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**INTEGRATION OF TRADITIONAL, COMPLEMENTARY, AND
INTEGRATIVE MEDICINE (TCIM) IN THE
INSTITUTIONALIZATION OF EVIDENCE-INFORMED
DECISION-MAKING: WHO MEETING REPORT**

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INTEGRATION OF TRADITIONAL, COMPLEMENTARY, AND INTEGRATIVE MEDICINE (TCIM) IN THE INSTITUTIONALIZATION OF EVIDENCE-INFORMED DECISION-MAKING: WHO MEETING REPORT

Amie Steel^{1*}

Daniel F. Gallego-Perez^{2,3*}

Nadine Ijaz^{4*}

Alana Gall^{5,6*}

Mukdarut Bangpan⁷

Laura dos Santos Boeira⁸

Mariana Cabral Schweitzer⁹

Anchalee Chutaputti¹⁰

Laurenz Mahlanza-Langer¹¹

Geetha Krishnan G Pillai³

Tipicha Posayanonda¹²

Sungchol Kim³

Darshan Shankar¹³

Tanja Kuchenmüller³

*These authors share first authorship.

1. Australian Research Consortium in Complementary and Integrative Medicine, Faculty of Health, University of Technology Sydney, Sydney, Australia
2. Physical Medicine and Rehabilitation Department, University of North Carolina at Chapel Hill, Chapel Hill, USA
3. World Health Organization (WHO), Geneva, Switzerland
4. Department of Law and Legal Studies, Carleton University, Ontario, Canada
5. World Federation of Public Health Associations Indigenous Working Group, Geneva Switzerland
6. Traditional, Complementary and Integrative Healthcare Coalition, Bruxelles, Belgium
7. Social Research Institute, University College London, London, United Kingdom
8. Veredas Institute, São Paulo, Brazil
9. Brazilian Academic Consortium of Integrative Health (CABSIN); Universidade Federal de São Paulo, São Paulo, Brazil
10. Department of Thai Traditional and Alternative Medicine, Ministry of Public Health, Bangkok, Thailand
11. Pan-African Collective for Evidence (PACE), Johannesburg, South Africa
12. Knowledge and Innovation Management Department, National Health Commission Office, Bangkok, Thailand
13. Trans-disciplinary University, Bangalore, India

Corresponding author:

Tanja Kuchenmüller Email: kuchenmullert@who.int

Evidence to Policy and Impact Unit, Research for Health Department, Science Division, World Health Organization (WHO)

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BACKGROUND AND CONTEXT

The use of evidence in policy and decision-making has exponentially grown, and it is now considered standard practice within health systems (1,2). However, the gap between research and practice persists. Seeking to translate health research findings into policy and practice, the World Health Organization (WHO) has advanced initiatives that promote the institutionalization of Evidence-informed decision/policy-making (EIDM) (3,4). The WHO Secretariat of the Evidence-Informed Policy Network (EVIPNet) has developed an EIDM institutionalization checklist that provides a structuring framework (5). The checklist, currently pilot-tested to assess its validity and feasibility (6), highlights six domains (governance; standards and routinized processes; leadership and commitment; resources and capacity-building/strengthening; partnership, collective action, and support; and culture), and five processes of EIDM institutionalization (5).

Both EIDM and the structuring of health systems based on Primary Health Care (PHC) have been recognized as essential for advancing toward universal health coverage (UHC) and health-related Sustainable Development Goals (SDGs) (5,7,8). PHC is a whole-of-society approach that was initially characterized as context-specific, based on research and experience, health needs-focused, intersectoral, and delivered by health teams that include traditional medicine practitioners (9). The Alma Ata conference recommended studying the contribution of “traditional systems of medicine” (9). The Astana Declaration, in turn, recognized the importance of traditional knowledge, in conjunction with scientific knowledge, to “strengthen PHC, improve health outcomes and ensure access for all people to the right care” (8).

Despite this recognition and the documented use of traditional, complementary, and integrative medicine (TCIM) by 88% of WHO Member States (10), countries have identified significant gaps in realizing TCIM’s potential contributions to improving health outcomes and wellbeing (10). They have requested that the WHO prioritize evidence and data to inform policies, standards, and regulatory frameworks for the safe, cost-effective, and equitable use of TCIM (10,11).

