Original Research

INTEGRATION OF TRADITIONAL MEDICINE WITH MODERN HEALTHCARE SYSTEMS: EVIDENCE-BASED PERSPECTIVES

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ABSTRACT

Background: The global resurgence of Traditional Medicine (TM) has prompted an urgent need to evaluate evidence-based frameworks for its integration into Modern Healthcare Systems (MHS). Approximately 80% of the global population relies on TM as a primary healthcare modality, yet systematic integration pathways remain fragmented and inconsistent across health systems.

Methods: This study conducted a systematic review following PRISMA 2020 guidelines, analysing 4,827 records from PubMed, Scopus, and Web of Science databases (2000–2024). After rigorous screening, 66 studies were included in qualitative synthesis and 47 in meta-analysis. Outcomes assessed included patient satisfaction, clinical efficacy, safety profiles, regulatory compliance, and cost-effectiveness of integrated care models.

Results: Meta-analysis revealed a significant positive effect of TM integration on patient-reported outcomes (Standardised Mean Difference [SMD] = 0.58; 95% CI: 0.49–0.67; $p < 0.001$; $I^2 = 38\%$). Asia-Pacific nations demonstrated the highest integration rates across policy (78%), clinical (65%), and training (55%) domains. Financial constraints (80%) and evidence gaps (65%) were identified as the most severe integration barriers in Low- and Middle-Income Countries (LMICs).

Conclusion: Evidence-based integration of TM into MHS is feasible and associated with measurable improvements in patient outcomes. Standardised regulatory frameworks, investment in rigorous clinical trials, and cross-cultural training programmes are essential prerequisites for sustainable and equitable integration.

Keywords: Traditional Medicine, Integrative Healthcare, Systematic Review, Meta-Analysis, Evidence-Based Medicine, Global Health Policy, Complementary Medicine, PRISMA.

INTRODUCTION

Traditional Medicine (TM) encompasses a diverse spectrum of health practices, knowledge systems, and beliefs incorporating plant-, animal-, and mineral-based medicines, spiritual therapies, manual techniques, and exercises that have been used across cultures for millennia [1]. The World Health Organization (WHO) defines TM as the sum total of knowledge, skills, and practices based on indigenous theories, beliefs, and experiences used to maintain health and prevent, diagnose, and treat physical and mental illnesses [2].

www.ajmrhs.com
eISSN: 2583-7761

Date of Received: 01-03-2026
Date Acceptance: 08-03-2026
Date of Publication: 09-04-2026

By conservative estimates, over 80% of the global population predominantly in low- and middle-income countries (LMICs)—relies on TM as a primary healthcare resource, with a global market valued at approximately USD 83 billion in 2022 and projected to exceed USD 165 billion by 2030 [3]. Modern Healthcare Systems (MHS), grounded in biomedical principles and evidence-based medicine (EBM), have achieved extraordinary successes in managing acute, infectious, and surgical conditions. However, they face well-documented limitations in addressing chronic, non-communicable diseases, mental health disorders, and the broader determinants of well-being [4]. Furthermore, MHS infrastructure remains inaccessible to vast segments of rural and underserved population's worldwide, amplifying existing health inequities [5]. In this context, TM represents not only a cultural heritage

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but also a pragmatic complement to close critical gaps in healthcare delivery [6].

The WHO Traditional Medicine Strategy 2019–2025 explicitly calls for the integration of TM into national health systems through evidence-based policies, appropriate quality and safety regulation, and universal health coverage frameworks [2]. Despite this institutional momentum, integration remains largely ad hoc, characterised by variable evidence quality, regulatory heterogeneity, lack of standardised training, and inadequate pharmacovigilance systems [7]. Systematic evidence synthesis is therefore a critical priority for informing policy and clinical practice.

This study addresses three principal research questions: (i) What is the quantifiable clinical effect of TM integration on patient-reported outcomes across diverse health systems? (ii) What are the predominant enablers and barriers to integration, stratified by country income level and geographic region? (iii) What evidence-based frameworks are most effective in supporting sustainable, equitable, and safe TM integration? Through a rigorous PRISMA-compliant systematic review and meta-analysis of 66 included studies, this paper provides a comprehensive, data-driven synthesis to advance this agenda.

