The continued development of training courses for Anthroposophic Medicine and the "WHO Benchmarks for Training in Anthroposophic Medicine"

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Last update: 04.02.2022

Abstract

The World Health Organization (WHO) will soon publish for the first time training standards for Anthroposophic Medicine, the "WHO Benchmarks for Training in Anthroposophic Medicine". This publication is the result of four years of thematic collaboration between the Medical Section at the Goetheanum, the International Federation of Anthroposophical Medical Associations (IVAA) and WHO. The publication reflects the current state of anthroposophic training, including some of the changes that have taken place in recent years through the Medical Section's International Coordination of Anthroposophic Medicine, in collaboration with anthroposophic professional associations.

In this article, we outline how the WHO collaboration came about, the process of establishing the WHO Benchmarks, and the most important changes in training curricula. We also provide a short background on the functioning of WHO and an outlook on how these WHO Benchmarks can be used in the coming years to achieve better, legal recognition of anthroposophical training at the national level.

Introduction

Training in Anthroposophic Medicine (AM), for physicians and for the various professional groups, has grown progressively over the last 100 years. In the first decades, training usually took place informally by working at one of the anthroposophical hospitals. Only over time have training courses been developed which have gone through a certification process and which teach a shared and agreed upon core curriculum; for some professional groups that process has only actually happened in recent years. This development was decisively driven by the International Coordination of Anthroposophic Medicine (IKAM) established by Michaela Glöckler (Head of the Medical Section at the Goetheanum 1988 – 2016) at the beginning of the twenty-first century. Early, structured trainings included, for example, eurythmy therapy (which requires a basic training in Eurythmy) and training in Rhythmical Massage Therapy. An important impulse in the growth and increasing internationalisation of AM over the last three decades was the International Postgraduate Medical Training (IPMT), started in 2002, which is connected to the Medical Section at the Goetheanum and for the first time introduced training that spanned national borders and often offered interprofessional learning.

In recent years there have been some important further developments in the training courses which occurred partly before and partly in parallel with the preparation of the World Health Organization (WHO) training standards for Anthroposophic Medicine, the "WHO Benchmarks for Training in Anthroposophic Medicine" (1). This present article presents the process of preparing the WHO Benchmarks and the most important changes in training

curricula. We also provide background information, for guidance, on the way WHO works and an outlook as to how these WHO Benchmarks can be used to work towards better legal recognition of anthroposophical training courses at national level in the coming years.

History of the WHO process

When the Dachverband Anthroposophische Medizin in Germany (DAMiD) and the US Academy of Integrative Health and Medicine organised an international congress on integrative medicine in Stuttgart in 2016 (2), we succeeded in getting Dr Zhang Qi, the WHO coordinator for traditional, complementary and integrative medicine (TCI), as a speaker. Dr Zhang was not previously familiar with AM and, like many other visitors to the congress, was deeply impressed by a tour of the Filderklinik hospital. This led to a discussion about a possible collaboration and Dr Zhang proposed drawing up training standards for AM. As early as 2010, WHO had published training standards (WHO Benchmarks for Training) for traditional Chinese medicine, Ayurveda, Tuina, Nuad Thai, Unani, Osteopathy and Naturopathy (at that time with the technical and financial support of the local government of Lombardy, Italy). In 2021, the "WHO Benchmarks for Training in Acupuncture" were published; "WHO Benchmarks for Training in Yoga" are in preparation.

Drawing up WHO training standards for AM appeared from the outset to be an important strategic opportunity for the Medical Section of the School of Spiritual Science at the Goetheanum/Switzerland and the International Federation of Anthroposophic Medical Associations (IVAA), in order to better to secure the recognition of AM training at national level and support the status of AM as a whole.

The WHO process for developing the WHO Benchmarks

In preliminary discussions in Geneva between Dr Zhang Qi from WHO, the Medical Section and the IVAA, it was important for WHO that an official presence of AM in several countries could be documented (3). Only in this way did WHO, as an international organisation, have the authority to develop international standards for AM. Questions were also asked about how AM differs from other traditional medical systems. From our side – Medical Section and IVAA – it was a precondition that we should be able to include all medical professional groups of AM in the document; this was affirmed by WHO after we were able to explain the practice of AM. Representatives of anthroposophical special needs education and social therapy did not wish to be included with their training standards in a medical document; this would also have been difficult for the WHO to reconcile with its mandate for health, not education.

