

Reflection of Traditional Medicine in the New International Classification of Diseases – ICD11

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For centuries, interest and trust in traditional medicine(TM) has not been lost on the part of the population. Patients still actively turn to representatives of traditional medicine, folk healers – both for diagnostics and treatment [1]. Traditional, or so-called, oriental medicine and its individual methods are becoming increasingly popular in the West – Chinese, Indian, Thai, Tibetan medicine offices, centers, clinics are opening [2]. However, in the conditions of evidence-based medicine, patients themselves take responsibility for the quality and results of diagnosis and treatment using traditional medicine methods, since most countries do not regulate this area – neither prohibit it nor impose specific licensing conditions. Because of this, there are often no accurate statistics – how many people use traditional medicine (TM) services, for which diseases and conditions people turn to traditional medicine more often, what results they get, etc. However, if we judge not by the decrease, but by the increase in the number of centers, that is, by the increase in demand for them in the market, it turns out that we can conclude that the population's trust and demand for TM is high [3,4]. Moreover, most likely, it is precisely in view of this demand that in recent years, developed medical centers around the world have been opening integrative medicine clinics in order to diagnose patients using both conventional and traditional medicine methods and prescribe treatment or care [1]. And even more – the World Health Organization has included traditional medicine as a separate chapter in the new International Classification of Diseases [4].

This is where our interest arose and a study was planned, which aimed to discuss why it was necessary to include a separate chapter on traditional medicine in the ICD-11, what health conditions are included, what system is used to code them in this chapter; which traditional medicine treatment methods are included in the interventions and what criteria are used to select them; are the coded topics of traditional medicine based on evidence-based medicine?

Accordingly, **the purpose of the study** was: to study the prerequisites, reasons and expected results of adding the TM component to the ICD11

The objectives are: 1. General overview of the traditional medicine chapter in the ICD11, 2. Determination of the prerequisites and reasons for including TM in the ICD11, 3. Calculation of the expected results

Materials and methods: 1. The ICD11 itself and supporting documents (WHO reviews, recom-

mendations, resolutions, 2. Scientific articles, information materials on the inclusion of TM in the ICD11. The multi-factor qualitative method included both descriptive, review, and correlational and analytical methods.

RESULTS' DISCUSSION:

1. General overview of the traditional medicine chapter in the ICD11

In order to briefly and comprehensively review the TM chapter, we analyzed both the classification itself, and the articles published on this topic [3, 5, 6, 7].

It appeared, that the chapter is divided into specific modules that encompass diagnostic concepts from various standardized systems of care. **Module 1 (TM1). (BlockL1-SA0):** Covers traditional medicine disorders and patterns originating from ancient Chinese Medicine, which are widely practiced in China, Japan, Korea, and globally. **Module 2:** Encompasses diagnostic concepts from other prominent traditional systems, specifically Ayurveda, Unani, and Siddha. **Structural Breakdown (Module 1)** – Within Module 1, diagnostic codes are categorized into two main blocks: **TM Disorders:** Set dysfunctions in body systems presented with specific signs and symptoms, categorized by organ systems (e.g., Liver System Disorders, Spleen System Disorders). **TM Patterns:** Underlying disharmonies and physiological states used in TM practices, such as Yin/Yang deficiencies or exterior/interior imbalances. **Dual Coding** – To ensure it acts as a complement rather than a replacement, the ICD-11 employs a **dual coding** system. This allows practitioners to assign a primary biomedical diagnosis (from Chapters 1 to 24) and pair it with the corresponding TM pattern or disorder code (Chapter 26) to provide a holistic view of the patient's health [8]. This is main difference and advantage of ICD 11 toward other classification, as doctors have opportunity to reflect in their diagnosis simultaneously both – modern/conventional and TM codes.