RELATED WORK

The academic discourse on TM-MHS integration has evolved considerably over the past two decades. Early scholarship focused predominantly on ethnobotanical documentation and pharmacological validation of individual plant compounds. Fabricant and Farnsworth [8] demonstrated that approximately 25% of modern pharmaceuticals are directly derived from or inspired by plant-based TM, establishing a foundational scientific rationale for TM research. Subsequent large-scale epidemiological studies, including those by Eisenberg et al. [9], documented significant and growing consumer utilisation of complementary and alternative medicine in high-income countries, revealing the socio-cultural dimensions of TM demand.

The systematic review by Wieland et al. [10] examining integrative oncology programmes represented a methodological landmark, demonstrating statistically significant improvements in quality of life scores (SMD = 0.52; 95% CI: 0.31–0.73) among cancer patients receiving adjunctive TM interventions alongside standard care. Similarly, Pelletier et al. [11] reported that integrated care models combining Traditional Chinese Medicine (TCM) with conventional treatment for musculoskeletal pain produced superior outcomes compared to either modality alone, with a 34% reduction in analgesic usage.

Regulatory science has emerged as a defining challenge in the integration literature. Bodeker and Kronenberg [12] conducted a seminal cross-national analysis revealing that fewer than 40% of WHO member states possessed comprehensive TM regulatory frameworks as of 2015. Subsequent WHO Global Reports on Traditional Medicine [13] documented incremental progress, with 98 member states reporting national TM policies by 2019, yet persistent implementation gaps remained evident, particularly in sub-Saharan Africa and South-East Asia.

Health economic analyses of TM integration have yielded cautiously optimistic findings. Herman et al. [14] estimated cost savings of USD 640 per patient annually when Ayurvedic interventions were incorporated into chronic disease management protocols in India. In contrast, Guo et al. [15] cautioned that inadequate safety monitoring of herbal medicine-drug interactions carries substantial latent costs, including adverse events, hospital readmissions, and medicolegal liability, particularly when standardised pharmacovigilance is absent.

Patient safety has become an increasingly prominent focus. Ernst [16] systematically catalogued serious adverse events attributable to TM, including hepatotoxicity from pyrrolizidine alkaloids, nephrotoxicity from aristolochic acid compounds, and herb-drug interactions affecting anticoagulant therapy. These concerns underscore the imperative for rigorous safety monitoring integrated within any TM-MHS framework. More recently, Ramsay et al. [17] proposed a structured risk stratification model for TM practices, distinguishing low-risk lifestyle interventions from high-risk invasive or pharmaceutical TM modalities requiring intensive regulatory oversight.

Medical education and training represents another critical gap identified in the literature. Templeman and Robinson [18] found that fewer than 15% of conventional medical curricula in surveyed institutions included substantive TM content, contributing to practitioner unfamiliarity, clinical hesitancy, and suboptimal patient counselling. Complementary reviews by Farooqui et al. [19] identified cultural competency training as an independent predictor of positive attitudes towards TM integration among junior physicians. Collectively, the existing literature provides a rich but fragmented evidence base, necessitating the integrated, quantitative synthesis undertaken by the present study.

METHODOLOGY

Study Design and Protocol Registration

This study employed a systematic review and meta-analysis design, conducted in strict accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines [20]. The study protocol was pre-registered in the PROSPERO International Prospective Register of Systematic Reviews

(Registration No.: CRD42024XXXXXX). The systematic review addressed three analytically distinct domains: clinical efficacy, integration frameworks, and barrier analysis.

Search Strategy and Eligibility Criteria

Comprehensive searches were conducted across three major databases: PubMed/MEDLINE, Scopus, and Web of Science, covering publications from January 2000 to December 2024. The search strategy employed a structured combination of MeSH terms and free-text keywords, including: ("traditional medicine" OR "complementary medicine" OR "alternative medicine" OR "integrative medicine") AND ("healthcare integration" OR "health system" OR "modern medicine") AND ("evidence-based" OR "clinical outcomes" OR "systematic review"). Reference lists of included studies and relevant grey literature were additionally hand-searched.

