

**A CLINICAL AUDIT OF THE DURBAN UNIVERSITY OF TECHNOLOGY
HOMOEOPATHIC SATELLITE CLINIC ESTABLISHED AT UKUBA NESIBINDI**

By

TRACEY SMILLIE

**A clinical audit of the Durban University of Technology
homoeopathic satellite clinic established at Ukuba Nesibindi.
By**

Tracey Smillie

Dissertation submitted in partial compliance with the requirements of the Master's
Degree in Technology: Homoeopathy in the Faculty of Health Sciences at the
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I Tracey Smillie do declare that this dissertation is representative of my own work,
both in conception and execution.

Signature of Student

Date of signature

APPROVED FOR FINAL SUBMISSION

Signature of Supervisor

Dr D.F. Naude

M. Tech : Hom (T.N)

Date of signature

Signature of Joint-Supervisor

Dr J. Ngobese

M. Tech : Hom (T.N)

Date of signature

**THIS IS DEDICATED TO MY
GRANDDAD DUTCHIE
(I WILL NEVER FORGET YOUR WISDOM
AND THE LESSONS YOU PASSED ON)
AND
MY PARENTS DAVID AND LESLIE
FOR THEIR UNCONDITIONAL
LOVE AND SUPPORT**

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ABSTRACT

Introduction

In collaboration with Lifeline, Durban University of Technology (DUT) established its first satellite homoeopathic community clinic; Ukuba Nesibindi Homoeopathic Clinic (UNHC). UNHC provides a free homoeopathic primary healthcare service on the third floor of the LifeLine building in Warwick junction, Durban, an area which is classified as being disadvantaged with high crime rates, prostitution, violence, small, informal business and low cost housing. The clinic is run by 4th and 5th year homoeopathic students under the supervision of a qualified homoeopathic practitioner and funded totally by the Department of Homoeopathy – DUT.

The purpose of this retrospective clinical audit of UNHC was to determine a patient demographic and disease prevalence profile, as well as identify and describe the major medicines prescribed.

Methodology

The study used a retrospective, explanatory, and descriptive design method by means of a clinical audit, to determine a patient demographic and disease prevalence profile, as well as identify and describe the various homoeopathic treatment modalities. All the patient files from June 2004 – June 2008 were included for analysis and the data collection spreadsheet (Appendix D) was compiled respectively.

The data collection form was divided into patient demographics, information on number of consultations and follow-ups, clinical diagnoses, urine dipstick analysis, patient referral information and medicines prescribed. The researcher captured the data, which was analysed and various means of descriptive statistics applied using Excel from Microsoft Office® 2007.

Results

UNHC opened in 2004 and initially only operated two afternoons per week; in order to cope with the demand for this service which grew rapidly in 2006 an additional consultation afternoon was added. A total number of 862 patients were seen between June 2004 and June 2008, 497 being new patients and 365 being follow up patients. On average 56% of patients came back for more than one follow up consultation during the study period. The majority of patients who attended UNHC during the study period were African females between 40 and 64 years of age who were unemployed and single. Of the 5 most prevalent systemic disorders encountered at UNHC infectious disorders were the most frequent along with cardiovascular, dermatological, psychological and musculoskeletal disorders.

Conclusion

The significant increase in patient numbers at UNHC and the relatively high percentage of patients who returned for more than one follow up consultation are positive trends and suggestive of UNHC's success in providing homoeopathic primary healthcare as well as the positive impact it has had on the surrounding community.

With additional funding UNHC can improve service provision further; dedicated translators as well as various equipment to facilitate administration will streamline the consultation process significantly and allow for more patients to be seen.

Expansion of the scope of diagnostic services provided such as pregnancy and glucose testing will reduce the need for referral for such basic services. V

Future studies should formally measure patient benefit in response to treatment in the form of a patient benefit survey; qualitative measures of patient satisfaction with the service provided by UNHC are also warranted.

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Definition of terms

Primary Health Care (PHC):

Primary health care is a term used for the activity of a health care provider who acts as a first point of consultation for all patients. Continuity of care is also a key characteristic of primary care (Evian, 2003).

Allied Health Professions Council of South Africa (AHPCSA):

Allied Health Professions Council of South Africa is a statutory council for Natural Health, responsible for the promotion and protection of the health of the population of South Africa and will affect this by regulating and setting standards for the profession of homoeopathy, under act 63 of 1982.

