

WHO global research priorities and agenda for traditional, complementary and integrative medicine 2025–2034



World Health
Organization

Global Traditional
Medicine Centre

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| Foreword

Billions of people worldwide, in communities across every region, rely on traditional, complementary and integrative medicine (TCIM) practices, products and practitioners as a primary or complementary pathway to health and well-being. For too long, this reality has outpaced the evidence, policy and actions needed to support it responsibly and equitably.

This report marks a significant step in addressing that gap.

Taking forward a key objective of the *Global traditional medicine strategy 2025–2034*, it presents a consolidated global roadmap for advancing TCIM research, evidence and learning, grounded in the recognition that strengthening the evidence base for TCIM is essential as both a scientific endeavour and as part of overall efforts to build resilient, sustainable and equitable health systems. Robust evidence enables better policy, including to ensure the efficient use of increasingly constrained resources. Better policy enables safer, more equitable access. And equitable access, underpinned by quality and accountability, is the foundation of universal health coverage and improved health outcomes.

The work documented here reflects a convergence within and beyond WHO. We have a shared opportunity and responsibility to ensure that decisions about the role of TCIM in health systems are grounded in the strongest possible evidence, and that where TCIM is integrated, this is done in ways that are people-centred and responsive to diverse contexts – while ensuring that TCIM is held to, and supported by, the highest standards of scientific rigour, innovation and global research collaboration. Together, these commitments define the approach this report advances: inclusivity aligned with scientific rigour, underpinned by disciplined, systematic and equitable engagement across communities, traditional medicine practitioners, researchers and policy-makers.

This is not a simple task. TCIM encompasses an extraordinary diversity of practices, traditions and knowledge systems, developed across centuries and cultures. Applying a single methodological lens would be both scientifically and ethically inappropriate. At the same time, the diversity of TCIM cannot be invoked to justify the absence of standards. The framework presented in this report charts a principled path between these realities, one that is adapted to TCIM's epistemological breadth while remaining anchored in internationally accepted standards for evidence quality and recommendation strength.

We extend our sincere appreciation to the many researchers, policy-makers, practitioners and partners across Member States and institutions whose expertise and commitment shaped this work. The breadth and depth of this collaboration is itself a reflection of what is possible when the global health community engages seriously with TCIM, and we look forward to building on these efforts together.

The pages that follow set out, in careful and practical detail, both the challenge and strategic directions for TCIM to make evidence-informed contributions towards health and well-being for all. We hope this report will serve as a resource, a reference point and an impetus for action. We encourage engagement with its recommendations by health ministers, research leaders, policy-makers and all those working to build resilient health systems that leave no one behind.

Dr Sylvie Briand

Chief Scientist, Science Division, and Acting Assistant Director-General, Health Systems, Access and Data Division
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Geneva, 2026



| Preface

Around the world, traditional, complementary and integrative medicine (TCIM) is the first place millions of people turn for care, and for many others it is a preferred choice.

Yet the support TCIM receives does not match its use. Less than 1% of global health research funding reaches TCIM. Regulatory systems remain fragmented, there are gaps in research capacities and methods, evidence is generated and applied unevenly across countries, and Indigenous knowledge systems are still insufficiently protected. Helping to overcome these structural barriers, so that people everywhere can access TCIM that is safe, evidence-informed, equitable and sustainable, is the purpose of this report.

In 2025, Member States of the World Health Organization adopted the *Global traditional medicine strategy 2025–2034*, which calls for a stronger evidence base for TCIM as one of its core objectives. To take this forward, the WHO Global Traditional Medicine Centre supported the development of a shared research agenda for the decade 2025 to 2034. Global research priorities were set collectively, through consultation across all six WHO regions with around 116 research institutions alongside a broad community of stakeholders, practitioners and knowledge holders, and through the synthesis of diverse evidence. The result is this report, the *WHO global research priorities and agenda for traditional, complementary and integrative medicine 2025–2034*.

The research agenda points towards the conditions, populations and cross-cutting issues where TCIM evidence can do the most good, and it strengthens the wider system that carries evidence into policy, funding and everyday practice. A practical framework helps regions, countries and communities adapt these global priorities to their own unique contexts, resources and cultures, with Indigenous peoples and knowledge holders as genuine partners throughout.

The *Global traditional medicine strategy 2025–2034* sets the direction. This research agenda provides an evidence-informed means to chart the path for regions, countries and communities to adapt to their unique contexts, towards successful outcomes for the health and well-being of people and planet.

Dr Shyama Kuruvilla

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WHO Global Traditional Medicine Centre

Geneva, 2026



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This research agenda was prepared under the overall guidance and stewardship of Shyama Kuruvilla, Director a.i., WHO Global Traditional Medicine Centre, and under the strategic leadership, technical oversight and coordination of Geetha Krishnan Gopalakrishna Pillai, Unit Head, Traditional Medicine Research, Data and Innovation Unit, WHO Global Traditional Medicine Centre, who led the overall development process.

Development of the research agenda followed the WHO systematic approach for conducting a research priority-setting exercise, and was carried out through the coordinated efforts of the Traditional Medicine Research, Data and Innovation Unit, WHO Global Traditional Medicine Centre, in direct collaboration with the Emerging Technologies, Research Prioritization and Support Unit, Research for Health Department, Science Division, WHO headquarters, particularly Anna Laura Ross, Unit Head, and Sarah Charnaud, Technical Officer, who provided methodological guidance and technical coordination throughout the priority-setting process. The Special Programme for Research and Training in Tropical Diseases, Science Division, WHO headquarters, contributed through Robert Fraser Terry, who provided technical, strategic and methodological guidance and core working group contributions, and John Reeder, who provided early strategic guidance that helped shape the direction of the initiative.

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The following individuals participated in targeted expert consultations undertaken across six specialized domains to deepen the research agenda's grounding in diverse stakeholder perspectives. Participants are listed alphabetically by family name within each group.

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Traditional healer participants

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Global professional association participants

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TCIM journal editor participants

Holger Cramer (Journal of Integrative and Complementary Medicine; University of Tübingen, Germany); Sat Bir Khalsa (International Journal of Yoga Therapy; Harvard Medical School, United States of America); Lixing Lao (Journal of Integrative Medicine; Virginia University of Integrative Medicine, United States of America); Charu Lata (Indian Journal of Traditional Knowledge; NISCP, India); Anastasia Widyadari (BMC Complementary Medicine and Therapies; BioMed Central, United Kingdom of Great Britain and Northern Ireland).



Ministerial commitments

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| Conflict of interest of external experts

Statement on the collection, assessment and management of conflict of interest of external experts:

All external experts submitted to WHO a declaration of interest disclosing potential conflicts of interest that might affect, or might reasonably be perceived to affect, their objectivity and independence in relation to the subject matter of this guidance. WHO reviewed each of the declarations and concluded that none could give rise to a potential or reasonably perceived conflict of interest related to the subjects discussed at the meeting or covered by the guidance.



| Abbreviations

AI	Artificial intelligence
AMR	Antimicrobial resistance
BIREME	Latin American and Caribbean Center on Health Sciences Information
HTA	Health technology assessment
PICO	Population, Intervention, Comparator, Outcome
SDG	Sustainable Development Goal
TCIM	Traditional, complementary and integrative medicine
TM	Traditional medicine
WHO	World Health Organization



Glossary

The following key terms are used consistently throughout this document. Standardized terminology is foundational to evidence translation, policy alignment and cross-border comparability in traditional, complementary and integrative medicine (TCIM) research.

Antimicrobial resistance (AMR)	The ability of microorganisms to resist antimicrobial drugs, rendering standard treatments ineffective and increasing the risk of infection spread and severe illness (1).
Complementary medicine	Additional healthcare practices that are not part of a country's mainstream medicine. Evidence-based complementary medicine has the potential to support mainstream medicine and more comprehensively support people's health and well-being needs (2).
Cross-sectoral issues	Large-scale challenges that originate across multiple sectors and interact with each other in ways that shape population health and health system performance worldwide.
Disability-adjusted life year	One year of healthy life lost due to illness, disability or premature death; combines years of life lost and years lived with disability (3).
Epistemic equity	The fair recognition and inclusion of traditional medicine knowledge as a legitimate source of evidence, alongside other evidence sources (4).
Health technology assessment (HTA)	A multidisciplinary process using explicit methods to determine the value of a health technology at different points in its lifecycle, used to inform policy and funding decisions (5).
Integrative medicine	An interdisciplinary and evidence-based approach to health and well-being that uses a combination of biomedical and traditional and/or complementary medical knowledge, skills and practices (2).
One Health	An integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems. It recognizes that the health of humans, domestic and wild animals, plants and the wider environment (including ecosystems) are closely linked and interdependent. The approach mobilizes multiple sectors, disciplines and communities at varying levels of society to work together to foster well-being and tackle threats to health and ecosystems, while addressing the collective need for clean water, energy and air, safe and nutritious food, taking action on climate change, and contributing to sustainable development (6).
People-centred care	An approach to care that consciously adopts the perspectives of individuals, carers, families and communities, recognizing them as participants in, and beneficiaries of, trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases (7).



Primary healthcare	A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities (8).
Traditional, complementary and integrative medicine (TCIM)	An umbrella term that collectively refers to traditional medicine, complementary medicine and integrative medicine (2).
Traditional medical knowledge	Health-related knowledge, know-how, skills and practices that are developed, sustained and passed on from generation to generation within a community, often forming part of its cultural identity (2).
Traditional medicine (TM)	Codified or non-codified systems for healthcare and well-being, comprising practices, skills, knowledge and philosophies originating in different historical and cultural contexts, which are distinct from and pre-date biomedicine, evolving with science for current use from an experience-based origin. TM emphasizes nature-based remedies and holistic, personalized approaches to restore balance of mind, body and environment (2).



| Executive summary

Why the research priorities and agenda are needed

Traditional, complementary and integrative medicine (TCIM) is widely used across all World Health Organization (WHO) regions and increasingly recognized in national health systems, primary healthcare and universal health coverage frameworks. Yet TCIM research priorities have not been consistently aligned with the evidence needs of policy-makers, health systems or the communities that rely on TCIM.

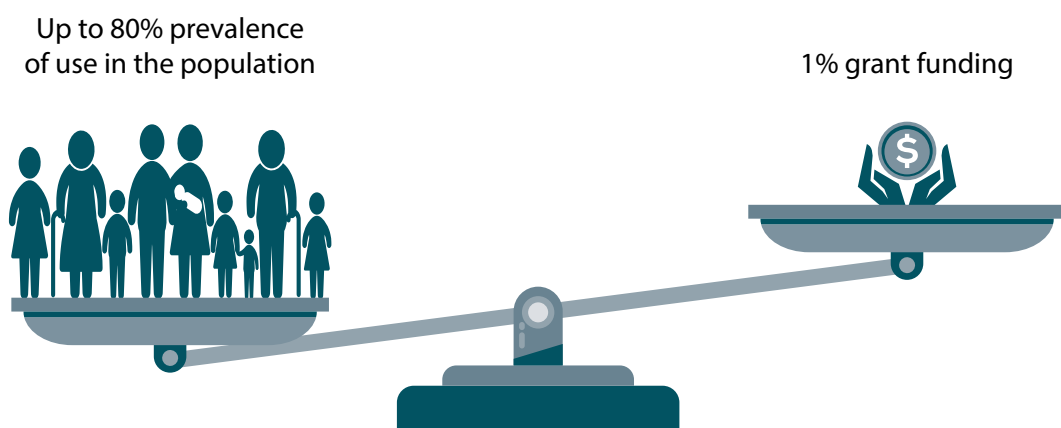
This limits governments' capacity to make informed decisions on regulation, safety, service delivery and TCIM financing – and prevents the evidence-to-policy translation that sustainable health system integration requires.

The core challenge: misalignment

Despite strong Member State commitments to integrate TCIM into universal health coverage, insurance, regulation and primary healthcare, a critical and persistent gap remains: the research needed to inform these commitments is not being generated at sufficient scale, quality or in the right areas. Existing research outputs remain disconnected from policy and regulatory development, public and private investment decisions, and reimbursement and service delivery models.

Globally, less than 1% of health research funding is directed to TCIM research (9) – a stark imbalance given TCIM's widespread use and growing recognition in national health systems (see Fig. 1). This pattern is further compounded by a methodological mismatch: complex TCIM systems are routinely simplified to fit biomedical research designs, producing evidence that fails to inform real-world decisions and reduces public health impact (10). A more deliberate balance is sought through epistemic equity – the fair recognition and inclusion of TCIM philosophies and traditional medicine knowledge alongside other evidence sources subject to rigorous and transparent evaluation.

Fig. 1: Imbalance between TCIM population use and research funding globally



The strategic response

The *WHO global research priorities and agenda for traditional, complementary and integrative medicine 2025–2034* provides a coherent, evidence-informed framework to guide TCIM research globally, built on a rigorous multi-phase process. The research involved analysis of 39 927 grants across 40 grant schemes, 78 reporting and critical appraisal guidelines, 57 published reports of TCIM research priorities, 116 TCIM research institutes from 67 countries, and 199 regional expert stakeholders from 75 countries, alongside 235 Delphi survey participants.

The agenda is explicitly aligned with major Member State commitments. At the closing plenary of the Second WHO Global Summit on Traditional Medicine in 2025, Member States committed to integrating TCIM into national health insurance and universal health coverage schemes by 2028, with other Member States prioritizing good manufacturing practice-compliant production by 2027 (11,12). Recognizing these diverse national commitments, the initial phase of this strategy prioritizes regulatory science, economic evaluation and evidence for policy-making to ensure national milestones can be met on schedule. The agenda is further aligned with the *Global traditional medicine strategy 2025–2034* (2), the *Delhi declaration on traditional medicine* (13) and the *WHO strategy on research for health* (14).

The strategic architecture: two dimensions

Dimension 1:

targeting research for the greatest benefit

Identifies high-burden clinical conditions, key populations and global cross-sectoral issues where TCIM research can deliver the highest value. Provides a six-criterion TCIM research priority-setting framework to guide national adaptation.

Dimension 2:

amplifying impact

Defines the four drivers – Translate, Mobilize, Implement, Catalyse – required to build a viable, ethical and sustainable TCIM research ecosystem that ensures evidence reaches policy and practice.

Priority clinical areas

The following high-burden clinical conditions are identified as immediate TCIM research priorities:

- Stroke: ranked third globally in causes of mortality and disability (3,15); less than 1% of TCIM grants address the condition (9).
- Mental health: ranked eighth in disability-adjusted life year contributor; very few or no identified TCIM-focused grants (3,16).
- Pain management: global equity deficit and demand for non-opioid alternatives (17).
- Musculoskeletal conditions: prominent global disability cause; under-researched relative to disease burden (3,16).
- Cancer: rising global incidence (18); demand for integrative oncology and palliative care (29).
- Metabolic health and endocrine conditions: key driver of noncommunicable disease burden (18).
- Reproductive health and childbirth: persistent burden and funding gap despite demonstrated capacity (16).

Infectious disease – particularly in the context of antimicrobial resistance (AMR) and pandemic preparedness – is addressed as a cross-sectoral priority in [Section 1.2](#).

Illustrative research questions for each priority condition are provided in [Annex 4](#).



