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Utility of Repertory in Community-Based and Surgical Homoeopathic Practice: A Clinical Review

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ABSTRACT

Background

The repertory occupies an important position in homoeopathic clinical practice by providing a systematic method for organizing patient symptoms and facilitating the selection of an appropriate medicine from the materia medica. Its application is traditionally associated with individual case management, but its potential utility can also be explored in community-based practice and in patients presenting with surgical conditions. Community medicine emphasizes prevention, early recognition, health promotion, continuity of care and appropriate referral, whereas surgical practice requires accurate diagnosis, assessment of severity, timely intervention and rigorous patient-safety measures.

Objective

To review the potential utility of repertory as a structured clinical reasoning tool in community-based and surgical homoeopathic practice, while defining its appropriate role within modern diagnostic, preventive and referral systems.

Methods

This narrative clinical review examines classical concepts of repertorial case analysis alongside principles of primary health care, clinical reasoning, patient safety and surgical care. The discussion focuses on symptom characterization, individualization, rubric selection, repertorization, materia medica confirmation, community-oriented case management and the limitations of repertorial prescribing in surgical conditions.

Discussion

In community practice, repertory may assist in organizing individual symptoms within the broader context of environmental, occupational, behavioural and social determinants of health. It may be particularly useful in chronic, recurrent and non-emergency conditions where individualized symptom assessment is appropriate. In surgical practice, repertory has a more limited adjunctive role. Accurate diagnosis, emergency recognition, investigations, specialist referral and definitive surgical management must take precedence over repertorization. Repertorial analysis may potentially contribute to the assessment of selected non-emergency symptoms, postoperative complaints after appropriate clinical assessment, and chronic conditions managed conservatively or alongside conventional care.

Conclusion

Repertory may have educational and clinical utility as a structured method of symptom analysis and individualized case formulation in community-based homoeopathic practice. Its role in surgical practice should remain complementary and strictly subordinate to diagnosis, patient safety, timely referral and evidence-based surgical care. Future research should evaluate the reproducibility of rubric selection, inter-rater reliability, clinical outcomes and the educational value of repertorial reasoning.

Keywords: Homoeopathic repertory; repertorization; community medicine; community health; surgery; clinical reasoning; individualization; primary health care; patient safety; homoeopathy.

1. Introduction

Clinical medicine requires the integration of history taking, physical examination, diagnostic reasoning, risk assessment, treatment planning and follow-up. The clinician must distinguish common symptoms from clinically significant findings and recognize circumstances requiring investigation, specialist referral or emergency intervention.

Within homoeopathy, the repertory has traditionally served as an organized index of symptoms that facilitates access to the extensive information contained in materia medica.[1-6] The repertory does not replace materia medica; rather, repertorization is traditionally used to narrow the field of possible medicines and assist the practitioner in comparing remedies.

Classical repertorial methods have evolved through the contributions of Hahnemann, Boenninghausen, Kent, Boger and other authors.[1-5] Different repertories emphasize different approaches to symptoms, including complete symptoms, location, sensation, modalities, concomitants, causation and constitutional characteristics.

The contemporary clinical environment, however, requires repertorial practice to be considered within a broader framework of patient safety and healthcare organization.

The World Health Organization's current primary-care framework emphasizes structured, systematic and person-centred encounters, including assessment of the main reason for consultation, emergency signs, vital signs, social factors, medications, physical examination and follow-up.[7] This is particularly relevant when considering repertory in community practice because individual symptom analysis should occur only after appropriate clinical assessment.

Similarly, surgery requires a high degree of diagnostic precision and safety. WHO emphasizes safe anaesthesia, prevention of surgical-site infection, effective teamwork, communication and standardized safety processes.[8-10]

Therefore, the question is not whether repertory should replace community medicine or surgery. The clinically appropriate question is:

What is the utility of repertory when incorporated responsibly into community-based and surgical homoeopathic practice?

This review explores this question from a clinical, educational and patient-safety perspective.

2. Concept of Repertory in Homoeopathic Practice

A repertory may be described as a systematic arrangement of symptoms with corresponding medicines, designed to facilitate the study and comparison of remedies.

The repertorial process traditionally involves:

1. Collection of the complete case.
2. Identification of characteristic symptoms.
3. Analysis of symptoms.
4. Conversion of symptoms into appropriate rubrics.
5. Selection of a suitable repertory.
6. Repertorization.
7. Comparison of candidate medicines.
8. Confirmation with materia medica.
9. Prescription and follow-up.