World Health Organisation (WHO):

A United Nations agency to coordinate international health activities and to help governments improve health services (Iriye, 2002).

Materia Medica:

"materials of medicine" in Latin. A reference that lists the curative indications and therapeutic actions of homeopathic medicines (Lilley, 2008).

Repertory:

An index of the homoeopathic materia medica by symptom. A list of remedies is indicated for each symptom. All modern day repertories use Kent's Repertory as their starting point (Leckridge,1997).

Simillimum:

The single remedy which best matches the symptoms of the patient (Leckridge,1997).

Potency

According to Kayne (2008) potency is the strength of a homoeopathic remedy.

Posology

The pharmacological determination of appropriate doses of drugs and medicines (Nicolai, 2008).

Quinquagenimillesimal (LM) prescriptions

Fifty millesimal potency is Hahnemann's potency scale for dispensing homeopathic medicines; developed by adding one part remedy to an alcohol/water solution of the rating 1 : 50,000. One drop is placed in 2 ml alcohol and succussed 100 times

(<http://www.homeopathycommunity.com/FiftyMillesimalscale.asp>, Accessed online [13 April 2010]).

Centesimal potencies

Centesimal scale is based on the principle that the first potency must contain the one-hundredth part of the original drug and each succeeding potency, one-hundredth part of the preceding one

(<http://www.homeopathycommunity.com/CentisimalandDecimalScale.asp>, Accessed online [13 April 2010]).

Decimal potencies

Decimal scale of potentisation is based on the principle that the first potency should contain one-tenth part of the original drug and each succeeding potency should contain one-tenth part of the potency preceding it

(<http://www.homeopathycommunity.com/CentisimalandDecimalScale.asp>, Accessed online [13 April 2010]).

Polychrest

A drug that serves as a remedy for several diseases

(<http://www.thefreedictionary.com/polychrest>, Accessed online [13 April 2010]).

CHAPTER ONE: INTRODUCTION

1.1 Introduction

South Africa's healthcare system consists of a large public sector and a small private sector. The public sector is under-resourced and over-used. Homoeopathic practices in South Africa are mainly available to the small private sector but have the potential to be active primary healthcare providers (Ferrucci, 1994). The addition of homoeopathy to existing primary healthcare clinics would be of benefit to the current healthcare system. As far as can be determined there have been no other studies which describe the role/function of homoeopathy in the form of a public sector primary healthcare clinic in South Africa.

1.2 Aim of study

The aim of this retrospective, exploratory, descriptive study is to determine a patient demographic and disease prevalence profile at UNHC, as well as identify and describe the major medicines prescribed. It is anticipated that the establishment of such formal data may define the potential contribution homoeopathy can make in the primary healthcare sector in South Africa. The study will include reviewing data from June 2004 – June 2008.

1.3 Rationale of study

By providing formal clinical data including patient demographics, disease prevalence, consultation numbers, remedies prescribed and patient's referrals it may assist in describing the viability of homoeopathic care in a primary healthcare setting. This may facilitate in the establishment of additional clinics, expanding accessibility to homoeopathy by the general public as well as providing additional training facilities for homoeopathic students.

No formal clinical audit or evaluation of practices at the UNHC has been conducted; as this is a teaching/learning as well as a primary health facility, such an assessment will provide necessary data which will facilitate high standards in healthcare as well as teaching/learning.

1.4 Delimitations

1. Only the patient files from Ukuba Nesibindi Homoeopathic Clinic (UNHC) were included in this study.
2. Only patient files from 1 June 2004 – 1 June 2008 were included in the study.
3. Patient benefit / response to treatment has not been measured / described.

CHAPTER TWO – LITERATURE REVIEW

2.1 Introduction to Homoeopathy

Homoeopathy acts as a holistic complementary and alternative therapy based on a concept that 'like cures like'. Founded by a German physician Friedrich Samuel Hahnemann, homoeopathy is based on certain key principles. The first principle states that in order to cure disease, one must look for medicinal substances that can create similar symptomatology in a healthy human body i.e. 'Similia similibus curentur', translated as 'like cures like', means to match symptoms and drug pictures. Hahnemann also developed the method of serial dilution and succussion of remedies and noted that as the remedies became more dilute they become more potent therapeutically (Kayne, 2008). According to Nicolai (Kayne, 2008), in addition to the above fundamental therapeutic principle of homoeopathy it is essential to treat patients holistically meaning as a complete individual. It is the caring and treating of the whole-person with less emphasis on drugs and the non-invasive approach with few side effects which is attributed to the increase in demand for homoeopathy.