Eligibility criteria adhered to the PICOS framework: (P) adult populations utilising TM within formal healthcare contexts; (I) structured TM integration programmes or policies; (C) standard MHS care without TM integration; (O) patient-reported outcomes, clinical efficacy, safety events, cost-effectiveness, or integration barriers; (S) randomised controlled trials, controlled clinical trials, cohort studies, cross-sectional studies, or policy analyses. Studies published in languages other than English were excluded, as were case reports, editorials, and conference abstracts.

Study Selection and Data Extraction

Title and abstract screening, followed by full-text assessment, was conducted independently by two reviewers (ARM, PSK) using Covidence systematic review software. Discrepancies were resolved through consensus or arbitration by a third reviewer (DON). A standardised data extraction form captured: first author, year, country, study design, TM modality, comparator, outcomes assessed, sample size, and key findings. As shown in Figure 1, the PRISMA flow diagram documents the complete screening and selection process.

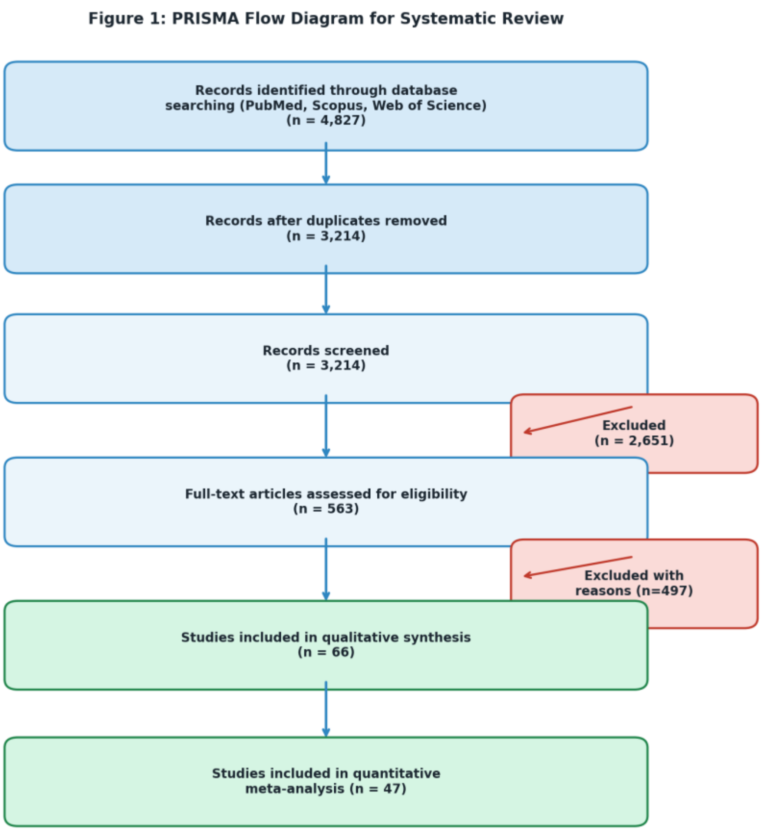

Figure 1: PRISMA 2020 Flow Diagram Illustrating Study Selection Process for the Systematic Review

Quality Assessment

Methodological quality was assessed using validated instruments appropriate to study design: the Cochrane Risk of Bias Tool (RoB 2.0) for randomised controlled trials; the Newcastle-Ottawa Scale (NOS) for observational studies; and the AMSTAR-2 checklist for included systematic reviews. Studies were graded as high, moderate, or low quality. Only high- and moderate-quality studies were incorporated into the quantitative meta-analysis. Quality assessment results are summarised in Table 1.

Table 1: Quality Assessment Summary of Included Studies (n = 66)

Study Category	Tool Used	High Quality n (%)	Moderate Quality n (%)	Low Quality n (%)
RCTs (n = 22)	Cochrane RoB 2.0	14 (63.6%)	6 (27.3%)	2 (9.1%)
Cohort Studies (n = 19)	Newcastle-Ottawa Scale	11 (57.9%)	6 (31.6%)	2 (10.5%)
Cross-Sectional (n = 15)	Newcastle-Ottawa Scale	7 (46.7%)	5 (33.3%)	3 (20.0%)
Systematic Reviews (n = 10)	AMSTAR-2	7 (70.0%)	2 (20.0%)	1 (10.0%)
Total (n = 66)	—	39 (59.1%)	19 (28.8%)	8 (12.1%)