The repertory therefore functions as an intermediate tool between the patient's clinical presentation and the materia medica.

A useful conceptual sequence is:

Patient → Case taking → Clinical assessment → Characteristic symptoms → Rubrics → Repertorization → Materia medica confirmation → Individualized management → Follow-up

The repertory should not be treated as an automated prescribing system. The numerical ranking generated during repertorization is only one component of clinical reasoning.

3. Community-Based Homoeopathic Practice

3.1 Meaning and scope

Community-based healthcare focuses on health needs at the level of individuals, families and populations. Primary healthcare incorporates health promotion, prevention, treatment, rehabilitation and coordination of services.

The WHO Primary Care Checklist emphasizes a structured patient encounter involving emergency assessment, vital signs, social factors, medication review, physical examination, preventive care and follow-up.[7]

These principles have direct relevance to repertorial case taking.

A community-based homoeopathic practitioner may encounter:

- recurrent respiratory complaints,
- gastrointestinal problems,
- headaches,
- musculoskeletal complaints,
- skin disorders,
- menstrual complaints,
- stress-related symptoms,
- sleep problems,
- recurrent minor ailments and
- chronic functional complaints.

In such cases, repertory may assist in organizing the patient's individual symptom pattern after appropriate clinical assessment.

4. Utility of Repertory in Community Practice

4.1 Individualization of common complaints

Many community health problems present with relatively common disease labels.

For example, several patients may present with headache. However, their individual symptom patterns may differ in:

- location,
- sensation,
- time,
- aggravating factors,
- ameliorating factors,
- associated symptoms,
- causation and
- constitutional characteristics.

Repertory provides a framework for organizing these differences.

Thus:

Common diagnosis $\neq$ identical individual presentation.

The repertorial approach attempts to identify the characteristics that distinguish one patient from another.

4.2 Recurrent conditions

Recurrent complaints are frequently encountered in community practice.

Examples include:

- recurrent upper respiratory symptoms,
- recurrent headaches,
- recurrent dyspepsia,
- recurrent skin complaints,
- recurrent musculoskeletal pain and
- recurrent sleep disturbances.

In such cases, longitudinal case documentation may provide additional information that is unavailable during a single consultation.

Repeated episodes can be evaluated for:

- triggers,
- periodicity,
- seasonal patterns,
- occupational factors,
- dietary associations,
- emotional factors and
- changing symptom characteristics.

Repertorial analysis may then be repeated when clinically appropriate.

4.3 Environmental and occupational factors

Community health is strongly influenced by environmental and occupational conditions.

Examples include:

- dust exposure,
- industrial chemicals,
- heat,
- noise,
- poor ventilation,
- prolonged computer work,
- repetitive physical activity and
- occupational stress.

A repertorial consultation should not merely convert these factors into rubrics.

The clinician should first identify whether environmental modification, occupational protection or medical investigation is required.

This is consistent with the broader primary-care concept of considering social and other factors that influence health.[7]

5. Repertory and Preventive Health

A community-oriented repertorial consultation can provide an opportunity for preventive counselling.

The practitioner should consider:

Lifestyle

- physical activity,
- sleep,

- diet,
- hydration and
- substance use.

Environmental factors

- sanitation,
- housing,
- ventilation,
- occupational exposure and
- allergens.

Preventive healthcare

- vaccination,
- screening,
- health education,
- maternal and child health and
- appropriate chronic-disease monitoring.

The repertory should therefore be integrated into, rather than isolated from, preventive health practice.

6. Repertory in Surgical Practice

Surgical practice presents a fundamentally different clinical environment.

Patients may present with:

- acute abdominal pain,
- trauma,
- wounds,
- abscesses,
- hernias,
- postoperative symptoms,
- anorectal disorders,
- skin and soft-tissue conditions,
- musculoskeletal injuries and
- chronic surgical conditions.

The first responsibility is to determine whether the patient requires:

- emergency care,
- hospitalization,
- imaging,
- laboratory investigation,
- surgical consultation,
- operative intervention or
- other definitive treatment.

WHO describes surgical and anaesthesia care as essential components of comprehensive health systems and emphasizes safe, timely and affordable access to operative care.[8]

Therefore:

Repertorization must never delay necessary surgical assessment or definitive treatment.