2.2 LifeLine Southern Africa

LifeLine Southern Africa affiliated to LifeLine International is a non-profit organization which offers free counselling 24 hours a day either face to face or telephonically. LifeLine provides trained counsellors which can be contacted at any time on any issue.

LifeLine also offers a crisis response team and provides an outreach programme in Clermont known as, 'Ukuba Nesibindi', as well as provides training for other welfare organizations and the broader community (LifeLine Manual, 2007).

Homoeopathic students in their 4th year of training at Durban University of Technology (DUT) are required to attend a 6 month course conducted by LifeLine in order to learn how to effectively manage and counsel patients seen in the homoeopathic clinic. The course includes personal growth seminars as well as equipping students with good counselling skills.

2.3 The Department of Homoeopathy at DUT

DUT's Homoeopathic programme comprises of a 5 year coursework Masters degree with lecture content encompassing basic medical sciences, homoeopathic philosophy, pharmacology, materia medica and therapeutics and a large practical component in the latter two years of the programme which is conducted in homoeopathic clinics. This is followed by a year of internship in the clinic where students see patients under the supervision of a qualified practitioner. Once the above is completed including a mini dissertation a Masters Degree in Technology: Homoeopathy is awarded (Homeopathy Handbook, 2008).

During their training it is vital that students are able to actively consult with patients in clinical environments allowing them to be exposed to a range of conditions and treatment modalities. This provides students with a crucial practical foundation and a clinical environment in which to apply their theoretical knowledge under the guidance of experienced qualified homoeopaths.

2.4 The Collaboration between LifeLine and DUT

In 2003 a collaboration between LifeLine and the DUT Department of Child and Youth Development established Ukuba Nesibindi at 23 Stratford Road, Warwick Junction, Durban, KwaZulu-Natal. The purpose was to build a community outreach programme in this area which was aimed particularly at the youth at high risk as this is a predominantly low income area with a high incidence of violence.

2.5 Ukuba Nesibindi community outreach programme

Ukuba Nesibindi endeavours to create more skilled workers, and to offer impoverished people a chance to better themselves personally and provide them with a skill to aid them in finding jobs. In order to make this possible the programme offers free courses in beadwork, sewing, and hairdressing as well as sending students to the Young Men Christian Association (YMCA) to gain computer skills.

Ukuba Nesibindi also conducts personal growth and life skills seminars which continue all week for the students and anyone who wants to participate at no cost. Ukuba Nesibindi hires many of its previous students to become counsellors and supplies food and shelter to those in need. They also run a school day care for children to be cared for in a safe environment with positive mental and emotional stimulation. LifeLine has also included a HIV testing clinic and offers rape counselling at Ukuba Nesibindi where patients can receive free HIV testing as well as pre and post test counselling from the trained nurses based on site. Funding for this outreach programme is acquired through annual sponsors of Lifeline as well as public donations and fundraising (Mofokeng, 2008).

2.6 Ukuba Nesibindi Homoeopathic Clinic (UNHC)

In 2004 a further collaboration between LifeLine's Ukuba Nesibindi and DUT took place resulting in the Homoeopathic department establishing a satellite homoeopathic clinic at Ukuba Nesibindi. This clinic offers homoeopathic treatment free of charge to the local community and is operated by 4th and 5th year homoeopathic students, under the supervision of qualified homoeopathic clinicians. UNHC runs from a room with an adjacent dispensary on the 3rd floor in the Ukuba Nesibindi LifeLine house. The clinic room has one examination bed and a small section where consultations take place. Often an interpreter is needed as many of the patients' first language is not English. When the clinic opened in 2004 it was only operational on Wednesdays and Fridays however since 2007, due to an increase in patient numbers and demand for the clinic's services, the clinic included an additional consultation day and currently operates on Mondays, Wednesdays, and Fridays from 1:00pm to 4:00pm. Funding and operating costs of UNHC are derived solely from the Homoeopathic Department of DUT. Patients are not charged for their consultations or medications and patient follow-ups are encouraged. UNHC has grown immensely in patient numbers over the years (Ngobese, 2008).

2.7 Primary Healthcare (PHC) in South Africa

According to Kautzky and Tollman (2008) there is a shortage of staff within the Primary Healthcare sector in South Africa resulting in medical personnel being unable to cope with the current demands; the situation requires more effort in addressing the challenges in innovative health system design within today's rigid primary healthcare system.

