Homœoprophylaxis – A Fifteen Year Clinical Study

A Statistical Review of the Efficacy and Safety of Long-Term Homœoprophylaxis

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Disclaimer:
This book is not intended to replace the services of a qualified practitioner. Any applications of the recommendations set forth in the following pages are at the readers' discretion and sole risk.

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Preface:

This book does much more than simply update *Homoeoprophylaxis – A Ten Year Clinical Study* that was published in 1997.

It reports on a new line of research into homoeoprophylaxis (HP), and considerably strengthens the existing line of research begun in 1986.

This 18 year journey has now reached a new phase for me. I have one new publication planned, to summarize every aspect of HP that I have studied over the years, as a definitive resource for practitioners. I also wish to write a 6th and final edition of my main book for parents, *Vaccination? A Review of Risks and Alternatives*, on the subject of vaccination and the homoeopathic option. Hopefully, both will be finished by the end of 2005.

I intend to keep lecturing on the topic, writing articles, and supporting new research by others, but my own personal involvement in new data collection will now reduce considerably. Short of receiving substantial resources for new research, I have done what I can to provide statistical evidence to support the efficacy and safety of HP.

You might be able to feel a huge sigh of relief coming from the page!!!

I hope others will take up the task of building the data base of evidence supporting the efficacy and safety of HP, to the point where even the most hardened skeptic will be forced to acknowledge what I and thousands of my colleagues worldwide already know – HP does offer a relatively effective means of preventing the potential damage caused by serious infectious diseases, without in any way compromising the health of those who use the method.

But life experience tells us that we never really know what will happen next, and what new challenges may lie before us to either take up, or walk away from.

I just have one overwhelming belief – that truth will overcome all obstacles in the end.

I hope you will see from the pages following that I have nothing to hide in terms of my own experience with HP. I know that not all players in the immunization debate can say the same.

God Willing, let the truth of the matter be revealed, for the benefit of all.

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1 INTRODUCTION

Homoeoprophylaxis (HP) may be defined as the systematic use of homoeopathically potentised substances to prevent the development of the characteristic symptoms of infectious diseases.

The key words in this definition are:

- systematic – the schedule of medicines given in an HP program is not random. The medicines are chosen using the Law of Similars. The medicines are administered in a potency and frequency designed by the homoeopath to give a maximum protective effect with a minimum of doses.
- potentised – if the substances are not potentised then the length of protection being offered by HP will be very brief, or zero. Clinical experience in both treatment and prevention with homoeopathically potentised remedies reveals that the higher the potency the longer the duration of action of the dose.
- characteristic – the remedies used in an HP program are chosen because of their similarity to the common or characteristic symptoms of the disease being targeted. If the patient does not experience these symptoms following disease exposure then the method has been successful. It is possible that the patient may actually contract the disease, but that the defence mechanism is so well prepared that the resulting symptoms are sub-clinical. This occurs in the real world every day as people are exposed to cold and flu viruses, glandular fever, and so forth, but develop no symptoms of the disease.

HP may be used for both short-term (epidemic) and long-term prevention.

This report examines the safety and efficacy of my long-term HP program. I first released the program in 1986, and from the beginning requested parents to complete annual questionnaires describing the experience of their children who were using the program.[1] Questions were asked regarding reactions to the remedies in the program, whether their child was exposed to an infectious disease covered by the program, whether their child contracted the disease, and any comments the parents wished to make about the program.

The evaluation of the efficacy (effectiveness) and safety of the program involved the analysis of questionnaires received from parents whose children used the program from 1986 to 2003. Because of the delay between first receiving a program and submitting a questionnaire, results were accumulated from 1988 to 2002, a fifteen year collection period. Late responses were collected into 2003. Over those fifteen years the parents of 1,159 children returned 2,342 questionnaires, each questionnaire covering one year of their child's life.

The statistical analysis of the questionnaire responses by parents is reported in the Tables throughout the report, and in the Appendices. The actual comments by parents which formed the basis of these Tables are shown in the Appendices, allowing readers to critically evaluate the classification methods used.

[1] The program was first discussed publicly in Golden I. Vaccination – A Homoeopathic Perspective. *Nature & Health,* Vol. 7, No.3, Sept **1986**, pp. 67-70.

The purpose of this report is firstly to provide the homoeopathic community with factual information about the efficacy and safety of my long-term HP program. Many different HP programs have been used by homoeopaths over the last 200 years, but the results reported here may be used as an objective benchmark against which to evaluate other programs.

Secondly, the information is intended to show governments and Public Health authorities the potential value of an appropriate HP program as an option to conventional vaccination. The point is made that a dual system of immunisation (HP and vaccination) has the potential to both expand national coverage against targeted infectious diseases (improve herd immunity), and reduce the incidence of childhood illnesses such as asthma and eczema.

Thirdly, the data, and especially the comments by parents of participating children, are made available to other parents to assist them to make informed decisions. Whilst most parents will use my book comparing vaccination and HP,[2] I know that some will like to obtain the source data that is in this book to make fully informed decisions.

This report is a practical document. It deliberately does not take issue with opponents of HP within either the homoeopathic or the pharmaceutical communities, nor with the risks and benefits of vaccination except as they directly compare to HP, nor does it discuss philosophical issues concerning HP, including the question of whether some diseases should be prevented at all.[3]

This report assumes that the decision has been made by at least some parents, practitioners, or Governments, that certain disease are worth preventing, and thus factual information is needed about the efficacy and safety of long-term HP from which informed decisions can be made. The report attempts to provide this information.

Some readers will understand that the work undertaken in collecting and reporting this information has been difficult. Apart from the (unfunded) costs in postage, printing, etc. and time, there has been great difficulty in maintaining current addresses of many people over 18 years.

My work has been attacked by some from within my own profession, and from many outside it. These attacks have included four investigations by Health Departments in two States of Australia, and a still current threat of a $27,000 fine from the Australian Government's Therapeutic Goods Administration (TGA). Without this latter threat, which limited my ability to provide HP programs to parents who lived outside of Victoria, the number of responses available to be processed would have been closer to 4,000. This shows the double standard of some in the hierarchy of orthodox medicine – they complain that homoeopaths do not undertake enough research, yet they actively work to restrict research opportunities.

The nationwide use of HP has been unaffected by the TGA's restrictions on my distribution of HP programs, since parents simply have obtained remedies from practitioners in their

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[2] *Vaccination? A Review of Risks and Alternatives* - 5th Edition.

[3] These issues are discussed in the author's other books:
Vaccination? A Review of Risks and Alternatives - 5th Edition.
Homoeoprophylaxis -- A Practical and Philosophical Review - 3rd Edition.

own states. However, there has been a significant reduction in my research data to analyse. So the TGA decision has effectively reduced the availability of data on which to make informed decisions without reducing the use of HP nationwide.

Despite this opposition, my research journey has been an intensely rewarding experience. The goodwill from parents using the HP program has been enormous - even on those few occasions when the program failed to protect their child against an infectious disease, most parents were grateful and supportive of the option they were given.

I believe that HP has a great deal to offer to parents. It can improve their children's quality of life through fewer episodes of distressing disease, through using a method of disease prevention which has no toxic reactions, and through better long-term health as demonstrated by my later research.

As mentioned earlier, HP also has the potential to save both State and Federal governments many hundreds of millions of dollars in reduced public health costs, through improving national coverage rates against targeted infectious diseases and by reducing the incidence of chronic health problems such as asthma and eczema. The Australian results may be readily applied to other countries, especially third world countries whose health budgets can ill afford the massive outlays on drugs and vaccines that a national vaccination program costs.

If Governments introduced a dual system of infectious disease prevention, the principal losers would be the multinational pharmaceutical companies, who would see demand for their products fall. The community overall would benefit. My hope is that one day some independently-minded politicians will access objective information about the HP option and make decisions which will benefit us all.

However, my views are not the point of this work, which is to describe the results of the present survey of the efficacy and safety of my long-term HP program.

2 THE HOMOEOPROPHYLAXIS PROGRAM

Three different programs have been used over the duration of this study.

The first, which was introduced in 1986, was based around single doses of, usually, an M potency of the preventative remedy for each disease.

In 1991 the program was substantially modified to allow the introduction of a single dose of 200c, followed one month later by a triple dose in ascending potencies, e.g. one dose of a 200c in the morning, a dose of an M in the evening and a third dose of a 10M next morning. If a reaction was observed to the single dose of 200c, then the triple dose would be deferred.

This modification was made in response to the author's experience with parents using the first program who accidentally antidoted the single remedy doses.[4] Once the decision to use triple doses was made, the decision to use ascending potencies followed. The triple doses were then spaced further apart over the 5 years of the program. A comparative analysis of the two programs will be made.

A final change to the program was made in 1993 to include the remedy for Hib (Haemophilis Influenzae type b), which was given in an M potency. A single dose was followed a month later by a triple dose, with triple doses being repeated nearly annually.

The program itself is flexible, and many parents include additional remedies for diseases such as Meningococcal Meningitis and Hepatitis B in the program, at ages that they determine to be appropriate based on their priority of concerns regarding the different diseases. Some parents choose not to give remedies to prevent Measles and Mumps, which they see as mild diseases in healthy children. The choice is theirs.

The current program is shown in Figure 1, where the Status Sheet that is distributed with the current program is reproduced. This shows the age at which doses are recommended to be administered, the remedy and potency recommended, and provides a place for parents to date and sign the administration of the dose.