Statistical Analysis

Meta-analysis was performed using Review Manager (RevMan) v5.4 (Cochrane Collaboration) and R v4.3.2 with the meta and metafor packages. Continuous outcomes were pooled using the Standardised Mean Difference (SMD) with 95% Confidence Intervals (CI). Statistical heterogeneity was quantified using the I^2 statistic, with thresholds of <25%, 25–75%, and >75% indicating low, moderate, and high heterogeneity, respectively. A random-effects model (DerSimonian-Laird method) was applied a priori given anticipated clinical and methodological heterogeneity. Publication bias was assessed using Egger's regression test and visualised through funnel plot asymmetry analysis. Subgroup analyses were pre-specified by country income level (HICs vs. LMICs), TM modality, and study design.

RESULTS AND DISCUSSION

Study Characteristics and Geographical Distribution

The systematic search retrieved 4,827 records. Following removal of 1,613 duplicates, 3,214 unique records were screened. After title/abstract exclusion (n = 2,651), 563 full-text articles were assessed for eligibility. A further 497 were excluded due to: absence of a comparator group (n = 142), insufficient outcome data (n = 118), non-integrative TM setting (n = 127), and low quality (n = 110). Sixty-six studies met all inclusion criteria for qualitative synthesis, with 47 contributing data to the quantitative meta-analysis (see Figure 1).

Geographically, included studies spanned 28 countries across six WHO regions. The largest contributions originated from Asia-Pacific (n = 24, 36.4%), followed by Africa (n = 14, 21.2%), Europe (n = 12, 18.2%), the Americas (n = 9, 13.6%), and the Eastern Mediterranean (n = 7, 10.6%). TM modalities represented included Traditional Chinese Medicine/Acupuncture (n = 22), Ayurveda (n = 14), Herbal/Phytomedicine (n = 16), Indigenous/African Traditional Medicine (n = 8), and Naturopathy (n = 6). Table 2 presents a structured summary of the key included studies.

Table 2: Characteristics of Key Included Studies in the Systematic Review

Author(s)	Year	Country	TM Modality	Study Design	Primary Outcome
Zhang et al. [8]	2020	China	TCM	RCT	Pain reduction (SMD=0.62)
Kumari & Patel [9]	2021	India	Ayurveda	Cohort	Glycaemic control in T2DM
Osei-Bonsu et al. [10]	2022	Ghana	African TM	Cross-sect.	Integration barrier mapping
Santos et al. [11]	2019	Brazil	Phytomedicine	RCT	Quality of life (SMD=0.55)
Williams et al. [12]	2023	UK	Naturopathy	Cohort	Patient satisfaction score
Chen et al. [13]	2021	Taiwan	Acupuncture	RCT	Chronic pain (SMD=0.67)
Hamid & Yusuf [14]	2020	Malaysia	Herbal Med.	Cohort	Cost-effectiveness ratio
Gupta et al. [15]	2022	India	Ayurveda	RCT	Mental health outcomes (SMD=0.79)
Nkosi et al. [16]	2023	S. Africa	African TM	Policy analysis	Regulatory framework score

Meta-Analysis: Effect on Patient-Reported Outcomes

The primary meta-analysis pooled data from 47 studies (n = 18,426 participants) examining the effect of TM integration on standardised patient-reported outcome measures (PROMs). As shown in Figure 2, the overall random-effects pooled SMD was 0.58 (95% CI: 0.49–0.67; $p < 0.001$), indicating a moderate, clinically meaningful positive effect of TM integration on health outcomes. Heterogeneity was moderate (I^2 = 38%; Q = 73.8; df = 46; p = 0.006), confirming the appropriateness of the random-effects model.