Priority clinical populations include preventive health and health promotion, healthy ageing and healthy childhood (14) – all underrepresented in current TCIM research relative to their population health significance (9).

Global cross-sectoral issues

Three global cross-sectoral issues require dedicated TCIM research attention:

One Health and climate resilience: map climate threats to TCIM natural resources; evaluate TCIM's role in sustainable healthcare; develop biodiversity conservation and pharmacopeial sustainability guidelines aligned with the *One health joint plan of action (2022–2026)*.

Artificial intelligence (AI): develop governance frameworks for safe, ethical AI use in TCIM research; protect traditional medical knowledge from misappropriation in digital datasets; investigate AI applicability to TCIM diagnostics and patient data.

Pandemics and AMR: evaluate TCIM for infection management, immune support and antibiotic-sparing effects – a critical global security priority; integrate TCIM research into national pandemic preparedness agendas.

TCIM research priority-setting framework

To enable national adaptation, the agenda provides a six-criterion TCIM research priority-setting framework with validated weightings, guiding Member States from priority identification to intervention selection (see [Section 1.3](#)).

Implementing the agenda: four core principles

Country-led adaptation: Member States tailor global priorities to their specific disease burdens, economic context and cultural realities, beginning with a national gap analysis using the TCIM research priority-setting framework.

Regional specificity: implementation plans in contexts with heightened structural barriers – particularly the African and Eastern Mediterranean regions – must prioritize foundational resource investment (Mobilize and Catalyse) as a prerequisite to methodological advancement.

Stakeholder-driven governance: implementation bodies must include TCIM practitioners, researchers and traditional medical knowledge holders to ensure epistemic equity and research legitimacy.

Phased development: recognizing that infrastructure cannot be built overnight, implementation follows the logic of Foundation and Governance (Phase 1: Years 1–2), then System Strengthening and Funding (Phase 2: Years 3–5), then Scale-up and Integration (Phase 3: Years 6–10).*

* Recognizing that Member States are at varying stages of readiness, each country can determine, based on its own self-assessment, the appropriate entry point and pace for implementing the agenda.

Strategic actions for Member States

- Align national TCIM research agendas with priority health conditions identified in this agenda.
- Apply the TCIM research priority-setting framework to national funding calls.
- Support research on the safe and effective integration of TCIM into health systems and universal health coverage.
- Strengthen research capacity, infrastructure and dedicated workforce development.
- Promote equitable collaboration with Indigenous peoples and traditional knowledge holders.
- Establish a formal TCIM research governance unit within the Ministry of Health.

Conclusion

This report transforms the global TCIM research landscape from a fragmented collection of individual studies into a coherent, policy-grade framework. Targeted investment in TCIM research can generate the evidence needed to ensure that the integration of TCIM into health systems is safe, effective and equitable – contributing to improved population health, stronger health system resilience and the fulfilment of Member State commitments made in the *Global traditional medicine strategy 2025–2034* (2) and the *Delhi declaration* (13).



Introduction

Traditional, complementary and integrative medicine (TCIM) is used by billions of people worldwide, yet the research needed to support its safe, effective and equitable integration into health systems remains critically underfunded and misaligned with population health needs. This document sets out to address that gap.

The *WHO global research priorities and agenda for traditional, complementary and integrative medicine 2025–2034* is a research prioritization framework. The research agenda is developed within the context of Member State commitments that identify TCIM integration as a strategic objective. It is not a clinical guideline, a regulatory instrument or a policy prescription. Its purpose is to direct investment, focus effort and generate the evidence that will enable informed decisions about how TCIM can most safely and effectively contribute to equitable and sustainable health systems over the next decade.

The agenda is organized around two mutually reinforcing dimensions. Dimension 1 identifies the highest-priority clinical conditions, cross-sectoral issues and population groups where TCIM research can deliver the greatest benefit. Dimension 2 defines the four structural drivers – Translate, Mobilize, Implement and Catalyse – required to build the research infrastructure and ecosystem that transforms evidence into policy and practice.

This document is intended for multiple audiences: health ministries and national research bodies making funding and priority decisions; international funders and development partners aligning investment; researchers designing studies; and WHO in its normative and technical convening role. The implementation annexes, particularly [Annex 2](#) and [Annex 3](#), provide actor-specific guidance for each of these audiences.

The agenda is designed as a living framework. A mid-term evaluation is planned for 2029, aligned with the review of the *Global traditional medicine strategy 2025–2034* (2), with a final evaluation in 2035. Member States are encouraged to treat the priorities presented here as a starting point, to be adapted, applied and built upon in ways that are nationally meaningful and locally grounded.



Why this matters: key points for decision-makers

Context: the case for action

- TCIM is widely used in all WHO regions and is increasingly considered in national health systems, primary healthcare and universal health coverage frameworks.
- Research priorities have not been consistently aligned with the evidence needs of policy-makers and health systems. This limits governments' ability to make informed decisions on regulation, safety, service delivery and TCIM financing.
- A global research prioritization exercise – the most rigorous and comprehensive ever undertaken for TCIM – was conducted to identify key areas where TCIM research can deliver the greatest public health and health system benefit.

Targeting research for the greatest benefit

- **Chronic disease prevention and management:** research on TCIM approaches for diabetes, metabolic disorders, dyslipidaemia and prevention and management of noncommunicable diseases.
- **Mental health and well-being:** TCIM approaches for anxiety, depression and stress; mind-body and movement-based therapies; culturally appropriate approaches to mental health resilience.
- **Healthy ageing:** TCIM exercise and movement therapies; multimodal approaches to maintaining physical and cognitive function.
- **Patient safety:** research on herb-drug interactions; monitoring and reporting of adverse events.
- **Integration of TCIM into health systems:** models for integration into primary healthcare; regulatory and quality assurance frameworks; economic evaluation and health system impact; barriers and facilitators to integration.
- **Global cross-sectoral issues:** climate change and biodiversity (sustainable use of medicinal plants); digital health and artificial intelligence (AI) (responsible data use and protection of traditional medical knowledge); pandemics and infectious diseases (infection prevention, community resilience and antibiotic-sparing strategies).

Amplifying impact: four drivers

Translate: improve mechanisms linking research evidence to policy, regulation, clinical practice and public use.

Mobilize: establish dedicated funding mechanisms aligned with global health priorities.

Implement: develop evidence on safe and effective integration of TCIM interventions into health systems.

Catalyse: strengthen research infrastructure, training programmes and international collaboration.

The opportunity

Targeted investment in TCIM research can generate the evidence needed to support safe, effective and equitable integration of TCIM into health systems worldwide – contributing to improved population health, stronger health system resilience and the fulfilment of Member State commitments under the *Global traditional medicine strategy 2025–2034* (2) and the *Delhi declaration* (13).

Methodology: a robust and comprehensive approach

This report was developed through critical examination of published literature, secondary analysis of public data, and extensive consultation with expert stakeholders from all six WHO regions. A series of mixed-methods studies, nested within four sequential and interdependent phases, informed the identification of global TCIM research priorities (see [Fig. 2](#) and [Table 1](#)).

While acknowledging previous work exploring research priorities in TCIM, the investigation informing this agenda adopts a more holistic and in-depth approach to global TCIM research priority-setting. Beyond identifying critical topics requiring immediate research attention, the agenda provides a TCIM research priority-setting framework that extends previous prioritization efforts – which largely applied methods developed for biomedicine – by establishing formal criteria tailored to the distinct features of TCIM (19).

Table 1: Key activities and outputs for the research agenda

Phase	Key activities and outputs
Phase 1: Scoping and planning	Project management plan developed per WHO guidance on systematic research priority-setting. Extensive consultation with WHO units, departments, technical advisors and the editorial board.
Phase 2: Landscape analysis – literature review	Five research activities (2A–2E) examined the global TCIM landscape: 2A Funding status of TCIM research: 39 927 grants and 40 grant schemes. 2B Reporting and appraisal guidelines for TCIM research: 73 guidelines identified from 21 861 citations. 2C Published research priorities and gaps: 57 documents from 15 435 citations. 2D Evidence-informed decision-making in TCIM: 40 policy and strategy documents from across all world regions. 2E TCIM research capacity: 116 TCIM research institutes from 67 countries (research institute analysis); 396 TCIM researchers identified among 93 046 health researchers (workforce capacity); 40 publications reporting innovative TCIM capacity-building initiatives (capacity-building innovations).
Phase 3: Delphi study – stakeholder consultations and survey rounds	Three sub-phases: 3A Regional stakeholder consultations: In-person regional forums with 199 participants from 75 countries at WHO regional meetings. 3B Targeted stakeholder consultations: Online consultations with 38 participants across six key stakeholder groups. 3C Surveys (Delphi panel rounds): Two-round Delphi survey with 235 expert panellists from across all world regions.
Phase 4: WHO TCIM research agenda and implementation mapping	Integration of all phase findings; cross-checking against the <i>Global traditional medicine strategy 2025–2034</i> (2), <i>Delhi declaration</i> (13) and <i>WHO strategy on research for health</i> (14); synthesis into this research agenda and implementation mapping. Inputs included 22 Member State commitments, two global TCIM strategy and implementation documents, six Regional Director reports and other inputs.



Fig. 2: Total inputs across all project phases

Phase 1:			
Scoping and planning			
1 <u>Project management plan</u> Consultation with WHO units, departments, technical advisors and editorial board			
Phase 2:			
Landscape analysis			
2A <u>Funding status of TCIM research</u> 39 927 grants and 40 grant schemes	2B <u>Reporting and appraisal guidelines for TCIM research</u> 73 guidelines identified from 21 861 citations	2C <u>Published research priorities and gaps</u> 57 documents from 15 435 citations	2D <u>Evidence-informed decision-making in TCIM</u> 40 policy and strategy documents from across all world regions
2E <u>TCIM research capacity (research institute analysis)</u> 116 TCIM research institutes from 67 countries	2E <u>TCIM research capacity (capacity-building innovations)</u> 40 publications reporting innovative TCIM capacity-building initiatives	2E <u>TCIM research capacity (workforce capacity)</u> 396 TCIM researchers identified among 93 046 health researchers	
Phase 3:			
Delphi study			
3A <u>Regional stakeholder consultations</u> 199 participants from 75 countries	3B <u>Targeted stakeholder consultations</u> 38 participants from 6 key information groups	3C <u>Surveys (Delphi panel rounds)</u> 235 participants from across all world regions	
Phase 4:			
Research agenda and implementation mapping			
4 <u>Integration and alignment with WHO documents and Member State commitments</u> 22 Member State commitments, 2 global TCIM strategy and implementation documents, 6 Regional Director reports and other inputs			

Note: labels 2A–2E denote the five research activities within Phase 2; labels 3A–3C denote the three sub-phases within Phase 3.

The project was planned in accordance with the WHO guidance, *A systematic approach for undertaking a research priority-setting exercise* (20), applying a series of mixed-methods studies (21) nested within four phases. Once analysis was complete, identified research priorities were cross-checked for congruence with the *Global traditional medicine strategy 2025–2034* (2) and other foundational inputs (7,8,12,13,22–28), then synthesized to ensure alignment with the *WHO strategy on research for health* (14).

The strategic framework

Aim and scope

This global research agenda for TCIM aims to outline the actions required to strengthen and grow TCIM research globally. It provides priority actions for the WHO Secretariat, Member States and non-State actors, addressing the research needed to fulfil TCIM's potential as a contributor to equitable, effective and sustainable health systems.

Alignment with Member State commitments (2025–2027)

During the closing plenary of the Second WHO Global Summit on Traditional Medicine in 2025, Member States committed to integrating TCIM into national health insurance and universal health coverage schemes by 2028, and other Member States prioritized good manufacturing practice-compliant production by 2027 (12). Recognizing the commitments of these diverse nations, the initial phase of this agenda prioritizes regulatory science, economic evaluation and evidence for policy-making to ensure these national milestones can be met on schedule. These commitments are supported by a comprehensive set of foundational inputs informing this agenda (2,7,8,13,22–28).

At the Global Summit, 22 Member States made specific commitments to advance TCIM research infrastructure, funding and evidence systems (Table 2). These commitments directly inform the priority actions in this agenda.

The commitments predominantly reflect investment in research infrastructure and capacity (Catalyse), dedicated funding streams (Mobilize) and evidence systems integration (Implement) – directly aligned with the four drivers of this agenda.

Table 2: Member State commitments to advance TCIM research

Member State	Research commitment
African Region	
Cabo Verde	Establish a national traditional medicine (TM) research centre for evidence strengthening by 2026.
Cameroon	Strengthen and reposition the Institute of Medical Research and Medicinal Plants Studies as the national reference institute for TM research, with increased and sustainable funding and regional research hubs by 2026.
Liberia	Establish a national botanical garden (medicinal plants) for biodiversity, conservation, research and local production by 2027.
Malawi	Establish a national TM research centre by December 2028.
Mauritius	Establish an Ayush Centre of Excellence with state-of-the-art facilities by 2027; propose a Global Traditional Medicine Centre collaborating centre by 2027.
Sao Tome and Principe	Establish a national TM research institute and a dedicated research budget for evidence generation by 2029.
Seychelles	Establish a national TM research institute and evidence generation platform by 2027; establish a dedicated research budget for TM and the health sector.



Member State	Research commitment
Senegal	Establish a national research institute by 2028.
South Sudan	Strengthen evidence-based TM through research and data collection by 2027.
United Republic of Tanzania	Establish a TM centre of excellence by 2030; allocate a significant research budget for TM of up to TSh 10 billion by 2030.
Region of the Americas	
Barbados	Promote national TM research as part of the work of the Barbados Living Laboratory by 2027.
Trinidad and Tobago	Establish a TM research centre for evidence strengthening.
South-East Asia Region	
Bangladesh	Contribute to innovation and scientific validation.
India	Anchor a multi-country TM research consortium for high-quality clinical and implementation studies; support TM-based start-ups through grants, incubation centres and access to research facilities; establish fellowships and structured training pathways for researchers.
Maldives	Establish a national TM research centre for evidence strengthening by 2026; establish a national TM committee by 2026 to explore strengthening research and institutional capacity.
Nepal	Operationalize the Nepal Ayurveda, Panchakarma and Yoga Centre by 2026; implement the ICD-11 TM-2 module in the Ayurveda Health Information and Management System across the country.
Sri Lanka	By 2028, incorporate TM diagnosis and procedures into the national health information system using WHO TM classifications; by 2027, establish a national pharmacovigilance/adverse event reporting system.
Thailand	Develop and implement a national strategic research plan and an evidence generation platform in collaboration with academic institutions by 2027.
Eastern Mediterranean Region	
Afghanistan	Establish a national TM research centre and a dedicated research budget for evidence strengthening by 2026.
Iran (Islamic Republic of)	Launch a national platform for clinical trials; strengthen research and evidence and publish in reputed journals; launch a WHO collaborating centre.
Western Pacific Region	
Fiji	Establish a national governance framework, in consultation with relevant institutions, for research and integration of traditional healthcare by 2028.
Micronesia (Federated States of)	Establish a national TM research institute and a dedicated research budget for evidence generation by 2027.

An integrated, two-dimensional architecture

This agenda moves beyond linear actions. It integrates two distinct, mutually reinforcing dimensions to generate high-impact TCIM evidence, as illustrated by Fig. 3 and Table 3.