The instructions that accompany the Status Sheet advise parents how to administer the oral doses of the remedies, what to do if the child begins the program later than one month of age (i.e., to give monthly doses, ignoring gaps in the program, until the child's age and the program age coincide), and directions to contact me if reactions occur to medicines in the program.

It should be noted that HP is not my invention. Dr Hahnemann first documented his use of the remedy Belladonna to prevent Scarlet Fever in 1801.[5] Since that time our greatest

[4] This experience was described in Golden I., A Report of a Pertussis Outbreak and Prevention in Unvaccinated Children. *Similia* – the Journal of the Australian Homoeopathic Association, July 1991**,** Vol. 5, No. 2, pp. 72-82.

[5] Hahnemann S. The Cure and Prevention of Scarlet Fever. *Lesser Writings.* 1801. Jain Publishers, New Delhi. pp. 369-385.

homoeopaths have used different forms of HP.[6] My original 1986 program was prepared by drawing on the enormous body of practical experience reported in our literature.

[6] A brief list of references to the historical use of HP is given in Golden I., *Homoeoprophylaxis – A Practical and Philosophical Review* – 3rd ed., 2001, pp. 28-34.

Figure 1 The Current Homoeoprophylaxis Program, and Status Sheet

Homoeopathic Preventative Program Against Infectious Diseases

STATUS SHEET

Name _____. is being protected against the following infectious diseases using high potency homoeopathic remedies. Clinical studies over 200 years indicate that this program is comparably effective to conventional vaccines, and is non-toxic. The following chart indicates the current program status of the patient and has been dated and signed by the parent, and signed by the homoeopath who prepared the program.

Age Recomm /Given	Remedy	Potency	Remedy Label	Date of Admin.	Administered By
1 month	Pertussin	200			
2 months	Pertussin	200, M, 10M			
4 months	Lathyrus Sativus	200			
5 months	Lathyrus Sativus	200, M, 10M			
6 months	Haemophilis	M			
7 months	Haemophilis	M, M, M			
9 months	Diphtherinum	200			
10 months	Diphtherinum	200, M, 10M			
11 months	Tetanus Toxin	200			
12 months	Tetanus Toxin	200, M, 10M			
13 months	Pertussin	200, M, 10M			
14 months	Morbillinum	200			
15 months	Morbillinum	200, M, 10M			
16 months	Lathyrus Sativus	200, M, 10M			
17 months	Haemophilis	M, M, M			
19 months	Parotidinum	200			
20 months	Parotidinum	200, M, 10M			
22 months	Diphtherinum	200, M, 10M			
24 months	Tetanus Toxin	200, M, 10M			
26 months	Lathyrus Sativus	200, M, 10M			
28 months	Haemophilis	M, M, M			
32 months	Pertussin	200, M, 10M			
41 months	Tetanus Toxin	200, M, 10M			
46 months	Haemophilis	M, M, M			
50 months	Diphtherinum	200, M, 10M			
54 months	Morbillinum	200, M, 10M			
56 months	Lathyrus Sativus	200, M, 10M			
60 months	Tetanus Toxin	200, M, 10M			

Remedy-Disease Relationship: Pertussin -- Whooping Cough; Tetanus Toxin -- Tetanus; Haemophilis -- Hib Influenzae; Lathyrus Sativus – Polio; Diphtherinum – Diphtheria; Morbillinum -- Measles: Parotidinum -- Mumps;

Homoeopath _____

3 THE METHOD OF DATA COLLECTION AND ANALYSIS

The data analysed in this survey were collected by sending annual questionnaires to parents whose children used my long-term HP program. Some parents returned only one questionnaire, while others returned questionnaires each year for up to 8 years.

Each questionnaire returned covered one year of their child's life experience, and parents were asked to report any reactions to remedies in the program, exposure to diseases covered by the program, and any such disease contracted.

The reporting of reactions to medicines in the HP program was fairly uncomplicated. Occasionally a parent was uncertain whether the symptoms that occurred following a dose were caused by the remedy, or whether they were coincidentally caused by other factors such as infections, teething, emotional upsets, and so forth.

The area of most interest, and controversy, involved the identification of diseases acquired by participating children for which HP remedies had been previously given, and the measurement of the exposure to diseases covered by the program. This information is needed to calculate the effectiveness of the HP method - the area of greatest disagreement with those in orthodox medicine.

All that can be said is that I believe that parents answered to the best of their ability, given the range of comments returned, but also given the consistency of comments from thousands of parents over 18 years. Quite a few mentioned that they just could not be sure whether exposure occurred, even though they felt it was likely. A number of reports of disease were also questionable as no definite diagnosis was made and the symptoms were very mild. All the responses by parents are recorded in the Appendices for the reader to examine and thus to make up his/her own mind as to whether data were classified appropriately.

It should be noted that while the program was first made available in 1986, the first figures were not analysed until 1998 to allow for the program to be used for at least 12 months by the first respondents.

I conducted two additional pieces of research from 2001-2003 to further test the reliability of the data in this report. This research was undertaken as part of a doctoral thesis at the Graduate School of Integrative Medicine at the Swinburne University of Technology, Melbourne, Australia. When references are made to "the thesis" it means the document that was produced as a result of the doctoral research.

A flowchart outlining the progress of my research from 1986 to 2003 is shown in Figure 2. The two new research projects were as follows.

A. A detailed follow-up analysis of data reported by parents of participating children, resulting in seven additional tests being performed on data collected from 1978 to 2003. The tests were:

1. The accountability rate of the final 5-years' data was calculated to ensure a significant level of accountability (>70%) and thus greater reliability of results.

2. Non-respondents were surveyed to ensure that the questionnaires that were received gave responses that were reflective of the entire population.
3. Respondents who reported acquisition of a disease were surveyed to verify the accuracy of their initial report.
4. Respondents who reported exposure to a disease were surveyed to verify the accuracy of their initial report.
5. A more detailed statistical analysis of the data was undertaken to determine confidence limits for the figure for the efficacy of HP.
6. The accuracy of the measurements of efficacy based on notifications of and exposure to diseases was tested by calculating the *sensitivity* and *specificity* of the data (these are defined statistical measures of reliability).
7. A comparison with national disease attack rates was undertaken to provide an effective control group against which to compare results.

B. A General Health Survey of 781 children was undertaken using a retrospective questionnaire analysis.

Questions were asked examining early childhood factors such as birth weight, gestation, APGAR scores, length of breastfeeding and method of disease prevention. The child's health experience with asthma, eczema, ear and hearing problems, allergies and behavioural problems was examined, as was the parents' evaluation of their child's general health. Cases of whooping cough, measles and mumps were recorded, as was each child's hospitalisation experience. With both health conditions and infectious diseases, respondents were asked whether a diagnosis by a medical practitioner was made.

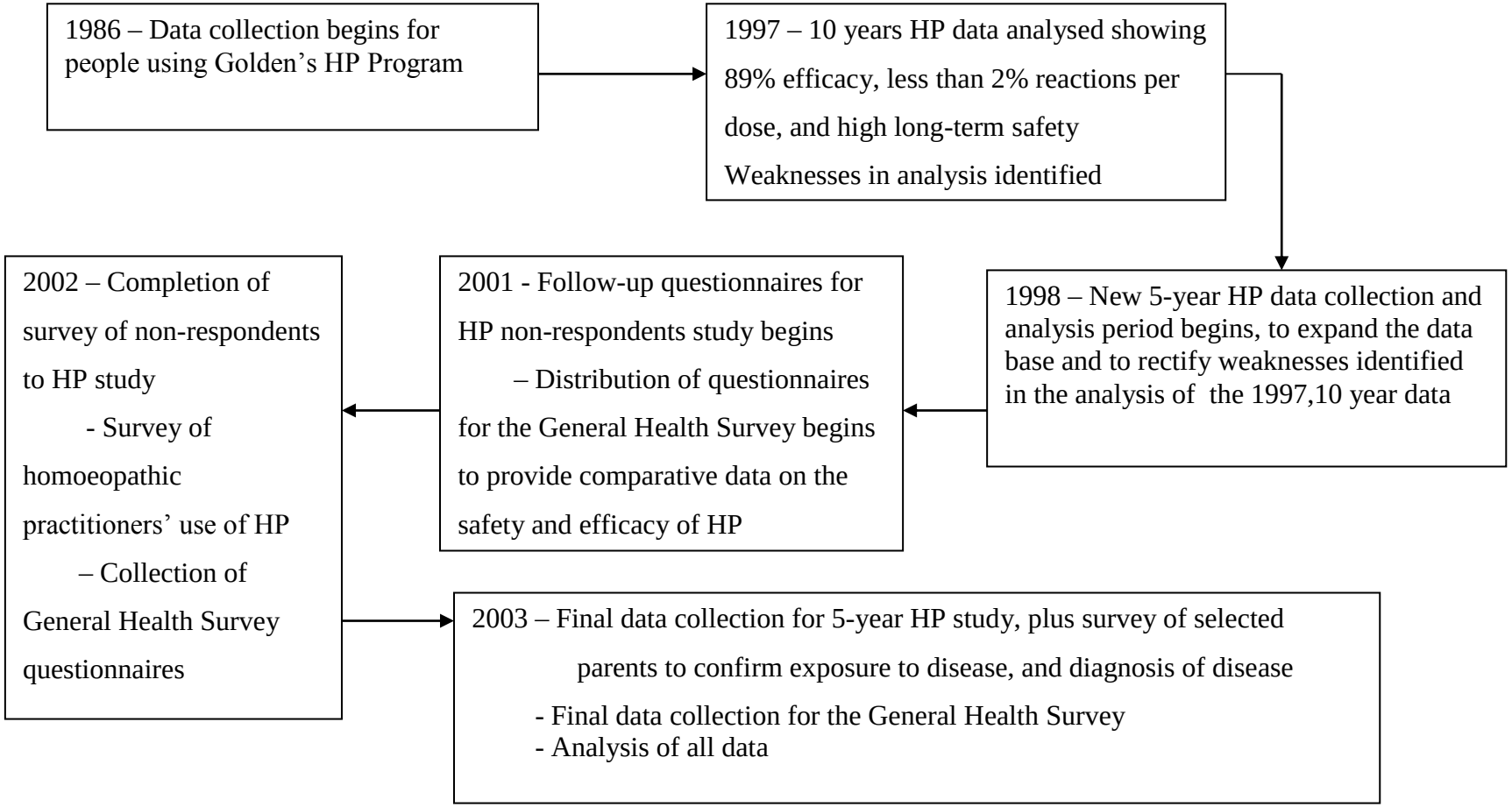
Whilst the results of the General Health Survey will not be described in detail in this report, a summary of findings that support the fifteen year research program will be given.

