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CONTENTS

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Large Homoeoprophylaxis Interventions by Government Institutions

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Abstract

Introduction: Previous studies have identified the use of large homoeoprophylaxis (HP) programs. The primary purpose of this article is to update previous figures, to re-analyse the new dataset and show the "official" use of HP by Government-associated authorities.

A new method for measuring the effectiveness of HP interventions is proposed.

Methods: Using two previous analyses as a starting point, data was re-analysed to show the use and effectiveness of HP in Government-associated interventions in three countries. Data was also assembled to determine objective and subjective measures of HP effectiveness.

Results: Thirty annual HP interventions were noted in India, Cuba and Brazil. When counted by person, by disease, and by year, over 250 million people were covered by the interventions studied. The effectiveness of HP appears to range between 63% and 99% with a weighted average around 88%. These results are consistent across endemic and epidemic use.

Discussion: HP is used to prevent targeted diseases in large and small populations. Its use is often directed by government agencies and conducted by medical doctors and scientists. HP is potentially valuable, especially in situations where vaccination is not possible either due to there being no vaccine for the disease, or when an existing vaccine cannot be obtained either in sufficient quantities or in time to treat an outbreak. However, it also has potential value in all other situations where disease-prevention is required.

Conclusion: There are proven benefits from the widespread use of appropriate HP interventions, including saving lives and preventing suffering. HP can provide governments a very economical and practical option to combat infectious diseases in both endemic and epidemic situations.

Keywords: homoeoprophylaxis, epidemic, endemic, immunisation, effectiveness

Conflict of Interest: The author declares that he consults parents regarding immunisation options, including homoeoprophylaxis.

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Introduction

An article by the author in *Similia* in 2018 quantified the use of homoeoprophylaxis (HP) in three countries in 91,956,110 people on an annualised basis (i.e. by person, by disease, per year).[1]

One purpose of this article is to update this figure, and also to re-analyse new data in order to illustrate the "official" use of HP by Government-associated authorities in three countries. Whilst the evidentiary base of both homoeopathic treatment and prevention is steadily growing, it is hoped that evidence produced as a consequence of Government-associated interventions, and undertaken mainly by orthodox practitioners, will be more readily accepted by orthodox authorities in other countries.

Further, a new analysis of how to measure the effectiveness of HP interventions is introduced, given that standard meta-analysis techniques are not applicable in situations where different interventions are dissimilar both in the methodology of the intervention and in the measurement methods used.

This analysis does not (and in fact cannot) quantify every HP intervention because many are undertaken in emergencies which require an immediate practical remedy distribution, and where meticulous pre-planning and highly organised record-keeping are secondary to saving lives and suffering. [2]. Instead it provides a guide to the growing evidence base supporting HP.

Methods

An analysis published in the *American Journal of Homeopathic Medicine* (AJHM) in 2019 documented the use of HP in over 250 million people on an annualised basis in three countries. [3] This data was used as the starting point for this study but was adjusted to include only Government-associated interventions.

The AJHM study included significant new information about the use of HP to provide protection against Japanese Encephalitis (JE) and Acute Encephalitis Syndrome (AES) in Andhra Pradesh and Telangana States. Because this intervention is the largest documented, it was studied carefully to ensure the accuracy of the data.

An extension to the previous JE program was identified, and data concerning JE and AES from 1997 to 2017 was obtained from a variety of relevant sources.[4] Confounding factors were recognised: (1) in July 2014 Andhra Pradesh was separated into two states, with a new state Telangana being formed. Hence the data series had to accommodate this change; (2) data regarding JE and AES was originally combined but has been shown separately in government data from 2008 onwards. Some AES cases are caused by JE and some are not, making data classification difficult.[5] However, since HP is based on the *Principle of Similars*, and the symptoms of JE are similar to AES, the HP program against JE would have some benefit against AES because of this similarity. In order to provide as much consistency in the data trends as possible, the data for JE and AES was combined, as were the results for Andhra Pradesh and Telangana States. Detailed analysis was presented in the AJHM article [3].

A new method of combining measures of effectiveness was proposed, and Tables of results assembled for consideration.

Results

The numbers covered by the HP interventions in three countries in the above-mentioned articles are summarised in Table 1. Many more examples of HP interventions both in these and in other countries exist.[6]

Intervention programs are counted both by type of program and by years. For example, the largest single HP intervention against JE (noted above) was recorded as a single program under "type" but as running over 11 years in the AJHM analysis.