Fig. 3: The two dimensions of the TCIM research strategic framework

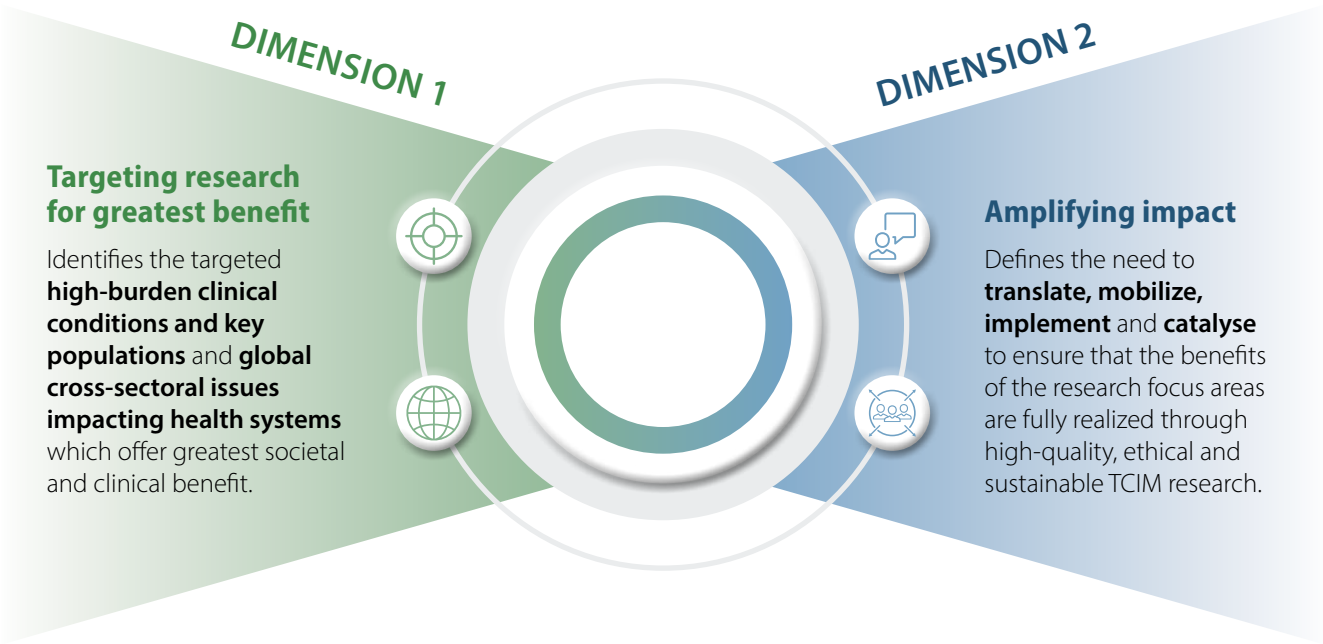


Table 3: The two dimensions of the TCIM research strategic framework

Dimension	Definition
Dimension 1: targeting research for the greatest benefit	Focuses on high-value research areas – the specific health and societal challenges where TCIM research can deliver the highest value globally and regionally. Priorities fall into two categories: • high-burden clinical conditions and key populations • global cross-sectoral issues.
Dimension 2: amplifying impact	Defines ecosystem enablers – the structural drivers necessary to create a viable, ethical and sustainable TCIM research ecosystem. The four drivers (Translate, Mobilize, Implement, Catalyse) span the entirety of the research spectrum to ensure all dimensions can flourish.



Dimension 1: targeting research for the greatest benefit

Despite widespread community use and growing policy-maker recognition, TCIM research remains poorly aligned with major global health challenges. Clinical conditions receiving TCIM research attention are often driven by individual interest rather than collective efforts to address the highest societal and health system burden. This agenda corrects that misalignment.

1.1 High-burden clinical conditions and key populations

Aligning research with real-world care and population need

Global analysis reveals a critical mismatch between disease burden and TCIM research focus and capacity. While some conditions such as cancer receive relatively more TCIM research attention, urgent investment is required for high-burden conditions and key populations that are currently neglected in the TCIM research landscape. Clinical studies have greatest value when designed around actual care pathways, patient priorities and service delivery models.

Across these conditions – from mind-body therapies for mental health and pain, to herbal preparations for metabolic conditions, to integrative approaches in oncology and rehabilitation – TCIM interventions have shown promising results in clinical research, with an emerging evidence base that warrants investment to generate the robust evidence needed for informed decision-making. Yet in every case, evidence remains at an early stage, with progress to health system integration requiring both sustained research investment and resolution of key uncertainties regarding effectiveness, safety and implementation (see [Table 4](#)).

Table 4: TCIM research gap across health conditions

Condition	Disease burden context	Current TCIM research gap
Stroke	Ranked third globally in causes of mortality and disability (3,15).	Receives less than 1% of TCIM-funded grants (9).
Mental health	Eighth highest contributor to disability-adjusted life years (3,16).	No identified TCIM grants specifically focused on mental health conditions.
Pain management	Global challenges around equity of access to care and demand for non-opioid treatment options (17).	Under-researched relative to burden; significant unmet need.
Musculoskeletal conditions	Prominent cause of disability globally (3,16).	Moderate research capacity exists among TCIM researchers, but current volume does not match disease burden.

Condition	Disease burden context	Current TCIM research gap
Cancer	Rising global incidence across many cancer types (18). Strong demand for integrative oncology and palliative care (29).	Substantial existing TCIM research capacity; needs scaling and sustained investment.
Metabolic health and endocrine conditions	Metabolic risk factors increasingly drive noncommunicable disease burden globally (18).	Investment needed to sustain and grow existing TCIM research capacity in this area.
Reproductive health and childbirth	Maternal and reproductive health challenges persist in contributing to global disease burden (16).	Demonstrated TCIM research capacity exists; substantial funding gap remains.

For example, strokes are ranked third globally in causes of mortality and disability, but remain one of the most underfunded conditions in TCIM research, receiving less than 1% of TCIM research grants despite an emerging body of research evaluating TCIM interventions in rehabilitation and recovery.

Infectious disease – particularly in the context of AMR and pandemic preparedness – is addressed as a global cross-sectoral priority in [Section 1.2](#).

Priority clinical populations

Beyond specific conditions, three population-level priorities were identified. With almost half the global burden of disease attributed to modifiable risk factors, preventive health and health promotion is critical to improving population health. Yet the topic is underrepresented and underfunded in TCIM research. Global demographics are shifting towards an ageing population, reflecting TCIM stakeholders' consistent prioritization of healthy ageing and geriatric care – an area where TCIM physical therapies, herbal preparations and mind-body practices are widely used but remain under-researched relative to the scale of the ageing challenge (30). Children are disproportionately affected by health equity issues such as malnutrition and environmental exposures. TCIM approaches are widely used in many communities for paediatric health, and warrant dedicated research attention to evaluate their safety, effectiveness and appropriate integration into child health services (31,32).

Strategic actions: high-burden conditions

Implementation actions for Member States and partners in response to these priorities are detailed in [Annex 3](#).

WHO Secretariat: map the global TCIM research-to-burden gap across all priority conditions, establish minimum evidence standards for health system integration, and convene a coordinated multilateral commissioning mechanism to ensure no identified high-burden condition remains without a funded, multi-site research programme within the first five years of implementation.

1.2 Global cross-sectoral issues impacting health systems

Intersectional and complex global issues extend beyond specific clinical populations and can cause or result from widescale societal, structural and technological changes. TCIM research must contribute to solutions that improve, avoid or ameliorate the impacts these cross-sectoral issues have on global health (see [Table 5](#)).

Table 5: Top issues and priority actions for TCIM research

Issue	Why it matters for TCIM research	Priority actions
One Health and climate resilience	Climate change poses imminent threats to biodiversity and the natural resources underpinning many TCIM systems. Research is urgently needed to map these threats and evaluate TCIM's contribution to sustainable health systems, including its role in achieving the <i>One health joint plan of action (2022–2026)</i> .	Map the threats posed by climate change to the natural resources underpinning TCIM systems, evaluate TCIM's contribution to sustainable health systems, and develop biodiversity conservation and pharmacopeial sustainability guidelines in support of the <i>One health joint plan of action (2022–2026)</i> .
AI	Rapid adoption of AI offers opportunities to analyse complex TCIM data and mine codified traditional medical knowledge, but also poses risks to data sovereignty and exposes traditional medical knowledge to misinterpretation.	Develop governance frameworks for the safe, effective and ethical use of AI in TCIM research, ensuring data sovereignty and protection of traditional medical knowledge. Investigate the applicability of AI methods – including analysis of digitized patient records, wearable device data and traditional medical knowledge sources – to advance TCIM research quality and reach.
Pandemics and AMR	As microbial resistance grows, evaluating TCIM as a resource for infection management, immune support and antibiotic stewardship is a critical global security priority.	Evaluate TCIM as a resource for infection management, immune support and antibiotic stewardship. Integrate TCIM research systematically into national pandemic preparedness and response frameworks to strengthen health system resilience.

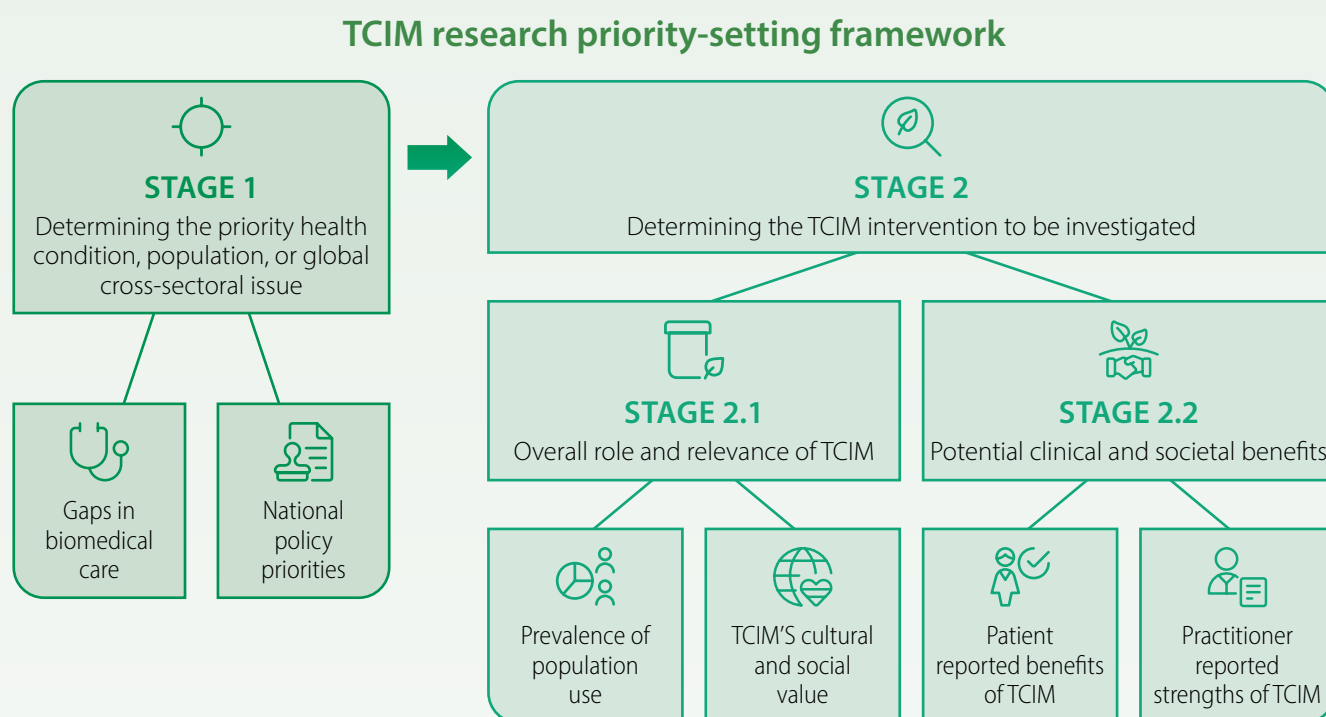
The *One health joint plan of action (2022–2026)* (20) specifically addresses biodiversity conservation and the interdependence of human, animal and environmental health – areas where TCIM research can make a meaningful contribution.

1.3 Applying the TCIM research priority-setting framework

This agenda provides not only global priorities but also a structured framework enabling Member States to adapt those priorities to national circumstances. Six key criteria were identified and weighted by global TCIM expert participants (Table 6) through a rigorous multi-phase consultation and Delphi process (Fig. 4). Annex 4 provides illustrative Population, Intervention, Comparator, Outcome questions for each of the seven priority clinical conditions, demonstrating how the framework can be applied to generate specific, context-sensitive research questions.

Table 6: Key criteria and weighting for research priority-setting framework

Criterion	Weight	Definition
1. Gaps in biomedical care	19.2%	Conditions for which biomedicine does not fully meet population health needs.
2. Prevalence of population use	18.9%	Individual TCIM interventions with high or increasing utilization in the population.
3. National policy priorities	17.7%	Conditions, populations and cross-sectoral issues identified as priorities in national or subnational strategies.
4. Patient-reported benefits	16.4%	TCIM interventions reported by users as providing direct or indirect health benefits.
5. Practitioner-reported effects	15.4%	TCIM practitioners' observations of positive effects and documented adverse events.
6. TCIM's cultural and social value	12.6%	Cultural and social value of TCIM within the general population and within specific groups including Indigenous and culturally diverse communities.

Fig. 4: TCIM research priority-setting framework: criteria and stages of application**Stage 1: determining the priority health condition, population or cross-sectoral issue**

Two criteria guide selection at Stage 1: gaps in biomedical care (19.2%) and national policy priorities (17.7%). Member States should identify where biomedical care does not meet population needs, and synthesize health conditions and cross-sectoral issues outlined in national and subnational policy documents.

Stage 2: determining the TCIM intervention

Once the priority area is identified, four criteria guide selection of the specific TCIM intervention: prevalence of population use (18.9%), TCIM's cultural and social value (12.6%), patient-reported benefits (16.4%) and practitioner-reported effects (15.4%). The first two criteria identify the overall role and relevance of TCIM within the community; the second two assess potential clinical and societal benefit for the priority condition or population.

Implementing the framework

The framework can be applied across the full cycle of research planning, prioritization and funding – from collation and synthesis of national evidence, to scoring of proposed research projects, to periodic review and update of priorities.

Additional implementation guidance is provided in [Annex 2](#).



Dimension 2: amplifying impact

Identifying the right research areas is necessary but not sufficient. The four drivers illustrated in [Fig. 5](#) – Translate, Mobilize, Implement and Catalyse – constitute the structural ecosystem required to ensure the benefits of focused TCIM research are fully realized. These drivers span the entire research spectrum, from evidence generation to policy integration. [Table 7](#) provides more detail on the actions required across the four drivers.