I have made every attempt that time and finances allowed to improve the reliability of the findings presented in Chapter 4. If significant resources had been available then the General Health Survey could have attracted many more respondents, and the statistical significance of the results based on the information collected would have been higher as a result.

The reader will make up his/her own mind as to how much reliance may be placed on the research findings. At the very least they show that a case exists for further research into long-term HP. However, I have no doubt that many readers will feel that the level of testing reported here is sufficient to give them considerable confidence in the high level of efficacy of long-term HP, as well as complete confidence in its demonstrated safety.

When the data are compared to the 200 year experience of eminent homoeopaths using HP, I believe that any objective analyst would conclude that the use of appropriate long-term HP programs has the potential to benefit both individuals and the nation.

Figure 2 Flowchart of Chronological Development of Research



4 THE SURVEY RESULTS

The following ten topics will be examined in this Chapter:
- The Responses Collected
- Diseases Suffered by Children Using the Program
- Exposure to Diseases Suffered by Children Using the Program
- Tests to Validate the Data for Efficacy
- The Efficacy of the Long-term HP Program
- Reactions to Remedies in the Program
- Comments on a General Health Survey of Children Using a HP Program
- General Comments by Parents of Children Using the Program
- The Safety of the Long-term HP Program
- A Comparison of Different HP Programs

4.1 The Responses Collected

Table 1 shows the responses received over the fifteen year data collection period. 2,342 questionnaires were collected from 1,159 different children.

As noted in the Introduction, the TGA's restriction on my distribution of HP programs has significantly reduced the amount of information collected for this study.

Table 1 Responses Received – 1988 to 2002/3

15 Year Clinical Study - 1988 to 2002/3 - Responses Received															
					Year and Survey										
	Sur.1	Sur.2a	Sur.2b	Sur.3	Sur.4	Sur.5	Sur.6	Sur.7	Sur.8a	Sur.8b	Sur.9	Sur.9	Sur.9	Sur.9	Sur.9
	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002/3
Series															
1	50	40	23	19	11	11	9	6	0	0	0	0	0	0	0
2		39	13	8	11	10	4	6	0	0	0	0	0	0	0
3			48	25	18	15	7	10	1	1	0	0	0	0	0
4			2	60	47	33	26	18	0	1	3	3	0	0	0
5					55	30	24	20	1	0	0	0	0	0	0
6						135	77	65	34	32	1	0	0	0	0
7						3	64	25	13	13	0	0	0	0	0
8								48	20	22	14	12	10	6	4
9								3	43	14	11	12	10	7	5
10										42	19	18	17	16	2
11											72	41	21	17	29
12												78	47	36	30
13													97	61	57
14														90	54
15															87
Total	**50**	**79**	**86**	**112**	**142**	**237**	**211**	**201**	**112**	**125**	**120**	**164**	**202**	**233**	**268**

Total Responses Series 1-5	708		Group A	
Total Responses Series 6-10	817		Group B	
Total Responses Series 11-15	817		Group C	
TOTAL RESPONSES	**2342**		**Total Groups**	

4.2 Diseases Suffered by Children Using the Program

Tables 2 and 3 summarize reports of diseases contracted after taking the appropriate HP remedies. Because of the mildness of the symptoms, there was uncertainty expressed in some responses as to whether a disease was actually contracted. Readers can examine the actual responses in Tables 1.1, 1.2 and 1.3 in the Appendix 1 to assess whether the responses were classified appropriately.

It is suggested that the figures tend to overstate the level of failure of HP rather than understate it. Some extremely mild diseases were recorded, based on parental classification, even though a disease may not have actually been contracted.

Table 1.4 in Appendix 1 shows the amended reports of diseases contracted. These figures arose from follow-up surveys of Series 11-15 parents originally reporting a disease, and they resulted in some changes to the original figures. The information reported in Tables 2, 3 and 4 below takes into account the amended figures for Series 11-15 diseases contracted.

The type and number of the four diseases reported are not surprising - Measles, Whooping Cough, Mumps and Hib. The welcome absence of Polio should be noted, given that exposure to the virus via contacts with recently vaccinated children would definitely have occurred (the oral vaccine is used in Australia, and the virus can be shed through the faeces).

It is clear from the figures that the use of triple doses in higher potencies has significantly reduced the likelihood of a child contracting a disease - from 4.5% to 2.5% for all reports (both definite and possible), and from 2.5% to 1.4% for definite reports of diseases.

The analysis in later sections will recalculate these figures as proportions of children who were exposed to diseases, not proportions of all children whether or not exposure occurred. The new figures will also show a reduction in the likelihood of a child contracting a disease when using triple doses.

The final efficacy rate of 90.4% reported in Table 25 is similar to the expected efficacy reported for orthodox vaccines of between 75% and 95%.[7]

[7] Vaccination? A Review of Risks and Alternatives -- 5th Edition. Page 45.

Table 2 Reports of Diseases Contracted After Taking Appropriate Remedies - Summary

	Series 1-5			**Series 6-10**			**Series 11-15**			**Totals**	
Total Responses	**708**			**817**			**817**			**2,342**	
Parents Reporting Definite Disease	**18**			**11**			**11**			**40**	
% to Total Responses	2.5	%		1.4	%		1.4	%		1.7	%
Parents Reporting Possible Disease	**14**			**9**			**9**			**32**	
% to Total Responses	2.0	%		1.1	%		1.1	%		1.4	%
Total Reports	**32**			**20**			**20**			**72**	
% to Total Responses	4.5	%		2.5	%		2.5	%		3.1	%

Table 3 Reports of Diseases Contracted After Taking Appropriate Remedies - Actual Diseases Reported

	Series 1-5				Series 6-10				Series 11-15				Totals		
	Def.	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**
Whooping Cough	4	5	**9**		3	4	**7**		7	4	**11**		14	13	**27**
%			1.3				0.9				1.4				1.2
Tetanus	0	0	**0**		0	0	**0**		0	0	**0**		0	0	**0**
%			0.0				0.0				0.0				0.0
Polio	0	0	**0**		0	0	**0**		0	0	**0**		0	0	**0**
%			0.0				0.0				0.0				0.0
Diphtheria	0	0	**0**		0	0	**0**		0	0	**0**		0	0	**0**
%			0.0				0.0				0.0				0.0
Measles	11	8	**19**		8	5	**13**		2	3	**5**		21	16	**37**
%			2.7				1.6				0.6				1.6
Mumps	3	1	**4**		0	0	**0**		0	1	**1**		3	2	**5**
%			0.6				0.0				0.1				0.2
Hib	0	0	**0**		0	0	**0**		2	1	**3**		2	1	**3**
%			0.0				0.0				0.4				0.1
Totals Reported *	18	14	**32**		11	9	**20**		11	9	**20**		40	32	**72**
% to total responses			4.5				2.5				2.5				3.1
* - includes multiple responses.			(708)				(817)				(817)				(2342)

The time profile of definitely acquired diseases is shown in Table 4. The time profile shows whether the disease was acquired within the 1st year following the commencement of the HP program, within the 2nd year following commencement, and so on.

It is to be expected that the failure rate of the program (the rate of diseases acquired) would reduce as more doses of each preventative remedy are given, and this did occur.

The figures also show that there is a noticeable difference between the original and the present HP programs. They suggest that once the first round of the present program is completed (shown by Series 11-15), a significantly higher level of protection is achieved than with the original program (shown by Series 1-5), as evidenced by a reduced rate of diseases being reported in the later years of Series 11-15.

This reinforces the value of using triple doses in ascending potencies in the current program.

Table 4 Time Profile of Diseases Definitely Acquired - Summary

Diseases occurred in	**Series 1-5**	**Series 6-10**	**Series 11-15**	**Total (Series 1-15)**
1st year	27.7%	36.4%	54.5%	37.5%
2nd year	22.2%	36.4%	18.2%	25.0%
3rd year	33.3%	18.1%	18.2%	25.0%
4th year	5.6%	9.1%	9.1%	7.5%
5th year				0.0%
6th year	5.6%			2.5%
7th year				0.0%
8th year	5.6%			2.5%

4.3 Exposure to Diseases Suffered by Children Using the Program

Tables 5 and 6 report one of the most difficult pieces of information to collect and analyse, i.e., the exposure to diseases covered by the program.

