladeshi patients often book packages including hotels, flights, and a post-operative vacation, making healthcare a gateway for multiple-sector economic engagement (Gupta, 2016). However, it remains difficult to quantitatively measure the impact of healthcare diplomacy between India and Bangladesh. This is because relations in the healthcare sector have been a component of a larger foreign policy strategy involving both state and informal

interactions. The resulting economic interactions that took place before Sheikh Hasina's ousting were in many ways, a testament to India's effective approach. Bilateral trade between the countries stood at \$15.9 billion in FY23, and cooperation was taking place on all fronts (Ministry of External Affairs, 2024). Pharmaceutical exports were also significant in shaping these ties, with India exporting around \$45 million worth of pharmaceutical products to Bangladesh in 2024 alone (Ministry of Commerce and Industry, n.d.). Indian companies such as Biocon and Cipla had established a strong presence in Bangladesh, supplying affordable generic medicine to almost all cities of the country. This was possible precisely due to India's focus on healthcare development and simultaneous pursuit of a healthier relationship with its neighbour in the aforementioned sector. India was also Bangladesh's largest development partner, consistently investing "in strengthening railway infrastructure of Bangladesh through Lines of Credit program" (Ministry of External Affairs, 2024). As such, India-Bangladesh relations during the Hasina regime exemplified the creation of a multi-sectoral ecosystem that fused both economic integration and neighbourly benevolence at an unprecedented scale. In South Asia, this level of economic integration allows Indian health-tech firms and institutions to expand regionally, establishing themselves as first movers in an emerging healthcare services corridor. Familiarity with Indian firms and medical protocols smoothens further collaboration in health data systems and services. These established channels that initially find grounding through market forces, gradually evolve into semi-formal institutions that sustain this collaboration. This dynamic aligns with the liberal institutionalist theory of Keohane and Nye, as functional institutions become drivers of diplomatic cooperation. In this context, healthcare diplomacy emerges as a central mover in reinforcing durable architectures between India and Bangladesh, ultimately transforming the economic relationship into a long-term asset of regional leadership.

Healthcare diplomacy with Bangladesh has also had a subtle impact in advancing India’s strategic interests on the political frontier. By embedding itself into Bangladesh’s healthcare infrastructure as well as its very conception of herbal treatment, India has almost established a form of normative hegemony. The strategic benefit of this lies in bolstering positive sentiments towards India to cement its alliances as a regional leader, which in turn preempts rival influence from China. In advancing the Neighbourhood First Policy, India’s objectives have been clashing with China’s, which aims to secure connectivity and market access in Bangladesh as part of its Belt and Road Initiative (BRI)(Al Amin, 2025). However, by cultivating warm relations with Hasina’s government and simultaneously fortifying people-to-people linkages, India had preserved its status as a priority partner despite China’s ascension as Bangladesh’s top trade ally. This was still beneficial primarily in two ways. Firstly, with Bangladesh being forced to play a game of strategic hedging— balancing both sides to maximize profit, India could still maintain access to key infrastructure and ports in the Bay of Bengal. Secondly, even as Dhaka flirted with Chinese investments, India could continue embedding its healthcare systems into Bangladesh’s framework, thereby giving India what is termed “sticky power”: a power neither soft nor hard, but one that attracts another party and then economically traps them (Mead, 2004). In this case, India’s economic as well as healthcare leadership had been assimilating Bangladesh into its system, making disengagement both costly and highly unlikely. From Wendt’s (1999) constructivist standpoint, this approach could also be fostering a “logic of appropriateness” within the Bangladeshi mentality. This refers to the creation of “internalized prescriptions of what is socially defined as normal”, which supersedes the prescription that maximises utility (1999). As Indian healthcare methods and institutions become embedded, their perceived normalcy constrains the policy space available for Bangladesh to diversify due to the established cognitive understanding. This would guide the success of greater strategic goals that India has in South Asia – enhancing security and “physical, digital and people to people connectivity” with its

neighbours (Ministry of External Affairs, 2024). As such, the mere fact that China had surpassed India as Bangladesh's foremost trade partner did not appear to thwart Indian strategic ambitions, as engagement in all sectors was growing until the July Revolution in 2024.