In September 2017, the IVAA signed a project cooperation agreement with the WHO, including a timeframe and budget. The IVAA agreed to bear a large part of the costs and received the generous support of a foundation. Further below we discuss why the WHO, as a governmental organisation, cannot bear such costs itself although this would be important for its own independence.

At the suggestion of the Medical Section and the IVAA, WHO then appointed two anthroposophical physicians with considerable previous experience in working with the

WHO and governments, Iracema Benevides and Tido von Schoen-Angerer, to prepare the first draft of the document on behalf of WHO. WHO input was limited to a basic structure and approximate length of the document. The first draft was then prepared by the two authors, with significant participation of the Medical Section with its coordinators for the various professional groups and other anthroposophical experts. In addition to drafting the texts for the training courses, there was also intensive work on creating an appropriate presentation of the historical background, the basic concepts of AM and the definition of anthroposophical technical terms, for example for the constitutional elements of the human organism, which in the context of this document had to be brief but as specific as possible. The detailed internal consultations in this regard led to some new agreements on the English language terminology on basic anthroposophical concepts – such as the term "formative forces of the human being" for "Wesensglieder" – which should be helpful in internal and external communication in the years to come.

Following an initial editorial review by the WHO, the text was discussed in depth at a specially convened WHO Working Group Meeting in December 2018. The meeting was hosted by the Havelhöhe Community Hospital in Berlin, with representatives from the WHO, AM and its professional groups, experts from other systems of medicine (Traditional Chinese Medicine, Ayurveda, Homoeopathy, Naturopathy) and scientists and government representatives involved with TCI (the list of participants can be found at the end of the WHO Benchmarks). Participants from all continents were represented. This meeting led to a significant restructuring of the text and other far-reaching changes which were subsequently implemented by Tido von Schoen-Angerer on behalf of WHO. Two Global Reviews were conducted in 2019 and 2020, in which WHO requested expert reviews from around 200 experts. In total, both reviews produced dozens of expert opinions each, including many from anthroposophic experts; the expert opinions were each time incorporated into the text by Tido von Schoen-Angerer. In November 2020, a WHO Expert Consultation took place, attended exclusively by WHO representatives and anthroposophic experts, in order to agree on and finalise the document on a technical level. After that, no more changes were made to the content; the document still underwent a final editorial process, WHO forewords were prepared and the document was signed off within the WHO organization hierarchy.

Within AM, in addition to the collaboration with the above-mentioned bodies, an account has been given each year since 2016 to the boards of the anthroposophic medical associations, i.e. the 38 national member associations of the IVAA.

During the process described above, the WHO TCI team showed great, sympathetic interest in AM and complete respect for its content. The process led to a deeper understanding of AM, at least within the small TCI team. Within AM, the WHO process has been a significant stimulus to improve the coherence of the entirety of AM training courses and to modernise them where necessary. We found the constructive peer review by high-ranking representatives of other medical systems, such as Traditional Chinese Medicine, Ayurveda, etc., as well as by scientists and government representatives involved with TCI, particularly helpful.

What the WHO Benchmarks are and what they are not

The WHO Benchmarks represent the minimum requirements for AM training courses and serve as a reference for countries wishing to evaluate and recognize AM training courses in order to ensure qualified practice; countries are not, however, obliged to implement them. The WHO Benchmarks are further intended to the promote safe practice of AM through consideration of contraindications and minimizing the risk of adverse events (1).

The WHO Benchmarks reflect the position of the training standards recommended by the Medical Section; the WHO does not establish new standards for AM that were not first established by the AM community itself. Any still outstanding adjustments in national training courses therefore relate exclusively to the implementation of the training guidelines of the Medical Section and the relevant professional associations and are not a new requirement of WHO. The WHO Benchmarks describe the entry criteria for the training courses, core training content and training duration; specific curriculums with hours allocated are attached to the document and are intended as examples. This means that the document will remain accurate even if the anthroposophical professional associations want to make changes and reallocate hours in curriculums.

The WHO Benchmarks do not imply WHO recognition of AM ; such a recognition process for TCI systems does not exist in the WHO. The WHO has established the Benchmarks because it considers AM to be an internationally relevant TCI system and, in accordance with its strategy, to provide guidance on the appropriate regulation of TCI training. With this document, WHO does not express any opinion on the effectiveness of AM and does not make any recommendation on its use. This does not detract from the value of the WHO Benchmarks, whose significance is better brought to bear through appropriate presentation than over-interpretation. *Legal recognition of AM training courses can only take place at national level*.