Some reports of exposure seemed totally unambiguous. Others were less certain. A few parents reported a disease but no exposure. In such cases exposure was recorded since it obviously did occur.

Some parents said that they believed there must have been some exposure as a consequence of their child attending school, kinder, etc., but gave no definite evidence of outbreaks where their children may have been exposed. Their responses were not included in Tables 5 and 6 below.

The actual responses made by parents are reported in Tables 2.1, 2.2 and 2.3 in the Appendix 2. Readers may draw their own conclusions as to the accuracy of my classification of these responses, which is summarised in Table 6 below.

Once again, the findings that the highest number of exposures was to Measles and Whooping Cough were not surprising. The reported exposure to Mumps in the first five years of data collection was significant, although this fell away in the following two data collection periods, with a few reports of Hib emerging in the final 5 year period.

Diphtheria is hardly present in the Australian community, so reports of exposure are not expected.

Only two reports of exposure to the Polio virus were recorded, although a greater level of exposure would almost certainly have occurred through contact with recently (orally) vaccinated children. Awareness of this type of exposure is low and so few reports were expected.

In summary, it is likely that some parents reported an exposure which did not occur. It is also likely that some exposures went unreported simply because the child did not fall ill, and the parents were unaware of exposure.

It is impossible to know how these two factors balance out, although it is suggested that an under-reporting of exposure is most likely. As part of my doctoral research, I surveyed respondents in the 1998-2002 reporting period to measure the accuracy of their reports of diseases and exposure. The results of the surveys relating to disease exposure are reported in Table 2.4 in Appendix 2. The figures for Series 11-15 responses in Tables 5 and 6 below have allowed for the necessary corrections as a result of the follow-up surveys. A high overall accuracy of parental reports is confirmed by the follow-up study.

Table 5 Reported Exposure to Diseases Covered by Program, After Taking Appropriate Remedies - Summary

	Series 1-5		Series 6-10		Series 11-15		Totals	
Total Responses	**708**		**817**		**817**		**2342**	
Parents Reporting Definite Exposure to the Disease	**177**		**127**		**113**		**417**	
% to Total Responses	25.0	%	15.6	%	13.8	%	17.8	%
Parents Reporting Possible Exposure to the Disease	**37**		**33**		**33**		**103**	
% to Total Responses	5.2	%	4.0	%	4.0	%	4.4	%
Total Reports	**214**		**160**		**146**		**520**	
% to Total Responses	30.2	%	19.6	%	17.9	%	22.2	%

Table 6 Reported Exposure to Diseases Covered by Program, After Taking Appropriate Remedies – Actual Exposure Reported

Total Disease Exposure Reported															
		Series 1-5				**Series 6-10**				**Series 11-15**				**Totals**	
		Def.	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**		**Def.**	**Poss.**	**Total**
Whooping Cough		30	8	**38**		42	10	**52**		48	19	**67**		120	37	**157**
	%			5.4				6.4				8.2				6.7
Tetanus		0	11	**11**		1	4	**5**		0	2	**2**		1	17	**18**
	%			1.6				0.6				0.3				0.8
Polio		0	0	**0**		0	1	**1**		1	0	**1**		1	1	**2**
	%			0.0				0.1				0.1				0.1
Diphtheria		1	0	**1**		0	0	**0**		0	0	**0**		1	0	**1**
	%			0.1				0.0								0.0
Measles		106	16	**122**		74	18	**92**		53	11	**64**		233	45	**278**
	%			17.2				11.3				7.8				11.9
Mumps		40	2	**42**		5	0	**5**		6	1	**7**		51	3	**54**
	%			5.9				0.6				0.9				2.3
Hib		0	0	**0**		5	0	**5**		5	0	**5**		10	0	**10**
	%			0.0				0.6				0.6				0.4
Totals Reported *		177	37	**214**		127	33	**160**		113	33	**146**		417	103	**520**
	%	25.0	5.2	**30.2**		15.5	4.0	**19.6**		13.8	4.0	**17.9**		17.8	4.4	**22.2**
No specific diseases identified		2	6	**8**		0	13	**13**		0	5	**5**		2	24	**26**
* Multiple diseases identified																
NOTE: A number of responses which identified a general likelihood of exposure due to attendance at kinder, at creche and at school, and exposure to recently vaccinated children, and puncture wounds were not included.																

4.4 Tests to Validate the Reliability of the Data for Diseases and Exposure

As mentioned in Chapter 3, seven tests were applied to Series 11-15 data to validate the results that were extracted from the data. The findings of these tests were fully documented in my doctoral thesis. Table 7 summarises the results of these seven tests.

It can be seen from Table 7 that the effort made to validate the results was significant, but was limited by available resources and TGA restrictions. These limitations did restrict both the total number of responses collected, and the return rate of subsequent-year responses.

The reliability of the results for efficacy of my long-term HP program, based on the Series 11-15 data, was found to be high.

It is reasonable to conclude that there is a similar reliability of the Series 1-5 and Series 6-11 data, given that (1) the method of collection was the same as for the Series 11-15 data, and (2) that the differences between Series 1-5 and Series 6-10 results was as expected by homoeopaths (i.e., higher efficacy, plus high rates of reactions expected from the use of higher potencies and a triple dose).

Table 7 Tests to Validate the Results Reporting the Efficacy of Long-Term HP

No.	Test	Result
1	The accountability rate (the % of those surveyed who responded) of the final 5-years' data was calculated to ensure a significant level of accountability (>70%) and thus greater reliability of results.	>70% accountability of first year responses was achieved
*2	Non-respondents were surveyed to ensure that the questionnaires that were received gave responses that were reflective of the entire population.	Responses from non-respondents were consistent with respondent replies.
3	Respondents who reported acquisition of a disease were surveyed to verify the accuracy of their initial report.	High level of accuracy of initial reports.
4	Respondents who reported exposure to a disease were surveyed to verify the accuracy of their initial report.	High level of accuracy of initial reports.
5	A more detailed statistical analysis of the data was undertaken to determine confidence limits for the figure for the efficacy of HP.	Confidence limits were: CI = 87.6% - 93.2% (P=95%)
6	The accuracy of the measurements of efficacy based on notifications of and exposure to diseases was tested by calculating the *sensitivity* and *specificity* of the data.	High levels of *sensitivity* (disease = 90.9%, exposure = 95.6%), and *specificity* (disease = 98.1%, exposure = 99.2%).
7	A comparison with national disease attack rates was undertaken to provide an effective control group against which to compare results.	Weighted average national disease attack rate = 79%; HP associated with reduction in disease, P > 99%.

NOTE: *Sensitivity* is the proportion of respondents who have experienced a disease or exposure, and are correctly classified as having had the experience. *Specificity* is the proportion of respondents who have not experienced a disease or exposure, and are correctly classified as not having had that experience.

4.5 The Efficacy of the Long-Term HP Program

Table 8 shows the figures for the efficacy of my long-term HP program over three individual Series – Series 1-5; Series 6-10 and Series 11-15 – as well as the figures for the combined Series 1-15.

If we examine only the 417 reported cases of definite exposure and the 40 cases of definite diseases, we find an average efficacy of 90.4%, or conversely a failure rate of 9.6%. This means that for every 100 children using my long-term HP program, who were definitely exposed to diseases covered by the program, 90 did not contract the disease, and 10 did.

This figure for efficacy is totally consistent with reports in the homoeopathic literature quantifying the efficacy of both short term and long-term HP over the last 200 years.

There has been an increase in average efficacy over the three data Series from 89.8% to 91.3% and 90.3% through using triple doses in ascending potencies. This is expected by homoeopaths because both changes provide a stronger and longer lasting dose.

These figures are definitely comparable to reported efficacy rates of conventional vaccines, which range from 75-95%.[8]

Table 9 shows the confidence limits for the three Series, and the combined Series 1-15.

The figures show 95% confidence limits of 87.6% to 93.2% for the efficacy of HP for the combined Series 1-15.

Once again, these figures are totally compatible with the published figures for vaccine efficacy.

[8] The rates of vaccine efficacy are taken from figures reported in *Vaccination? A Review of Risks and Alternatives*. 5th Edition. p. 45.

Table 8 Efficacy of Golden's HP Program Over All Data Collection Periods

	Series 1-5		Series 6-10		Series 11-15		Series 1 - 15	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Responses	708		817		817		2,342	
Diseases	18		11		11		40	
Exposure to Diseases	177		127		113		417	
Efficacy of the Program	159/177	**89.8**	116/127	**91.3**	102/113	**90.3**	377/417	**90.4**

Table 9 Confidence Limits for the Efficacy of Series 1 – 15 Data

	Series 1-5	**Series 6-11**	**Series 11-15**	**Series 1-15**
Efficacy = Not Infected / Exposed	159/177	116/127	102/113	377/417
Proportion	0.898	0.913	0.903	0.904
Standard Deviation	0.303	0.282	0.298	0.295
Significance level	0.05	0.05	0.05	0.05
Confidence range	0.045	0.049	0.055	0.028
Efficacy Range - upper	0.943	0.963	0.957	0.932
lower	0.854	0.864	0.888	0.876

4.6 Reactions to Medicines in the Program

Tables 10, 11 and 12 report reactions to the medicines in the HP Program.

The majority of reactions were to the medicine Pertussin (as expected due to the recorded history of reactions to the pertussis vaccine). However, the number of reactions to the medicine Diphtherinum was significant. They suggest that there are a number of children whose parents or grandparents had contracted Diphtheria, and not completely eliminated the effect of the disease. The nosode Diphtherinum would have a balancing (healing) effect in such cases, and possibly explain the reported reactions.