CHAPTER IV: FUTURE OF HEALTHCARE DIPLOMACY POST

SHEIKH-HASINA

The July Revolution of 2024 threw India-Bangladesh relations into a flux. India's decision to shelter Hasina was met with considerable anger in Bangladesh, and the new interim government under Mohammad Yunus also chose to distance itself from the overtly pro-India posture of the previous regime. The impacts of this on India's healthcare sector have been largely negative:

First, in the short-term, MVT took a significant hit, reducing hospital revenues and hindering job growth. The effects of this were most pronounced in Kolkata. In December 2024 alone, some hospitals in Kolkata reported a drop in Bangladeshi patients of around 75% (Nag, 2024). Popular hospitals like Apollo and Manipal witnessed declines of more than 15% in international patient revenue in the following quarter (Apollo Hospitals Enterprise, 2025). At the same time, small enterprises such as hotels and restaurants catering to Bangladeshi patients were shutting early and facing significant losses (Javed, 2024). Although MVT remains an emerging sector and the immediate financial setbacks might appear localized, they underscore deeper fractures in the India-Bangladesh relationship. In light of the growing instability, India has restricted medical visas, whereas China has provided three hospitals in Kunming specifically to host Bangladeshi patients (Jasim, 2025). According to Seok Healthcare CEO Masumuzzaman, "those who would otherwise go to India or Thailand for treatment are now thinking about China" (bdnews24.com, 2025). The options China is offering have also wooed patients because their costs are not much higher than Bangladesh, but the quality is "on par with international standards" (2025). This demonstrates a mutual exchange that establishes China as the new healthcare hub in Bangladesh's psyche. With word-of-mouth being the primary driver of MVT

into India, it might be possible that the positive experiences of patients facilitate a shift away from India and towards China. The Chinese government has also pursued an active role in Bangladesh's domestic healthcare system. It has agreed to grant \$138.2 million in aid along with a new hospital to be built in Dhaka (Nikkei Asia, 2025). These developments point towards a shifting foreign policy that undermines India in favor of China amid growing sentiments in Bangladesh that India is asserting hegemonic influence (Singh, 2024).

Second, in the long-term, anti-Indian public discourse as a fallout of the revolution could fracture relations in the healthcare domain. Narratives portraying India as an interfering power—particularly in light of its perceived endorsement for Hasina, and reach into Bangladesh's economy—have found traction and undermined the soft power India built through past initiatives. Beyond being held responsible for “emboldening” Hasina, India has been accused by Bangladeshi students and protesters of acting “superior” and effectively rendering Bangladesh into a “satellite state” (Bhardwaj, 2024). There is also the suspicion that Muslims are being discriminated against in the country, discouraging Bangladeshis from seeing India as a partner (Al Jazeera, 2024). These perceptions could erode the trust required for healthcare cooperation, particularly in sectors like MVT, AYUSH services, and student exchanges in traditional medicine and health sciences. Not only will this discourage Bangladeshi patients from seeking treatment in India, but also limit bilateral partnerships and prompt Dhaka to continue diversifying its dependencies. This highlights a key limitation of soft power—namely, that it is still a form of power and might be perceived as such, especially when political alliances change. In such cases, established institutions that for decades have nurtured perceptions, could very easily be substituted. China's healthcare model is already displaying itself as an alternative way of treatment, as Chinese traditional medicine is being combined with modern practices in hospitals

catering to Bangladeshi patients. Gradually, this could fundamentally alter Bangladesh's healthcare identity and alienate India from its healthcare ecosystem.

CHAPTER V: POLICY RECOMMENDATIONS

This chapter offers policy recommendations for India to recalibrate its healthcare diplomacy with Bangladesh in the aftermath of the July Revolution of 2024. As previous chapters have shown, India's strategy anchored in MVT, traditional medicine, and vaccine diplomacy proved to be successful until Hasina's ousting. Going forward, India must recognize the importance of legitimacy and cultural proximity in soft power, and develop its healthcare infrastructure accordingly. To this end, three key policy pillars are proposed in order of immediate importance:

5.1 Development of West Bengal and Eliminating Visa Restrictions

India's strength in healthcare diplomacy lies in its cultural and historical affinity with Bangladesh— through shared linguistic and cross-border familial ties. This is mostly rooted in West Bengal which is situated on the Bangladeshi border and serves as gateways for patients. Kolkata, as discussed previously, already plays a central role in MVT. However, in recent years, Kolkata's reputation as a healthcare hub has been tarnished. Many residents are leaving the province to seek treatment in cities like Chennai and Mumbai because of the “callousness, greed, and incompetence” of its doctors (Sharma, 2019). Scandals at hospitals involving fraudulent degrees and malpractice have further damaged Kolkata's healthcare landscape (Banerjee, 2017). Kolkata has also not acquired the branding that other cities in India have. It is well known in Bangladesh that India's best doctors are in centers such as Bangalore, Mumbai, Delhi and Chennai (Khan, 2025). This brand image has been cultivated over several decades through trust as well as media campaigns. In the case of Kolkata, this reputation is in decline, as its MVT remains largely limited to Bangladeshi nationals, with minimal inflow from other foreign patients.

