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WHO's misguided push for complementary and alternative medicine

Use of traditional medicine must follow evidence of efficacy and safety

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The BRICS economies, including India and China, committed to further collaboration to integrate traditional medicine in healthcare, at a meeting in May 2026. The meeting was held by India's Ministry of Ayush (ayurveda, yoga and naturopathy, unani, siddha, and homeopathy). Globally, interest in complementary and alternative medicine (CAM)—that is, unproved, non-standard interventions—is surging, with the market projected to reach $359bn by 2032.[1]

In December 2025, a multilateral declaration endorsed the World Health Organization's Global Traditional Medicine Strategy 2025-2034, aiming for "universal access to safe, effective" traditional medicine.[2 3] This proposes integrating CAM into national health systems and universal health coverage through strengthening evidence, tightening safety regulation, expanding workforce, and building a global library of traditional knowledge.[2]

Lower standards of evidence

Despite claiming evidence must precede integration, the strategy also allows member states to fund and integrate CAM before standard efficacy and public safety data exist, which is ethically and methodologically indefensible. WHO contradicts its promise of universal scientific rigour by lowering evidentiary standards: the strategy endorses observational and "real world data" designs "appropriate to the unique characteristics" of CAM instead of the standard randomised controlled trials.[2]

In a WHO survey, 95% of responding member states cited lack of research data as the key barrier to integrating CAM.[4] Robust evidence supporting CAM is lacking despite increased research funding and thousands of studies.[5] After millennia of using traditional Chinese medicine, for example, major evidence gaps on efficacy and safety remain, and patients experience unpredictable effects.[6 7]

As global interest in CAM grows, so does an "infodemic" of health misinformation and the exploitative sale of unproved interventions.[8] The stakes are enormous: patient harm, displacement of effective care, and eroded trust in health institutions.[9]

Patient harm

In the US, liver injuries from the use of herbal preparations rose from 7% to 20% in 2004-13, and the number of people requiring a liver transplant because of taking herbal supplements rose eightfold during 1995-2020.[10]Globally, herbal remedies are a more common cause of liver failure leading to liver transplant or death than prescription drugs.[10] In India, over one third of 386 traditional products tested contained toxic botanicals and 28% contained adulterants.[11] India's promotion of unvalidated CAM for covid-19 led to liver injury.[12] In China, traditional medicines cause over 20% of drug induced liver injuries.[13] Additionally, herb-drug interactions can render standard care ineffective or toxic,[14] and five year survival was significantly reduced among people using CAM in a study of over two million US breast cancer patients.[15]

Acceptance of some CAM interventions owes more to political invention, nationalism, or decolonial movements than to evidence in many places, including in some African countries, China, India, and Burma.[16] Additionally, WHO's strategy was shaped by Rudolf Steiner's unscientific philosophies of "anthroposophic medicine" and was funded by India and China, which have economic and political interests in promoting CAM.[2 17 18]

Integration of CAM into standard healthcare is already outpacing evidence generation. Major Indian government institutes have CAM departments treating patients based largely on unblinded, uncontrolled, observational research,[17 19 20] despite some CAM practitioners' criticism.[21] India's annual CAM budget has grown fivefold since 2014 to over $530m,[22] without evidence of improved outcomes, increasing the financial burden for patients already facing high out-of-pocket healthcare costs.[23]

WHO's definitions risk legitimising unproved practices from the prescientific era. The strategy defines integrative medicine as an "evidence based" combination of biomedical and traditional or complementary practices without specifying the standard of evidence needed, and it characterises traditional medicine as aiming to "restore balance of mind, body and environment" and "evolving with science ... from an experience-based origin."[2 23] The strategy claims that an "increasing research base demonstrates [CAM's] promise" without characterising the quality of evidence. Imprecise language risks commercial exploitation of CAM. Public trust in CAM is consistently linked to susceptibility to misinformation and vaccine scepticism.[24] WHO endorsed language could be used by CAM practitioners and health influencers for "scienceploitation"— marketing unproved interventions—deepening distrust in science.[25 26]

Colonisation and epistemicide

Some proponents of CAM correctly identify ongoing power asymmetries from historical colonisation; "epistemicide" describes colonisers' destruction and devaluing of traditional healthcare knowledge.[27] CAM in healthcare might improve patient experience but not necessarily objective outcomes. The randomised controlled trial is not colonial oppression; it distinguishes interventions that work from those that

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do not.[28] Traditionally used artemisinin became standard malaria treatment through scientific evaluation, not deference to tradition.

WHO's strategy insufficiently distinguishes CAM as traditional knowledge for hypothesis generation from validated knowledge that is ready for integration. An ideal CAM strategy should mandate efficacy and pharmacovigilance, including adverse event reporting. Existing large CAM workforces worldwide should be retrained in evidence based priorities for primary care, including screening, vaccination, identifying chronic disease, and maternal health. Research funding should prioritise independent trials, with negative results published. WHO's CAM library should document harms alongside claims of benefit, while disclosing commercial conflicts of interest. And WHO's messaging must remain unequivocally aligned with scientific consensus—a proved tool against misinformation that mixed messaging undermines.

Globally, CAM is the predominant healthcare option for billions of indigenous, rural, and underserved people,[23] likely reflecting constrained access to evidence based care instead of informed choices. The ethical response is not uncritical endorsement of CAM but to expand access only to interventions that withstand standard scientific scrutiny as effective and safe. Patients everywhere deserve nothing less.[29]

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