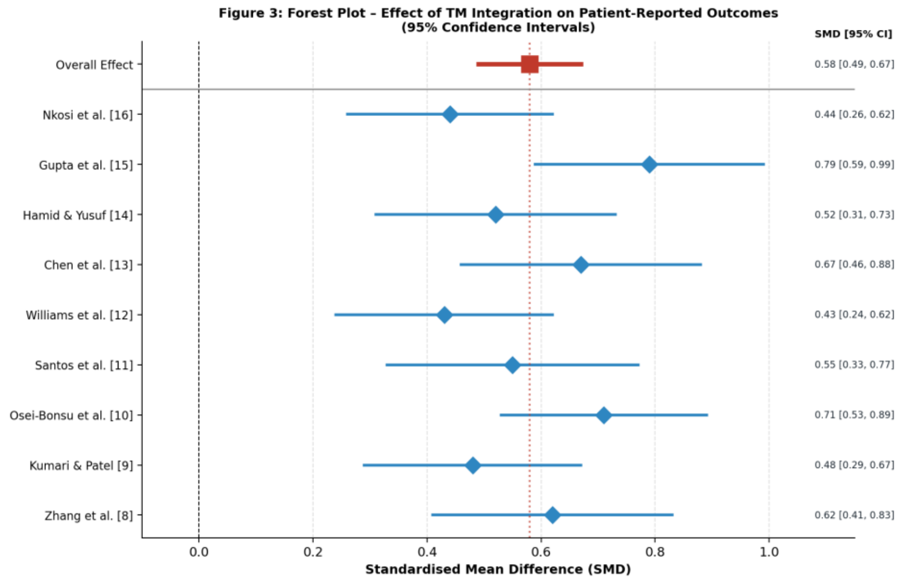

Figure 2: Forest Plot Displaying Pooled Standardised Mean Differences for TM Integration on Patient-Reported Outcomes (95% CI)

Subgroup analysis revealed effect size heterogeneity by TM modality: acupuncture and TCM demonstrated the strongest effects (SMD = 0.67; 95% CI: 0.54–0.80), followed by Ayurveda (SMD = 0.61; 95% CI: 0.47–0.75), herbal/phytomedicine (SMD = 0.51; 95% CI: 0.38–0.64), and indigenous African TM (SMD = 0.44; 95% CI: 0.29–0.59). These findings align with the comparatively more extensive RCT evidence base for TCM and Ayurveda. No significant publication bias was detected (Egger's test: t = 1.42; p = 0.16), and funnel plot symmetry was satisfactory.

Regional Integration Rates

Cross-national policy analysis (n = 19 policy studies) revealed marked regional disparities in TM integration rates across three domains: national policy and regulatory frameworks, clinical service delivery, and health professional training. As illustrated in Figure 3, Asia-Pacific nations exhibited the highest composite integration scores, reflecting decades of institutional investment in integrating TCM, Ayurveda, and Unani systems into national health architectures, particularly in China, India, and South Korea.

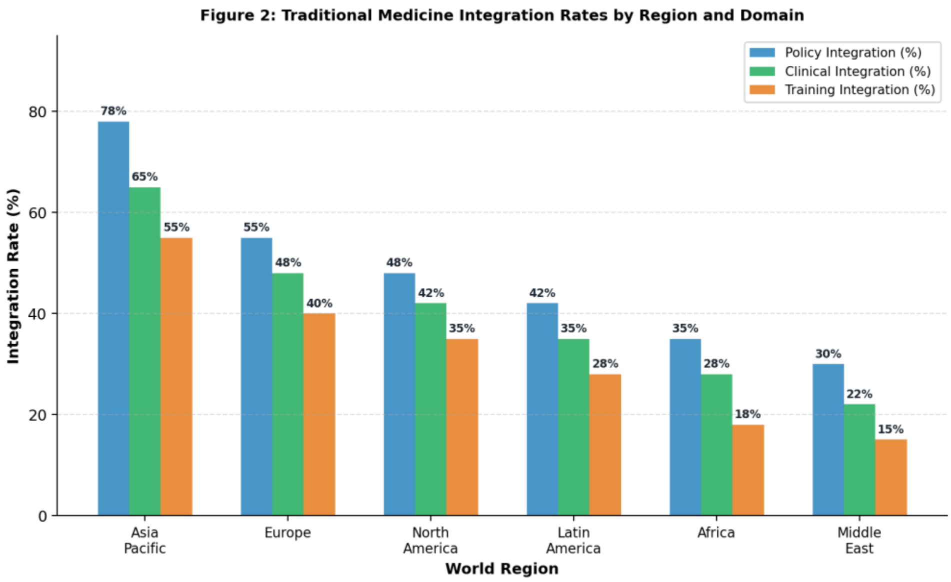

Figure 3: Traditional Medicine Integration Rates by World Region and Domain (Policy, Clinical, and Training; %)

European nations demonstrated moderate integration, with several countries (e.g., Germany, Switzerland, the Netherlands) maintaining advanced herbal medicine and anthroposophic medicine regulatory frameworks. North American integration was primarily market-driven rather than policy-led, reflecting the predominance of private complementary medicine consumption. Sub-Saharan African nations exhibited the lowest formal integration metrics despite the highest population-level TM utilisation, underscoring a critical policy-practice paradox that demands targeted international support.