The Gujarat Declaration of the first WHO Global Summit on Traditional Medicine (17-18 August 2023, Gandhinagar, India) articulated an action agenda including a focus on research and evidence. It proposed “making appropriate use of existing and new research, evidence syntheses and knowledge translation principles and WHO initiatives” (12). It also recommended capacity strengthening “to produce, translate and use TCIM research and Indigenous knowledges” and supporting “the evidence-based integration of TCIM in national health policies and systems based on highest quality research” (12).

The recently established WHO Global Traditional Medicine Centre (GTMC) is tasked with augmenting WHO’s capacities for mobilizing knowledge for policies and standards for TCIM practices and products. The GTMC will, in collaboration with WHO technical departments, implement the Gujarat Declaration proposals, complementing the core WHO functions of governance, norms, and country support carried out by its technical unit on Traditional, Complementary, and Integrative Medicine (TCI) and the six Regional Offices. Furthermore, the WHO is developing a new TCIM global strategy (2025-2034) (13) that will incorporate EIDM processes.

To support these goals, the WHO Evidence to Policy and Impact Unit, in collaboration with the Research and Evidence Unit of the WHO’s Global Traditional Medicine Centre (GTMC), hosted a side event at the 2024 Prince Mahidol Award Conference (PMAC) in Bangkok, Thailand. The side event explored the current state of EIDM’s institutionalization globally, and the implications of its intersections with TCIM in fostering inclusivity, health equity, epistemic justice, and decolonial global health governance (see Table 1). Side event participants, who represented multiple world regions,

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3 explored potential mechanisms (infrastructure, conditions, frameworks) for enhancing the use of
4 evidence in global policy development toward realizing TCIM's contribution to health and wellbeing.
5 This article presents a synthetic account of the event's discussed issues.
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8 **[Insert Table 1 here]**
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10 **EIDM AND TCIM: WHAT EVIDENCE? WHAT KNOWLEDGES?**

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14 The presenters at PMAC's side event discussed a series of distinct considerations that arise at the
15 interface of EIDM's institutionalization and TCIM. Foremost among these are questions pertaining to
16 what counts as evidence—and ultimately, what counts as legitimate knowledge—in the EIDM
17 process.
18

19 From the WHO's own definition (11), traditional medicine is

20
21 the sum total of the knowledge, skill, and practices based on the theories, beliefs, and
22 experiences [I]ndigenous to different cultures, whether explicable or not, used in the
23 maintenance of health as well as in the prevention, diagnosis, improvement or treatment of
24 physical and mental illness.
25

26 As this definition indicates, a key characteristic of TCIM therapeutic approaches, which are often not
27 "fully integrated into the dominant [biomedical] health-care system"(11), is that they are in many
28 cases underpinned by "medical rationalities", that is, systems of therapeutic knowledge and
29 practice, that differ distinctly from dominant biomedical science (14). Such therapeutic systems
30 include Indigenous healing systems characterized by orally-transmitted knowledges; codified
31 ethnomedical systems like Chinese and Ayurvedic medicine; as well as codified whole systems like
32 naturopathy, anthroposophy and osteopathy (15). Like biomedicine, each of these systems has its
33 own underlying cosmology, anatomical and physiological models, medical doctrine as to how health
34 and ill-health arise, and diagnostic and therapeutic systems (14). They are, in other words, distinct
35 systems of therapeutic knowledge and practice in their own right, despite not having the same
36 degree of social, economic and political capital as does biomedical science today.
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41 As historians and anthropologists have carefully documented, biomedicine is a relatively young
42 therapeutic system that developed in 17th century Europe (15). Along with its many notable
43 therapeutic contributions, biomedicine was used as a tool of empire, as part of the European
44 colonial encounter, through which many traditional and Indigenous medical systems and practices
45 were subjugated and in some cases decimated. Biomedicine's globalized political dominance today,
46 then, is at least partly built upon this history. Further, as Cloatre observes (16):
47
48

49 With colonial expansion, and as biomedicine became a powerful tool of domination and
50 population control, the separation of 'knowledge' and 'belief', or 'rational' and 'irrational', was
51 central to the settlement of socio-political power.
52