7. Role of Repertory in Surgical Case Assessment

The role of repertory can be considered under three broad categories.

7.1 Preoperative assessment

Repertory does not replace:

- clinical diagnosis,
- laboratory investigations,
- imaging,
- anaesthetic assessment,
- surgical consent,
- risk stratification or
- operative planning.

Its use, if considered, should remain complementary and should not influence decisions that require established surgical criteria.

7.2 Postoperative symptoms

Postoperative patients require particular caution.

Symptoms such as:

- increasing pain,
- fever,
- wound discharge,
- excessive bleeding,
- abdominal distension,
- persistent vomiting,
- breathlessness,
- altered consciousness or
- wound separation

require clinical assessment for complications.

The practitioner should not interpret these findings merely as repertorial symptoms.

The WHO Surgical Safety Checklist emphasizes standardized checks at critical stages of surgical care, including before anaesthesia, before skin incision and before leaving the operating room.[9,10]

7.3 Chronic and non-emergency surgical conditions

Selected chronic conditions may be managed conservatively or may require elective surgical evaluation.

In such circumstances, repertorial analysis may have an adjunctive role after appropriate diagnosis.

Examples may include:

- chronic uncomplicated anorectal symptoms,

- selected recurrent skin conditions,
- chronic postoperative complaints,
- non-acute musculoskeletal complaints and
- certain functional symptoms associated with surgical disorders.

However, progression of disease, treatment failure or development of red-flag symptoms should trigger reassessment and referral.

8. Repertorial Methodology for Community and Surgical Cases

A structured methodology can improve consistency.

Step 1: Identify the chief complaint

Document the patient's main reason for consultation.

Step 2: Establish clinical diagnosis

Use history, examination and investigations where indicated.

Step 3: Assess severity and red flags

Identify conditions requiring urgent referral.

Step 4: Define the complete symptom

A useful classical framework includes:

Location + Sensation + Modalities + Concomitants + Causation

Step 5: Identify characteristic symptoms

Not every symptom has equal repertorial value.

Greater attention may be given to symptoms that are:

- peculiar,
- strongly characteristic,
- clearly modalized,
- causally related,
- unusual,
- intense or
- strongly individualizing.

Step 6: Select the repertory

The repertory should be selected according to the nature of the case and the practitioner's methodological approach.

Step 7: Construct rubrics

The selected rubric should represent the patient's actual symptom as accurately as possible.

Step 8: Repertorize

The repertorization identifies possible remedy candidates.

Step 9: Confirm through materia medica

The final decision should be based on the totality of the case rather than numerical repertorial ranking alone.

Step 10: Follow up

The outcome should be assessed using objective and patient-centred parameters.

9. Proposed Clinical Algorithm

COMMUNITY / SURGICAL PATIENT

↓

HISTORY AND EXAMINATION

↓

DIAGNOSIS / DIFFERENTIAL DIAGNOSIS

↓

RED-FLAG ASSESSMENT

↓

Emergency / Surgical indication?

YES → Immediate appropriate referral / definitive management

NO ↓

INDIVIDUALIZED CASE ANALYSIS

↓

CHARACTERISTIC SYMPTOMS

↓

RUBRIC SELECTION

↓

REPERTORIZATION

↓

MATERIA MEDICA CONFIRMATION

↓

INTEGRATED MANAGEMENT

↓

FOLLOW-UP AND OUTCOME ASSESSMENT

This algorithm places patient safety before repertorial analysis.

10. Clinical Examples

Case Example 1: Community respiratory complaint

A 30-year-old teacher presents with recurrent episodes of nasal obstruction and cough during dusty working conditions.

Clinical assessment

The clinician assesses:

- duration and recurrence,
- fever,
- respiratory distress,
- wheezing,
- allergic history,
- occupational exposure,

- smoking exposure and
- need for investigation.

If there are no emergency features, the individual symptom pattern may be documented.

Repertorial analysis

Relevant characteristics may include:

- aggravation from dust,
- time of aggravation,
- nature of nasal discharge,
- cough characteristics,
- associated symptoms and
- constitutional features.

Repertorization may then be used as an adjunct to materia medica study.

Community intervention

Environmental exposure reduction and appropriate preventive advice remain essential.

Case Example 2: Chronic headache

A 40-year-old office employee reports recurrent headache after prolonged computer use.