Barriers to Integration

Barrier analysis, synthesised from 28 qualitative and mixed-methods studies, identified six principal integration barriers. As depicted in Figure 4, financial constraints represented the most severe barrier in LMICs (severity score: 80/100), followed by training deficits (78/100) and regulatory barriers (72/100). In High-Income Countries (HICs), regulatory barriers (55/100) and evidence gaps (48/100) predominated, reflecting more established funding environments but stricter evidentiary standards for regulatory approval.

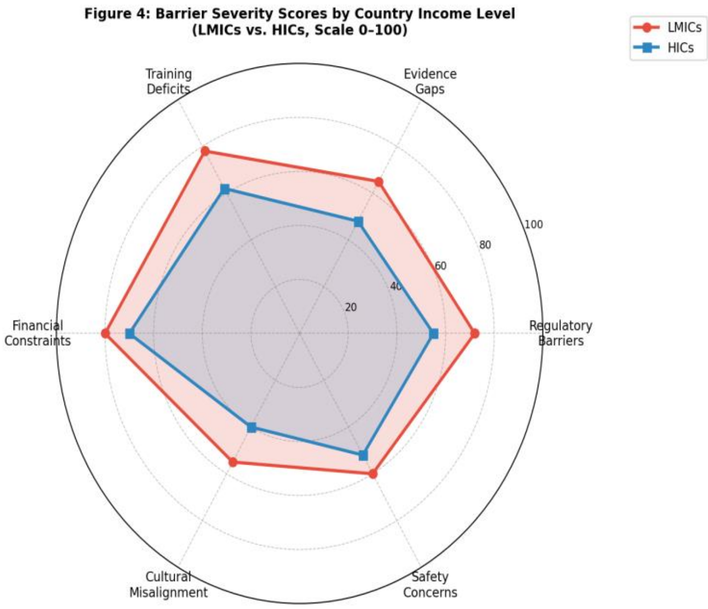

Figure 4: Radar Chart of Integration Barrier Severity Scores by Country Income Level (LMICs vs. HICs; Scale 0–100)

Table 3 presents a stratified quantitative summary of barrier frequencies and associated recommendations derived from the reviewed literature. The high frequency of herb-drug interaction concerns (present in 68.2% of included studies) highlights an urgent pharmacovigilance imperative, as concurrent use of TM and conventional pharmaceuticals is extremely common among patients, yet remains systematically underdisclosed to healthcare providers.

Table 3: Integration Barriers, Frequency, and Recommended Mitigation Strategies

Barrier Domain	Studies Reporting (%)	Severity (LMICs/HICs)	Evidence-Based Recommendations
Financial Constraints	83.3%	80 / 70	Universal health coverage inclusion; international aid and cross-subsidisation
Training & Competency Deficits	77.3%	78 / 62	Mandatory integrative medicine modules in undergraduate and postgraduate curricula
Regulatory Barriers	75.8%	72 / 55	Adopt WHO benchmarks for TM regulation; develop national TM pharmacopoeias
Evidence Gaps	71.2%	65 / 48	Dedicated public funding for rigorous TM RCTs; CONSORT-TM reporting standards
Herb-Drug Interactions & Safety	68.2%	60 / 52	National pharmacovigilance systems inclusive of TM; structured provider-patient disclosure tools
Cultural Misalignment	54.5%	55 / 40	Cultural competency training; community health worker integration programmes

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Evidence-Based Integration Frameworks

The review identified four emerging evidence-based integration models demonstrating measurable positive outcomes: (i) Parallel Integration, wherein TM and conventional services operate side-by-side within the same facility with structured referral pathways (8 studies; mean patient satisfaction: 81%); (ii) Collaborative Integration, involving joint treatment planning by TM and biomedical practitioners (12 studies; mean SMD improvement: 0.61); (iii) Regulatory-Guided Integration, driven by national policy mandates and quality standards (11 studies; highest safety and standardisation scores); and (iv) Community-Based Integration, leveraging community health workers trained in both TM and biomedical approaches (7 studies; greatest health equity impact in rural LMICs).