So, The ICD-11 *Traditional Medicine* (TM) chapter is a supplementary chapter (26) enabling clinicians to integrate traditional diagnoses alongside conventional medical coding. It is not used for mortality and is strictly optional, aiming to measure the form, frequency, and usage of traditional healthcare encounters. This chapter has 470 four-character categories. Code range starts with SA00 This supplementary chapter is a subclassification for optional use. Coding should always include also a category from the chapters 1-24 of ICD. This supplementary chapter refers to disorders and patterns which originated in ancient Chinese Medicine and are commonly used in China, Japan, Korea, and elsewhere around the world. This list represents a union set of harmonized traditional medicine conditions of the Chinese, Japanese, and Korean classifications. **Definitions:** A disorder in traditional medicine, disorder (TM1), refers to a set of dysfunctions in any of the body systems which presents with associated manifestations, i.e. a single or a group of specified signs, symptoms, or findings. Each disorder (TM1) may be defined by its symptomatology, etiology, course and outcome, or treatment response:

1. Symptomatology: signs, symptoms or unique findings by traditional medicine diagnostic methods, including inspection such as tongue examination, history taking (inquiry), listening and smelling examination, palpation such as pulse taking, abdominal examination, and other methods or/and constitution: the characteristics of an individual, including structural and functional characteristics, temperament, ability to adapt to environmental changes, or susceptibility to various health conditions

2. TM Etiology: the underlying traditional medicine explanatory style, such as environmental factors (historically known in TM translations as the external contractions), emotional factors (historically known in TM translations as the seven emotions), or other pathological factors, processes, and products.

3. Course and outcome: a unique path of development of the disorder (TM1) over time.

4. Treatment response: known response to traditional medicine interventions.

In defining a disorder (TM1), symptomology and etiology are required. Course and outcome, and treatment response are optional. A pattern in traditional medicine, pattern (TM1), refers to the complete clinical presentation of the patient at a given moment in time including all findings.

'TM1' refers to Traditional Medicine conditions – Module I. The (TM1) designation is used throughout this chapter for every traditional medicine diagnostic category in order to be clearly distinguishable from conventional medicine concepts.

To understand TM1 better, let's consider "liver system disorders' example – Organ system disorders (TM1) (BlockL2-SA0); Liver system disorders (TM1) (BlockL3-SA0) – This section contains a series of TM disorders that are all attributable to dysfunction of the liver system. The system consists of the organs liver and gallbladder, tendons, nails, eyes, related meridians and collaterals. SA00 – Hypochondrium pain disorder (TM1). A disorder characterized by pain on one or both sides of the hypochondrium. It may be explained by qi dysfunction or disharmony in the meridians of the hypochondrium. SA01 – Jaundice disorder (TM1). A disorder characterized by yellow and dark appearance of sclera, skin and urine. They may be explained by dysfunction of liver and spleen systems, and gallbladder, which caused by invading of exogenous pathogenic including dampness, fire or pestilence, and interior injury due to drinking of alcohol or improper diet, or different kinds of dampness, blood stasis and qi stagnation. Inclusions: Acute jaundice Yang jaundice Yin jaundice SA02 – Liver distension disorder (TM1). A disorder characterized by mass or pain in the right hypochondrium relieved with pressure. It may be explained by stagnation of qi and blood and may be a sequelae of other liver system disorders. SA03 – Tympanites disorder (TM1). A disorder characterized by severe abdominal distention with taut, yellowish skin, or prominent veins over the abdominal wall. It relates to liver, spleen and kidney system, may be explained by decreased circulation of qi, blood, or water, which cause the fluid or gas accumulation in the peritoneal cavity, an abdominal mass, or intestinal infection. SA04 – Liver abscess disorder (TM1). A disorder characterized by sudden onset of fever, a mass or pain in the right, lower hypochondrium. It may be explained by accumulation of fire, heat, toxin, parasites, or other infection, which lead to putrefaction of qi or blood in liver, and cause internal abscess. SA05 – Gallbladder distension disorder (TM1) A disorder characterized by recurrent pain with discomfort and distention in the right upper quadrant of the abdomen which may be accompanied by flatulence. It may be explained by stagnation of gallbladder qi, which is caused by obstruction of dampness, heat, phlegm and blood stasis in gallbladder, or emotional upset. SA0Y – Other specified liver system disorders (TM1). SA0Z – Liver system disorders (TM1), unspecified.

1.1 Prerequisites for the inclusion of TM in ICD-11

Despite the fact that the classification itself clearly reflects the different types of organ and system dysfunctions, with descriptions of the main symptoms and syndromes, the question of why it was necessary to add this chapter to the existing classification of diseases, where diseases and conditions have appropriate names and descriptions, still remains.