To remedy this, India must launch a targeted rebranding initiative for Kolkata and key border cities, coordinated jointly by the Ministry of Health and Family Welfare (MoHFW) and the Ministry of External Affairs (MEA), in collaboration with the West Bengal state government and select private hospital groups. This initiative should focus on attracting reputable, internationally accredited doctors through financial incentives, streamlined accreditation, and co-branding opportunities with the internationally renowned hospital networks. Simultaneously, it must explicitly highlight the familial, linguistic, and emotional ties that bind Bangladesh to India through Bengali-language campaigns and policy outreach by the Press Information Bureau and diplomatic missions. Despite the growing interest in Chinese healthcare services, Bangladesh's cultural familiarity with India remains a strategic asset. West Bengal and Bangladesh share Bengali as the dominant language, and cross-border family connections ensure that Bangladesh cannot entirely sever its linkages with India. This view is also held by Dr. Kiron Khan, who states that "there is no doubt that Bangladeshis will definitely seek treatment in India" if visa restrictions are relaxed (Khan, 2025). Eliminating visa restrictions would thus prevent any unnecessary long-term distancing and fractures in the informal web of relations. Therefore, strengthening Kolkata's healthcare profile whilst simultaneously easing visa hurdles will continue attracting MVT, as patients will prefer a familiar destination over a relatively alien one like China. Finally, in order to evaluate the success of this policy, patient satisfaction scores, along with Bangladeshi medical arrivals, and third-party standard checks should be considered as performance benchmarks.

5.2 Diversification of Healthcare Centers

In parallel, India should also strengthen the healthcare infrastructure of Northeastern states bordering Bangladesh— such as Assam and Sikkim. These states have been prominent

tourist hubs, but lack the necessary hospital infrastructure to accommodate patients in large numbers. More importantly, out of the 61 US-based Joint Commission International (JCI) accredited hospitals in India, hardly any are in these provinces (Bose, 2025). As such, the branding and quality of healthcare in these regions is falling behind the rest of India. To integrate these regions into the vision of healthcare diplomacy with Bangladesh, the Indian Ministry of Health and Family Welfare and Ministry for Development of Northeastern Region should establish public-private tertiary care centers in cities like Guwahati, Agartala, and Gangtok. This should be envisioned with MVT in mind, rivalling China's Kunming model and offering multilingual support and AYUSH services in combination with modern medical treatment. With accreditation and high-quality medical technology, it would not take long for Northeastern hospitals to acquire a reputation on par with other JCI-approved hospitals in India. Special incentives must also be provided for private hospitals to set up centers in prominent cities in the region.

Equally essential is enhancing connectivity. While industrial development through projects like the Agartala-Sabroom-Chattogram rail corridor and Sabroom SEZ is underway, these routes have not been harnessed to support cross-border medical flows (Bose, 2023). Also, even though the Northeast has several airports, very few like Guwahati and Agartala offer international connections. Expanding connectivity with cities in Bangladesh like Chattogram and Sylhet would significantly reduce travel time for patients and caregivers, particularly when compared to the longer and more expensive journeys required to reach Chinese or Southeast Asian medical centers. Some connectivity upgrades were already taking place before the July Revolution, but need to be integrated with healthcare systems. For instance, the Indira Gandhi International Airport in New Delhi hosts a dedicated Medanta hospital counter, enabling international patients to check in immediately upon arrival and receive direct transport to the

hospital. Similar services at airports in the Northeast would vastly improve the patient experience, and encourage Bangladeshi patients to explore new health centers in India.