The WHO will not accredit AM training courses or centers; that is not its role. The accreditation of training courses will continue to be carried out at an anthroposophical level on the basis of the relevant handbooks, in a process recognized by the Medical Section. In those countries where a training is also recognised by the appropriate authorities, the training courses can additionally be accredited by these authorities. *However, training courses can state that they are being held in accordance with the WHO training standards for AM*. It should be noted that publication of the WHO Benchmarks does not create any rights to use of the WHO logo. We therefore advise replicating the entire front page of the WHO Benchmarks for making any references or copies, if needed.

The further development of training programs in Anthroposophic Medicine

The WHO process prompted IKAM to conduct an internal review of AM training courses and their curriculums, some of which were at different stages of development. At the beginning of the WHO process, for example, there was not yet an international curriculum for physician training, although this had long existed for other professional groups. The international curriculum for Anthroposophic Arts Therapy had already been formulated in an

exemplary and modern way in earlier years, in line with the core competences to be acquired, while other curricula still consisted of long lists of training content.

Here we give an overview, in bullet points, of the most important changes in the training curriculums, some of which took place before and some during the WHO process:

Relating to all training courses:

- Competences are formulated as training objectives and as evaluation parameters for all professional groups. Training content, on the other hand, is listed in sample curriculums.
- A subdivision of the training courses into general themes was made for all professional groups, in order to enable a better overview and facilitate comparison between the professional groups (see table at the end of the article).
- The calculation of training periods includes both contact time, as well as self-study, as has been common practice in university training for some time. For several professional groups this resulted in an apparent increase in training periods; in fact, however, their length had previously been understated. The ratio of contact time to self-study is 1:1 for the physician training, but this may be distributed differently for other professional groups (there are no international guidelines for this).
- The preparation of case reports for the final examination is now required for all professional groups.
- For all training courses, entry criteria have been established for professional groups from other TCI systems (e.g. doctor of Traditional Chinese Medicine, naturopathic Doctor) and the way they can obtain anthroposophic training titles. This question had already come up several times at IPMTs and was raised by representatives of other TCI systems and the WHO during the WHO Working Group Meeting.
- Despite the harmonisation of content and competencies mentioned above, there continues to be a historically-grown heterogeneity of training, which is reflected in the quite different length of training courses, among other things.

Specific to the professional groups:

- Physicians: an international core curriculum was developed in 2017 and adopted by the Conference of Councils of Anthroposophic Medical Associations (4) and has already been implemented internationally.
- Nursing: apart from the changes affecting all professional groups, there were only certain linguistic adjustments and tidying up for the WHO Benchmarks.
- Midwifery: an international curriculum was formulated for the first time, in relatively close alignment with nursing training.
- Pharmacists: the documents adopted in 2010 and 2016 by the International Association of Anthroposophic Pharmacists on training in Anthroposophic Pharmacy (5, 6) underwent only a few clarifications and minor changes in the WHO process.
- Dentists: an international curriculum was drawn up for the first time, based essentially on the established training courses in Germany and Brazil.
- Psychotherapy: internationally, the state regulations regarding requirements for admission criteria, training content, and objectives leading to professional authorisation and the use of the title "psychotherapist", differ considerably. This was

acknowledged in an extensive coordination processes which took place within the umbrella organisation "International Federation of Anthroposophic Psychotherapy Associations". Ultimately, it was possible to draw up a binding curriculum for further training in anthroposophic psychotherapy.

- Eurythmy Therapy: this training is currently being further developed. While the basic training in general Eurythmy continues to be the prerequisite for admission to Eurythmy Therapy training, on the initiative of the Medical Section there is an independent pilot course which combines the study of general Eurythmy and Eurythmy Therapy from the outset. The WHO Benchmarks do not stand in the way of such innovations.
- Anthroposophic Arts Therapies: apart from the changes affecting all professional groups, there were only certain linguistic adjustments and tidying up for the WHO Benchmarks.
- Anthroposophic Body Therapy: even before the WHO process, it was laid down in recent years that Anthroposophic Body Therapy require prior para-medical training with authorisation to work with patients (such as physiotherapy) as there are currently no stand-alone training courses for Anthroposophic Body Therapy (the possibility of future stand-alone training is mentioned in the WHO Benchmarks). The body therapies recognised so far by the Medical Section and mentioned in the WHO Benchmarks are: Rhythmical Massage Therapy, Simeon Pressel Massage Therapy, Oil Dispersion Bath Therapy and Spacial Dynamics.

Background on the World Health Organisation

WHO has often been criticised in the course of the Covid-19 pandemic; in certain circles, even among individuals in AM, a real opposition has developed. Without discussing these points of criticism here, it seems appropriate to consider the general functioning of the WHO as part of the background for collaboration between the WHO and representatives of AM, which seems justified to us.