Before repertorization, the practitioner should assess:

- blood pressure,
- neurological symptoms,
- visual problems,
- migraine features,
- medication use,
- sleep,
- hydration and
- occupational ergonomics.

After excluding concerning features, the characteristic symptom picture may be repertorized.

The case demonstrates that repertorization should follow—not precede—clinical assessment.

Case Example 3: Postoperative wound pain

A patient presents after minor surgery with increasing local pain.

The practitioner must first examine:

- wound condition,
- erythema,
- swelling,
- discharge,
- temperature,
- systemic symptoms and
- wound integrity.

If infection or another complication is suspected, immediate surgical review is required.

Repertorization should not be used to delay investigation or definitive treatment.

Case Example 4: Chronic anorectal symptoms

A patient reports recurrent anal discomfort and occasional bleeding.

The first step is clinical examination and appropriate investigation to establish the cause.

Potential serious causes must be excluded.

Once the diagnosis is established and an appropriate management plan is in place, individual symptoms may be documented for repertorial analysis where complementary homoeopathic management is appropriate.

This demonstrates the distinction between:

diagnostic evaluation and **individualized repertorial analysis**.

11. Educational Utility

Repertory can also be used as an educational tool for postgraduate students.

Students can be trained to move through the following sequence:

Disease

What is the clinical diagnosis?

↓

Danger

What could be life-threatening or require referral?

↓

Individualization

What makes this patient's presentation distinctive?

↓

Symptom analysis

Which symptoms are characteristic?

↓

Rubric

Which repertory rubric represents the symptom?

↓

Repertorization

Which medicines are suggested?

↓

Materia medica

Which medicine best corresponds to the complete picture?

↓

Outcome

How will improvement be measured?

This approach can transform repertory teaching from simple rubric memorization into structured clinical reasoning.

12. Community Medicine–Repertory Integration

A useful conceptual model is:

Community Medicine Component	Repertorial Contribution
Health assessment	Detailed symptom characterization
Environmental assessment	Identification of causative/modifying factors
Occupational history	Individualization through exposure patterns
Preventive care	Identification of health risks
Chronic disease follow-up	Longitudinal symptom documentation
Health education	Patient-centred counselling
Referral	Recognition of symptoms outside repertorial management
Follow-up	Assessment of symptom evolution

The repertory therefore has greatest potential utility when incorporated into a comprehensive clinical encounter.

13. Surgery–Repertory Integration

Surgical Component	Appropriate Role of Repertory
Diagnosis	Repertory cannot replace diagnosis
Emergency assessment	Emergency management takes priority
Imaging	Cannot be replaced by repertorization
Operative decision	Must follow accepted surgical criteria
Anaesthesia	Requires specialist assessment
Postoperative monitoring	Standard clinical monitoring is essential
Chronic symptoms	May provide adjunctive symptom organization
Follow-up	Can assist in documenting individualized symptoms
Patient education	Can complement broader counselling

This distinction is essential to maintain professional and ethical standards.

14. Patient Safety Considerations

Patient safety should remain the central principle of any integrated approach.

WHO's Primary Care Checklist includes emergency assessment, vital signs, relevant physical examination, medication review, preventive care and follow-up.[7] These components illustrate the importance of structured clinical encounters.

Similarly, the WHO Surgical Safety Checklist was developed to reduce errors and adverse events and to improve communication and teamwork in surgical care.[9,10]

The checklist approach has an important conceptual lesson for repertorial practice:

Structured processes reduce omissions.

A repertorial case sheet could therefore incorporate a safety section containing:

- vital signs,
- red-flag symptoms,
- relevant medications,
- allergies,
- investigations,

- referral status,
- provisional diagnosis,
- definitive diagnosis where established,
- repertorial analysis and
- follow-up outcome.

Such documentation would improve transparency and facilitate clinical audit.

15. Limitations

15.1 Subjectivity

Rubric selection can vary between practitioners.

15.2 Differences between repertories

Different repertories have different structures and remedy coverage.

15.3 Mechanical repertorization

Numerical ranking should not automatically determine prescribing.

15.4 Diagnostic limitations

Repertory cannot replace pathology, imaging, laboratory investigations or specialist assessment.

15.5 Surgical limitations

Acute surgical conditions may deteriorate rapidly. Any delay in definitive care can be harmful.

15.6 Evidence limitations

Evidence concerning the effectiveness of homoeopathic prescribing and individual repertorial methods is heterogeneous. Claims of clinical efficacy therefore require appropriately designed research.