In the latest series, Series 11-15, there was a relatively high level of reactions to Lathyrus Sativus, the remedy used as the poliomyelitis preventative. The reactions may be due to the likelihood of a fairly high level of exposure to the virus through contacts with recently vaccinated infants.

Table 10 Reactions to Remedies in Golden's Long-Term HP Program

	Definite Reactions to HP – per person		Reactions to HP – per dose (estimated) *
	No.	**%**	**%**
Series 1-5	51/708	7.2	1.2
Series 6-10	81/817	9.9	1.7
Series 11-15	81/817	9.9	1.7
Series 1-15	213/2342	9.1	1.5

* Note: the per-dose reaction rate is calculated by assuming on average 6 doses of medicine are administered each year. This takes into account the fact that many parents miss doses from time to time, and that in the later years of the program, doses are given more that one month apart.

Table 11 Reactions Reported to Medicines in the Program - Summary

	Series 1-5			**Series 6-10**			**Series 11-15**			**Totals**	
Parents Reporting Definite Reactions	**51**			**81**			**81**			**213**	
% to Total Responses	7.2	%		9.9	%		9.9	%		9.1	%
Parents Reporting Possible Reactions	**5**			**31**			**36**			**72**	
% to Total Responses	0.7	%		3.8	%		4.4	%		3.1	%
Total Number of Reactions											
including multiple responses	**56**			**112**			**117**			**285**	
% to Total Responses	7.9	%		13.7	%		14.3	%		12.2	%

Table 12 Reactions Reported to Medicines in the Program - Actual Reactions Reported

Actual Medicines Reported	**Series 1-5**			**Series 6-10**			**Series 11-15**			**Totals**		
	Def.	**Poss.**		**Def.**	**Poss.**		**Def.**	**Poss.**		**Def.**	**Poss.**	
Pertussin	**11**	**3**		**25**	**5**		**20**	**6**		**56**	**14**	
	1.6	0.4	%	3.1	0.6	%	2.5	0.7	%	2.4	0.6	%
Tetanus Toxin	**5**	**0**		**6**	**1**		**6**	**1**		**17**	**2**	
	0.7	0.0	%	0.7	0.1	%	0.7	0.1	%	0.7	0.1	%
Lathyrus Sativus	**8**	**0**		**8**	**3**		**16**	**0**		**32**	**3**	
	1.1	0.0	%	1.0	0.4	%	2.0	0.0	%	1.4	0.1	%
Diphtherinum	**8**	**0**		**12**	**2**		**6**	**2**		**26**	**4**	
	1.1	0.0	%	1.5	0.3	%	0.7	0.3	%	1.1	0.2	%
Morbillinum	**7**	**1**		**9**	**1**		**4**	**3**		**20**	**5**	
	1.0	0.1	%	1.1	0.1	%	0.5	0.4	%	0.9	0.2	%
Parotidinum	**2**	**1**		**1**	**1**		**3**	**0**		**6**	**2**	
	0.3	0.1	%	0.1	0.1	%	0.4	0.0	%	0.3	0.1	%
Hib	**0**	**0**		**2**	**1**		**8**	**1**		**10**	**2**	
	0.0	0.0	%	0.3	0.1	%	1.0	0.1	%	0.4	0.1	%
Total Identified Medicine Reported	**41**	**5**		**63**	**14**		**63**	**13**		**167**	**32**	
	5.8	0.7	%	7.7	1.7	%	7.7	1.6	%	7.1	1.4	%
No Medicine Identified	**10**	**0**		**18**	**17**		**18**	**23**		**46**	**40**	
	1.4	0.0	%	2.2	2.1	%	2.2	2.8	%	2.0	1.7	%
Total Responses	**51**	**5**		**81**	**31**		**81**	**36**		**213**	**72**	
	7.2	0.7	%	9.9	3.8	%	9.9	4.4	%	9.1	3.1	%
(Total Respondents)	*(708)*			*(817)*			*(817)*			*(2,34*		

The classification of the intensity and duration of the Series 11-15 reactions of my HP program is summarised in Table 13 below. Not all responses by parents showed their child's intensity or duration of reactions, and so the Table shows the figures for all responses, as well as the figures that exclude responses where no details were given.

Further, figures are shown for (a) all reactions that are classified as either "possible" or "definite", as well as (b) just for reactions classified as "definite". The "definite" figures are shown in brackets.

Note that the count in Table 13 is by respondent. The reason for this is that not all parents who reported a reaction to more than one remedy made clear which reaction was associated with which remedy.

There were 82 definite reports of reactions to kit remedies. However, 14 parents reported definite reactions to two diseases. That means that there were 68 questionnaire responses covering the 82 definite remedy reactions.

Table 10 reported that definite reactions were experienced in less than 1.5% of doses. The analysis of reactions in Table 13 shows that most were mild (56.7%), and very few were strong (1.5%). The figures showed that 41.8% were classified as moderate in intensity.

If nothing else, this certainly shows that homoeopathic remedies containing only the "energy" of substances can produce definite and observable changes in infants and young children where the likelihood of a placebo effect is small.

The clear majority of respondents (85.7%) who reported the reactions stated that they were brief, lasting between 1-5 days. In fact, only 2 respondents who reported a reaction classified as moderate or strong also reported that the reaction was more than brief. Another 11 did not indicate the duration of the reaction.

The general comments of these 13 respondents were checked to see if there was any evidence of long-term health problems. One respondent (#11138) reported that her child had contracted whooping cough and was still unwell 6 months later. Two others (#14221 and #15110) repeated comments on the reactions that they had already reported. The others either made no comments, or positive comments about the health of their children.

Thus, it seems reasonable to conclude that whilst reactions to the remedies in the HP program are possible, the overwhelming experience of most children using the program shows that short-term reactions are very unlikely, and those that do occur are usually mild and brief.

We can, however, clearly see that the use of triple doses in higher potencies has significantly increased the level of both definite and possible reported reactions to medicines in the kit, from 7.9% to 14.3% per person. The rise in the rate of definite reactions was from 7.2% to 9.9% per person. This emphasises the importance of precise parental instructions to ensure that any reaction to a medicine in a lower potency is followed by a suitable delay before administering higher potencies.

It should be noted that the above figures translate to a HP remedy reaction rate of less than 2% per dose of medicine, given the assumption of six doses from the program annually.

As expected, the rate of reactions to medicines in the HP program is significantly less than that experienced with vaccination. For example, the National Health and Medical Research Council has stated that "Most vaccines have minor side effects" which "commonly follow immunisation with some vaccines and should be anticipated".[9]

The results clearly demonstrate that an appropriate long-term HP program is very safe, as would be expected given that there are no toxic materials in the medicines, unlike vaccines which do contain toxic chemicals as well as antigenic material. Further information will be presented in section 4.7 below supporting this conclusion.

[9] NH&MRC. *The Australian Immunisation Handbook*. 7th ed., 2000, p. 22.

Table 13 A Summary of the Intensity and Duration of Reactions to the Series 11-15 HP Program, by Respondent

		Intensity/Duration of Reactions				
			All Responses			
		Mild/ Brief	**Moderate**	**Strong/ Long**	**No Details Given**	**Total Respondents**
Intensity	#	65 (38)	33 (28)	1 (1)	3 (1)	102 (68)
	%	63.7 (56.7)	32.4 (41.8)	1.0 (1.5)	2.9 (1.5)	100.0
Duration	#	46 (36)	7 (5)	1 (1)	48 (26)	102 (68)
	%	45.1 (52.9)	6.9 (7.4)	1.0 (1.5)	47.1 (38.2)	100.0
		Excluding Responses With No Details				
		Mild/ Brief	**Moderate**	**Strong/ Long**	**Total Respondents**	
Intensity	#	65 (38)	33 (28)	1 (1)	99 (67)	
	%	63.7 (56.7)	32.4 (41.8)	1.0 (1.5)	100.0	
Duration	#	46 (36)	7 (5)	1 (1)	54 (42)	
	%	85.2 (85.7)	13.0 (11.9)	1.9 (2.4)	100.0	

(1) The figures in brackets are for reactions classified as “definite”. Other figures are for all reactions, classified as either “possible” or ”definite”.

(2) Classification of Duration of Reaction:
1 - 5 days – “Brief”; 6-13 days - “Moderate”; 14 + days - “Long”

(3) These 102 classifications are made by respondent, not by individual reaction (117), due to the nature of parental responses which did not always allow a classification by reaction.

The time profile of reactions by respondent is shown in Table 14 below.

These profiles show that most reactions occur within the first year of the program, i.e., with the first doses of a new remedy. This result is expected by homoeopaths and, as with homoeopathic treatment, if a patient is sensitive to a substance (remedy) this will usually manifest most obviously with the first one or two doses, and so previous doses of HP remedies prepare the way for future doses.

Since the level of reactions falls throughout the program, this also suggests that the program is not administering excessive doses of each remedy. If the doses were excessive, then we would expect reaction rates to rise.

The higher percentage of reactions in the first two years for Series 6-10 and Series 11-15 suggests that the use of triple doses has brought forward the reaction rate to the medicines in the program. Once again, this is expected from a classical homoeopathic perspective, given that a triple dose is a stronger challenge to the recipient than a single dose, and so a potential sensitivity will be activated more by a triple dose than a single dose.