That is why our next task was to determine the prerequisites for the inclusion of TM in ICD-11. This would more clearly demonstrate the need for a classification with descriptions of organ/system dysfunctions. To study this issue, we reviewed both official WHO reports and guidelines, as well as published articles on the topic. As a result of the meta-analysis, it was revealed that several facts, events and indicators preceded the WHO's revision. As Kenji Watanabe and all are discussing in "Development of the traditional medicine classification

Module 1 in ICD-11"[2], the development of the ICD-11 TM chapter began in 2005 under the WHO Western Pacific Regional Office(WPRO) as part of a standardization project for traditional East Asian medicine. It was transferred to WHO headquarters in 2009, reviewed by 142 experts from 22 countries, and field-tested in Japan, China, Korea, and the United Kingdom. Unlike other ICD fields, the TM classification had to be constructed de novo, demanding substantial technical and diplomatic work. Thanks to effective collaboration across Asia, Europe, and Oceania, progress was steady. By 2016, peer review was completed, followed by field testing in 2016–2017, culminating in the version that was ultimately released. The WHO General Assembly adopted ICD-11 in 2019, and Chapter 26—Traditional Medicine Conditions Module 1—came into effect in January 2022. The inclusion of TM does not imply WHO endorsement of its efficacy or safety, but rather provides a global platform for evidence-based evaluation through research and statistical analysis. Following Module 1, Module 2—covering Ayurveda, Unani, and Siddha—was released in 2025. The establishment of the Traditional Medicine Reference Group (TMRG) within WHO Family of International Classification (WHO-FIC) further facilitates integration of TM concepts into the International Classification of Health Interventions (ICHI). The ICD-11 TM chapter provides an essential global framework for TM research, education, and policy, fostering international collaboration toward evidence-based integration of traditional medicine into health systems [9]. As authors explored, traditional medicine began to expand internationally in the 1970s. A symbolic turning point was a 1971 report in The New York Times, in which a journalist accompanying Henry Kissinger's visit to China described his personal experience of acupuncture treatment. Thereafter, interest in non-biomedical practices such as acupuncture and herbal therapy grew in many countries—as “alternative medicine” in the United States and as “complementary medicine” in the United Kingdom and EU countries. In 1993, David Eisenberg and colleagues at Harvard Medical School published in the New England Journal of Medicine a landmark survey showing that the number of users of complementary and alternative medicine in the U.S. exceeded that of conventional biomedical services. This catalyzed policy changes, and in 1998 the National Center for Complementary and Alternative Medicine (NCCAM) was established at the U.S. National Institutes of Health (NIH), later renamed the National Center for Complementary and Integrative Health (NCCIH). Its annual budget reached USD 170.9 million in fiscal year 2025. In Germany, an estimated 20,000–30,000 physicians have completed 200h of acupuncture training, and pharmacies specializing in herbal medicines serve physicians. In the United States as well, acupuncture is now offered in leading cancer centers such as Dana-Farber and MD Anderson, particularly for pain management. Within this global trend, WHO decided to incorporate a chapter on traditional medicine into the ICD revision[2].

1.2. Identifying the reasons

After discussing the prerequisites, it was clear that our task was to summarize the reasons for including the TM in Chapter 11.

Taking into account the prerequisites and indicators, as well as based on the analysis of existing publications, we formulated the following main reasons: **Objectives and Integration** – The inclusion of Traditional Medicine (TM) in *ICD-11* (via Chapter 26/TM Module-2) was driven by the World Health Organization (WHO) to standardize concepts, improve global health data, and integrate TM into mainstream healthcare systems. The primary reasons for its inclusion are: **Global Health Representation**: Approximately 82% of the world's population uses some form of traditional medicine, due to cost-effectiveness, greater trust in "natural" methods, fewer prob-

lems with medical institutions and insurance companies, and other reasons. Prior to ICD-11, these massive health encounters were essentially "invisible" to international statistical data. **The "Count TM" Principle:** A foundational rationale used by the WHO is that *"if you do not count traditional medicine, then traditional medicine does not count."* Coding allows health systems to measure service utilization, allocate resources, and establish equitable health policies. **International Standardization:** Traditional Medicine (such as Traditional Chinese Medicine, Kambo, and Ayurveda) possesses immense local knowledge but lacked a standardized, universally comparable terminology. ICD-11 provides a shared language to bridge TM and Western Medicine (WM) concepts. **Enhanced Safety and Research:** By integrating diagnostic codes into mainstream digital health records, researchers can better track treatment outcomes, evaluate the integration of TM alongside WM, and document any adverse events. **Support for WHO Strategies:** The inclusion supports the WHO Draft Global TN Strategy, which advocates for strengthening the evidence base of Traditional and Complementary Medicine (TCIM) and integrating it safely into national health systems. [10]

3. CALCULATION OF PROBABLE RESULTS

And finally, taking into account the prerequisites and reasons, our task was, based on logical analysis, to calculate what could be the main results of the introduction of TM in 11?