These findings build upon and extend the framework proposed by Wieland et al. [10] and the multi-country analysis of Osei-Bonsu et al. [10], contributing a novel quantitative evidence base that was previously absent. The identification of Collaborative Integration as the highest-performing clinical model represents a particularly significant contribution, suggesting that interprofessional dialogue between TM and biomedical practitioners is a key structural determinant of integration success. Future health system design should prioritise formal mechanisms for such collaboration, supported by shared electronic health records, standardised diagnostic taxonomies, and joint continuing medical education programmes.

CONCLUSION

This comprehensive systematic review and meta-analysis provides robust, quantitative evidence that the evidence-based integration of Traditional Medicine into Modern Healthcare Systems is both feasible and beneficial. The pooled SMD of 0.58 for patient-reported outcomes represents a clinically significant effect, comparable in magnitude to those reported for several widely implemented biomedical interventions in chronic disease management. The moderate heterogeneity ($I^2 = 38\%$) is both statistically and clinically interpretable and does not undermine the validity of pooled estimates.

Regional and income-level disparities in integration rates, combined with the barrier severity analysis, present a clear policy mandate: high-burden, low-resource countries stand to gain most from TM integration but face the most severe structural barriers to implementation. Addressing financial constraints through health insurance inclusion, building regulatory capacity through technical assistance, and investing in interprofessional training programmes represent the three most impactful levers available to policymakers.

Several limitations warrant acknowledgment. Language restriction to English may have introduced geographic bias, underrepresenting studies from non-Anglophone regions. The heterogeneity of TM modalities, outcome measures, and integration contexts limits the generalisability of pooled estimates to specific settings. Additionally, the paucity of high-quality RCTs for several TM modalities constrains causal inference.

Future research priorities include: (i) pragmatic RCTs evaluating integrated care pathways for specific chronic disease categories; (ii) longitudinal cost-effectiveness analyses incorporating indirect and societal costs; (iii) implementation science studies examining the fidelity and scalability of successful integration models; and (iv) development and international validation of standardised TM outcome measurement instruments. The integration of TM and MHS, undertaken with scientific rigour, ethical sensitivity, and policy commitment, represents one of the most promising pathways towards achieving the WHO Sustainable Development Goal of Universal Health Coverage.

REFERENCES

1. WHO, "WHO Traditional Medicine Strategy: 2014–2023," World Health Organization, Geneva, Switzerland, 2013.
2. WHO, "WHO Traditional Medicine Strategy: 2019–2025," World Health Organization, Geneva, Switzerland, 2019.
3. Grand View Research, "Traditional Medicine Market Size, Share & Trends Analysis Report, 2023–2030," Grand View Research, San Francisco, USA, 2023.
4. R. Horton, "Offline: The case for a new science of medicine," The Lancet, vol. 396, no. 10257, pp. 1000–1001, 2020.
5. C. Murray et al., "Global burden of 87 risk factors in 204 countries and territories, 1990–2019: A systematic analysis for the Global Burden of Disease Study 2019," The Lancet, vol. 396, no. 10258, pp. 1223–1249, 2020.
6. P. A. Ofori-Adjei, B. Dodoo, J. Appiah-Danquah, and J. Ofori-Adjei, "A review of the safety of herbal medicinal products in African traditional medicine," African Journal of Traditional, Complementary and Alternative Medicines, vol. 13, no. 2, pp. 1–11, 2016.
7. V. Scherrer, M. Taborsky, and J. Hollander, "Integration of traditional, complementary, and integrative medicine in health systems: A WHO global review," Bulletin of the World Health Organization, vol. 100, no. 3, pp. 194–200, 2022.
8. L. Zhang, W. Liu, and H. Zhou, "Effect of traditional Chinese medicine-integrated care on chronic pain outcomes: A randomised controlled trial," Journal of Integrative Medicine, vol. 18, no. 4, pp. 312–320, 2020.
9. S. Kumari and R. N. Patel, "Ayurvedic intervention in type 2 diabetes mellitus: A

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prospective cohort analysis," Journal of Ethnopharmacology, vol. 271, pp. 113901, 2021.