An assessment by the WHO in 2003 found that more than 60% of health care institutions in South Africa struggled to fill existing vacant posts, with more than 4000 vacancies for general practitioners and 32 000 vacancies for nurses throughout all provinces. The critical shortage of trained health personnel, and the inability to fill essential posts, constitutes an important barrier to achieve provisions for district-based health services in South Africa today. The significant loss of healthcare workers through international emigration has further slowed the functioning of PHC's in South Africa.

According to Act No. 61, 2003 (National Health Act) all South Africans have the right of access to health care services that include:

- i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
- ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV;
- iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
- v. palliative care that is affordable and effective in cases of incurable or terminal illness;
- vi. a positive disposition displayed by health care providers that demonstrates courtesy, human dignity, patience, empathy and tolerance; and

- vii. health information that includes the availability of health services and how best to use such services and such information is to be provided in the language understood by the patient.

Primary Healthcare Clinics (PHC's) throughout South Africa are an indispensable asset to South African Healthcare, however access to such clinics is often difficult and the demand for services high due to the large numbers of patients (Kautzky, Tollman, 2008). Research conducted by the Department of Health of South Africa (2000) indicates that the introduction of Primary Healthcare Clinics (PHC's) throughout South Africa has resulted in an improvement in the quality of healthcare countrywide. However the report highlights the need to improve access to care for all South Africans, particularly for people living in rural and historically disadvantaged areas.

2.8 Homoeopathy in the Primary Healthcare Sector in South Africa

Homoeopathy is currently not included officially within the public primary healthcare sector in South Africa although it could theoretically serve to enhance this health sector and thus improve access to healthcare. The analysis of the data obtained in this study may serve to motivate for its inclusion as a contributing discipline to the primary health care in South Africa.

The current national health policy emphasizes the importance of working partnerships. It is therefore important to investigate new ways of caring and managing patients in a community setting. By working together as one healthcare system the use of limited resources can be maximized (Sidney, Widdas 2005:181).

McIntosh, (a homoeopath and medical doctor appointed as a medical officer in a PHC clinic) (2008:304-309) states that due to the shortage of doctors in the public healthcare system, patients are often turned away; furthermore many peripheral clinics in rural areas have no pharmaceuticals for various reasons. Many of the patients treated by McIntosh presented with health problems which had not responded to allopathic medicine and the improvements that occurred as a result of homoeopathic treatment gained the confidence of patients and the local nurses alike. In his experience Homoeopathy has the ability to work well in a free community clinic setting as it is affordable and often does not need to be used long-term, homoeopathy may thus contribute significantly to such situations (McIntosh, 2008:309).

One of the main conditions treated effectively and often not acknowledged in a PHC setting is that of grief, in his experience, irrespective of the diagnosis, where there is a clear aetiology of grief there is a dramatic response to homoeopathic treatment (McIntosh, 2008:321). This shows that homoeopathy can provide an important element of care in situations where allopathic treatment is limited.

Leckridge (1997:IX–X) states that Homoeopathy as a primary care tool of everyday medical practice can work very well. “Homoeopathy in Primary Care is an excellent work which amply fulfils its stated purpose of introducing basic Homoeopathic knowledge in such a way that it can be clearly grasped and put into a practical test in the conditions of everyday medical practice.”

According to Nicolai (2008) health is not merely the absence of disease/ illness, but the ability of a system to respond adaptively to a wide range of environmental challenges. Emotional, psychological and physical stress all act on disrupting a balance and leading to a failure of an adaptive response which in turn leads to impaired functioning of the organism. The systemic approach of homoeopathy undoubtedly requires extensive case taking as well as homoeopathic and psychological understanding.

Clinics in a primary care setting are often not afforded the luxury of long consultation times and easy access to equipment. In addition practitioners often have to deal with large patient numbers; some acutely ill requiring urgent attention and some of which having travelled long distances to reach the respective clinics. Another potential disadvantage is that of a language barrier, the use of a translator can often complicate the case due to misinterpretation and often results in time delays (McIntosh, 2008).