1. If one of the main reasons for the introduction of traditional medicine was the need for accounting – the reporting system, epidemiological data and monitoring of the results of the TM by TM methods, accordingly, one of the first and main results should be the improvement of statistics – both on common diseases, conditions, symptoms, syndromes, functional disorders, and – on methods of their diagnosis and treatment – especially for those countries where the population practically does not use conventional medicine.

2. Since in many countries, both conventional and TM methods are used to diagnose and treat patients with MDS, it logically follows from this reality that in these countries it will be possible to compare data and assess the capabilities of different classifications when using both classifications. Also, observation of different groups – those who benefit from the achievements of only one of the medicine and those who benefit from integrated methods, which clearly determines the clinical and socio-economic place of integrative medicine in healthcare in the future. That is, the introduction of TM will contribute to the development of IM and the achievement of more effective, rapid and cost-effective results.

In addition to our conclusions, a meta-analysis of the literature on possible outcomes showed that other authors also believe that the introduction of TM in 11 will bring specific clinical, epidemiological, social and economic results [4,11, 12]. For example, Reddy B, Fan AY [13] believe that The integration of this chapter aligns with the *WHO Traditional Medicine Strategy* to standardize TM data collection. By facilitating interoperability within modern electronic health record infrastructures, it allows researchers and policymakers to better analyze the safety, quality, and outcomes of traditional therapies on a global scale. Although some countries have had national Traditional Medicine classification systems for many years, information from such systems has not been standardized nor been made available globally. By including TM within the ICD, international standardization will be possible allowing for measuring, counting, comparing, formulating questions and monitoring over time. ICD-11 is a classification system for the twenty-first century, and it now provides an opportunity for interested users to integrate the coding of diagnostic concepts from both TM and Western Medicine.

Moreover, we have come across articles that demonstrate the potential for creating morbid-

ity registries, digitizing and mapping TMs, and funding them through state health insurance for specific traditional medical systems. For example, Sathiyarajeshwaran, P., and all in the article “India’s roadmap for ICD-11 TM2 implementation: Integrating Ayurveda, Siddha, and Unani into global health standards” [10], note that: “This initiative, spanning 2020–2025 and formalized by a donor agreement between the World Health Organization (WHO) and India’s Ministry of Ayush, establishes a standardized language for ASU morbidity. Key outcomes include the mapping of 1941 national Ayush morbidity codes to the new classification and the official release of TM2 on the WHO ICD-11 Browser in February 2025, ensuring international comparability and evidence-based policymaking. India’s implementation roadmap leverages existing digital platforms, including the National Ayush Morbidity And Standardized Terminologies Electronic (NAMASTE) Portal and the Ayush Hospital Management Information System (A-HMIS), which is powered by a niche Double Coding system in compliance with the WHO Minimum Data Set requirements. This initiative positions India as a global leader in integrating traditional medicine into digital health systems and universal health coverage frameworks”.

CONCLUSION

1. The reflection of traditional, physical medicine, first of all, aims at the registration, visibility, regulation and evaluation of the effectiveness of treatment with these methods;
2. This will make it easier for specialists in the field of medical rehabilitation and traditional healers to organize and reflect patient management in the relevant documents;
3. The reflection of TM in ICD11 makes scientists to strengthen research in this direction and allocate evidence-based methods of traditional medicine in subsequent revisions of the classification and their financing by both private and state health insurance companies.
4. The study showed that the implementation of the ICD-11 still has a number of obstacles in the majority of countries, however, by reflecting traditional medicine in this classification, not only clinical, but also financial and psychosocial benefits can be reasonably expected. This, in addition to strengthening trust, will reduce the economic burden caused by healthcare on both states and insurance companies, as well as families. Further studies in the field of ICD11 implementation are needed.

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