Table 1: Interventions by Person, by Year and by Disease

Country	Similia Analysis - 2018			AJHM Analysis – 2019		
	Programs by Type	Years	Doses by Person, by Year and by Disease	Programs by Type	Years *	Doses by Person, by Year and by Disease
Cuba	5	7	25,520,000	5	6	25,020,000
India	6	10	65,364,071	5	17	224,717,386
Brazil	5	7	1,072,039	3	8	857,399
	16	**24**	**91,956,110**	**13**	**31**	**250,594,785**

* each individual year of each program is shown. For example, the final Brazilian program which ran from 2007 to 2012 is counted as 6 years.

The quality of analyses of the HP interventions listed is variable. Some interventions were controlled, but none were randomised. Sometimes *Nosodes* (N) (homoeopathic preparations from diseased material) were used, and sometimes *Genus Epidemicus* remedies (GE) (homoeopathic preparations of remedies used to treat the targeted disease). Single remedies or groups of remedies were used.

Further, methods used to measure the effectiveness of results were variable. Table 2 shows the classification scheme used by the author in Table 3 to provide readers with a guide to the methodology used in each intervention, and how effectiveness was assessed when no percentage calculation was available.

Table 2: Classification of Effectiveness

Code	Description
Statistical Method (Type)	
A	Direct control group
B	Indirect control group [7]
C	Simple % of cohort protected
D	Historical trend of actual reports
E	Fall factor analysis [8]
F	No control or historical trend
Descriptive Assessment	
G	Clear and strong positive result
H	Somewhat positive result
I	Unclear result
J	Somewhat negative result
K	Clear and strong negative result
L	Results not yet published

Data in Table 3 is taken from data reported in articles [1] and [3] noted above but amended to show only those interventions that were directed by Government-associated agencies and undertaken by Government-accredited Institutes or Universities.

Table 3: Major HP Interventions by Government Agencies in Three Countries

Year	Disease	Numbers	Government directed	Remedy ***	Type	Effectiveness
	CUBA[9][9]	**25,020,000**				
2007	Leptospirosis	2.2 million	Finlay Institute	N	B	H
2007	Hepatitis A	1 million	Finlay Institute	N	D	I
2008	Leptospirosis	2.2 million	Finlay Institute	N	B	G
2009	Dengue Fever	20,000	Finlay Institute	N, GE	A	74.1% - 100.0%
2010	Swine Flu	9.8 million	Finlay Institute	N	D	I
2010	Pneumococcal	9.8 million	Finlay Institute	N	D	G
	INDIA	**224,717,386**				
1989 1991 1993	Japanese Encephalitis[10]	322,812 persons 39,250 follow up	CCRH	GE	C	99.96%
1996	Dengue[11]	> 39,200. Follow up 23,520	CCRH	GE	C	99.97%
1999 - 2009	Japanese encephalitis[12]	20,000,000 per annum 14 years and younger	Government Department of Indian Medicine and Homoeopathy.	GE+N+ Const.	B	G
2007	Epidemic fever[13]	Distributed to 1,855,374 In 8 wards.	Kerala government's RAECH program. Average intake 58.86% 6,602 surveyed.	GE	A C	63.9% 73.83%
2012	Dengue[14]	2,500,000	Medical and Health Department, Chittorr.	GE	Not known	L
	BRAZIL	**857,399**				
1998	Meningococcal[15]	65,826 HP 23,532 not HP	Government-funded study, conducted by two Professors of Medicine from the Uni Foundation in Blumenau, Brazil, and a Blumenau specialist physician and Health City Secretary.	N	A	95% 6 mths to 91% 12 mths
2007	Dengue[16]	156,000 people 216,000 doses **	Secretary of Health of the municipality of Macaé, Rio de Janeiro,	GE comp. 1 – 2 doses	B	86.7% Inferred rate
2007–2012	Dengue[17]	Doses * 2007: 216,000; 2008: 203,878; 2009: 211,059; 2010: 178 677; 2011: 150,682; 2012: 125,621.	Secretary of Health the municipality of Macaé, Rio de Janeiro,	GE comp.	B	89.4% inferred rate

* The number of persons who used HP in the five years from 2008 to 2012 is estimated to be 628,273 using the ratio of doses to people shown in the 2007 intervention [16]

** Also shown in following reference [17]

*** Const. = Constitutional Remedy; Comp. = Complex Remedy

If further details of each intervention are required then they are available in the earlier analyses noted above [1], [3].

Measurement of HP Effectiveness

The lack of homogeneity of studies as well as the variable quality of analyses makes a reliable meta-analysis of data problematical. There is some consistency among reports of the seven interventions which quantified effectiveness (ranging between 63.9% to 99.96%), but the question of how to summarise the overall effectiveness of these and the non-quantified interventions remains.

A two-stage analysis is suggested to determine effectiveness when a meta-analysis is not viable.