16. Future Research

The following areas deserve investigation:

1. Inter-observer reliability of rubric selection.
2. Reproducibility of repertorization.
3. Comparison of different repertories in identical cases.
4. Digital versus manual repertorization.
5. Educational outcomes of structured repertorial training.
6. Patient-reported outcomes.
7. Quality-of-life assessment.
8. Longitudinal observational studies.
9. Documentation of referral patterns.
10. Safety outcomes in community-based practice.
11. Integration of repertory with standardized electronic case records.
12. Development of validated clinical outcome measures.

Future studies should distinguish between the **validity of repertorial reasoning** and the **clinical effectiveness of individual homoeopathic medicines**. These are separate research questions and should not be conflated.

17. Discussion

The repertory has historically been valued for its ability to organize complex symptomatology. In community-based practice, this characteristic may be particularly useful because patients often present with multiple complaints influenced by environmental, occupational, behavioural and psychosocial factors.

However, the repertory should not be viewed as a substitute for public-health principles.

A patient presenting with recurrent respiratory complaints may require environmental intervention. A patient with hypertension requires appropriate blood-pressure assessment and management. A patient with unexplained weight loss may require investigation. A patient with suspected malignancy requires appropriate diagnostic referral.

Repertorial analysis should operate within these clinical realities.

The situation is even more important in surgery.

Surgery involves time-sensitive decision-making. WHO identifies surgery and anaesthesia as essential components of comprehensive healthcare and emphasizes safe, timely access to surgical services.[8] The WHO Surgical Safety Checklist is based on the principle that standardized communication and safety checks can reduce avoidable errors.[9,10]

Consequently, repertory should not be positioned as an alternative to surgery when surgery is indicated.

Its potential role is better conceptualized as **adjunctive symptom analysis in appropriately selected cases**.

This distinction also has educational importance. Homoeopathic students should not be taught that repertorization is synonymous with diagnosis. They should instead learn to integrate:

clinical diagnosis + safety assessment + individualization + repertorial analysis + materia medica + outcome assessment.

Such an approach may produce practitioners who are more attentive to both individual symptoms and broader clinical responsibilities.

18. Proposed Integrated Model

The following model can be proposed for community and surgical homoeopathic practice:

A. Clinical Foundation

History → Examination → Diagnosis → Investigations

↓

B. Safety Foundation

Red flags → Emergency assessment → Referral

↓

C. Individualization

Location → Sensation → Modality → Concomitant → Causation → Chronology

↓

D. Repertorial Analysis

Rubric selection → Repertorization → Remedy differentiation

↓

E. Materia Medica Confirmation

Clinical correspondence → Remedy verification

↓

F. Integrated Care

Appropriate homoeopathic care + conventional treatment when indicated + preventive measures + referral

↓

G. Follow-up

Clinical outcome → Patient-reported outcome → Objective assessment → Reassessment

This model emphasizes that repertory is one component of a larger clinical process.

19. Conclusion

Repertory may have meaningful utility in community-based homoeopathic practice as a structured method of organizing individual symptoms and facilitating individualized case analysis. Its greatest potential may be seen in recurrent, chronic and non-emergency presentations where detailed symptom characterization can complement broader primary-care assessment.

In surgical practice, however, the role of repertory is necessarily limited and adjunctive. Diagnosis, emergency recognition, investigation, surgical consultation, anaesthetic assessment and definitive intervention must take precedence whenever indicated.

The clinically responsible position is therefore not to consider repertory as an alternative to community medicine or surgery, but as a **structured symptom-analysis tool operating within a comprehensive clinical framework**.

The proposed model—

Clinical Assessment → Safety Assessment → Individualization → Repertorization → Materia Medica Confirmation → Integrated Management → Follow-up

—may provide a useful framework for teaching and clinical documentation.

Future research should focus on reproducibility, reliability, clinical outcomes, patient safety and educational effectiveness. Such research may clarify the precise contribution of repertorial reasoning to contemporary homoeopathic clinical practice.

The ultimate utility of repertory should be measured not by the number of rubrics selected or the numerical score of a medicine, but by its contribution to **systematic observation, individualized clinical reasoning, appropriate referral, safe practice and meaningful patient-centred care**.