Fig. 5: Relationship between the four drivers of TCIM research impact

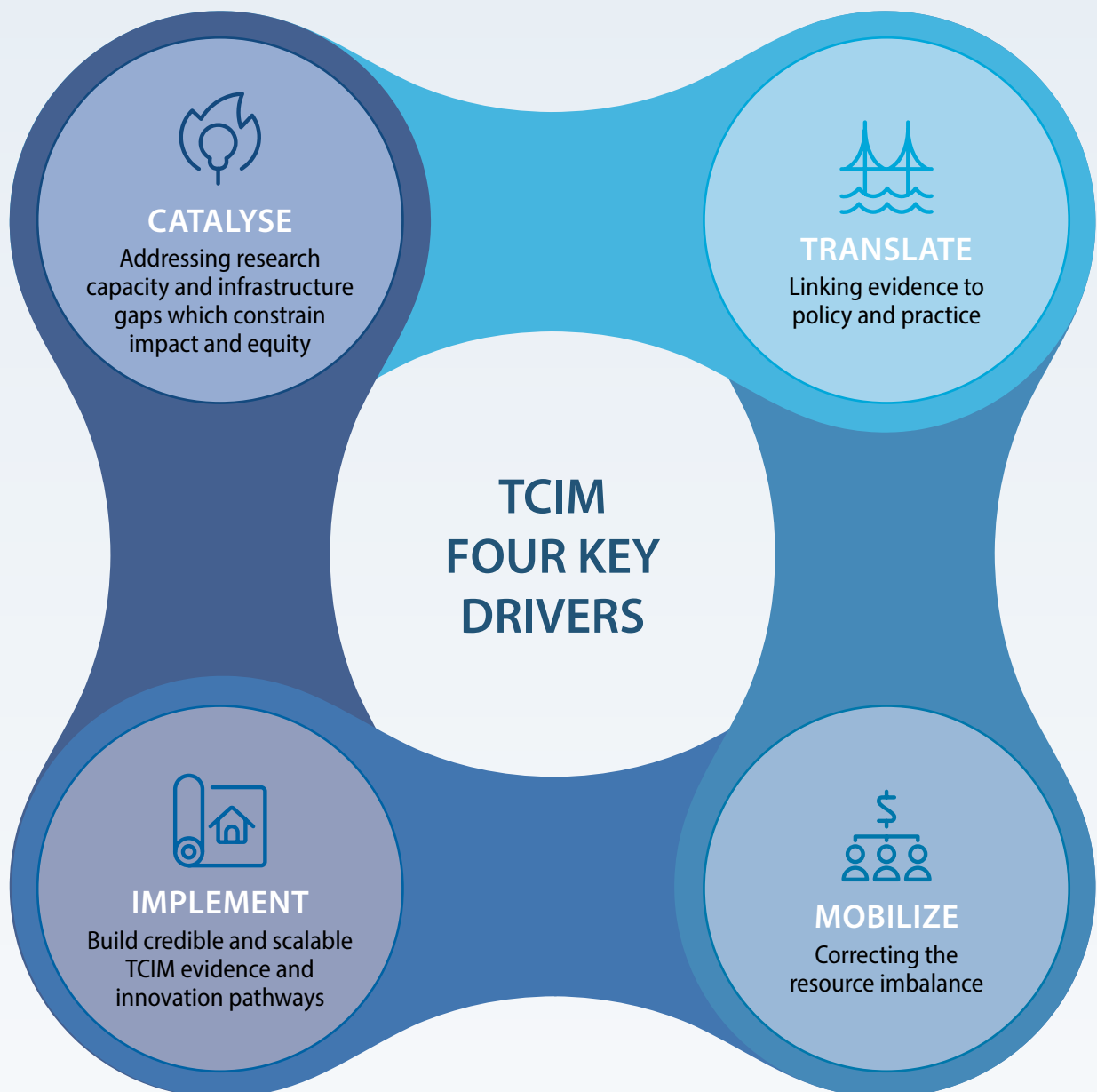


Table 7: Actions required across the four drivers of TCIM research impact

Translate	<i>Bridge evidence and decision-making</i>	• Standardize TCIM terminology in national health policies and research frameworks. • Embed TCIM-experienced stakeholders in research governance, ethics committees and advisory boards. • Update health technology assessment (HTA) frameworks to incorporate cost-effective TCIM interventions and patient-centred outcomes. • Co-design TCIM research priorities and protocols with community and patient representatives, ensuring inclusion of patient-reported outcomes and lived experience to guarantee research relevance and epistemic equity (33). • Conduct rapid reviews and cost-effectiveness studies to support Member States committed to TCIM integration into universal health coverage and insurance schemes by 2027/2028. • Produce policy briefs and accessible public communication materials on TCIM evidence.
Mobilize	<i>Correct the funding imbalance of less than 1%</i>	• Create dedicated TCIM research funding streams within national research budgets. • Build diversified TCIM funding ecosystems incorporating government, competitive grants, philanthropy and community contributions. • Employ blended finance and advanced market commitments to de-risk TCIM innovation. • Develop TCIM-specific grant guidelines that recognize methodological diversity. • Institutionalize TCIM expertise across all stages of funding governance.
Implement	<i>Build scalable evidence and innovation pathways</i>	• Fund research using whole-systems approaches, real-world data and adaptive trial designs. • Establish enabling policies to protect Indigenous intellectual property and traditional medicinal knowledge. • Develop regulatory science for TCIM including good manufacturing practice, non-animal toxicology and product standards. • Develop WHO guidance on TCIM-specific methodologies and “two-eyed seeing” frameworks to ensure research designs fit the holistic theories of TCIM interventions, respecting distinct epistemologies and allowing Indigenous and biomedical knowledge to coexist (10,34). • Develop methodological guidance to study intercultural and person-centred dimensions of health, including psychosocial, experiential and meaning-related outcomes associated with traditional and integrative care practices, with appropriate measurement frameworks that complement biomedical indicators (10,35,36). • Support co-design of research with Indigenous leadership and equitable benefit-sharing. • Develop a TCIM-specific evidence assessment framework, grounded in globally accepted methodological principles that enables rigorous, transparent and context-sensitive assessment of TCIM evidence in alignment with global methodological standards (2,37,38).
Catalyse	<i>Build the TCIM research ecosystem</i>	• Establish government-embedded TCIM research institutes with a mandate for funding coordination and mentorship. • Designate national and regional centres of research excellence with international collaboration networks. • Fund scholarships, fellowships and mentorship programmes for TCIM researcher development. • Integrate TCIM data into national health information systems and electronic health records. • Develop and maintain global TCIM research databases with standardized metadata.

2.1 Translate: linking evidence to policy and practice

The longstanding gap between evidence and decision-making is intensified in TCIM due to inconsistent terminology, the wide range of evidence types – from contemporary research to traditional medical knowledge – and limited mechanisms for meaningful engagement between decision-makers and TCIM knowledge holders (39). Foundational work is needed to standardize terminology and incorporate TCIM perspectives into HTA frameworks so that evidence is considered legitimate, interpreted accurately and used effectively (40). This requires the development of evidence-to-decision frameworks and evidence quality approaches that are philosophically aligned with TCIM, enabling diverse forms of information relevant to TCIM – including traditional medical knowledge and real-world practice data – to be assessed systematically and considered appropriately within policy and decision-making processes (4).

2.2 Mobilize: correcting the resource imbalance

Globally, less than 1% of health research funding is invested in TCIM research (9). This level of investment does not match community needs or the increasing pressures on health systems. Global analyses also show that research funding remains heavily skewed towards biomedical priorities, while high-burden areas central to TCIM practice are persistently under resourced. Sustainable funding strategies should address this imbalance by prioritizing research according to real-world use and burden of disease.

2.3 Implement: building credible and scalable TCIM evidence pathways

A significant methodological mismatch persists between how TCIM is practised and how it is typically evaluated. Research designs developed for single-component biomedical interventions are often applied to complex, multicomponent TCIM systems, producing evidence that is difficult to interpret in real-world settings and undervalued by decision-makers.

Methods for generating evidence for complex TCIM interventions

The following evidence generation methods are particularly suited to the complexity of TCIM and should be supported and adopted in TCIM research programmes (Table 8).

Table 8: Evidence generation methods relevant to TCIM

Method	Definition and relevance to TCIM
Real-world evidence	Clinical evidence about the safety and effectiveness of health interventions generated from data collected during routine healthcare practice. Sources include electronic health records, patient registries, insurance claims, patient-reported data, and data from mobile health applications and wearable devices (36).
Multi-criteria decision analysis	Integrates stakeholder perspectives, collected via qualitative methods, with quantitative models to represent stakeholder preferences and evaluate performance of different options – well suited to the multi-dimensional nature of TCIM value (37,38).
Living evidence synthesis	Systematically appraised and continually updated summaries of research evidence, such as living evidence-based guidelines, living systematic reviews and living policy briefs – allowing rapid response to emerging TCIM evidence (41).

Methods for evaluating complex TCIM interventions

TCIM systems require evaluation methods that can accommodate complexity, multicomponent interventions and real-world practice variability. Table 9 describes recommended methodologies.



Table 9: Evaluation methods relevant to TCIM

Method	Application to TCIM evaluation
Complexity science	Examines systems with many interacting components and emergent behaviours, making it well suited to evaluating TCIM as a complex adaptive system where linear cause-and-effect models are often inadequate (42).
Systems biology	An integrative approach combining multi-omics, physiology and environmental data to understand biological networks, aligning with TCIM frameworks that view health as the balance of interconnected systems (43).
Whole-system trials	Trial designs that evaluate the full TCIM intervention package – including the practitioner-patient relationship, consultation process and combined therapeutic components – rather than isolating a single active ingredient. Whole-system trials are essential for TCIM modalities where therapeutic effect is inseparable from the integrated delivery context (35,44).
Pragmatic trials	Trials designed to evaluate interventions under routine real-world clinical conditions rather than tightly controlled experimental settings. Pragmatic designs accommodate the natural heterogeneity of TCIM practitioners, patient populations and treatment protocols, generating evidence that is directly applicable to health system decision-making (45,46).
Bayesian adaptive platform trials	Flexible clinical trial designs using Bayesian updating to test multiple interventions and adapt in real time, reflecting the iterative, individualized nature of TCIM care more accurately than conventional fixed randomized controlled trials (47,48).
Stepped-wedge cluster designs	A staggered roll-out trial design in which all clusters eventually receive the intervention, making it especially appropriate for evaluating TCIM programmes implemented at service, community or system levels (49).
N-of-1 designs	Single-patient crossover trials in which an individual serves as their own control across multiple treatment periods, directly aligned with TCIM's philosophy of individualized, person-centred care. N-of-1 designs generate robust evidence of treatment effect at the individual level and are particularly valuable where population-average effects mask meaningful variation in response (50,51).
Big data approaches	Methods that analyse large real-world datasets – from electronic health records to wearables – to detect patterns and outcomes, offering a powerful way to study TCIM's widespread, diverse and context-rich real-world use. AI methods, particularly machine learning, are increasingly integral to big data approaches, enabling pattern recognition across large heterogeneous TCIM datasets, natural language processing of codified TM texts, and predictive modelling of treatment outcomes (52).
Practice-based research networks	Collaborative research infrastructures embedded in routine clinical settings, ideally positioned to generate real-world evidence reflecting the ways TCIM is actually delivered across diverse practice contexts (53).
Patient-reported outcome frameworks	Structured measurement frameworks for capturing outcomes reported directly by patients – including quality of life, symptom burden, functional status and treatment acceptability – without clinician interpretation. Patient-reported outcome frameworks are essential for TCIM evaluation, which frequently targets holistic and experiential outcomes that standard biomedical end-points do not capture (54).
Precision medicine	A tailored approach to healthcare that, like TCIM, uses an individualized approach considering unique genetic make-up, environment and lifestyle to guide disease prevention, diagnosis and treatment (55,56).

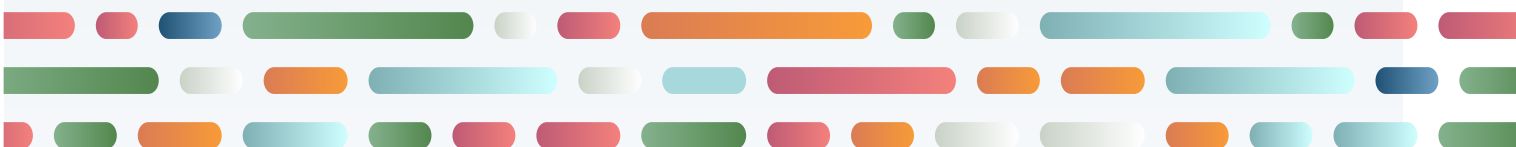
Addressing methodological mismatch also requires clearer routes from evidence generation to product development, service innovation, regulatory approval and market access – supported by appropriate mechanisms for intellectual property protection and benefit-sharing. Implementation research is essential for generating operational evidence to inform service delivery models and reimbursement decisions.

2.4 Catalyse: addressing research infrastructure and workforce gaps

Current gaps in research capacity and infrastructure significantly limit the quality, relevance and scalability of TCIM research. TCIM researchers currently comprise only 0.43% of health researchers globally, and infrastructure is unevenly distributed, with a median of only two TCIM research centres per country. Building a strong and sustainable TCIM research ecosystem requires targeted investment in human resources, institutional capacity and collaborative structures.*

Dedicated TCIM research institutes with clear, consensus-driven mandates should be established within ministries of health, supported by independent centres of research excellence. A globally coordinated TCIM database will enhance transparency, support evidence-informed decision-making and strengthen the global TCIM knowledge base.

**Both figures are derived from Phase 2E: TCIM research workforce capacity and TCIM research institute analysis, conducted as part of the rigorous multi-phase methodology underpinning this agenda. See [Annex 1](#) for full methodological detail.*



Indigenous medicine research agenda (2025–2034)

Indigenous medicine requires a distinct and dedicated research agenda. Prevailing research structures continue to privilege Western epistemologies and governance models, creating risks of cultural appropriation and undermining Indigenous authority over traditional medicinal knowledge. Embedding Indigenous leadership in research is non-negotiable – it is essential to uphold knowledge sovereignty, cultural integrity and community benefit.

Consultations and expert deliberations consistently highlight the need to protect intellectual property rights for knowledge custodians and to ensure that decision-making processes meaningfully reflect Indigenous perspectives. Members and leaders of Indigenous medicine communities emphasized that research must be grounded in community-defined priorities and guided by Indigenous-led governance. Experts noted accelerating risks of intergenerational knowledge loss driven by urbanization, environmental pressures and global health disruptions.

Core principles for Indigenous medicine research

- **Community-defined priorities:** research must be grounded in community-defined priorities and guided by Indigenous-led governance.
- **Self-determination:** participatory methodologies and culturally anchored approaches must be central to decolonizing research practice.
- **Benefit-sharing:** governance structures must uphold cultural protocols and ensure outcomes are ethically sound and genuinely beneficial.
- **Preservation and revitalization:** documentation and knowledge transmission methodologies must preserve depth and context without reductionist interpretation.
- **Epistemic integrity:** research must recognize Indigenous knowledges as legitimate, valued and vital components – not subordinate to biomedical frameworks.

Strategic actions

Protect Indigenous intellectual property

National policies, legislation and ethical review processes must embed Indigenous governance frameworks and culturally appropriate intellectual property protections before any research activity involving traditional medicinal knowledge is initiated.

Ensure self-determination and community benefit

All research must be co-designed and co-implemented under Indigenous leadership, with transparent benefit-sharing agreements established prior to commencement and governance structures that uphold cultural protocols throughout.

Safeguard and strengthen Indigenous medicine

Documentation, validation and transmission of Indigenous medicine systems must occur exclusively through community-owned methodologies, under Indigenous control, with findings disseminated in ways that protect sensitive knowledge and benefit the communities involved.