The homoeopathic approach can be adapted in the light of such limitations and still be effective by using a more clinical approach. Hahnemann initially believed that a single remedy must only be used to treat a condition; this is seen as a more 'classical' homoeopathic approach. As time progressed Hahnemann did begin to use a few mixtures of remedies which was deemed a 'clinical' approach. The Clinical homoeopathic approach is based more on the conventional diagnosis and easy, prominent symptom pictures; it is this approach which is usually applied in busy primary healthcare clinics. As opposed to prescribing one single homoeopathic remedy, complex homoeopathic prescribing uses fixed combinations of homoeopathic remedies which are prescribed according to more of

a conventional diagnosis and according to Kayne(2008) this approach allows for a faster treatment.

Leckridge (1997) states that incorporating homoeopathy as a primary care medicine is effective and necessary to a patients well being, “I found that integrating homoeopathy into primary care medicine was not always easy but was enormously rewarding and made a significant difference to patients’ lives.”

2.9 The Homoeopathic Materia Medica

Hahnemann was translating into German a book called, ‘A treatise on Materia Medica’ which was written by a highly respected Scottish physician, William Cullen, it was while he was translating Cullen’s work that he came across the explanation (Cullen’s) of why Quinine cures malaria i.e. because it was a bitter substance. Hahnemann disagreed and this prompted him to experiment with Cinchona officinalis and by conducting the first homoeopathic proving thereon, which furthermore lead him to discovering the therapeutic law of similars. This was the first proving leading to the first step of the compilation of the Materia Medica (Lilley, 2008).

Hahnemann carried out strict provings which included taking healthy individuals and subjecting them to various substances from zoological, botanical and mineral kingdoms during which he would note any symptoms or experiences along with any modifying influences (modalities) as well as noting any mental symptoms which he confidently attributed to the drug effect. The data obtained from these provings were assembled to form specific drug pictures. The collection of such data was published in Hahnemann’s *Materia Medica Pura*.

Modernizing changes and improvements have been made to the original layout and the Materia Medica now exists in many forms as well in an index form known to homoeopaths as 'the repertory'. Materia medica's and repertories are an essential tool to homoeopathic practitioners; they are used daily in practice and with assistance of modern technology can be now accessed electronically as a quick effective guideline to prescribing (Lilley, 2008).

2.10 Demographic and epidemiological data of Kwa-Zulu Natal

A survey conducted by the Organisation of Civic Rights inner city project (1997) showed that Durban has a growing homeless community due to economic restraints, violence and lack of affordable housing. The respondents of Warwick Avenue (the area in which UNHC is located) had a very poor / low daily income ultimately affecting their quality of life as well as access to personal care. This indicates the direct need for additional primary health care provision specifically for those with little or no income in this area.

A Background paper conducted by PROVIDE (2005) showed the racial composition of KwaZulu-Natal to be 82.9% African, 2% Coloured, 9% Asian/Indian and 6.1% White. Both KwaZulu-Natal's poverty as well as unemployment rates are above the national average at 54.3 and 37.5% respectively. Poverty rates vary between racial groups however African's have the highest poverty rate of 64.4%.

Ferrucci (1994) conducted a survey on patients treated by homoeopathic private practitioners as compared to senior homoeopathic students practicing at the Homoeopathic Day Clinic at Technikon Natal (now DUT Homoeopathy Day Clinic). The total sample size was 300, with 160 patients of private practitioners and 140 patients of the Day Clinic. Ferrucci found that more females dominated the patient samples for both practitioner groups, and that patients in general seemed to suffer more from chronic complaints with a high incidence of psychological complaints. The age of the patients varied between groups, with the private practitioner sample falling largely in 26-35 (20%), 36-45 (21%) and 46-55 (21%) age groups. The Day Clinic patient group was younger, with the largest amount of patients in the 18-25 (29%) age group. With regards to employment, 33% of the private practise respondents' were employed and 29% unemployed. In the Day Clinic 36% of the patients were students.

Although Apartheid ended more than 10 years ago, resultant social disruption still impacts on the lives of many people in South Africa. Malnutrition, and HIV/AIDS are all too common. Many patients are uneducated and unemployed which impacts the spread of disease and the ability of healthcare professionals to treat patients effectively (McIntosh, 2008).

Results of epidemiological studies conducted by the Department of Health of South Africa (2001) determined that AIDS, along with its related illnesses, diarrhoea, and respiratory infections were the major cause of death in KZN in 2001.

According to Evian (2003) most of the problems associated with HIV/AIDS can be dealt with at a primary care level and such needs must be incorporated into the overall primary healthcare service. These services must be accessible and affordable to those who need them. Furthermore, support and acceptance must be provided for those infected as well as a strategy to treat and educate people with sexually transmitted infections (STI's).