53 In other words, the persistence of biomedicine's global dominance is predicated at least partly on its
54 discursive self-presentation as uniquely rational and universal despite the notable diversity of
55 therapeutic rationalities that persist across cultures and regions.
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58 Further, the research methods that underpin today's 'evidence-based medicine' movement are
59 substantially aligned with the biomedical paradigm, and can fall short in rigorously studying many
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3 TCIM approaches, whose underlying paradigms differ considerably. This problem of ‘paradigmatic
4 (dis)alignment’ is currently the focus of a WHO-commissioned evidence review of TCIM research
5 approaches (17).
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8 To align with the WHO’s repeated calls for traditional and Indigenous knowledges to be recognized
9 in the TCIM integration process (11), advocates of EIDM’s institutionalization in this context must
10 contend with the realities of therapeutic knowledge diversity (or, ‘epistemic pluralism’). The concept
11 of ‘epistemic justice’ is often used, including by the United Nations Educational, Scientific and
12 Cultural Organization (UNESCO), to characterize a decolonial construct that is ultimately a “condition
13 for realising social and environmental justice” (18). Epistemic justice, in the TCIM context, may be
14 understood as a “two-fold call for: a) the equitable engagement, within health systems, of
15 biomedical as well as TCIM paradigms—both at the level of knowledge and practice; and b) the
16 respectful and socially-just recognition of the perspectives and contributions of community
17 members, knowledge holders, and health care professionals alike” (15).
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21 This pursuit of epistemic justice is closely reflected in the work of Nugruho and colleagues (19), who
22 have outlined three major categories of knowledge important to decolonial EIDM. These are: 1)
23 scientific knowledge (from multiple research approaches), 2) professional knowledge (across various
24 communities of expertise), and 3) local knowledge (from community stakeholders). Ultimately such
25 an approach is aligned with the principles of evidence-based medicine (which emphasize scientific
26 evidence, clinical experience and peoples’ preferences and values); but, it requires a broader
27 conceptualization of what each of these tenets may mean in practice.
28
29

30 One useful knowledge translation framework developed in the TCIM field is the Contemporary
31 Implementation of Traditional Knowledge and Evidence (CITE) Framework (20). As shown in Table 2,
32 the framework includes guiding principles and criteria to support rigorous and respectful translation
33 of codified forms of TCIM knowledge into contemporary research, education, policy and practice.
34 However, how to apply—or rather, adapt—the Framework with reference to orally-transmitted
35 TCIM approaches, such as Indigenous Peoples’ traditional medicine, illustrates the complexity of
36 EIDM’s institutionalization in the TCIM field.
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41 **TCIM KNOWLEDGE TRANSLATION FOR INDIGENOUS TRADITIONAL MEDICINES**

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43 Translating Indigenous Peoples’ traditional medicine knowledges within an EIDM context—where
44 codified knowledges are taken as normative—poses distinct challenges. The CITE Framework
45 authors noted it was “primarily designed for use with knowledge from traditional medicine systems
46 with an established history of written traditional sources” (20). Thus, to be fruitfully applied with
47 reference to orally-transmitted knowledges, it would require adaptation.
48
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50 Key considerations for adapting the CITE Framework, consistent with principles affirmed in the UN
51 Declaration on the Rights of Indigenous Peoples (22), include: attention to issues of free, prior and
52 informed consent, and the equitable sharing of benefits arising from usage of Indigenous traditional
53 medicine approaches, with the communities from which related knowledges originates (22). It also
54 warrants note that within Indigenous communities, traditional medicines often carry not only
55 ‘therapeutic’ value but also cultural, spiritual and ecological meaning as part of a way of life. Further,
56 any process of knowledge evaluation would optimally be led by Indigenous peoples who have the
57 cultural authority to authenticate particular knowledges, practices, and safety-related claims. The
58 specifics of how such a process might be enacted may also vary across Indigenous communities,
59
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each of which has its own authority structures and laws determining who are knowledge holders and community representatives.

Existing EIDM tools and frameworks acknowledge evidence may take 'non-scientific' forms, such as 'tacit' or informal knowledges, including "opinions, values and habits"(23)s. However, epistemic justice principles call for expanding our understanding of what constitutes legitimate forms of evidence and knowledges in considering how to incorporate traditional knowledge (and TCIM) in EIDM. Further conceptual and applied developments are thus warranted. Examples can be found in several countries, whereby decision-makers have taken steps to incorporate both scientific and orally-transmitted knowledges into EIDM processes.