Stage 1 – For interventions where a percentage figure for effectiveness is available:

Calculate the following - (1) A simple average of the effectiveness percentages; (2) A simple average after removing the highest and lowest readings (sometimes an average figure can be distorted by either a very high or a very low reading); (3) A simple weighted average (to take into account the various sizes of the different interventions); (4) A weighted average excluding the highest and lowest readings; (5) A weighted average using numbers of participants followed-up instead of numbers participating in an intervention (where materially different); and (6) An average of the averages.

Table 4 summarises these six measures of effectiveness in the seven HP studies where a percentage figure was available. The calculations are shown in Table 5. The average-of-the-averages suggests an **average effectiveness of 86.15%** based on an average cohort size of 1,900,053 persons.

Table 4: Measures of HP Effectiveness

#	Measure	Numbers	%
1	Simple average of effectiveness percentages	3,087,485	86.43
2	Simple average less highest and lowest readings	1,192,911	88.23
3	Weighted average of effectiveness percentages	3,087,485	75.11
4	Weighted average less highest and lowest readings	1,192,911	91.74
5	Weighted average using followed-up numbers	939,471	89.26
6	**Averages**	**1,900,053**	**86.15**

Table 5: Data Used in Weighted Average Calculations

	Results	Total Numbers		Excluding Highest and Lowest		Participants Followed-up	
Interventions	%	#	%	#	%	#	%
2009 Finlay	74.1	20,000	0.48	20,000	1.24	20,000	1.58
1989-01 CCRH JE	99.96	322,812	10.45	322,812	27.05	**39,250**	4.18
1996 CCRH Dengue	99.97	39,200	1.27			**23,520**	2.50
2007 RAECH Ep Fev	63.9	1,855,374	38.40			**6,602**	0.45
1998 Govt Mening	91.0	65,826	1.94	65,826	5.02	65,826	6.38
2007 Macae Dengue	86.7	156,000	4.38	156,000	11.34	156,000	14.40
2008-12 Macae	89.4	**628,273**	18.19	**628,273**	47.08	**628,273**	59.79
		3,087,485	**75.11**	**1,192,911**	**91.74**	**939,471**	**89.26**

Stage 2 - For interventions where no percentage figure for effectiveness is available:

Of the seven interventions shown in Table 3 where a percentage figure was not available to measure effectiveness, there were four where the descriptive results allowed classification, one intervention where analysis had not been completed, and two where the results were unclear. Descriptive classifications of effectiveness were shown in Table 3 using the classifications shown in Table 2. It is now proposed to assign a percentage measure of effectiveness to each descriptive classification to enable a subjective comparison to be made with the quantified measures. This is shown in Table 6.

Table 6: Effectiveness Measures for Non-Statistical Effectiveness Results

Code	Description of Results	#	People	Assigned Measure
G	Clear and strong positive result	3	232,000,000	81-100%
H	Somewhat positive result	1	2,200,000	61-80%
I	Unclear result	2	10,800,000	-
J	Negative result	0	0	41-60%
K	Clear and strong negative result	0	0	0-40%
L	Results not yet published	1	2,500,000	-

The average effectiveness using this approach is **86.25%** using a simple average or **89.85%** using a weighted average (which is heavily dependent on the highly successful intervention against Japanese Encephalitis in India). However, these figures are similar to the average figure determined under Stage 1 of **86.15%.**

Table 7 summarises the Government-associated interventions in this analysis. The numbers are somewhat less than the 250,609,145 found in the full 2019 AJHM analysis, but are significant. Measures of effectiveness range between **63.9% to 99.96%,** and the average effectiveness as measured by the Two-Stage analysis shown above ranges between **86% to 90%.**

Table 7: Summary of Government-associated HP Interventions by Person, by Year and by Disease

Country	Programs by Type	Years *	Persons Annualised
Cuba	5	6	25,020,000
India	5	17	224,717,386
Brazil	2	7	850,099
	12	**30**	**250,587,485**

* each individual year of each program is shown. For example, the Indian JE program which ran from 1999 to 2009 is counted as 11 years.

Discussion

The first part of this analysis has quantified the annualised use of HP by Government-associated institutions in three countries in over 250 million people. There has been no attempt to identify every HP intervention is these countries, nor in other countries internationally. In fact, such identification would not be possible because most HP interventions occur in rapid-onset epidemic situations. They are not academic exercises, but real-world interventions to save lives and suffering, and detailed data recording is not always possible due to a lack of resources and the need for immediate action.

However, the extensive use of HP by Government-associated institutions that has been quantified should put to rest claims that HP is only used in marginal numbers by fringe practitioners.