References

1. Hahnemann S. *Organon of Medicine*. 6th ed. New Delhi: B Jain Publishers.
2. Kent JT. *Repertory of the Homoeopathic Materia Medica*. New Delhi: B Jain Publishers.
3. Boenninghausen C von. *The Therapeutic Pocket Book*. New Delhi: B Jain Publishers.
4. Boger CM. *Boger-Boenninghausen's Characteristics and Repertory*. New Delhi: B Jain Publishers.
5. Boericke W. *Pocket Manual of Homoeopathic Materia Medica and Repertory*. New Delhi: B Jain Publishers.
6. Murphy R. *Homeopathic Medical Repertory*. 3rd ed. Pagosa Springs: Murphy Books; 2010.
7. World Health Organization. Primary Care Checklist. Geneva: World Health Organization; 2025.
8. World Health Organization. Surgical and Anaesthesia Care. Geneva: World Health Organization; 2026.
9. World Health Organization. *WHO Guidelines for Safe Surgery 2009: Safe Surgery Saves Lives*. Geneva: World Health Organization; 2009.
10. World Health Organization. *WHO Surgical Safety Checklist and Implementation Manual*. Geneva: World Health Organization; 2009.
11. Haynes AB, Weiser TG, Berry WR, Lipsitz SR, Breizat AH, Dellinger EP, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med*. 2009;360(5):491-499.
12. World Health Organization. Clinical Checklists. Geneva: World Health Organization; 2025.
13. World Health Organization. Safe Surgery Saves Lives. Geneva: World Health Organization.
14. World Health Organization. Surgical Safety Checklist: Adaptation Guide. Geneva: World Health Organization; 2025.
15. World Health Organization. Surgical Site Infection Prevention in the Primary Health Care Setting. Geneva: World Health Organization; 2023.
16. Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ*. 1996;312(7023):71-72.
17. Guyatt GH, Cairns J, Churchill D, Cook D, Haynes B, Hirsh J, et al. Evidence-based medicine: a new approach to teaching the practice of medicine. *JAMA*. 1992;268(17):2420-2425.

18. Starfield B. *Primary Care: Balancing Health Needs, Services, and Technology*. New York: Oxford University Press; 1998.
19. Donabedian A. The quality of care: how can it be assessed? *JAMA*. 1988;260(12):1743-1748.
20. Reason J. Human error: models and management. *BMJ*. 2000;320(7237):768-770.
21. World Health Organization. *Declaration of Alma-Ata*. Geneva: World Health Organization; 1978.
22. World Health Organization, UNICEF. *A Vision for Primary Health Care in the 21st Century: Towards Universal Health Coverage and the Sustainable Development Goals*. Geneva: World Health Organization; 2018.
23. World Health Organization. *Declaration of Astana*. Geneva: World Health Organization; 2018.
24. Hahnemann S. *The Chronic Diseases: Their Peculiar Nature and Their Homoeopathic Cure*. New Delhi: B Jain Publishers.
25. Kent JT. *Lectures on Homoeopathic Materia Medica*. New Delhi: B Jain Publishers.
26. Clarke JH. *A Dictionary of Practical Materia Medica*. New Delhi: B Jain Publishers.
27. Allen TF. *The Encyclopedia of Pure Materia Medica*. New Delhi: B Jain Publishers.
28. Close S. *The Genius of Homoeopathy: Lectures and Essays on Homoeopathic Philosophy*. New Delhi: B Jain Publishers.
29. Roberts HA. *The Principles and Art of Cure by Homoeopathy*. New Delhi: B Jain Publishers.
30. Vithoulkas G. *The Science of Homoeopathy*. New York: Grove Press; 1980.
31. World Health Organization. *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*. Geneva: World Health Organization; 2019.
32. World Health Organization. *Quality of Care: A Process for Making Strategic Choices in Health Systems*. Geneva: World Health Organization; 2006.
33. World Health Organization. *Medication Without Harm: Global Patient Safety Challenge*. Geneva: World Health Organization; 2017.
34. World Health Organization. *Global Patient Safety Action Plan 2021-2030*. Geneva: World Health Organization; 2021.
35. World Health Organization. *Global Patient Safety Report 2024*. Geneva: World Health Organization; 2024.
36. World Health Organization. *Hand Hygiene in Health Care: A Summary*. Geneva: World Health Organization.
37. World Health Organization. *WHO Guidelines on Hand Hygiene in Health Care*. Geneva: World Health Organization; 2009.
38. World Health Organization. *Integrated People-Centred Health Services*. Geneva: World Health Organization.