WHO consists of the World Health Assembly, the WHO Executive Board and the WHO Secretariat with its headquarters in Geneva and its six regional offices. Founded in 1948 as a sub-organisation of the UN, the organisation has both a medical-political and a medical-technical character and it is important to understand the interplay of these factors (7).

Political aspects of the WHO:

- The health ministries of the member states determine the direction of WHO and its priorities through the annual World Health Assembly in Geneva and through their rotating membership of the WHO Executive Board.
- Member states can additionally try to influence WHO's work by supporting experts from their own country to be appointed to senior WHO positions.
- The WHO Director-General and the WHO Secretariat have only limited power because they are the executive body of the member states:
  - WHO can make recommendations, but it is up to member states to implement them. Influencing member states, for example to improve tuberculosis treatment in a country, always has to be done with a lot of diplomatic skill. WHO cannot afford to

publicly criticise important member states such as China, USA, Germany, etc.
    - Only in the case of the rarely applicable International Health Regulations does WHO have the possibility to issue legally binding health measures. In the case of Covid-19, the International Health Regulations Emergency Committee has so far only issued temporary recommendations. (Example of a recommendation of 21 April 2021: "Do not require proof of vaccination as a condition of entry, given the limited (although growing) evidence about the performance of vaccines in reducing transmission and the persistent inequity in the global vaccine distribution. (8))
- The problematic funding situation of WHO creates a considerable imbalance and undue influence of individual governments and foundations:
    - The "assessed contributions" by member states, i.e. the regular membership fees, have not been raised for many years due to a lack of consensus among the member states and have also not been adjusted to take account of the increased gross national product of middle-income countries. On the one hand, member states are constantly assigning new tasks to WHO, but on the other hand, their regular contributions only finance less than 20% of the WHO's total budget (9).
    - Governments and foundations can make "voluntary contributions"; the largest came in 2019 from the US ($334 million), the Bill & Melinda Gates Foundation ($226 million), the United Kingdom ($215 million) and Germany ($143 million) (10). Ninety percent of these voluntary contributions are earmarked for specific programmes and therefore allow the donor to advance their own priorities within the internationally agreed strategies and to influence the design of WHO programmes to a certain extent. The extent of funding and thus the influence of the Bill & Melinda Gates Foundation are of particular concern. Before Covid-19, 61% of the Gates funding to WHO went to polio eradication, 9% to reproductive health and 5% to vaccine-preventable diseases (11). Sufficient funding through regular contributions from member states is urgently needed to prevent dependence on individual donors.
- Industry and civil society
    - Funding by industry-related foundations or by the pharmaceutical industry is low (less than 0.01% of the total budget per foundation/industry). The pharmaceutical industry, like accredited civil society organisations, can participate in the World Health Assembly but has no decision-making power (unlike, for example, at the vaccine alliance GAVI). Often it is the delegations of rich member states that represent industry interests and sometimes even have industry lobbyists in their delegations. Overall, WHO is strongly concerned to maintain sufficient distance from industry: the pioneering and still active programme of the "Essential Medicines List" could only be established in the 1970s against considerable resistance from industry (and industrialised nations) (12).
    - Non-governmental organisations can have a significant impact through relevant advocacy on issues of public interest. An historical example is the devastating impact of baby milk formula marketing in poor countries in the 1970s, which could be stopped by non-governmental organisations in cooperation with WHO (13).

Technical-medical aspects of WHO:

- WHO is the only internationally recognised organisation for "setting norms and standards" in medicine.

- A significant proportion of the WHO Secretariat is staffed by medical doctors and other experts; these are often recognised international experts in their field from national health programmes or academia.
- WHO guidelines and other directives are produced through elaborate evidence based reviews and by expert panels selected according to established criteria. A WHO recommendation is therefore not an "opinion" of the WHO, but reflects the consensus of the world's leading experts. The example of this process was also used in the creation of the WHO Benchmarks for AM: WHO guaranteed a rigorous process, the content itself was determined by the anthroposophic experts. However, the tendency resulting from these procedures is often for conservative recommendations and slow processes.

All in all, the WHO is a highly complex entity where many different interests vie for influence and to have a say, but where leading medical expertise is also assembled; the "single" WHO does not exist. For all its strengths and weaknesses, WHO is the only place for global agreement, priority-setting and standard-setting in medicine.