[Insert Table 2 here]

CASE EXAMPLES OF EIDM INSTITUTIONALISATION FOR TCIM

PMAC side event presenters reported on international case examples from Thailand and Brazil that demonstrate opportunities and successes in implementing EIDM institutionalisation for TCIM.

Thailand

Thailand has implemented a citizen engagement process to support the integration of TCIM-based EIDM into institutions. This process was used to draft the National Health Act, which was enacted in 2007, and led to the development of the institutional structure and a National Health System Charter to support drafting of health-related policies and strategies, including TCIM, that focus on good health system governance. Moreover, since Thailand's health system reform in the 1990s, several laws related to Thai traditional medicine have been enacted.¹

The Charter explicitly commits to 'promoting, supporting, utilising and developing health wisdom, Thai traditional medicine, [I]ndigenous medicine and other alternative medicines' (Section 46-48, National Health Act 2007). Its implementation enabled the government to better support participatory processes by funding, monitoring and evaluating public servant training and formal social participation structures that integrate traditional wisdom, including health policy and planning processes. The Charter also led to policy recommendations which could drive funding supports on TCIM medical services and related issues. Consequently, the percentage of out-patients receiving Thai traditional and alternative medical services, and the number of research studies on Thai traditional and alternative medicines have grown.

Thailand has also employed institutionalised EIDM to the process of developing a National List of Essential Herbal Medicines (NLEHM) that includes three different categories:(1) Thai Traditional Medicines, (2) Thai Indigenous medicines, and (3) Herbal medicines. This initiative recognises traditional medicines based on written classical texts as well as oral knowledge from Indigenous healers adopted, manufactured, and dispensed by community hospitals. It also provides some acknowledgement and guidance of traditional medicines that have been modified from traditional use (e.g., by modifying manufacturing process or dosage form) and the process for recognising scientifically established herbal medicines. More than 100 traditional and herbal medicines have been selected through this process into the NLEHM and covered by the three health security

¹ Protection and Promotion of Thai Traditional Medicine Knowledge Act B.E. 2542 (1999), National Health Security Act B.E. 2545 (2002), Laws on the establishment and departmental organizational structure of the Department for Development of Thai Traditional and Alternative Medicine B.E. 2545 (2002), Thai Traditional Medical Professions Act B.E. 2556 (2013).

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3 systems of Thailand. Further, community pharmacists have been provided training to ensure they
4 can safely dispense selected items in the NLEHM for common illnesses.
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6 **Brazil**

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8 The Brazilian Coalition of Evidence (<https://coalizaopelasevidencias.org.br/>) is a network of
9 academic, government and civil society representatives working within or committed to evidence
10 translation and dissemination across Brazil with a particular focus on social policies. The Coalition
11 applies tools developed by EVIPNet such as the Situation Analysis Manual and the WHO Checklist for
12 EIDM. Brazil has seen numerous institutionalised evidence units open since 2018 and the Coalition
13 has undertaken an exploratory study of EIDM institutionalisation.
14
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16 In parallel, a collaboration of TCIM researchers across the Americas region (i.e., TCIM Americas
17 Network, the Brazilian Academic Consortium for Integrative Health, and the Pan American Health
18 Organization/World Health Organization (PAHO/WHO)'s Latin American and Caribbean Center on
19 Health Sciences Information) have adapted an evidence-mapping method to synthesize and
20 translate TCIM research for EIDM among health professionals, decision-makers, and researchers.
21 The Evidence Map methodology involves a six-step process of (1) Search, (2) Selection, (3)
22 Categorization, (4) Infometrics, (5) Evidence map, and (6) Gaps. The Maps resulting from this process
23 present a matrix that provides an overview of the evidence pertaining to particular TCIM
24 interventions and specific health outcomes (24).
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27 To date, the Evidence Map team has produced 26 TCIM Evidence Maps derived from more than
28 2000 systematic reviews, which are increasingly influencing TCIM-related decision-making in Brazil.
29 In 2020, for example, Brazil's national health council issued guidance advising the country's health
30 systems actors to review TCIM-related evidence produced by the aforementioned Evidence Map
31 collaboration in developing interventions for COVID-19 (25). Further, in 2023, the city of Sao Paulo
32 released clinical guidance for chronic pain informed by a related TCIM Evidence Map (26). Currently,
33 the Pan American Health Organization is reviewing the Evidence Maps to include TCIM-related
34 interventions in its technical co-operation activities. Some Evidence Maps are also now being
35 translated into public education materials.
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40 **DISCUSSION AND WORKSHOP RECOMMENDATIONS**