Regional research agendas (2025–2034)

While WHO's global research agenda sets the normative framework, effective implementation requires regional adaptation. The priorities below apply the global framework to each WHO region – reflecting region-specific disease burdens, cultural contexts, economic realities, ecosystem opportunities and barriers. Implementation must be sensitive to both interregional and intraregional variation. [Fig. 6](#) and [Table 10](#) map the research priorities and actions for TCIM across the globe.

Fig. 6: Immediate TCIM research priorities by WHO region

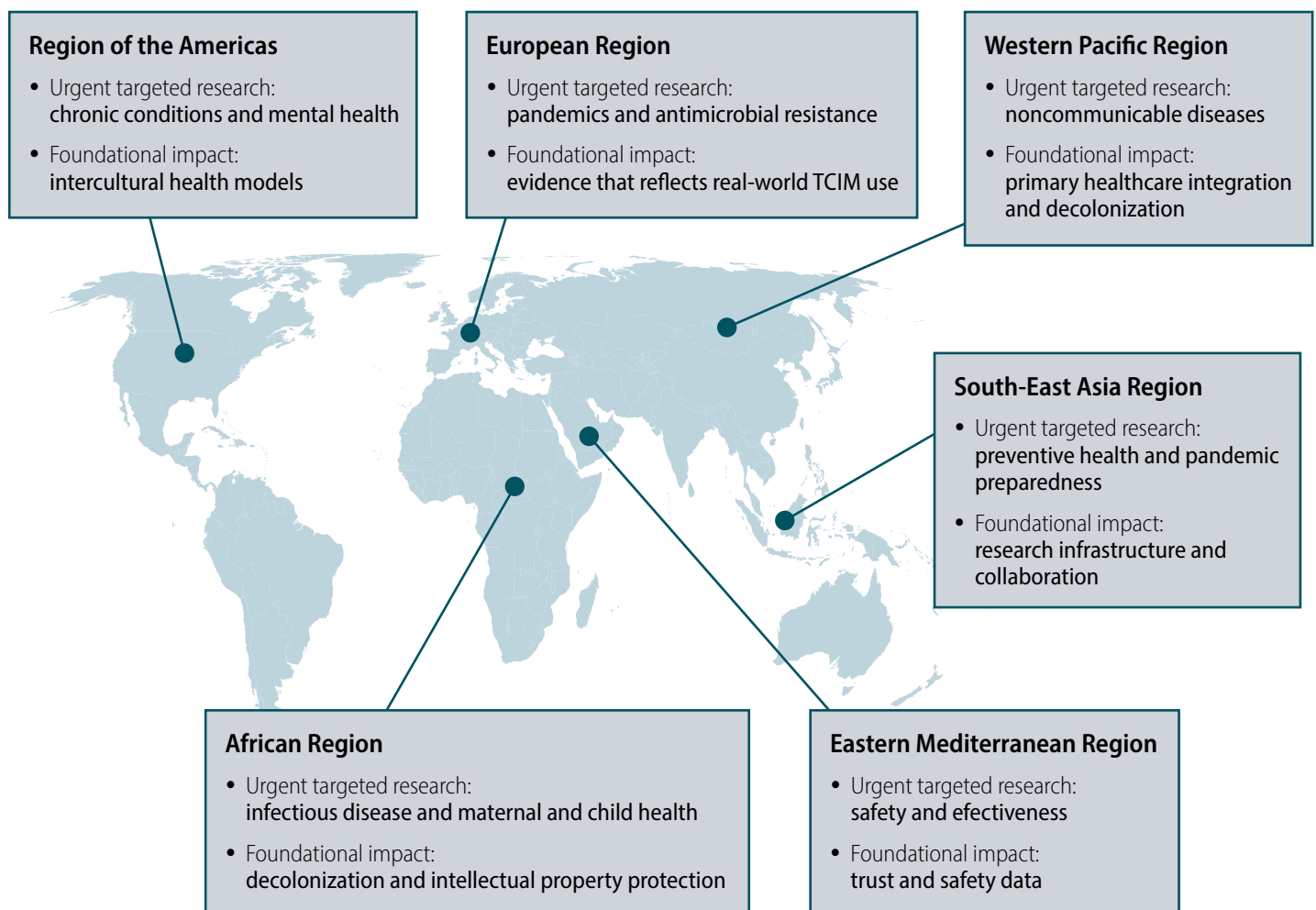


Table 10: Regional research priorities and actions across the four drivers

African Region	
Clinical research priorities	• Infectious disease: investigate TCIM's role in treating HIV, malaria and tuberculosis; identify effective TCIM approaches to support antimicrobial stewardship. • Mental health: explore therapeutic outcomes of ritualistic and traditional healing practices for community mental health resilience. • Preventive health and noncommunicable diseases: describe TCIM's contribution to health promotion and resilience across the life course, with particular focus on chronic and noncommunicable disease prevention. • Maternal and child health: evaluate the safety and efficacy of traditional midwifery, herbal resources in primary care and TCIM practices for paediatric populations.
Translate	Embed best practice intellectual property protection processes into legal frameworks, policy and commercial processes relevant to TCIM, safeguarding intergenerational knowledge and ensuring equitable benefit-sharing before commercialization.
Mobilize	Establish funding streams specifically for TCIM research. Investigate the economic viability of taxation models on TCIM products or TCIM-related health tourism as sources of sovereign revenue to reduce foreign donor dependence. Develop evidence-informed government-supported national TCIM research agendas promoting national economic independence.
Implement	Ensure research methods and governance processes are sensitive to best practice on intellectual property protections when traditional medical knowledge sources are used. Establish policies recognizing Indigenous and community-embedded governance structures in the design, implementation and translation of TCIM research.
Catalyse	Establish and expand allied networks of national TCIM research centres for meaningful and sustainable collaboration. Create culturally and epistemologically aligned databases mapping medicinal plant biodiversity to monitor climate-driven changes and prevent species depletion. Ensure researchers have access to laboratories with standardized capabilities for product development and biodiversity mapping.

Region of the Americas

Clinical research priorities	• Mental health: investigate TCIM to support mental health, including sleep and psychosocial resilience. • Pain management: examine TCIM approaches to pain management in place of and alongside pharmacological pain medication. • Healthy ageing: develop evidence on TCIM's role in ensuring health in later life through prevention across the life course as well as geriatric care. • Metabolic syndrome: build stronger evidence for TCIM-based lifestyle interventions in prevention and treatment of metabolic syndrome and related conditions. • Maternal and child health: address the gap in preventive integrative care models for women and children.
Translate	Conduct rigorous economic studies to inform TCIM inclusion in public funding and insurance schemes and optimize cost-effectiveness. Investigate integration and regulation models to inform policies that support Indigenous healers and TCIM practitioners as recognized providers within hospitals and clinics.
Mobilize	Mandate the inclusion of TCIM experts in processes of designing, assessing and making decisions for funding allocations relevant to TCIM research. Foster a diversified funding ecosystem allowing conservation of Indigenous knowledge beyond federal biomedical channels and promoting intraregional collaboration.
Implement	Adopt research frameworks that utilize Indigenous methods of inquiry such as “two-eyed seeing” and culturally sensitive, community-led, non-hierarchical approaches to bridge Indigenous and Western paradigms. Develop intercultural health policies and research approaches that recognize Indigenous land rights and ancestral knowledge as integral to health outcomes.
Catalyse	Share findings and global knowledge resources in accessible formats over investment in physical infrastructure. Promote equitable representation of TCIM experts throughout all stages of research planning, conduct and dissemination with a focus on multi-stakeholder collaborations. Invest in infrastructure and practitioner research training pathways to sustain future TCIM research workforce capacity.



South-East Asia Region	
Clinical research priorities	• Preventive health and healthy ageing: investigate TCIM for health and quality of life across the lifespan. • Pain and musculoskeletal conditions: identify effective TCIM interventions for musculoskeletal conditions and pain management. • Sleep and insomnia: explore TCIM interventions supporting healthy sleep and treating insomnia. • Pandemic preparedness: leverage lessons from COVID-19 to research TCIM's role in addressing pandemics, zoonotic diseases, population health resilience and regional emergency response preparedness. • Climate change and sustainability: examine potential impacts of climate change on TCIM and improve sustainability of TCIM processes and resources.
Translate	Develop multi-stakeholder alliances across research, health systems, policy, commercial players, TCIM practitioners and grass roots communities to foster context- and culture-sensitive communication of TCIM research. Develop, strengthen and update national TCIM research strategies providing greater inclusion of TCIM stakeholders in policy development. Progress integration of TCIM under universal health coverage through research connecting rigorous cost-effectiveness evidence to health systems and community context.
Mobilize	Investigate state-funded financial models that provide sustained, strategic funding dedicated to TCIM research and capacity-building across the region, with mutual benefit for public health infrastructure. Develop strategic partnerships with commercial stakeholders to advance standardization, quality, safety and efficacy of TCIM products through processes sensitive to traditional knowledge and the intellectual property rights of traditional medical knowledge custodians.
Implement	Employ practice-based research approaches that allow real-world data collection to improve the safety and quality of TCIM care. Undertake research to clearly codify TCIM diagnostics to reflect real-world practices for the purposes of policy development and traditional medical knowledge preservation.
Catalyse	Develop research infrastructure and skills in AI and other digital technologies to document TCIM practices and standardize practice-based data with appropriate consideration for intellectual property rights and benefit-sharing. Develop and strengthen national TCIM centres of research excellence and government-embedded research institutes. Invest in TCIM research workforce capacity, focusing on increasing practitioners' research skills through practice-based research.



European Region	
Clinical research priorities	• Mental health: investigate TCIM interventions to support mental health, psychosocial resilience and sleep. • Pandemics and AMR: investigate TCIM's role in addressing AMR, pandemic preparedness and health emergency responses. • Pain management: examine TCIM approaches to pain management in place of and alongside pharmacological pain medication. • Healthy ageing: develop evidence on TCIM's role in ensuring health in later life through prevention across the life course as well as geriatric care. • Integrative medicine: explore effectiveness and implementation of integrative care models to address high-burden clinical areas, particularly in oncology and palliative care.
Translate	Investigate models of care and policy mechanisms that support safe and effective integration of TCIM within established health systems. Undertake research and engagement with policy-makers to support integration of TCIM evidence, including traditional medical knowledge, into policy decision-making models and national clinical practice guidelines. Research legal and regulatory frameworks that enable TCIM insurance coverage and help reduce patients' out-of-pocket costs.
Mobilize	Require inclusion of TCIM experts in developing grant rules and determining the outcome of research grant applications. Establish dedicated TCIM grant schemes that enhance accessibility of funding for TCIM research and offer funding rules responsive to TCIM research approaches and needs. Explore ethical partnerships with public, private and commercial stakeholders to promote sustained, reliable TCIM research funding streams.
Implement	Shift to research approaches that centre patients in real-world contexts. Investigate approaches that advance regulation of TCIM practices and standardization of TCIM products.
Catalyse	Establish or strengthen government-embedded TCIM research institutes, necessary for advancement of innovative research methods and policy-related outcomes. Build research capacity through education, establishing mentoring programmes for emerging researchers, academic-clinician networks and interdisciplinary academic collaboration and exchange. Integrate TCIM-related biological samples and data into established biobanks. Create a European TCIM research registry to reduce duplication and consolidate evidence.



Eastern Mediterranean Region

Clinical research priorities	• Mental health: examine efficacy and effectiveness of TCIM interventions and approaches including plant medicine and spiritual practices for addressing mental health and stress. • Cancer: study effects of TCIM interventions on prevention and treatment of cancer, particularly integrative oncology. • Immunology: investigate TCIM interventions for autoimmune disease and other immunological conditions. • Musculoskeletal conditions: identify cost-effective and scalable TCIM interventions for musculoskeletal conditions such as osteoarthritis. • Humanitarian crises and conflict: explore TCIM's current and potential future contribution to meeting community health needs during humanitarian crises and conflict.
Translate	Conduct efficacy and effectiveness trials of TCIM based on traditional medical knowledge, particularly for region-specific interventions that may address existing gaps in population health needs (e.g. cupping/Hijama, Apitherapy). Collect and share safety data for TCIM to promote awareness and confidence among all health professionals. Investigate models of care and policy mechanisms that support safe and effective integration of TCIM within established health systems.
Mobilize	Urgently increase the number of funding opportunities dedicated to TCIM research from public and private sources, with emphasis on government funding. Produce robust economic outcome data to demonstrate the value of TCIM to private insurers and public funders. Develop grant rules that accommodate TCIM-specific study designs and methods, guided by the inclusion of TCIM experts in grant design and allocation.
Implement	Research and clearly define the actions and criteria required to support appropriate licensing of TCIM practitioners to build trust with the public and broader health systems. Develop and implement TCIM product standards that preserve and validate traditional medical knowledge. Map the status and implementation of TCIM regulation across countries to inform harmonization of standards.
Catalyse	Employ strategic use of AI and digital tools to address evidence gaps and connect research with practice-generated data. Establish infrastructure for effective pharmacovigilance and good manufacturing practice quality monitoring. Support the growth and upskilling of the existing TCIM research workforce through greater inclusion of TCIM stakeholders in research and policy, and interdisciplinary collaboration with biomedical stakeholders.

Western Pacific Region

Clinical research priorities	• Climate resilience: examine the sustainability of TCIM resources and its role in responding to climate change's population health impacts and building health system resilience. • Pain management: examine TCIM approaches to pain management alongside pharmacological medication. • Healthy ageing: develop evidence on TCIM's role in ensuring health in later life through prevention across the life course as well as geriatric care. • Mental health: investigate TCIM interventions to support mental health, psychosocial resilience and sleep. • Stroke rehabilitation: examine effectiveness of TCIM interventions for stroke rehabilitation and related quality of life.
Translate	Develop community-led research guidelines implementing best practice on intellectual property rights for Indigenous knowledge holders. Support integration of TCIM within broader public health systems through TCIM research communication and collaboration strategies that engage policy-makers, interdisciplinary researchers and healthcare providers.
Mobilize	Move from uncoordinated small grants to focused funding streams aligned with regional priorities (e.g. Māori and Pasifika health). Identify ways to reduce the administrative burden involved in securing TCIM funding and ensure national research centres and supporting administrative systems are appropriately resourced. Develop coordinated funding acquisition approaches leveraging mutual goals between researchers to maximize impact of TCIM research.
Implement	Focus on implementation research facilitating inter-professional collaboration for TCIM researchers within primary care and policy development. Employ research methods embedded in TCIM practice and traditional medical knowledge, exploring topics offering cultural value alongside material benefits, including community-led and Indigenous approaches where relevant. Establish standardized processes for clinical research data allowing studies to link across centres while retaining uniqueness and autonomy of TCIM-specific frameworks.
Catalyse	Utilize and further develop international and interdisciplinary networks between TCIM stakeholders to share knowledge, skills and resources. Develop infrastructure and capacity for strategic implementation of AI and digital technology that balances benefits with protections of intellectual property, data sovereignty and patient privacy.

Note: The research priorities listed for each WHO region reflect the collective assessment of regional stakeholders, obtained through a rigorous multi-phase consultation and Delphi process. All priorities within each region carry equal weight for implementation purposes. The order of listing does not imply relative urgency or rank.