The role of Traditional, Complementary and Integrative Medicine in WHO

The WHO unit working on Traditional, Complementary and Integrative Medicine (TCI) is small and relatively insignificant within the organisation. Nevertheless, it has a longer history and is politically important for many member states.

Shortly after the founding of the WHO in 1948, the first Assistant Director General, Dr Pierre Derolle, commissioned the ethno-anthropological study of traditional medicine in poorer member states. The aim was to avoid a traumatic transition from traditional practices to modern medicine and to achieve a certain harmony and integration among the approaches (14). In addition, China's important political role and India's new independence lent importance to traditional medicine at the time when the WHO was established. In the course of decolonisation, from the 1960s onwards, a number of African countries also emphasised the importance of traditional medicine, some of whom founded national institutes for traditional medicine and phytotherapy (14).

Immediately after his appointment in May 1973, Dr Halfdan Mahler, the most influential WHO Director-General to date (1973 – 1988), announced his intention to integrate traditional medicine (14). In 1976, WHO established a special programme on traditional medicine as a precursor to the current work unit. In the popular Alma-Ata Declaration on Primary Health Care of 1978, traditional medicine is explicitly mentioned – also because it was realised that universal access to health care required the help of traditional medicine.

As early as January 1973, the WHO Executive Board had considered adding a spiritual dimension to the definition of health; this was raised again by Muslim countries in 1980 but was blocked by the Soviet Union (with the support of the former German Democratic Republic) (15, 16).

The current work on TCI is defined by the "WHO Traditional Medicine Strategy 2014-2023" with its three main objectives: (1) To build the knowledge base for active management of TCI

through appropriate national policies; (2) To strengthen the quality assurance, safety, proper use and effectiveness of TCI by regulating products, practices and practitioners; (3) To promote universal health coverage by integrating TCI services into health care service delivery and self-care. The WHO's work on TCI is largely funded by voluntary contributions from China (the corresponding WHO coordinator is Chinese, like his predecessor); individual activities, such as the creation of the WHO Benchmarks for AM, require additional funding.

Outlook and next steps

The publication of the WHO Benchmarks for Trainings in Anthroposophic Medicine is an important milestone and provides a unique opportunity to obtain recognition of AM trainings at national level in the next two to three years. Even in countries where AM is currently under fierce attack, the WHO Benchmarks can help improve the status and acceptance of AM. One does not have to agree with all WHO activities to recognise the strategic value of the WHO Benchmarks for AM. This is all the more so because AM did not have to adapt or change its content in any way in developing the WHO Benchmarks.

A state recognition is not an end in itself because AM does not derive its justification and goal from external recognition. However, the continued existence of AM with its anthroposophic hospitals, practices, medicines and therapies can only be secured in the present time if AM remains in discussion and cooperation with "official medicine" and can gain official recognition at a national level for its trainings, medicines and therapies. The importance of the recognition of training is even more significant for therapists than for doctors: the status of eurythmy therapists, for example, is completely unsecured legally and financially in almost all countries. A positive example of recognition is Switzerland: AM physician training is recognised by the Swiss Medical Association; specific anthroposophic medical services provided by physicians as well as medications are covered by basic insurance; the Eurythmy Therapy training, for example, leads to a Swiss federal diploma in complementary medicine, and Eurythmy Therapy is reimbursed by complementary insurances. Artistic therapists may obtain a federal professional diploma by passing the Higher Professional Examination.

The publication of the WHO Benchmarks does not mean that national recognition will happen by itself: the real work is now beginning for the AM community. Many countries will not even take note of the WHO Benchmarks; neither are they obliged in any way to implement the standards. It therefore lies solely in our hands to seek specific contact with professional associations, ministries of health, etc. to familiarise them with the WHO Benchmarks and to work towards cooperation in their implementation. A good example of this comes from the osteopaths, who were able to gain official recognition in several countries after the publication of the "WHO Benchmarks for Training in Osteopathy" in 2010. The IVAA is already in discussion with all its members, i.e. the national anthroposophic medical associations, in this regard in order to develop a strategy adapted to each country and is offering assistance for the upcoming cooperation with decision-makers from politics, professional associations and others. As the WHO Benchmarks affect all AM professional groups, a joint and coordinated approach by the different professional groups in each country is particularly important. Furthermore, in many countries it will not be possible to obtain recognition of AM training courses by going it alone but it might be more effective to

work towards recognised qualifications in integrative medicine (specialising in AM, as well as other TCI systems) in cooperation with representatives of other TCI systems.

For the table "Distribution of training hours / Comparison between the professional groups" click here.

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