5.3 Health Systems Architecture for Cross-Border Care

India also needs to step up its cooperation with Bangladesh on the healthcare front. Beyond improving infrastructure and branding, a coordinated health systems architecture that monitors and scales cross-border care should be built. A major challenge in understanding healthcare engagement between the two countries is the absence of structured monitoring and health information systems. Most of the data available on patient satisfaction and treatment history is provided by independent researchers and third-party organizations, even if patient flows are monitored by the central Indian government. For India's healthcare diplomacy to become resilient and responsive, India should first establish a Bilateral Health Systems Coordination Platform, jointly administered by the Ministry of Health and Family Welfare (MoHFW) and the Bangladesh Ministry of Health. This would serve primarily two functions: first, to create a secure cross-border electronic record that tracks treatment histories and experiences of patients, and second, it sets common treatment and referral standards, and establishes a list of accredited hospitals eligible for cross-border care partnerships. This would ensure greater service quality and transparency in institutional accountability. In tandem, India could also appoint health systems officers at high-traffic consulates and medical centers to maintain standards and provide better insights into the needs of the healthcare system. As discussed previously, trust and familiarity are important factors in facilitating India's healthcare diplomacy, and this platform will institutionalize that trust through reliable systems rather than informal networks. Finally, the information gathered from this platform could guide further policymaking. The Indian government should publish an annual report detailing values like

patient volume, satisfaction scores, and hospital performance in treating foreign nationals as well as Bangladeshi patients. Institutionalizing this reporting mechanism would boost competition between hospitals, discouraging complacency and incentivizing quality care, as publicly available data would carry financial and reputational implications in both the domestic and international market.

CONCLUSION

This investigation aimed to capture the strategic employment of healthcare diplomacy by India in its bilateral relationship with Bangladesh, particularly in the context of regional competition, soft power, and political instability—as diplomatic tools to strengthen its economic and strategic position in the region. These instruments have allowed India to project an image of benevolence, cultural familiarity, and care-based leadership. However, to what extent this image has contributed to India’s political and economic standing remains to be seen, due to the lack of direct evidence demonstrating a causal relationship between healthcare collaboration and strategic alignment. While favorable perception indicators from independent researchers suggest a positive relationship, there is little systematic data confirming that these healthcare initiatives have translated into sustained diplomatic leverage and policy alignment. At the same time, the political transition in 2024 showed India’s reliance on informal networks, MoUs and affordable healthcare to be insufficient in establishing long-term influence. To move forward from this, this thesis laid out three policy recommendations in chapter V: (i) rebranding Kolkata and strengthening West Bengal’s health institutions; (ii) investing in hospital infrastructure and transport connectivity in the Northeast; and (iii) developing a bilateral health systems architecture. Together, these recommendations seek to transform India’s diplomacy with Bangladesh into formal networks of co-dependency that elevate India’s healthcare quality to withstand political shocks.

Nevertheless, limitations with the research and methodology must be noted. First, while the research benefits from extensive Indian government documentation, the lack of publicly available data from Bangladeshi institutions limits an understanding of the bilateral impact. Similarly, in discussing soft power and diplomatic engagements, emphasis is placed on

state-to-state diplomacy, with limited acknowledgement of regional actors and local governments which often shape grassroots action. Second, the constructivist analysis of the interview and secondary literature provides valuable perspective but may not fully represent the public sentiment in such diverse countries. Third, the reliance on government-affiliated sources may introduce an inherent bias, facilitating a formal and positive representation of healthcare diplomacy as opposed to capturing its informal successes and failures on the ground. The descriptive nature of quantitative analysis also prevents any causal inference or predictive modeling, thereby limiting attribution of economic or strategic trends to India's healthcare diplomacy. This places constraints on understanding the rapidly evolving political situation in Bangladesh following the July Revolution of 2024, since the recommendations of this study are primarily valid within the post-2014 period. Finally, the policy recommendations rely on the premise that India-Bangladesh relations will improve and Bangladesh will be receptive to future healthcare initiatives. Given recent developments in the China-Bangladesh relationship, such receptivity cannot be taken for granted.

Despite said limitations, the thesis expands on the relatively scarce understanding of healthcare diplomacy as a sustained tool of influence, especially in the context of South Asia. This thesis thus demonstrates the expansive role of healthcare in generating an entirely separate ecosystem of influence that operates across borders— aided by cultural bonds and accessibility. In doing so, it also highlights the role of institutions in strategically cultivating ideological convergence and utilizing people-to-people networks to establish normative hegemony. Therefore, by reframing healthcare as an essential foreign policy asset, this thesis invites future research into how states can embed ideological influence through care, and expand their economic and political standing whilst doing so. Moreover, as Bangladesh's new government takes shape, further research should consider comparative analysis on its evolving health-driven

engagement with both India and China. This would be crucial in forecasting the durability of healthcare diplomacy strategies and assessing how political dynamics shape health outcomes.

Amidst a tumultuous global order, trust may prove to be the most enduring asset of diplomacy. If India seeks to preserve and develop its position in South Asia, it needs to view healthcare no longer as a peripheral sector in foreign policy, but as a definitive frontier of 21st-century diplomacy and global power.

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