Table 14 Time Profile of Definite Reactions to Program Medicines by Respondent

Reactions occurred in	**Series 1-5**	**Series 6-10**	**Series 11-15**	
1st year	64.3% (27)	76.8% (53)	83.3% (55)	
2nd year	16.7% (7)	15.9% (11)	10.6% (7)	
3rd year	11.9% (5)	4.4% (3)	4.6% (3)	
4th year	7.1% (3)	2.9% (2)	1.5% (1)	
Totals	100% (42)	100% (69)	100% (66)	

4.7 Comments on a General Health Survey of Children Using HP Programs

As part of my doctoral studies at Swinburne University between 2001 and 2004, I collected a two page questionnaire from parents of 781 children aged between 4 and 12 years of age. The questionnaire and covering letter are reproduced in Figure 1 in the Appendix.

This retrospective study used measures of the child's health experience such as the incidence of asthma, eczema, ear and hearing problems, allergies and behavioural problems, as well as the parents' evaluation of their child's general health.

Cases of whooping cough, measles and mumps were recorded, as was each child's hospitalisation experience.

With both health conditions and infectious diseases, respondents were asked whether a diagnosis by a medical practitioner was made.

These indices of health were compared to early childhood factors such as birth weight, gestation, APGAR scores, length of breastfeeding and method of disease prevention. The latter factor is of most interest in this study.

Four different types of immunisation history were questioned. They were:

- Homoeoprophylactically protected with disease-specific medicines.
- Vaccine protected
- "Constitutionally" protected, (i.e., any general health measures intended to improve overall health, and thus improve overall immunity against all infectious diseases)
- No specific or general protection against infectious diseases.

Because of the possible combinations of alternatives, eight different categories were examined. They were:

- Homoeoprophylaxis only
- Vaccination only
- General/constitutional protection only
- Homoeoprophylaxis and vaccination
- Homoeoprophylaxis and general protection
- Vaccination and general protection
- Homoeoprophylaxis, vaccination and general protection
- No method of protection.

The aim of my thesis was to determine whether an appropriate long-term HP program can safely prevent targeted infectious diseases.

An overview of results is shown in Table 15 below, which also summarises results from the 15 year clinical study. The "HP only" option is reported in Table 15 to avoid the complicating factors involved with the multiple use options.

Table 15 Summary of Evidence

15 Year Study – # = 2,342	**General Health Survey - # = 781**
(1) EFFICACY	
Mean Efficacy = 0.904 (C.I. = 0.876 – 0.932; P = 95%) (Table 8) Efficacy took into account exposure rates (377 no-diseases from 417 exposures). Non-respondents checked. Reports of diseases and exposure checked (Appendix, Tables 4 and 8). Other tests to validate the figures (section 4.4). No comparison with other methods of immunisation.	Mean Efficacy of HP only = 0.79 (C.I. = 0.70 – 0.89; P = 95%) (Thesis, Tables 5.1-11) No ability to account for exposure rates, or to follow-up respondents. Comparison made with vaccinated, unvaccinated, and do-nothing groups. Included parents who used my long-term HP program (10.3%), and those who used other programs (9.2%). The efficacy of other HP programs shown to be lower (section 4.10).
(2) SAFETY	
1. Short term safety – reactions to 1.5% of doses (Table 10). Reactions typically brief and mild (Table 13). **2. Long term safety** – General Comments by parents re general health of child – 92.3% positive; 7.7% negative (Table 21).	**Long term safety of HP only** – 1. Absolute safety of HP only – Odds ratio < 1 for every condition studied: asthma = 0.12 Eczema = 0.38 Ear/hearing = 0.92 Allergies = 0.55 Behaviour = 0.45 (Table 18) 2. Relative safety of HP only - asthma - safest; P = 0.0004 eczema - safest; P = 0.015 ear/hearing - 3rd safest; P = 0.8 allergies - 2nd safest; P = 0.07 behaviour - 2nd safest; P = 0.17 (Table 18) (P = Chi squared probability) 3. Accumulated parental rankings of general health of their child - HP only is associated with the highest level of health over all rankings. (Thesis, Figure 5.19)

Conditions studied: asthma, eczema, ears/hearing, allergies, and behavioural problems.
Methods of immunisation studied: HP only, vaccination only, general only, nothing.

The findings of the General Health Survey were inconclusive regarding the efficacy of HP only, as a consequence of a lack of sufficient responses to make the figures statistically reliable.

However, the results were statistically significant, (P>95%), in regards to the safety of HP only. The analysis was divided into measures of absolute safety, and measures of relative safety.

The Absolute Safety of HP

The data from the General Health Survey link five health conditions – asthma, eczema, ear/hearing problems, allergies, behavioural problems - with four different methods of immunisation, including HP.

Two statistical measures of the absolute safety of HP were used in the analysis.

1. Proportion (SHP1) = $\frac{\text{Persons with the Condition (using HP only)}}{\text{All Persons (using HP only)}}$

The lower the value of SHP1, the more safe the method (HP). This proportion was compared to the national average for each condition, where available.

The figure was also calculated for conditions where a diagnosis was made by a GP, and this was compared with the total figures for all conditions. Whilst a GP diagnosis may not always be correct, and other diagnoses may not always be incorrect, it does give another insight into the reliability of the total figure.

Note that in order to minimise the influence of confounding variables (i.e. those than may cause a distortion of results), the analysis considered those children who used HP only, and excluded other children who used a variety of preventative methods together with HP.

2. Odds Ratio (SHP2) = $\frac{\text{Condition (using HP only)}}{\text{No Condition (using HP only)}} \Big/ \frac{\text{Condition (not using HP)}}{\text{No Condition (not using HP)}}$

If the Odds Ratio was greater than 1, the method would be classified as unsafe. For a method to be regarded as very safe we would expect the Odds Ratio to be significantly below 1.

I constructed the following classification of degrees of safety as shown in Table 16. This classification provides a subjective guide only to the safety of a method.

Table 16 Definition of Degrees of Safety

0.00 < Odds Ratio <=0.25	– very safe
0.25 < Odds Ratio <= 0.50	– safe
0.50 < Odds Ratio <= 0.75	– moderately safe
0.75 < Odds Ratio <= 1.00	– not safe
Odds Ratio > 1.00	– unsafe

In addition to the Odds Ratio, the Chi Squared probability of the association between "the use of HP only" and "the observed condition" being a coincidence was calculated.

A measure will not be accepted unless its confidence level is at least 95%. This requires a Chi Squared probability of 0.05 or less. The lower the Chi Squared figure, the greater the likelihood that the association between the health condition (e.g. asthma) and the method of immunisation used (e.g. HP only) as reflected in the Odds Ratio is NOT a coincidence. These ratios and probability estimates are listed in Table 17 below.

The figure for SHP1 shows that the incidence of asthma among children who use only HP as a method of disease prevention (3%) is well below the national average of 19%. It further shows that the incidence of behavioural problems is extremely low, with very modest levels for the remaining conditions.

However, the Odds Ratio is the more reliable of the two figures. It is less than unity for every condition studied, which shows that HP only is not linked with an increase in the incidence of any of the conditions examined.

Further, we can say with a high probability (P>98%) that HP only is associated with a lower than average chance of acquiring asthma and eczema, with a moderate probability (P=93%) of developing fewer allergies, and with a low probability of having fewer behavioural problems (P=83%) than children not using only HP. The result linking HP only with ear and hearing problems indicated that HP only was not safe based on the classification described in Table 16; however, the result was not statistically significant.

Thus, in absolute terms HP only is shown to be a safe method of disease prevention.

Table 17 Ratio Analysis of the Safety of HP Only

Condition	**Proportion (SHP1)**			**Odds Ratio (SHP2)**	**Chi Squared Probability**	**Results**	
	No GP diagnosis	With GP diagnosis	National Average		P	**Safety**	**Confidence**
Asthma	0.03	0.03	0.16** - 0.19*	0.117	0.0004	Very safe	Very high
Eczema	0.10	0.04	N/A	0.382	0.015	Safe	High
Ear/hearing	0.17	0.11	N/A	0.917	0.79	Not safe	Nil
Allergies	0.15	0.04	0.09 – 0.16**	0.550	0.07	Moderately safe	Medium
Behaviour	0.04	0.01	N/A	0.446	0.17	Safe	Low

References:

* (Australian Bureau of Statistics, *Health – Mortality and Morbidity: Asthma.* Australian Social Trends, 1999).

** (Australian Bureau of Statistics, *Summary of Results, Australia.* National Health Survey, 2003).

The Relative Safety of HP

A more precise measure of safety can be found by examining the relationship between HP and other methods of immunization, and the five different chronic health conditions covered by the General Health Survey questionnaire. This relationship is examined in Tables 18 and 19 below. The measures for each condition that are statistically significant are shown in bold print.

The relationship between the five conditions and HP programs supplied by Golden is also shown in Table 18. The difference between HP programs supplied by Golden and other HP programs is discussed fully in section 4.10 below. A significant difference is found.

We may summarize the statistically significant findings ($P<0.05$) for each condition using the above data as follows:

Asthma - we can say with 99% confidence that HP only is 15 times safer than vaccination and 6 times safer than no method of protection.

Eczema - we can say with 98% confidence that HP only is 1.8 times safer than no method of protection.

Ears/Hearing Problems, Allergies, Behavioral Problems - we are not able to draw conclusions about the safety of HP only with a greater than 95% confidence that the conclusion is correct.

Thus, for the two conditions where statistically significant results were found, HP only was the safest option in both conditions when compared with vaccination and the do-nothing option. This result also applied to HP programs supplied by Golden.