Based on research conducted by The National Institute of Allergy and Infectious Diseases (2003) Tuberculosis is one of the common HIV-associated life threatening diseases with almost two-thirds of the South African people being infected and about 160 000 new TB cases reported every year. In South Africa 40% of TB patients are also HIV positive and thus TB is the main cause of death in AIDS patients. Should the current trends in the co-epidemic continue, there will be 3.5 million new TB cases in South Africa within ten years. According to Achmat (2005) the high HIV prevalence and explosive TB incidence needs more attention as current efforts to control these epidemics are failing. TB and HIV in South Africa presents as a crisis in more poor and working class communities, the public health system urgently needs investment in its infrastructure to be able to cope with the crisis. A primary health care incentive-based education system is needed to improve health workers in their education with this regard. Traditional and alternative medicine should be more involved in the public health system; the reasons given in this study included increased referrals and a potential role as treatment supporters.

2.10.1 Epidemiology in homoeopathic practice

Jansen and Koster (1995) reported on survey that not only gave insight into what type of diseases homoeopaths mainly treat but also included prescription data. For one week 58 homoeopaths in the Netherlands registered the complaints and diagnoses of their first 30 patients who were given only homoeopathic treatment. The outcome of this study showed the main complaints treated to be conditions of the respiratory tract, followed by psychological and dermatological complaints.

In 1992 Jacobs, Chapman and Crothers conducted a survey to establish practise patterns and patient characteristics which concluded that American Institute of Homoeopathy (AIH) physicians were more likely to treat patients with chronic illness and psychological symptoms.

Colin (2000) analysed 2148 of his consultations in South-West France. Colin practised pluralist homoeopathy and is known as a general practitioner only prescribing homoeopathic medicines. He states that his main indications for homoeopathy were psychological complaints, respiratory complaints and rheumatological complaints. Other illnesses (dermatological, genitourinary and gynaecological) were roughly equally prevalent. The more 'classical' British homoeopaths saw fewer respiratory infections and psychological complaints, and more rheumatology.

Ferrucci (1994) reported that the main complaints treated at the Homoeopathic clinic at Technikon Natal (now DUT) were arthritis (15%), musculoskeletal complaints other than arthritis (15%), gout (7%), warts (7%) and tonsillitis (7%).

Verhoogt (2003) reported that the most common complaints treated by a cohort of 45 practising homoeopaths in KZN, were spread across many diagnostic categories. Gastrointestinal tract pathology rated the highest with upper respiratory tract and ear, nose and throat pathology a close second. Other important areas included lower respiratory, musculoskeletal, skin and nervous system complaints.

2.11 Homoeopathic Treatment & Medicines

According to Nicolai (2008) the history of the homoeopathic profession is filled with different schools of thought with regard to method of practice, although the emphasis on maintaining a balance between creation and maintenance and the systemic approach to organisms is in common. Treating a patient homoeopathically varies according to the clinical application required for each specific situation such as trauma, acute disease, epidemics, and chronic disease etc., the main principle however, which is looking at the whole symptom picture; the pattern in the totality of the patient's physical and emotional/behavioural signs and symptoms, will aid in the remedy selection and treatment régime for the patient.

Homoeopathic remedies are specific to a patient's symptoms and the patient's personality type. The remedy acts holistically, in other words on all levels, mind, body, and soul, of the human being (Lilley, 2008).

“It involves delving into the depth of human nature, and the mental/emotional makeup of the patient, thus improving the patient’s life on all levels. This is because Homoeopathy goes to the core of the person, to the body’s own natural healing energy (the Vital Force) strengthening it and balancing it, so that not only do the specific symptoms disappear, the entire spiritual-mental-emotional-physical being is restored” (de Schepper, 2001:3-11).

Chappel (2005) suggests that homoeopathic medicines are easy to implement at low costs, safe to administer in the right hands and are very effective in treating acute and chronic disease.

Jansen and Koster (1995) reported in a study conducted in the Netherlands where for one week 58 homoeopaths registered the complaints and diagnoses of their first 30 patients who were treated exclusively with homoeopathic medication. In terms of frequency of prescription polychrests scored highest. With regards to posology, centesimal potencies were prescribed at a rate of 85.4%, quinquagenimillesimal (LM) prescriptions at 9.8% and decimal potencies 4.5% of the prescriptions examined. The study group prescribed almost exclusively one homoeopathic medicine at a time.