Implementation, monitoring and evaluation

The *WHO global research priorities and agenda for traditional, complementary and integrative medicine* is designed as a living document enabling the strategic implementation of effective, equitable TCIM research. Implementation must be country-led, flexible and adapted to national capacities and needs. Success is measured not only by publications, but by the establishment of governance, security of funding and translation of evidence into policy.

Four guiding principles for implementation

Implementation of the research agenda and priorities should be both country-led and regionally specific, and driven by stakeholders across four phases ([Table 11](#)).

Table 11: Guiding principles for implementation of research agenda and priorities

Principle	Description
1. Country-led adaptation	Member States tailor these global priorities to their specific disease burdens, economic context and cultural realities. Implementation should begin with a national gap analysis against the roadmap using the TCIM research priority-setting framework.
2. Regional specificity	Recognizing that structural barriers are particularly impactful in the African and Eastern Mediterranean Regions, implementation plans in these contexts must prioritize foundational resource investment (Mobilize and Catalyse) as a prerequisite to methodological advancement.
3. Stakeholder-driven governance	Implementation bodies must include TCIM practitioners, researchers and traditional medical knowledge holders to ensure epistemic equity and research legitimacy.
4. Phased development	Recognizing that infrastructure cannot be built overnight, implementation follows the logic of Foundation and Governance (Years 1–2), then System Strengthening and Funding (Years 3–5), then Scale-up and Integration (Years 6–10).



Phased implementation timeline

The first phase of implementation focuses on foundational steps that support governance, and provides a robust basis for a thriving TCIM research ecosystem in years to come (Table 12). The actions in this phase are the most time-sensitive and without taking these steps, future efforts to achieve TCIM research outputs and impact may fail.

Table 12: Phased implementation timeline

Phase	Key actions:
Phase 1: Foundation and Governance <i>Years 1–2 (suggestive)</i>	• Establish a dedicated TCIM research unit or ministerial focal point within the ministry of health. • Adopt globally standardized TCIM definitions and terminology. • Institutionalize TCIM stakeholder representation in national research advisory and ethics bodies. • Conduct national landscape mapping of TCIM use and existing research capacity. • Provide legislative evidence summaries to Member States integrating TCIM into universal health coverage or insurance schemes (committed by 2027). • Develop harmonized TCIM product quality standards to support local production commitments.
Phase 2: System Strengthening and Funding <i>Years 3–5 (suggestive)</i>	• Establish dedicated TCIM research funding streams and competitive grant schemes. • Launch government-embedded TCIM research institutes. • Develop and implement intellectual property protection and benefit-sharing guidelines. • Integrate TCIM modules into health professional research training curricula. • Develop TCIM-specific research grant guidelines reflecting methodological diversity.
Phase 3: Scale-up and Integration <i>Years 6–10 (suggestive)</i>	• Operationalize practice-based research networks linked to national health information systems. • Establish independent centres of research excellence with international collaborations. • Integrate TCIM evidence into HTA frameworks and national coverage policies. • Establish global TCIM consortium for cross-sector investment and intellectual property management. • WHO Secretariat mid-term evaluation (2029): assess global TCIM research ecosystem and adjust priorities for 2030–2034.

Note: The phases above are indicative – they represent a recommended logical sequence, not a fixed timeline. Member States may enter the implementation journey at any phase based on their own self-assessment, existing capacity, available resources and national context.



Monitoring and evaluation framework

The monitoring and evaluation matrix (Table 13) provides a standardized tool for Member States and the WHO Secretariat to track progress against priority actions and ensure alignment with the *Global traditional medicine strategy 2025–2034* (2) and the *Delhi declaration* (13). Actions are mapped across four strategic domains: Evidence, Regulation, Integration and Collaboration.

Table 13: Monitoring and evaluation matrix, Global TCIM research agenda and priorities 2025–2034

Strategic action	Key performance indicator	Primary responsibility	Driver (Translate/Mobilize/Implement/Catalyse)
Core indicators (Sustainable Development Goal [SDG]-linked) – Monitored by the WHO Global Observatory on Health Research and Development			
Funding allocation	Gross domestic research and development expenditure on health as percentage of GDP [SDG 9.5.1].	Member States/funders	Mobilize
TCIM research workforce	Health researchers (full-time equivalent) per million inhabitants by WHO region [SDG 9.5.2].	Member States/WHO Secretariat	Catalyse
Supporting indicators			
High-burden conditions and populations	Proportion of funded TCIM studies targeting priority conditions; year-on-year increase in research output on priority conditions.	Member States/WHO Secretariat	Mobilize
Cross-sectoral issues	Number of studies on One Health, AI, pandemics and AMR commissioned; evidence of integration into national preparedness or digital health strategies.	Member States	Implement
TCIM priority-setting framework	Proportion of Member States applying framework; number of national research agendas revised accordingly.	Member States/WHO Secretariat	Translate
Terminology standardization	Number of national documents adopting WHO-defined TCIM terminology; existence of national TCIM glossary aligned with WHO vocabulary.	Member States/WHO Secretariat	Translate
Stakeholder engagement	Percentage of research governance committees with at least one TCIM-experienced representative; number of national protocols requiring TCIM community engagement.	Member States	Translate
Evidence-informed decision-making	Number of HTA assessments or clinical guidelines citing TCIM evidence; TCIM inclusion in national evidence-to-policy mechanisms.	Member States/WHO Secretariat	Translate
Universal health coverage and insurance integration	Number of cost-effectiveness or budget impact analyses conducted; extent of TCIM inclusion in national insurance schemes.	Member States	Implement

Strategic action	Key performance indicator	Primary responsibility	Driver (Translate/Mobilize/Implement/Catalyse)
Strategic dissemination	Number of policy briefs produced for decision-makers; availability of public-facing TCIM evidence summaries.	WHO Secretariat/ Member States	Translate
Sustainable and equitable funding	Existence of dedicated TCIM research budget line; year-on-year increase in TCIM research funding allocation.	Member States	Mobilize
Indigenous-led research	Existence of national frameworks ensuring Indigenous governance and benefit-sharing; number of Indigenous-led TCIM research projects.	Member States	Implement
Regulatory science and quality standards	Adoption of good manufacturing practice and safety standards for TCIM products; number of validated safety assessments conducted annually.	Member States	Implement
Methodological innovation	Number of TCIM research protocols registered using whole-systems, adaptive or real-world data designs; existence of published national TCIM methodology guidance.	Member States/WHO Secretariat	Implement
Government TCIM research oversight	Existence of government-embedded TCIM research oversight unit; annual reporting on TCIM research activity completed.	Member States	Catalyse
TCIM research workforce	Number of scholarships and fellowships funded; TCIM modules in research training curricula; national mentorship programmes established.	Member States/WHO Secretariat	Catalyse
Practice-based research networks	Number of networks operational; TCIM data integrated into national health information systems.	Member States/partners	Implement
Centres of research excellence	Number of designated and funded national centres of research excellence; active international collaborations.	Member States/WHO Secretariat	Catalyse
Global coordinated databases	Number of TCIM studies registered in the WHO International Clinical Trials Registry Platform or equivalent; progress towards a WHO-coordinated TCIM research database with standardized metadata and intellectual property protections.	WHO Secretariat/ Member States	Catalyse

Mechanism for review

- National review: Member States are encouraged to report on these indicators every two years as part of their contribution to the global report on traditional and complementary medicine.
- Global review: the WHO Secretariat will conduct a mid-term evaluation in 2029 to assess the health of the global TCIM research ecosystem and adjust priorities for the final phase (2030–2034).



| Conclusion: the way forward

This report marks a decisive shift in how the global community approaches TCIM research. It transforms a historically fragmented, under resourced and misaligned research landscape into a coherent, evidence-informed and policy-grade framework capable of driving systemic change.

The path ahead is clear: research must be targeted where the burden is greatest and where TCIM has the highest potential for positive clinical and societal impact. The ecosystem enabling that research – translated into policy, sustainably funded, implemented with methodological rigour and supported by a growing skilled workforce – must be built in parallel. Indigenous peoples and traditional knowledge holders must be genuine partners, not subjects, in this enterprise. Regional adaptation ensures that global commitments translate into locally meaningful action.

Member States, the WHO Secretariat, non-State actors, funders, researchers and communities each have a defined role in delivering this agenda. The evidence generated over the decade 2025–2034 will be critical to ensuring that the integration of TCIM into health systems, as committed to by Member States under the *Global traditional medicine strategy 2025–2034 (2)*, translates into improved health outcomes – or remains aspirational.

The opportunity

Targeted investment in TCIM research can generate the evidence needed to ensure that the integration of TCIM into health systems is safe, effective and equitable – contributing to improved population health, stronger health system resilience and the fulfilment of Member State commitments under the *Global traditional medicine strategy 2025–2034 (2)* and the *Delhi declaration (13)*.

The global TCIM research community has the knowledge, the motivation and, with this agenda, the roadmap. The next step is action.



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Annex 1:

Methodological detail

Aims and objectives

The project aimed to develop a global TCIM research agenda through a rigorous, stakeholder-informed process. Four interrelated objectives guided the work:

- Map the current global TCIM research landscape, including funding patterns, quality standards and existing priority-setting exercises.
- Identify research priorities and gaps through systematic literature analysis and stakeholder consultation across all WHO regions.
- Develop a TCIM research priority-setting framework with criteria and weightings validated by global TCIM experts.
- Synthesize findings into an actionable, implementation-ready agenda aligned with the *Global traditional medicine strategy 2025–2034* (2).

Underpinning principles and values

The project was guided by principles of epistemic equity, cultural safety, self-determination and scientific rigour. It recognized that TCIM encompasses diverse knowledge systems and that research processes must be designed to reflect – not reduce – that diversity. The project methodology was informed by WHO guidance on “A systematic approach for undertaking a research priority-setting exercise” (20) and the mixed-methods study design (21) was aligned with the *WHO strategy on research for health*, seen in [Table A1.1](#) (14).

Table A1.1: Alignment with the *WHO strategy on research for health*

WHO research for health goal	How this project addressed it
Creating and sustaining research capacity	Phases 2B and 3 mapped global TCIM research capacity across 116 institutes in 67 countries; they identified structural capacity gaps for targeted action in the implementation framework.
Defining and setting research priorities	The Phase 3 Delphi process and regional consultations generated globally validated research priorities; Phase 4 synthesized these into the TCIM research priority-setting framework.
Producing and applying research evidence	All phases generated actionable, policy-grade evidence; Phase 4 mapped implementation pathways ensuring research informs health system practice.
Strengthening research for health systems	The implementation framework explicitly links research priorities to Member State health system integration commitments.



Annex 2:

Guidance on implementing the TCIM research priority-setting framework

Governance and process

National implementation of the framework should be coordinated through a formal governance structure – ideally the TCIM research unit or ministerial focal point established in Phase 1. This body should include TCIM practitioners, researchers, patients and traditional knowledge holders to ensure epistemic equity.

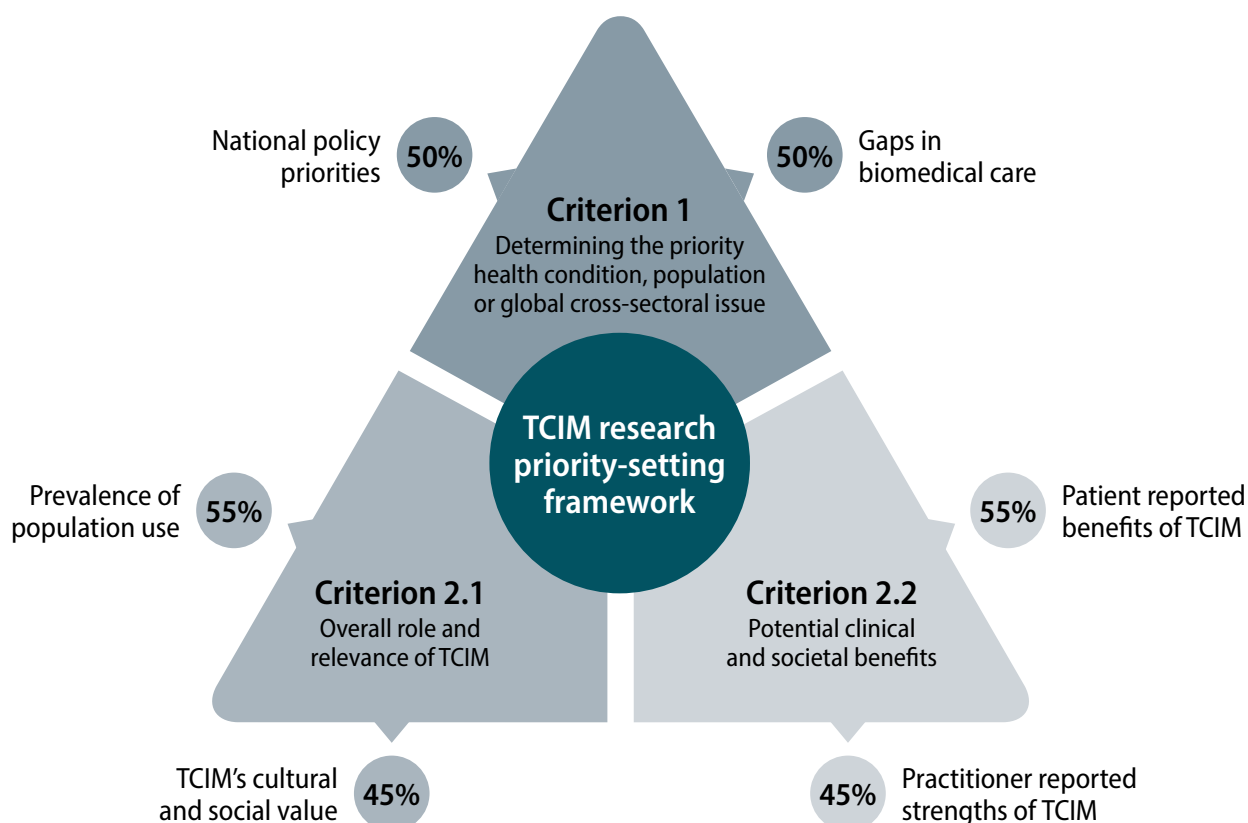
Inputs and evidence

The framework first supports collation and synthesis of evidence across its six criteria. This includes analysing the burden of disease data; reviewing national policy priorities; assessing TCIM utilization patterns; and engaging communities and practitioners to identify needs and perspectives.

Scoring and prioritization

The TCIM research priority-setting framework criteria should be applied using a multi-criteria scoring matrix with weights agreed in advance (see [Fig. A2.1](#) for illustrative weightings; weightings can be adapted nationally). Thresholds and tiebreak rules can be used (e.g. equity impact, cost-utility potential).