Table 18 The Relative Safety of HP – All Conditions

		Method				
Condition	**Measurement**	**HP only**	**Vaccination only**	**General only**	**Nothing**	**HP supplied by Golden**
Asthma	Odds Ratio	**0.117**	**1.75**	0.464	**0.74**	**0**
	Chi Test P	**0.0004**	**0.0025**	0.102	**7.9E-40**	**0.017**
Eczema	Odds Ratio	**0.382**	1.315	0.781	**0.674**	**0.153**
	Chi Test P	**0.0146**	0.121	0.513	**5.3E-40**	**0.035**
Ear/Hearing	Odds Ratio	0.917	1.149	0.585	**0.533**	0.393
	Chi Test P	0.792	0.459	0.222	**2.3E-40**	0.193
Allergies	Odds Ratio	0.550	1.220	0.653	**0.520**	0.60
	Chi Test P	0.074	0.239	0.254	**1.2E-40**	0.351
Behaviour	Odds Ratio	0.446	0.869	2.103	**0.397**	0
	Chi Test P	0.170	0.593	0.063	**2.7E-40**	0.123

Note: Statistically significant figures are shown in bold type.

The overall reliability of these measures can be tested by re-examining the above results, but only including those conditions that have been diagnosed by a medical practitioner. Of course not all such diagnoses may be correct. Further, diagnoses made by non-medical practitioners or by parents themselves may be quite valid. These new figures are shown in Table 19 below.

It seems reasonable to assume that if the overall rankings of safety in the Tables 18 and 19 are consistent, then the results are reliable.

We find that many more measures in Table 19 have $P<0.05$ than in Table 18.

We may summarise the findings using the GP diagnosed data as follows for each condition, including only those results with a confidence level of 95%:

Asthma - we can say with 99% confidence that HP only is 15 times safer than vaccination and 5.6 times safer than no method of protection.

Eczema - we can say with 99% confidence that HP only is 7.4 times safer than vaccination, with 97% confidence that HP is 0.06 times less safe than general protection, and with 99% confidence that HP is 2.8 times safer than no method of protection.

Ear/Hearing Problems - we are not able to draw conclusions about the safety of HP only with a greater than 95% confidence that the conclusion is correct. However, we can say with 95% confidence that Vaccination is 3.9 less safe than doing nothing

Allergies - we can say with 94% confidence that HP only is 5 times safer than vaccination, and with 99% confidence that HP is 2 times safer than no method of protection.

Behavioral Problems - we are not able to draw conclusions about the safety of HP only with a greater than 95% confidence that the conclusion is correct. However, we can say with 95% confidence that doing nothing is twice as safe as general protection. We can say with 94.5% confidence that HP is the safest option.

Examining the statistically significant results from both tables, we find that only once was HP only shown to be less safe than another method, and that was only 0.06 times less safe in that instance.

Thus we may conclude that, with the exceptions of ear and hearing problems, we can say with a high level of confidence (>95%) that HP only is relatively a very safe method of disease prevention.

Table 19 The Relative Safety of HP - All Conditions - GP Diagnoses Only

Condition	**Measurement**	**HP only**	**Vaccination only**	**General only**	**Nothing**
Asthma	Odds Ratio	**0.124**	**1.89**	0.49	**0.69**
	Chi Test P	**0.0006**	**0.0007**	0.13	**6.5E-40**
Eczema	Odds Ratio	**0.239**	**1.76**	**0.225**	**0.665**
	Chi Test P	**0.0097**	**0.006**	**0.025**	**6.5E-40**
Ear/Hearing	Odds Ratio	0.703	**1.517**	0.599	**0.401**
	Chi Test P	0.364	**0.04**	0.282	**9.4E-41**
Allergies	Odds Ratio	**0.307**	1.518	0.446	**0.608**
	Chi Test P	**0.038**	0.061	0.171	**5.8E-40**
Behaviour	Odds Ratio	**0.541**	0.784	**1.675**	**0.784**
	Chi Test P	**0.055**	0.613	**0.049**	**1.2E-40**

Note: Statistically significant figures are shown in bold type.

4.8 General Comments by Parents of Children Using the HP Program

At the end of each HP questionnaire, parents were invited to make comments if they wished to. Tables 13, 14 and 15 in the Appendix reproduce those parental comments which relate to the general health of their children.

One purpose of this analysis is to gauge whether there appears to be any evidence of a systematic weakening of children's immunity through using my long-term HP program.

While there are understandable biases in the figures, such as parents who were unhappy with the HP program not bothering to respond (although some clearly did), the figures seem to suggest quite clearly that children using the program enjoyed better-than-average medium-term health than their peer group.

This supports the proposition made in previous publications that a properly constructed and administered long-term HP program in no way weakens the general health and vitality of those children using the program.[10]

A classification of general comments made by Series 11-15 respondents to my HP program was made to assess the long-term wellbeing of children using the program. These comments are shown in Appendix 4 in Table 4.3. A summary of responses is shown in Tables 20 and 21 below.

Table 20 shows the breakdown of all comments into "positive", "neutral" and "negative" for three categories of response – "health related comments", "administration of the program" and "other comments".

However, the very large percentage of comments in the "neutral" categories (58.3%) means that a meaningful analysis of the figures is difficult. Therefore, "neutral" comments are removed in Table 21 and only positive and negative comments are recorded. They provide a more accurate indication of the relative strengths or weaknesses of the program.

Three conclusions may be drawn from the data in Table 21:

1. Parents of children using the program who commented on the health of their child reported significantly more positive health experiences (92.3%) than negative ones (7.7%). This long-term figure, combined with earlier findings of a less than 2% reaction rate per dose, suggests that the program is safe both in the short and long terms.

2. Parents of children using the program who commented on the administration of the program reported a significant level of problems (72.5%). These problems mainly related to difficulties in administering the pilules, especially the need to dose between meals. There is little that can

[10] Golden I. *Homoeoprophylaxis – A Ten Year Clinical Study,* 2004, p. 8.
Golden I. *Homoeoprophylaxis -- A Practical and Philosophical Review* - 3rd ed., 2001, p. 12.

be done to change the method of administration, since giving doses with meals would antidote most doses. Fortunately, these administration difficulties were reported in only 3.55 % of total responses (29/817). They cease to be an issue when the child is older and does not require regular feeding.

3. Parents of children using the program who made general comments on their experience with the program were generally very happy (89.7%), with only a minority (10.3%) voicing discontent.

The comments by Series 11-15 parents whose children used my long-term HP program strongly suggest that these children experience very few long-term problems with their health, and in fact many positive comments are made about how well the children are.

This data suggest that the long-term safety of the program is high. The data are also totally consistent with the conclusions made using data from the General Health Survey for children who used HP and/or other methods of disease prevention.

Table 20 Classification of "Other" Comments

	Health Related Comments		Administration of the Program		Other Comments	
	#	%	#	%	#	%
Positive	72	62.1%	11	13.7%	52	37.4%
Neutral	38	32.8%	40	50.0%	81	58.3%
Negative	6	5.1%	29	36.3%	6	4.3%
Total	116	100.0%	80	100.0%	139	100.0%

Table 21 A Re-Classification of "Other" Comments

	Health Related Comments		Administration of the Program		Other Comments	
	#	%	#	%	#	%
Positive	72	92.3%	11	27.5%	52	89.7%
Negative	6	7.7%	29	72.5%	6	10.3%
Total	78	100.0%	40	100.0%	58	100.0%

4.9 The Safety of the Long-term HP Program

The safety of an appropriate long-term HP program has been addressed in sections 4.6, 4.7 and 4.8 above.

In summary, it is clear that those children who used my long-term HP program reacted to less than 2% of the doses given. The reactions were typically very brief and very mild, although in a couple of cases longer or more severe reactions did occur (demonstrating yet again that homoeopathic potencies are not placebos).

The data from the General Health Survey strongly supported the safety of HP in general, and in fact suggested that a child's general health could be improved by using HP.

However, not all HP programs are the same, and the data from the General Health Survey also produced the opportunity to compare the results of using my long-term HP program with other HP programs. This comparison is made in section 4.10 following.

4.10 A Comparison of Different HP Programs

Respondents to the General Health Survey who reported using an HP program in fact used a variety of programs. It was possible, through matching respondents' names and addresses, to identify which respondents to the General Health Survey obtained their program from me, and those who did not.

It is possible that some respondents who did not obtain an HP program from me still used a program obtained from another practitioner who copied my program. However, it was not possible to identify these respondents from the data collected.

A comparison between respondents using HP programs obtained from me, and respondents using other HP programs, revealed noticeable differences. The actual numbers of respondents is shown in Table 22, and proportions are reported in Tables 23 and 24.

The results in Table 23 show that using HP alone gives a better result than using HP combined with other forms of disease prevention. This suggests that some users may have had a bad experience with other forms of prevention and then switched to HP (something I regularly see in practice), but this cannot be proved from the figures.

A comparison was reported in Table 24 between conditions and diseases for all HP users, and those who used HP only. All but one comparison (allergies – HP only) showed a better result for the programs supplied by me. However, the size of data collected does not allow the statistical significance of these comparisons to be calculated.

Chi Squared tests were performed to compare programs which I supplied, and programs which I did not supply. An odds ratio >1 would show an unfavourable result for programs supplied by me, and a result <1 would be favourable to programs I supplied.

The following results were statistically significant, and all showed that Asthma and the three diseases studied are all less likely to occur if a program supplied by me is used compared to one not supplied by me.