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42 Following a series of expert presentations, side event workshop participants discussed the content
43 of the presentations and proposed some areas that required further consideration. As shown in
44 Table 3, these discussions centralized the following issues: terminology and concepts; technology
45 and infrastructure; capacity and governance; TCIM-appropriate research methods; and,
46 implementation and dissemination. Insights across these broad topics offer initial guidance towards
47 addressing the aims of the event (see Table 1) and will support the activities of the WHO's GTMC
48 more broadly.
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51 **[Insert Table 3 here]**

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53 A noteworthy aspect of these recommendations is the implicit acknowledgment that research alone
54 is not sufficient for the effective integration of TCIM. Rather, a multi-pronged process of translating
55 knowledge into practice is needed. Such a process necessarily involves the synthesis, dissemination,
56 exchange, and ethically-sound application of knowledge to improve health services, provide more
57 effective health care, and strengthen health systems.
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3 In the context of TCIM, effective knowledge translation means ensuring that research findings are
4 not only published but are also communicated in a way that facilitates their integration into clinical
5 practice, education, and policy. TCIM knowledge translation also requires that TCIM research is
6 conducted in a way that effectively honours and represents TCIM knowledges at all stages. It also
7 requires active engagement with diverse stakeholders across sectors to adapt TCIM knowledge into
8 different healthcare contexts, while respecting cultural nuances, redressing historical inequities, and
9 addressing potential barriers to implementation.
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12 EVIPNet is an example of a WHO initiative that has been developing EIDM frameworks and tools for
13 effective knowledge translation in closing the evidence to policy gap. Systematic inclusion of TCIM
14 and traditional knowledge in EIDM processes, however, would require an expansion of the
15 conceptual and operational hallmarks used thus far in the said frameworks and tools. As highlighted
16 in the Gujarat Declaration, EVIPNet is uniquely positioned for catalysing the required developments
17 to make it possible and, with appropriate engagement with TCIM experts and community leaders,
18 may provide the infrastructure and support needed to achieve EIDM institutionalisation for TCIM
19 globally.
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24 CONCLUSION

25 This meeting highlights the pressing need to foster an intersection between EIDM institutionalization
26 and TCIM. It is critical that efforts in this regard align with decolonial principles of epistemic justice
27 and knowledge diversity. Moving forward, those seeking to advance EIDM institutionalization
28 initiatives related to TCIM would wisely consider conceptual frameworks and models that are
29 tailored to the unique features of TCIM worldviews, knowledges and practices. The meeting
30 outcomes offer conceptual guidance, case examples, and initial reflections for what is undoubtedly a
31 long and complex road ahead.
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36 LIST OF ABBREVIATIONS

37 EIDM: Evidence-informed decision-making

38 EVIPNet: Evidence-informed policy network

39 PHC: Primary health care

40 UHC: Universal health coverage

41 SDG: Sustainable development goals

42 WHO: World Health Organization

43 TCIM: Traditional, complementary and integrative medicine

44 GTMC: Global traditional medicine CH

45 PMAC: Prince Mahidol Award Conference

46 UNESCO: United Nations Educational, Scientific and Cultural Organization

47 CITE: Contemporary Implementation of Traditional Knowledge and Evidence Framework

48 UN: United Nations

49 NLEHM: National List of Essential Herbal Medicines

50 BIREME: Latin American and Caribbean Center on Health Sciences Information

51 PAHO: Pan-American Health Organization
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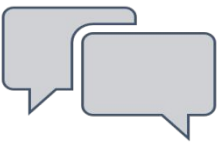




Table 1: Aims of the WHO-hosted side event of the Prince Maldihol Award Conference (PMAC) in Bangkok, Thailand 2024

1. Explore how the application of evidence-informed decision-making (EIDM) in the traditional, complementary and integrative medicine (TCIM) context could foster inclusivity, health equity, epistemic justice, and decolonial global health governance.
2. Assess the advances and challenges of integrating TCIM in EIDM institutionalization globally and the needed conditions to strengthen it.
3. Outline potential next steps for implementing the evidence-related proposals of the Gujarat Declaration, particularly regarding the “evidence-based integration of TCIM in national health policies and systems based on highest quality research” and advancing complementarities with existing (World Health Organization) WHO-led EIDM initiatives.