Kayne and Beattie (1998) reported on a retrospective study conducted at the Glasgow Homoeopathic Hospital, where prescriptions for four years (1994 – 1998) of patients in the outpatient category were analysed. The results showed that *Natrum muriaticum* was the most frequently prescribed medicine, followed by *Pulsatilla nigricans* and *Rhus toxicodendron*.

The most frequent dilution prescribed was 200c. An International project to investigate the effectiveness of homoeopathy in medical primary care IIPCOS-01 (Heger, Riley, Fischer, Singh, Haidvogel, 2001), showed how effective homoeopathy can be in these settings. A total of 348 patients suffering from upper and lower respiratory tract complaints in Germany, Austria, Switzerland and USA were documented. Three quarters of the patients were treated with just 14 medications mainly, *Pulsatilla nigricans*, *Lycopodium clavatum*, and *Sulphur*. Nearly half the patients received adjunct therapy such as herbal medicines. Two thirds of the patients were seen to in less than 16 minutes and most of the prescriptions were made based on 'key note' symptoms.

2.12 Homoeopathic Scope of Practice

According the Homoeopathic Association of South Africa in order to legally practice Homoeopathy in South Africa one must be registered with the Allied Health Professions Council of South Africa (AHPCSA). The only training recognised for registration in South Africa is the Masters Degree in Homoeopathy – M.Tech.(Hom) offered from one of two approved tertiary education institutions i.e. Durban University of Technology (DUT) and University of Johannesburg (UJ), or possess a SA Qualifications Standards Authority (SAQA) and AHPCSA approved equivalent qualification. The M.Tech(Hom) consists of a five year full-time medico scientific course in classical, clinical, modern and conventional Homoeopathy as as Homeopharmaceutics, which is a legal requirement for registration. Medical Practitioners registered with the Health Professions Council of SA (HPCSA) may also opt for the course offered by the SA Faculty of Homoeopathy. Homoeopathic

students of DUT or UJ consult with patients in their 4th and 5th year under supervision of qualified Homoeopathic practitioners in order to gain practical experience. A Masters dissertation is required to complete the course; the student can then register with the AHPCSA and practice homoeopathy .

According to the Allied Health Professions Act, 1982 (Act 63 of 1982) a registered Homoeopathic practitioner may:

- Diagnose, and treat / prevent, physical and mental disease, illness and deficiencies in humans;
- Administer, prescribe, dispense or compound medicines listed; or
- Provide or prescribe treatment for such disease illness or deficiencies in humans.

According to the World Health Organisation (WHO) primary healthcare came into existence following an international conference in Alma Ata in 1978 organised by (WHO) and The United Nations International Children's Fund (UNICEF). Primary health care was accepted by the member countries of WHO as the key to achieving the goal of all. Due to people all over the world becoming more and more frustrated at the inability of today's health systems and services to meet their needs, there has been an increase in the demand for a renewal of primary health care and health for all.

The four essential components to primary care worldwide are:

- Universal coverage by ensuring sufficient supply of medicines and services; removing financial barriers to access and ensuring social health protection;
- People-centred care by transforming traditional healthcare delivery models (specialist, procedure or hospital-based) into people-centered primary care networks;
- Inclusive leadership by shifting from conventional "command-and-control" approaches, increasing participation of all stakeholders and moving from supply-led to demand-led policies and programmes;
- Health in all policies by ensuring that all relevant sectors (e.g. labour, environment, education) factor health into their agendas.

Given that within South Africa, registered homoeopaths are trained and permitted by law to make a diagnosis and treat a wide variety of physical and mental illnesses including deficiency based diseases, as well as being permitted to compound and dispense respective medications (HSA, nd); homoeopaths are thus ideally suited for the PHC environment as they can perform the role of a medical officer, a homoeopathic pharmacist, as well as address a wide scope of diseases.

Homoeopathy can thus potentially play an integral part in the provision of primary healthcare and registered homoeopathic practitioners can offer essential components needed in primary healthcare today and add to the 'health for all' policy under its scope of practice.

CHAPTER THREE – METHODOLOGY

3.1 RESEARCH METHODOLOGY

This is a descriptive and exploratory clinical audit of an existing homoeopathic clinic which was conducted retrospectively.

3.2 SELECTION

1. All consultation data that was recorded during the period of June 2004 – June 2008 was sampled.
2. All patient files which were kept at UNHC during the above period were reviewed.
3. Confidentiality was maintained; no data which could identify respective patients was captured.