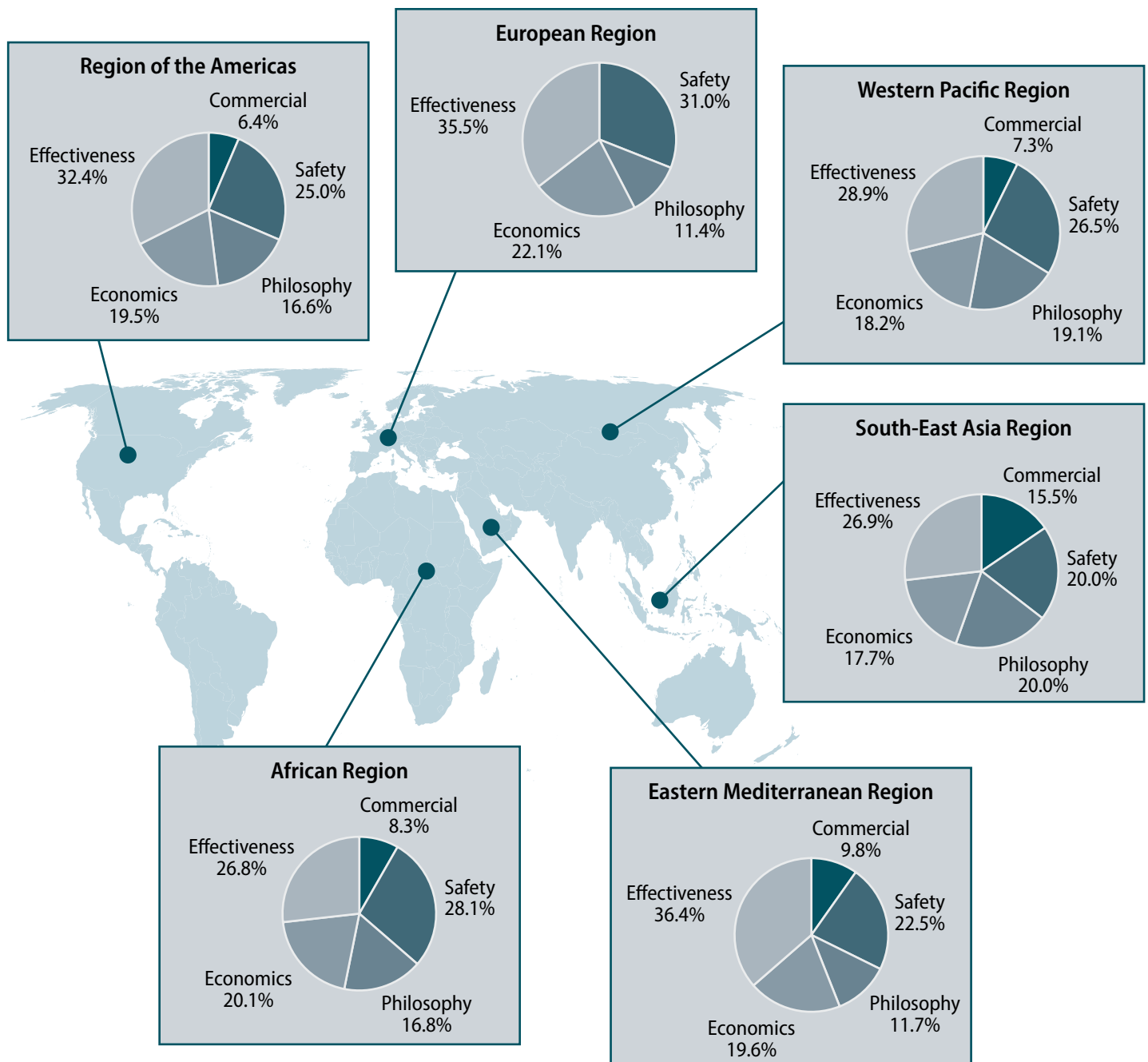
Fig. A2.1: Illustrative weighting for TCIM research priority-setting framework criteria



Decision-making and commissioning

Priorities should be translated into calls for proposals with aligned review criteria mirroring the TCIM research priority-setting framework criteria weights. Additional criteria should be integrated to determine the lens of inquiry for the priority topics (see regionalized examples in [Fig. A2.2](#)). Equity, safety and implementation plans will be required in proposals. Mixed-methods and real-world designs aligned to care pathways should be encouraged.

Fig. A2.2: Regionalized examples of approaches to TCIM research inquiry for priority topics



Monitoring, learning and updating

Member States should periodically update priorities as national needs evolve or as new evidence emerges. This ensures the framework remains a dynamic tool for adaptive decision-making, guiding long-term investment in TCIM research that is nationally meaningful while contributing to regional and global evidence needs.

Table A2.1: Context-specific guidance on weighting

National context	Recommended approach
Low TCIM research capacity or early-stage ecosystem	Weight national policy priorities and prevalence of population use most heavily to ensure foundational relevance and achievable initial research priorities.
Moderate capacity – building evidence base	Balance all six criteria as designed; focus on gaps in biomedical care to maximize complementarity with existing health services.
High capacity – mature TCIM research ecosystem	Emphasize patient-reported benefits and practitioner-reported effects to drive precision and real-world clinical impact.
Indigenous community research context	Centre TCIM’s cultural and social value and prevalence of population use while ensuring all processes are governed by Indigenous-led frameworks.



Annex 3:

Implementation actions by actor group

This Annex consolidates all actor-specific implementation actions from across the agenda. Actions are organized by actor group and aligned to the relevant strategic driver and implementation phase. For the strategic rationale, see the relevant section of the main document.

Member State actions

Table A3.1: Dimension 1: targeting research for the greatest benefit

Action area	Action	Phase
Priority-setting framework	Apply the TCIM research priority-setting framework to national funding calls and research commissioning decisions.	Phase 1
Priority-setting framework	Synthesize national health burden data, policy priorities and TCIM utilization patterns to identify context-specific research priorities.	Phase 1
High-burden conditions	Target funding towards high-burden clinical conditions and key populations to ensure research capacity is supported and clinical outcomes improved.	Phase 1–2
Priority populations	Ensure research programmes explicitly address preventive health, healthy ageing and paediatric populations as priority investment areas.	Phase 1–2
AI	Establish research programmes to evaluate safe, effective and ethical use of AI in TCIM; develop governance frameworks for data sovereignty and privacy in AI-assisted TCIM research.	Phase 1–2
Pandemics and AMR	Commission research into TCIM interventions for infection prevention and management; integrate TCIM into national pandemic preparedness and AMR research frameworks.	Phase 2
High-burden conditions	Commission research on TCIM integration into health systems including primary healthcare models, reimbursement frameworks and care pathways.	Phase 2–3
One Health and climate	Investigate sustainability of natural resources used in TCIM in geographies facing imminent climate or biodiversity risk.	Phase 2–3
Priority-setting framework	Periodically update national TCIM research priorities as evidence and national needs evolve.	Ongoing

Table A3.2: Dimension 2: amplifying impact

Driver	Action	Phase
Translate	Adopt standardized TCIM terminology within national health policies and research frameworks.	Phase 1
Translate	Include TCIM-experienced stakeholders in national research governance structures, ethics committees and health advisory bodies.	Phase 1
Implement	Enact or amend national legislation to formally protect traditional knowledge used in TCIM research, including benefit-sharing provisions and prior informed consent requirements aligned with the Nagoya Protocol.	Phase 1
Implement	Require national research ethics committees to include Indigenous representatives and apply culturally appropriate review criteria when approving TCIM research protocols involving Indigenous knowledge or communities.	Phase 1
Catalyse	Establish a formal governance structure within the Ministry of Health with a mandate to oversee TCIM research policy, funding and coordination.	Phase 1
Translate	Conduct rapid reviews and cost-effectiveness research to support TCIM integration into universal health coverage frameworks.	Phase 1–2
Translate	Update national HTA processes to include cost-effective TCIM interventions and patient-centred outcome measures.	Phase 2
Mobilize	Create dedicated TCIM research funding streams within national research budgets.	Phase 2
Mobilize	Institutionalize TCIM expertise across all stages of funding governance.	Phase 2
Mobilize	Sequence funding calls using the TCIM research priority-setting framework to align resources with national priorities.	Phase 2
Catalyse	Establish and resource government-embedded TCIM Research Institutes.	Phase 2
Catalyse	Integrate research and cultural safety training into TCIM professional education curricula.	Phase 2
Translate	Integrate TCIM evidence into national health communication strategies in accessible, culturally appropriate formats.	Phase 2–3
Mobilize	Build diversified TCIM funding ecosystems incorporating government, competitive grants, philanthropy and international partnerships.	Phase 2–3
Mobilize	Facilitate data sharing of TCIM funding allocations to build a global picture of TCIM research investment.	Phase 2–3
Implement	Fund research using whole-systems approaches, real-world data and adaptive trial designs.	Phase 2–3
Implement	Promote development and validation of non-animal toxicological assessments and Good Manufacturing Practice standards for TCIM products.	Phase 2–3
Catalyse	Facilitate national and regional research networks including government, academia, practitioners and civil society.	Phase 2–3
Catalyse	Fund scholarships, fellowships and mentorship programmes for TCIM practitioner researchers.	Phase 2–3
Catalyse	Integrate TCIM practice data collection into national health information systems and electronic health records.	Phase 2–3
Catalyse	Contribute national TCIM research data to global databases with compliance with intellectual property and data sovereignty frameworks.	Phase 2–3
Catalyse	Establish and fund practice-based research networks to connect practitioners with researchers and generate real-world evidence.	Phase 3
Catalyse	Designate and fund national or regional TCIM Centres of Research Excellence.	Phase 3

Table A3.3: Indigenous medicine

Action area	Action	Phase
Indigenous intellectual property	Establish enabling policies and legislation to protect Indigenous intellectual property and traditional medicinal knowledge.	Phase 1
Indigenous intellectual property	Ensure ethical review processes incorporate Indigenous governance and cultural protocols.	Phase 1
Self-determination	Facilitate partnerships between Indigenous communities and TCIM research institutions.	Phase 1–2
Safeguard knowledge	Ensure research programmes support transmission of traditional knowledge within communities under Indigenous control.	Phase 2–3

Table A3.4: Partner and stakeholder actions

Action area/driver	Action	Phase
Priority-setting framework	Co-design TCIM research priorities and protocols with community and patient representatives, ensuring inclusive and culturally safe processes.	Phase 1–2
Priority-setting framework	Advocate for inclusion of practitioner-reported effects in national TCIM research priority-setting processes.	Phase 1–2
Mobilize	Advocate for dedicated TCIM research units within health ministries and support capacity-building for national TCIM research governance.	Phase 1–2
Implement	Support co-design and co-implementation of research with Indigenous leadership, ensuring effective and appropriate benefit-sharing arrangements.	Phase 1–2
Priority-setting framework	Develop or adapt clinical tools to evaluate patient outcomes and experiences specific to TCIM interventions.	Phase 2
High-burden conditions	Strengthen clinical evidence in neglected high-burden conditions and key populations using systematic reviews and clinical trials.	Phase 2–3
One Health and climate	Collaborate on biodiversity conservation research and develop pharmacopeial monographs and sustainability guidelines for high-use medicinal plants.	Phase 2–3
Translate	Develop and disseminate WHO-aligned clinical documentation tools and coding standards to facilitate TCIM data integration into health information systems.	Phase 2–3
Implement	Invest in infrastructure and training for Indigenous TCIM research capacity.	Phase 2–3
Catalyse	Mobilize TCIM practitioners to participate in data collection and practice-based research networks.	Phase 2–3
Catalyse	Support TCIM stakeholder participation in broader mainstream health research alliances to reduce silos and build interdisciplinary collaboration.	Phase 2–3

Table A3.5: WHO Secretariat actions

Action area/driver	Action	Phase
Priority-setting framework	Develop guidelines to support comprehensive and accurate national surveys of TCIM use.	Phase 1
Translate	Lead development of globally agreed, consensus-based definitions for operative terms central to TCIM research.	Phase 1
Catalyse	Establish a Global TCIM Consortium to drive cross-sector investment, innovation and equitable benefit-sharing across the global TCIM research ecosystem.	Phase 1
Mobilize	Develop standardized terminology and metadata requirements for TCIM research grants.	Phase 1–2

Action area/driver	Action	Phase
Indigenous	Develop global standards and guidance for Indigenous-led TCIM research, including intellectual property protection and benefit-sharing frameworks.	Phase 1–2
Catalyse	Provide technical guidance on best practices for institutionalizing TCIM research governance within national health systems.	Phase 1–2
High-burden conditions	Map the global TCIM research-to-burden gap across all priority conditions; maintain a publicly available gap analysis updated every three years.	Phase 1–2
High-burden conditions	Convene a coordinated multilateral commissioning mechanism to ensure no identified high-burden condition remains without a TCIM research pathway.	Phase 1–2
Priority-setting framework	Develop global guidance and tools to assist Member States in applying the TCIM research priority-setting framework.	Phase 1–2
High-burden conditions	Establish minimum evidence standards for TCIM integration into health systems for each priority condition.	Phase 2
AI	Facilitate global dialogue on appropriate methodologies and ethical standards for application of AI in TCIM research and practice.	Phase 2
Priority-setting framework	Curate recommended tools for capturing patient-reported outcomes and experiences in TCIM contexts.	Phase 2
Translate	Develop the WHO Global Benchmarking Tool for TCIM to assess national regulatory maturity.	Phase 2
Translate	Develop global guidance on adapting HTA frameworks to incorporate methods that accommodate TCIM complexity.	Phase 2
Mobilize	Support indexing and classification of TCIM research grants within regional and global funding databases.	Phase 2
Implement	Develop global guidance on TCIM-specific methodologies for evaluating multicomponent interventions and complex systems.	Phase 2
Implement	Develop global guidance on Two-Eyed Seeing frameworks and paradigmatic alignment for TCIM research.	Phase 2
Catalyse	Establish a centralized plant medicine safety platform to synthesize global pharmacovigilance data and support regulatory decision-making.	Phase 2
Implement	Develop specific research guidelines for non-codified TCIM to ensure evidence capture without stripping cultural context.	Phase 2–3
Catalyse	Monitor and report on global progress in embedding TCIM research leadership within government systems.	Phase 2–3
Catalyse	Convene global and regional forums to connect TCIM stakeholders with mainstream health research networks.	Phase 2–3
Catalyse	Facilitate international mentorship and leadership programmes for emerging TCIM researchers.	Phase 2–3
Catalyse	Develop and maintain global TCIM research databases with standardized metadata and taxonomy.	Phase 2–3
Catalyse	Operationalize the WHO Traditional Medicine Global Library as a trusted, ethically governed global repository for TCIM research knowledge.	Phase 3
Translate	Produce policy briefs and evidence summaries of TCIM tailored for decision-makers.	Ongoing

Note: The phases above are indicative. They represent a recommended logical sequence, not a fixed timeline. Member States may enter the implementation journey at any phase based on their own self-assessment, existing capacity, available resources and national context. Phase 1: Foundation and Governance (Years 1–2, suggestive); Phase 2: System Strengthening and Funding (Years 3–5, suggestive); Phase 3: Scale-Up and Integration (Years 6–10, suggestive).

Annex 4:

Illustrative PICO questions for priority research areas

The following PICO (Population, Intervention, Comparator, Outcome) questions illustrate how the research priorities identified in this agenda can be operationalized into specific, researchable study questions. These examples are illustrative and indicative. They are not prescriptive or exhaustive. Member States, research institutions and funders are encouraged to adapt and refine these questions to reflect national health priorities, local TCIM practice contexts and available research infrastructure.

Each PICO is grounded in the disease burden context and current research gaps identified in [Section 1.1](#) of this agenda. The outcome column specifies the primary outcome measures; where a rationale for outcome selection is provided, it is shown in italics in parentheses to signal that the outcome addresses a gap identified in [Section 1.1](#), not general clinical convention. The suggested methodological approaches column draws from the methods presented in [Table 9](#). Approaches marked ‘aspirational: Phase 2–3’ presuppose research infrastructure that the report itself is working to build through [Annex 3](#); these are targets, not immediately available options in all settings.