Table 2: The Contemporary Implementation of Traditional knowledge and Evidence (CITE) Framework (ref: Steel et al, 2023)

Section 1: Guiding principles for the contemporary use of traditional knowledge	
1	Accountability during translation of knowledge
2	Importance of foundational assessment of traditional knowledge
3	Evolution of practice in living traditions
4	Pragmatic translation to balance traditional perspective and contemporary context
5	Peer-to-peer knowledge sharing and empirical observation
Section 2: Criteria for critically appraising traditional knowledge sources	
1	Authenticity of the traditional knowledge source
2	Consistency of evidence across sources
3	Safety of the traditional knowledge in the contemporary context
Section 3: Criteria to guide the application of traditional knowledge in contemporary settings	
1	Alignment with core characteristics of the tradition
2	Ethical approaches: intellectual property and sociological considerations
3	Tradition-informed communication and framing
4	Person-centred translation
5	Accuracy of interpretation
6	Transferability of traditional knowledge to contemporary context
7	Accessibility and integrity of traditional resources
8	Comparative benefit between available traditional and non-traditional approaches

Table 3: Recommendations and insights arising from the workshop discussion

	<p style="text-align: center;">TERMINOLOGY AND CONCEPTS</p> <ol style="list-style-type: none"> 1. Develop terminology and conceptual frameworks that makes TCIM comprehensible without requiring it to retrofit to the biomedical lens 2. Address the diversity of classifications and terminology used with reference to: <ul style="list-style-type: none"> - different types of TCIM therapeutic approaches - different TCIM therapeutics used for the same biomedical diagnosis - different countries for the same TCIM system or practice
	<p style="text-align: center;">TECHNOLOGY AND INFRASTRUCTURE</p> <ol style="list-style-type: none"> 1. Use advanced technologies such as artificial intelligence 2. Build a global repository of TCIM knowledges, evidence, and policy 3. Design (or tailor existing) data systems to collect TCIM practitioner knowledges (e.g., case report portals) 4. ICD Module 1 & 2 and integration with RHIMS 5. Develop platforms to support researcher, practitioner, and policymaker collaboration
	<p style="text-align: center;">CAPACITY & GOVERNANCE</p> <ol style="list-style-type: none"> 1. Foster culturally-responsive leadership, champions of knowledge translation, and research skills development for TCIM 2. Develop TCIM-appropriate and protective governance mechanisms and regulatory pathways 3. Include TCIM policy-makers and practitioners in knowledge translation training opportunities 4. Funding for TCIM research (generation and translation) and practice within health systems 5. Develop national participatory mechanisms that facilitate co-production, shared decision-making, autonomy and power, inclusive of communication between TCIM groups
	<p style="text-align: center;">TCIM-APPROPRIATE RESEARCH METHODS</p> <ol style="list-style-type: none"> 1. Prioritise and innovate research approaches that align with TCIM knowledge paradigms (e.g., evaluates complex interventions and 'whole systems', incorporates TCIM diagnoses, accounts for herbal complexity) 2. Foster Indigenous research methodologies and their translation, including decolonial scholarly frameworks 3. Reevaluate evidentiary hierarchies and make use of research rigorously conducted across diverse disciplines, methodologies and methods 4. Support practice-based evidence and complexity science
	<p style="text-align: center;">IMPLEMENTATION AND DISSEMINATION</p> <ol style="list-style-type: none"> 1. Support mechanisms/methods to integrate different knowledge types 2. Build TCIM knowledge across biomedical practice and research communities 3. Foster Indigenous-led health care partnerships that incorporate TCIM knowledges and EIDM 4. Provide TCIM-inclusive community health education platforms, that involve local TCIM systems, practitioners and networks 5. Develop mandates and approaches for TCIM inclusion in EIDM

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