Asthma:	All HP:	Odds Ratio = 0.28;	P = 96%
Measles:	All HP:	Odds Ratio = 0.33;	P = 95%;
	HP Only:	Odds Ratio = 0;	P = 94%
Whooping Cough:	HP Only:	Odds Ratio = 0;	P = 97%
Mumps:	HP Only:	Odds Ratio = 0;	P = 100%

The results confirm that the type of HP program used does make a difference. They indicate, with some degree of significance, that children using HP programs supplied by me acquired fewer infectious diseases and reported fewer adverse long-term health conditions, than children using HP programs that I did not supply.

Table 22 Comparison of HP Use – Program Supplied/Not Supplied by Golden – Actual Numbers

	HP Supplied by Golden		HP Not Supplied By Golden		Combined	
	All HP	HP Only	All HP	HP Only	All HP	HP Only
Number of Respondents	59	25	100	47	159	72
HP only	25		47		72	
Vaccination also	20		31		51	
General Protection also	26		42		68	
(including all three methods)	12		20		32	
Number with Asthma	3	0	16	2	21	2
Number with Eczema	10	1	20	6	30	7
Number with Ear/Hearing	9	2	26	10	35	12
Number with Allergies	14	4	29	6	43	10
Number with Behaviour Issues	5	0	12	3	17	3
Number with Measles	4	0	18	6	22	6
Number with Whooping Cough	6	0	17	8	23	8
Number with Mumps	1	0	1	0	2	0

Table 23 Comparison of HP Programs Supplied/Not Supplied by Golden – Proportions (1)

	HP Supplied by Golden		HP Not Supplied By Golden		Combined	
	All HP	**HP Only**	**All HP**	**HP Only**	**All HP**	**HP Only**
Number of Respondents	59	25	100	47	159	72
HP only	42.4%		47.0%		45.3%	
Vaccination also	33.9%		31.0%		32.1%	
General Protection also	44.1%		42.0%		42.8%	
Proportion with Asthma	5.1%	0.0%	16.0%	4.3%	13.2%	2.8%
Proportion with Eczema	17.0%	4.0%	20.0%	12.8%	18.9%	9.7%
Proportion with Ear/Hearing	15.3%	8.0%	26.0%	21.3%	22.0%	16.7%
Proportion with Allergies	23.7%	16.0%	29.0%	12.8%	27.0%	13.9%
Proportion with Behaviour Issues	8.5%	0.0%	12.0%	6.4%	10.7%	4.2%
Proportion with Measles	6.8%	0.0%	18.0%	12.8%	13.8%	8.3%
Proportion with Whooping Cough	10.2%	0.0%	17.0%	17.0%	14.5%	11.1%
Proportion with Mumps	1.7%	0.0%	1.0%	0.0%	1.3%	0.0%

Table 24 Comparison of HP Use – Program Supplied/Not Supplied by Golden – Proportions (2)

	All HP		HP Only	
	Golden	**Not Golden**	**Golden**	**Not Golden**
Number of Respondents	59	100	25	47
HP only	42.4%	47.0%		
Vaccination also	33.9%	31.0%		
General Protection also	44.1%	42.0%		
Proportion with Asthma	5.1%	16.0%	0.0%	4.3%
Proportion with Eczema	17.0%	20.0%	4.0%	12.8%
Proportion with Ear/Hearing	15.3%	26.0%	8.0%	21.3%
Proportion with Allergies	23.7%	29.0%	16.0%	12.8%
Proportion with Behaviour Issues	8.5%	12.0%	0.0%	6.4%
Proportion with Measles	6.8%	18.0%	0.0%	12.8%
Proportion with Whooping Cough	10.2%	17.0%	0.0%	17.0%
Proportion with Mumps	1.7%	1.0%	0.0%	0.0%

4.11 Summary

Table 25 contains a summary of accumulated results.

It clearly shows that the current program using triple doses and higher potencies has resulted in both a greater number of reactions to medicines in the kit, and a higher level of protection.

In view of the low incidence of reactions (less than 2% per dose), and the relatively mild and brief reactions that were generally reported, many parents would regard this as an acceptable trade-off.

However, further study will concentrate on developing the program to maintain efficacy rates while lowering the level of reactions.

Table 25 Summary of Results of a Fifteen Year Study into Long-Term Homoeoprophylaxis

Measures of Reactions & Efficacy Data After Follow-Up Surveys	**Data Series**				
	Series 1-5	**Series 6-10**	**Series 11-15**		**Totals**
Total Responses	**708**	**817**	**817**		**2342**
1 Previously vaccinated	73	102	110		285
	10.3%	**12.5**%	**13.5**%		**12.2**%
2. Definite reactions to remedies	50	83	82		215
Reactions per person	**7.1%**	**10.2**%	**10.0**%		**9.2**%
Reactions per dose (est.)	**1.2%**	**1.7%**	**1.7%**		**1.5%**
3. Definitely suffered from diseases covered by main	18	11	11		40
program (a measure of failure)	**2.5**%	**1.3**%	**1.4**%		**1.7**%
4. Definitely exposed to diseases	177	127	113		417
covered by main program	**25.0**%	**15.5**%	**13.8**%		**17.8**%
5. Definitely suffering diseases, after definite exposure and after	18/177	11/127	11/113		40/417
taking the appropriate remedy	**10.2**%	**8.7%**	**9.7**%		**9.6**%
(a measure of failure)					
6. Definitely not suffering diseases, after definite exposure and after taking appropriate	159/177	116/127	102/113		377/417
remedy (a measure of success)	**89.8**%	**91.3**%	**90.3**%		**90.4**%

5 CONCLUSIONS

The material presented in this report represents the culmination of a long and at times difficult process of data collection, processing, and interpretation.

The survey is without doubt statistically incomplete. The number of responses is significant, but more responses would have increased the statistical power of the study. The need to rely on the opinion of parents as to the exposure and incidence of disease, and remedy reactions, has lead to uncertainty. The inability to include a control group in the trial is a consequence of limited resources, and does affect the outcome - as does the difficulty of achieving a high level of questionnaire return, which has at times been very frustrating.

However, the fact remains that a significant number of questionnaires were collected. It also appears that parents in general have answered in good faith, given the range of answers, yet their consistency over 15 years.

There is no indication that the results are artificially biased in favour of HP. In fact, the reverse is true since only two reports for Polio exposure have been recorded when in fact exposure would have been more extensive than this due to contacts with recently vaccinated children. Also, many parents would not have been aware of exposure to a disease when their children did not fall ill, and therefore no exposure would have been reported.

The goal set in 1997 to achieve a greater than 70% response rate from parents in the new groups of respondents has been achieved, and a variety of follow-up tests to validate the data have been performed.

The new figures (Series 11-15) are consistent with the previous figures reported in the 1997 study (Series 1-10). This gives even greater confidence in the data supporting the efficacy and the safety of my long-term HP program.

The aim has been to provide the most comprehensive and reliable data (given the limitations of time and resources) from which to draw conclusions concerning the efficacy and the safety of long-term HP. While the sceptics will no doubt remain, I believe there is much that an objective observer can learn from this study.

I have not discussed the question of whether certain infectious diseases should be prevented. I believe the final decision for each child belongs to their parents, and as I said earlier, this issue has been discussed elsewhere. This report assumes that a decision has been made to prevent at least some infectious diseases, and examines the HP option.

I reached the following conclusion to my doctoral thesis - “This study has shown that the use of HP offers the potential to benefit children through both a greater level of national protection against targeted infectious diseases, as well as through lower levels of chronic health conditions. The case for further research is compelling.” (p.230).

I believe the data contained in this study show that a dual system of immunisation, where vaccination programs and appropriate long-term HP programs are both available to parents to choose, offers the most cost-effective solution to the dilemma of how best to protect our children against preventable infectious diseases.

For 200 years, homoeopathy has offered this alternative, but only the educated few have taken advantage of it. It is now time for health bureaucrats to put prejudice aside, look at the evidence presented in this and other references, and support a dual immunisation system.

Politicians will not make decisions without the bureaucrats' approval. Let men and women who call themselves "scientists", who pride themselves on being objective and unbiased, take the next step.

God Willing, let us hope to see this happen in our lifetimes, for the benefit of all in our global community, especially our children on whom the future wellbeing of our planet rests.

Make no mistake – this issue is that important!

6 A NOTE FOR FUTURE RESEARCHERS

If any readers are interested in building on the work reported in this book, then I believe that the most cost-effective next step would be to reproduce the General Health Survey with the aim of attracting at least 4,000 responses.

In Australia, this could be achieved with reasonable resources, and with the cooperation of the Education Departments in every State. Such a study could be completed within two years and produce results that were highly statistically significant.

I would be happy to assist any genuine endeavor along these lines.

I had hoped to undertake a small controlled clinical trial of HP, but this was blocked by the ethics committee at Swinburne University.

I also found that my attempts to recruit respondents to the General Health Survey via the New South Wales primary school system were opposed by the NSW Health Department. Their opposition meant that the NSW Education Department refused my request to distribute invitations to primary school parents to participate in the Study.

For whatever reasons, research into HP is never uncomplicated. Future researchers need to consider their preparedness to deal with pressure from Health Department officials.

In an ideal world, we would be working together to find out what was best for our children. But this is not an ideal world, so be prepared.

Also, be prepared for strident criticism from a few opponents of HP from within the homoeopathic community. As in life, the more narrow the view, the louder the criticism.

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9 APPENDICES