The measurements of the levels of effectiveness attempted above are novel, and thus open to criticism and improvement. Given that most HP interventions are not pre-determined trials there will always be challenges with how to measure effectiveness. Standard meta-analysis techniques are not possible due to the heterogeneity of the different interventions, which is why a Two-Stage method is proposed involving collecting a series of differing averages and then striking an average of those measurements, or subjectively ranking unquantified results and assigning a percentage weighting to each. The resulting average figure of **86.15% to 89.85% effectiveness** appears to provide a realistic summary of the interventions studied.

This figure is similar to the author's experience from 1985 to the present day using annual doses of indicated remedies against a range of endemic diseases in Australia (some of which also have seasonal increases), including Pertussis, Pneumococcal disease, Hib, Meningococcal meningitis and Tetanus. [18]. The author's study of endemic use in Australia from 1986 to 2002 showed an HP effectiveness of **90.4%** (95% CI; 87.6% – 93.2%).[19]

It is worth noting that both the largest Indian and the largest Brazilian interventions studied, where the disease was endemic with seasonal increases, involved giving annual doses of HP remedies, which is similar to the dosing the author uses in long-term/endemic HP.

Practical HP interventions show that appropriate HP programs [20] provide Governments with infectious disease options for epidemic and endemic diseases which are very flexible (potentially against any strains of infectious diseases), can be made rapidly available, are easily distributed, have zero toxic side-effects, and are relatively inexpensive. HP is potentially valuable, especially in situations where vaccination is not possible either due to there being no vaccine for the disease, or when an existing vaccine cannot be obtained either in sufficient quantities or in time to treat an outbreak.

Appropriate HP programs also offer travellers infectious disease options and may offer protection against diseases for which no vaccine is available (such as AES and Chikungunya). And they may be used by families for long-term protection against endemic diseases.

The practical differences in prescribing for short-term/epidemic and long-term/endemic diseases – remedy selection, potency and frequency of doses – are discussed in detail elsewhere and are beyond the scope of this article.[21] However, evidence above and in other studies suggests that HP effectiveness is similar for both short-term and long-term diseases.[22]

Reactions to the HP remedies have not been recorded in most of the interventions studied which, as stated above, are immediate responses to save lives rather than carefully managed analyses. The author's doctoral study did collect data on reactions which occurred in less than 2% of doses and were typically brief and mild.[23] The safety of appropriate HP interventions allows treatment of every person in a cohort without the need for pre-screening.

A Next Step: There is always a need to expand the substantive evidence base of HP. To that end a conference in Delhi in January 2020 will bring together researchers who have been collecting data regarding the effectiveness of a variety of HP programs, hopefully allowing the data shown above to be expanded[24].

Conclusion

The ability of appropriate homoeoprophylaxis programs targeting specific infectious diseases to produce a significant level of protection has been confirmed time and again in large HP interventions, some of which have been presented here. No one study is perfect, but together they reveal consistently positive results.

Appropriate HP programs using either nosodes, genus epidemicus remedies and/or a miasmic-GE approach (as used against JE and AES) have value against both epidemic and endemic diseases, and have the potential to save many lives, even more suffering, as well as giving individuals and governments a very safe, economical and practical immunisation option.

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(Endnotes)

1. Golden I. Use of Homoeoprophylaxis in Three Countries. *Similia.* **2018**; **30**(1):23-27.
2. Whilst anecdotal, given that data were not collected, the author has been told of interventions both in Cuba and India where outbreaks of infectious diseases were responded to by local homoeopathic doctors who provided prophylaxis as well as treatment, just as Hahnemann had done in 1798. He has also heard from homoeopathic colleagues in Australia of local outbreaks of particular diseases being met with prophylaxis among the practitioners' own patients. In recent times, government-associated interventions have generally been documented, although with varying degrees of thoroughness.
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7. A direct control group is where the control is part of a single cohort where an intervention against a targeted disease is being studied, e.g. a HP and a non-HP group within the same city, or same region. An indirect control group is where a single disease is intervened within say one State or one suburb, and notifications and deaths from the disease are compared to those in other States or suburbs.
8. A fall factor analysis compares the rates of decline in the incidence of a targeted infectious disease in different regions or different cohorts within one region. These rates can be plotted to show a simple visual comparison.
9. The pre-2014 Cuban interventions are summarised in Bracho G, Golden I. A Brief History of Homoeoprophylaxis in Cuba, 2004-2014. *Homœopathic Links.* **2016**; **29**(2):128-134.
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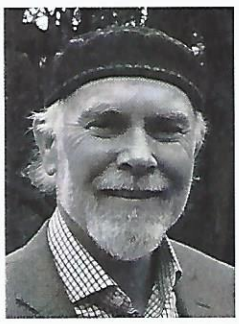

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