Note on system-neutral language: the intervention column uses categorical language – such as ‘manual therapies’, ‘mind-body practices’ and ‘herbal preparations’ – to encompass relevant TCIM modalities from all traditions. This is consistent with the system-neutral position of the report and does not imply that well-evidenced modalities within these categories are absent from the evidence base. For example, acupuncture is among the most extensively researched TCIM modalities and falls within the ‘manual therapies’ category across several conditions; similarly, herbal and dietary preparations from tradition-specific systems, including but not limited to Ayurveda, traditional Chinese medicine, Kampo, Unani, and Indigenous plant medicine traditions, are encompassed within ‘herbal preparations’. Researchers are encouraged to specify the relevant modality based on the existing evidence base and their national TCIM context.

Note on mind-body practices: as used in this Annex, mind-body practices refer to structured interventions that use the interaction of mind, body and behaviour to promote health. This category includes, but is not limited to, meditation, yoga, mindfulness-based stress reduction, tai chi, qigong, guided imagery and culturally embedded equivalents. Researchers should refer to existing WHO TCIM classification frameworks and [Table 9](#) of this agenda for further methodological guidance.

PICO questions marked (Translate) are specifically oriented towards health system integration, policy adoption and cost-effectiveness, reflecting the Translate driver of the TCIM framework. In these PICOs, the intervention is a policy framework or integration model rather than a specific TCIM modality; specific interventions are indicated as ‘to be specified based on national context and available evidence’, consistent with the agenda’s recognition that national adaptation is both necessary and appropriate.

Basis for these PICO questions: these PICO questions are derived from the research gaps and priority populations identified in [Sections 1.1](#) and [1.2](#) of this agenda. They do not introduce new evidence claims or populations beyond those established in the main document. No external evidence sources have been used to construct the PICO elements; all population, intervention and outcome specifications trace back to content already present in the agenda. Researchers developing full study protocols from these illustrative PICOs should conduct systematic searches of the current TCIM evidence base and apply the TCIM research priority-setting framework ([Section 1.3](#)) to assess local context, feasibility and alignment with national priorities.



Table A4.1: PICO questions for stroke research gap

Research gap: receives less than 1% of TCIM research grants despite being ranked third globally in mortality and disability.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 1.1	Adults following acute ischaemic or haemorrhagic stroke with residual motor or cognitive impairment, across diverse health system contexts.	Structured TCIM manual and/or movement-based therapy programme delivered as an adjunct to standard rehabilitation.	Standard post-stroke rehabilitation alone.	Functional recovery, activities of daily living, and quality of life at 3, 6, and 12 months (<i>outcomes currently absent from TCIM stroke research across income settings</i>).	• Pragmatic randomized trial. • Stepped-wedge cluster design across rehabilitation facilities.
PICO 1.2	Stroke survivors in community settings with limited access to specialist rehabilitation services, including in low-resource contexts.	Structured TCIM intervention (which may include mind-body practices, movement-based therapies, or other culturally embedded approaches) delivered by trained community health workers integrated into primary healthcare.	Usual community care without structured rehabilitation.	Long-term functional independence, caregiver burden, and health service utilization (<i>addressing the gap in community-level TCIM stroke rehabilitation data</i>).	• Pragmatic randomized trial. • <i>Practice-based research network (aspirational: Phase 2–3).</i>
PICO 1.3 (Translate)	Health ministries and primary healthcare planners in countries with high stroke burden.	Integration of evidence-based TCIM interventions – to be specified based on national context and available evidence – into national post-stroke care pathways.	Existing national stroke care pathways without TCIM components.	Cost-effectiveness, health system acceptability, and coverage of rehabilitation services (<i>addressing the absence of health system integration evidence for TCIM in stroke</i>).	• Mixed-methods implementation study. • <i>HTA (aspirational: Phase 2–3).</i>

Table A4.2: PICO questions for mental health research gap

Research gap: no identified TCIM research grants specifically focused on mental health conditions, despite mental health being the eighth highest disability-adjusted life year contributor globally.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 2.1	Adults aged 18–65 with mild to moderate depression or anxiety disorders in primary healthcare settings, including in contexts with limited specialist mental health access.	Structured mind-body TCIM intervention (including but not limited to meditation, yoga, mindfulness-based approaches, tai chi, qigong, or equivalent culturally embedded practices) delivered in primary healthcare or community settings.	Usual primary care with or without medication; waitlist control.	Symptom severity, functional status and health-related quality of life at 3 and 6 months, measured using patient-reported outcome frameworks (<i>filling the evidence gap in TCIM mental health interventions across diverse health system contexts</i>).	• Pragmatic randomized trial. • N-of-1 design for individual response variation.
PICO 2.2	Older adults (65+) experiencing age-related mental health decline, social isolation and stress-related conditions.	Integrated TCIM programme combining mind-body practice and herbal preparation delivered within a geriatric or community care setting.	Standard geriatric care without TCIM components.	Patient-reported well-being, social connectedness and reduction in psychotropic medication use, assessed using validated patient-reported outcome instruments (<i>outcomes currently absent from the TCIM evidence base for healthy ageing populations</i>).	• Whole-system trial with patient-reported outcome measurement. • Stepped-wedge cluster design across community care sites.
PICO 2.3 (Translate)	Policy-makers and health system planners in countries with high mental health burden and low mental health service coverage.	Policy frameworks integrating evidence-based TCIM mental health interventions – to be specified based on national context and available evidence – into national mental health strategies and universal health coverage packages.	National mental health strategies without TCIM integration.	Mental health service coverage, treatment gap reduction, and cost per disability-adjusted life year averted (<i>addressing the absence of health system cost-effectiveness evidence for TCIM in mental health</i>).	• Mixed-methods policy evaluation. • HTA (<i>aspirational: Phase 2–3</i>). • Real-world data analysis (<i>aspirational: Phase 2–3</i>).

Table A4.3: PICO questions for pain management research gap

Research gap: under-researched relative to global burden; significant unmet need around equity of access and non-opioid alternatives.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 3.1	Adults with chronic non-cancer pain in primary care and community settings, including underserved and low-resource contexts.	Whole-system TCIM pain management programme combining manual therapies, herbal preparations and mind-body approaches as delivered in routine practice.	Standard primary care pain management (analgesics, physiotherapy referral where available).	Pain intensity, functional impairment, and analgesic use at 3, 6, and 12 months (<i>outcomes underrepresented in current TCIM pain research across diverse health system contexts</i>).	• Whole-system trial. • Pragmatic randomized trial.
PICO 3.2	Adults with chronic pain who have failed or declined conventional pharmacological treatment, including populations at risk of opioid dependency.	Structured TCIM non-pharmacological intervention as a primary or adjunct pain management strategy.	Continued conventional pharmacological management; waitlist control.	Opioid or analgesic reduction, quality of life, and patient-reported treatment acceptability (<i>directly addressing the non-opioid alternatives gap identified in the report</i>).	• N-of-1 design. • Bayesian adaptive platform trial.
PICO 3.3 (Translate)	Health systems in low-resource contexts with high chronic pain burden and constrained pharmaceutical supply chains.	Integration of evidence-based TCIM non-pharmacological pain management – to be specified based on national context and available evidence – into primary healthcare service delivery protocols.	Conventional primary care pain protocols without TCIM.	Cost-effectiveness, health system feasibility, and reduction in pharmaceutical expenditure on analgesics (<i>filling the health system integration evidence gap for TCIM pain management</i>).	• Mixed-methods implementation study. • <i>Practice-based research network (aspirational: Phase 2–3).</i> • <i>HTA (aspirational: Phase 2–3).</i>

Table A4.4: PICO questions for musculoskeletal conditions research gap

Research gap: research capacity exists, but volume does not match global disability burden, particularly in ageing populations and underserved communities.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 4.1	Adults aged 60 and older with osteoarthritis of the knee or hip experiencing functional limitation, in community or primary healthcare settings.	TCIM manual and/or movement-based therapy programme delivered in community or primary healthcare settings.	Standard physiotherapy or analgesic-based management.	Joint function, mobility, pain, and quality of life (<i>filling the evidence gap in diverse settings where most existing musculoskeletal TCIM research is from high-income contexts</i>).	• Pragmatic randomized trial. • Stepped-wedge cluster design across community sites.
PICO 4.2	Working-age adults (18–65) in occupational settings with high prevalence of chronic low back or neck pain.	TCIM manual and/or movement-based therapy intervention delivered in or near occupational settings.	Usual care (analgesics, rest or conventional physiotherapy).	Work-related disability, absenteeism and productivity, assessed using patient-reported outcome instruments (<i>outcomes underrepresented in the existing TCIM musculoskeletal evidence base</i>).	• Pragmatic randomized trial with patient-reported outcome measurement. • N-of-1 design for individualized response.
PICO 4.3 (Translate)	HTA bodies and insurance scheme decision-makers in countries with high musculoskeletal disease burden.	Formal evaluation of evidence-based TCIM manual and movement-based therapies – to be specified based on national context and available evidence – for inclusion in national coverage schemes.	Current coverage policies without TCIM physical therapies.	Cost per quality-adjusted life year, health system adoption rates, and reduction in surgical or pharmaceutical expenditure (<i>directly addressing the scaling and investment gap identified in the report</i>).	• Systematic review and evidence synthesis. • HTA (<i>aspirational: Phase 2–3</i>).

Table A4.5: PICO questions for cancer research gap

Research gap: research capacity exists but needs scaling and sustained investment. Specific gap: integrative oncology in palliative care and in contexts with limited specialist infrastructure.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 5.1	Adults undergoing active cancer treatment with limited access to specialist supportive care, across diverse health system contexts.	Integrative oncology TCIM programme (mind-body interventions, herbal preparations for symptom management) delivered alongside standard oncological treatment.	Standard oncological treatment without integrative TCIM component.	Treatment-related side-effects (nausea, fatigue, pain), quality of life and treatment completion rates, assessed using patient-reported outcome instruments (<i>addressing the scaling and investment gap in TCIM integrative oncology evidence</i>).	• Pragmatic randomized trial with patient-reported outcome measurement. • Whole-system trial.
PICO 5.2	Cancer patients in palliative care settings, including in low-resource and underserved contexts.	Whole-system TCIM palliative care programme integrated into existing palliative services.	Conventional palliative care without TCIM integration.	Symptom burden, patient-reported well-being, dignity, and family caregiver outcomes (<i>outcomes absent from TCIM palliative care evidence across diverse settings</i>).	• Whole-system trial. • N-of-1 design for individualized palliative response.
PICO 5.3 (Translate)	Oncology services and hospital systems seeking to implement integrative oncology models in settings with limited specialist resources.	Structured integrative oncology implementation programme embedding TCIM practitioners – with modalities to be specified based on national context and available evidence – within oncology wards and outpatient services.	Standard oncology service delivery without embedded TCIM practitioners.	Service utilization, patient satisfaction, cost per patient, and health system feasibility (<i>addressing the need for sustained investment evidence in integrative oncology</i>).	• Mixed-methods implementation study. • Stepped-wedge cluster design. • Practice-based research network (<i>aspirational: Phase 2–3</i>).

Table A4.6: PICO questions for metabolic health and endocrine conditions research gaps

Research gap: investment needed to sustain and grow existing research capacity. Specific gap: long-term effectiveness and health system integration evidence.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 6.1	Adults with Type 2 diabetes or metabolic syndrome in primary care settings, including in low-resource contexts with limited specialist endocrine services.	Herbal preparation and/or TCIM lifestyle intervention as adjunct to standard metabolic care.	Standard primary care management (lifestyle advice, first-line pharmacotherapy).	Glycaemic control, lipid profiles, body mass index, and patient-reported self-management at 6 and 12 months (<i>filling the long-term follow-up gap in TCIM metabolic research across diverse settings</i>).	• Pragmatic randomized trial. • N-of-1 design for individualized metabolic response.
PICO 6.2	Adults at high risk of developing Type 2 diabetes (pre-diabetes or metabolic syndrome) in community prevention settings.	Structured TCIM preventive health programme (mind-body practice, dietary therapy, herbal preparation) delivered in community settings.	Standard lifestyle advice or watchful waiting.	Progression to Type 2 diabetes, metabolic risk factor improvement, and long-term adherence (<i>addressing the preventive health under-representation identified in the Priority Populations section</i>).	• Whole-system trial. • <i>Practice-based research network (aspirational: Phase 2–3).</i>
PICO 6.3 (Translate)	National noncommunicable disease programme planners in low-resource contexts with rising metabolic disease burden.	Integration of evidence-based TCIM lifestyle and herbal preparations– to be specified based on national context and available evidence – into national noncommunicable disease prevention and management protocols.	Standard noncommunicable disease management protocols without TCIM.	Programme reach, cost-effectiveness, and noncommunicable disease-attributable mortality reduction (<i>sustaining and growing the research investment needed to build the health system evidence base</i>).	• Mixed-methods implementation study. • <i>HTA (aspirational: Phase 2–3).</i> • <i>Real-world data analysis (aspirational: Phase 2–3).</i>

Table A4.7: PICO questions for reproductive health and childbirth research gaps

Research gap: demonstrated TCIM research capacity exists; substantial funding gap remains. Specific gap: safety evidence and health system integration across diverse settings.

PICO	Population	Intervention	Comparator	Outcome	Suggested methodological approaches
PICO 7.1	Pregnant women in antenatal care settings where TCIM is part of cultural practice, including in low-resource contexts.	Evidence-based TCIM intervention integrated into antenatal care (herbal preparation for nausea, manual and/or movement-based therapy for low back pain, or mind-body practice for anxiety).	Standard antenatal care without TCIM component.	Symptom relief, maternal quality of life, safety outcomes for mother and infant, and birth outcomes, assessed using patient-reported outcome instruments (<i>filling the safety and integration evidence gap for TCIM in antenatal care across diverse settings</i>).	• Pragmatic randomized trial with patient-reported outcome measurement. • Whole-system trial.
PICO 7.2	Women of reproductive age experiencing menstrual disorders or fertility challenges in primary healthcare settings.	Structured TCIM intervention (herbal preparations, mind-body practice) as primary management delivered in primary healthcare.	Usual primary care management (hormonal therapies, analgesics, watchful waiting).	Symptom severity, menstrual health outcomes, patient acceptability, and quality of life (<i>addressing the funding gap for TCIM reproductive health research across populations</i>).	• N-of-1 design. • Whole-system trial.
PICO 7.3 (Translate)	Maternal health programme planners in low-resource contexts where traditional birth attendants and TCIM practices are integral to maternity care.	Formally integrated model of TCIM and biomedical maternity care – with specific TCIM components to be specified based on national context and available evidence – incorporating trained traditional birth attendants within a supervised clinical framework.	Biomedical-only maternity care models or unintegrated traditional practice.	Maternal and neonatal safety, facility delivery rates, and community acceptability (<i>translating demonstrated TCIM reproductive health research capacity into health system integration evidence</i>).	• Stepped-wedge cluster design. • Mixed-methods implementation study. • Practice-based research network (<i>aspirational: Phase 2–3</i>).

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