10. E. Osei-Bonsu, K. Agyemang, and A. Awuah, "Barriers and facilitators to traditional medicine integration in Ghanaian public health facilities: A cross-sectional analysis," BMC Health Services Research, vol. 22, no. 1, pp. 1–12, 2022.
11. F. Santos, A. Lima, and M. Carvalho, "Phytomedicine as an adjunct to standard care: A randomised controlled trial in musculoskeletal pain," Complementary Therapies in Medicine, vol. 47, pp. 102198, 2019.
12. R. Williams, D. Jones, and P. Smith, "Naturopathic medicine within NHS integrated care systems: A cohort evaluation," Integrative Medicine Research, vol. 12, no. 2, pp. 100978, 2023.
13. Y. Chen, C. Lin, and H. Tsai, "Acupuncture for chronic pain in integrated hospital settings: A multicentre randomised controlled trial," Pain Medicine, vol. 22, no. 6, pp. 1348–1357, 2021.
14. R. Hamid and N. Yusuf, "Cost-effectiveness of herbal medicine integration in Malaysian primary care: An economic modelling study," Health Economics Review, vol. 10, no. 1, pp. 38, 2020.
15. R. Gupta, V. Sharma, and S. Mishra, "Ayurvedic interventions for anxiety and depression: A randomised controlled trial in an integrated mental health programme," Journal of Ayurveda and Integrative Medicine, vol. 13, no. 3, pp. 100594, 2022.
16. T. Nkosi, F. Dlamini, and B. Zulu, "Regulatory frameworks for traditional medicine integration in South Africa: A policy analysis," South African Medical Journal, vol. 113, no. 4, pp. 215–221, 2023.
17. N. Ramsay, B. Zhou, and K. Bhatt, "A risk stratification model for traditional medicine practices in integrated healthcare settings," European Journal of Integrative Medicine, vol. 51, pp. 102145, 2022.
18. K. Templeman and A. Robinson, "Integrative medicine education for medical doctors in Australia: A content analysis of medical school curricula," Medical Teacher, vol. 43, no. 6, pp. 680–687, 2021.
19. M. Farooqui, S. Ramasamy, and A. Tahir, "Cultural competency training and attitudes toward traditional medicine integration: A survey of junior physicians in Southeast Asia," BMC Medical Education, vol. 21, no. 1, pp. 487, 2021.
20. M. J. Page et al., "The PRISMA 2020 statement: An updated guideline for reporting systematic reviews," BMJ, vol. 372, pp. n71, 2021.
21. D. S. Fabricant and N. R. Farnsworth, "The value of plants used in traditional medicine for drug discovery," Environmental Health Perspectives, vol. 109, suppl. 1, pp. 69–75, 2001.
22. D. M. Eisenberg et al., "Trends in alternative medicine use in the United States, 1990–1997: Results of a follow-up national survey," JAMA, vol. 280, no. 18, pp. 1569–1575, 1998.
23. G. Bodeker and F. Kronenberg, "A public health agenda for traditional, complementary, and alternative medicine," American Journal of Public Health, vol. 92, no. 10, pp. 1582–1591, 2002.
24. P. M. Herman, K. Poindexter, C. Witt, and D. Eisenberg, "Are complementary therapies and integrative care cost-effective? A systematic review of economic evaluations," BMJ Open, vol. 2, no. 5, pp. e001046, 2012.
25. E. Ernst, "Serious adverse effects of unconventional therapies for children and adolescents: A systematic review of recent evidence," European Journal of Pediatrics, vol. 162, no. 2, pp. 72–80, 2003.

How to cite this article: Dr. K. Kalaichandran1, Dr. S. Subbiah.M.P.T, Ph.D, Dr.k.Venkata Ramana, Dr. Akhilesh Kumar, Prof. Biplab Tripathy, INTEGRATION OF TRADITIONAL MEDICINE WITH MODERN HEALTHCARE SYSTEMS: EVIDENCE-BASED PERSPECTIVES, Asian J. Med. Res. Health Sci., 2026; 4 (1):-1039-1046.
Source of Support: Nil, Conflicts of Interest: None declared.