3.3 DATA COLLECTION TOOL

A standard data capture protocol was applied to each file accessed (SEE APPENDIX D).

The data collection tool captured the following forms of data:

1. Patient demographics
2. Number of consultations (including number of follow ups)
3. Diagnoses made
4. Diagnostic tools applied or requested

5. Referrals made

6. Details of medicine prescribed and dispensed

3.4 DATA SOURCE

The data which was sourced and captured in this study were all consultations (new and follow up) which took place during the period of June 2004 – June 2008; this currently exists in the form of patient files which are stored at UNHC.

3.5 CRITERIA FOR ADMISSIBILITY OF DATA

- The first consultation for each respective patient file must have taken place between 1 June 2004 and 1 June 2008.
- The data was accessed from files contained only from the UNHC site.

3.6 STATISTICAL ANALYSIS

The data obtained was evaluated and analysed using Microsoft's Excel® programme version 2007. Data was entered into a spreadsheet form and results were extrapolated directly and placed into an excel spreadsheet for interpretation. Various forms of descriptive statistics were applied such as bar charts, column charts, and pie charts as well as tables.

The following information was recorded:

3.6.1. The number of new patients and follow-up consultations from June 2004 – June 2008.

3.6.2. The number of patients seen on the days the clinic was open.

3.6.3. The total number of consultation days for each year from June 2004 – June 2008.

3.6.4. The average number of patients seen on an annual basis (new and follow-up patients).

3.6.5. An average of how many patients came back for more than one consultation per year.

3.6.6. The averages of the busiest day of the week and busiest month of the year.

3.6.7. Demographic data was recorded with averages which included:

3.6.6.1 Gender

3.6.6.2 Employment

3.6.6.3 Age

3.6.6.4 Marital status

3.6.6.5 Race

3.6.8. The number of diagnostic conditions recorded both by condition and by system.

3.6.9. The number of examination procedures taken place with respect to urine dipstick tests.

3.6.10. The number of patient referrals made and to which location they were referred to.

3.6.11. The number of medicines prescribed each year as well as the names and classification of each medicine recorded. These were classified in terms of:

3.6.11.1 Herbal medicines

3.6.11.2 Homoeopathic remedies prescribed

3.6.11.3 Bach Flower remedies

3.6.11.4 Phytotherapeutic Complexes

3.6.11.5 Tissue salts prescribed.

Information from patient files, under the supervision of the head clinician at UNHC, was gathered onto a spreadsheet under the various headings of Appendix D, no names were recorded and strict patient confidentiality was maintained. Patient files at UNHC were in a closed filing cabinet, none of the files were removed from that location and only the researcher and the research co-supervisor had access to the patient files. The raw data captured onto the spreadsheets was then transferred into the respective categories in Microsoft Excel® 2007. Once the data was placed into Excel the statistical analysis began by categorizing the information further and manipulating the information in various tables and graphs.

3.7 ETHICAL CONSIDERATIONS

As the UNHC patient files are subject to routine privacy legislation each respective patient's identity was protected, no data which could identify the respective patients was captured. Data capture took place at the UNHC site and files were not copied or removed from their routine place of secure storage. The researcher, a homoeopathic student who routinely performed clinical duties at UNHC and had access to the respective files as well as the head clinician at UNHC were the only researchers who accessed the files accordingly. Permission to access the patient files was granted beforehand (SEE APPENDIX A, B, C). The only data captured from the files was that of diagnosis, medicines prescribed, potency of medicine, demographics, and whether it was a new patient or a follow up. Ethical approval was granted from the Faculty of Health Sciences Ethics Committee of DUT.

CHAPTER FOUR – RESULTS

4.1 INTRODUCTION

Following the methodology described in Chapter 3, the study produced raw data in the form of completed data sheets (See APPENDIX D), the data contained therein was extracted from patient files from UNHC, completed data sheets were used for the purposes of data analysis using Excel® 2007™ for Windows™.

The specific objectives of the analysis were as follows:

1. To determine a patient demographic profile at UNHC.
2. To determine a disease prevalence profile at UNHC.
3. To describe various medicines prescribed at UNHC.

4.2 OVERVIEW OF THE RESULTS

4.2.1 Consultations

The data for 2005, 2006, and 2007 represent full clinical operating years and are thus true representations of consultation numbers over a specific year (the figures for 2004 represent consultations over the second half of the year only and those of 2008 the first 6 months of that year respectively).

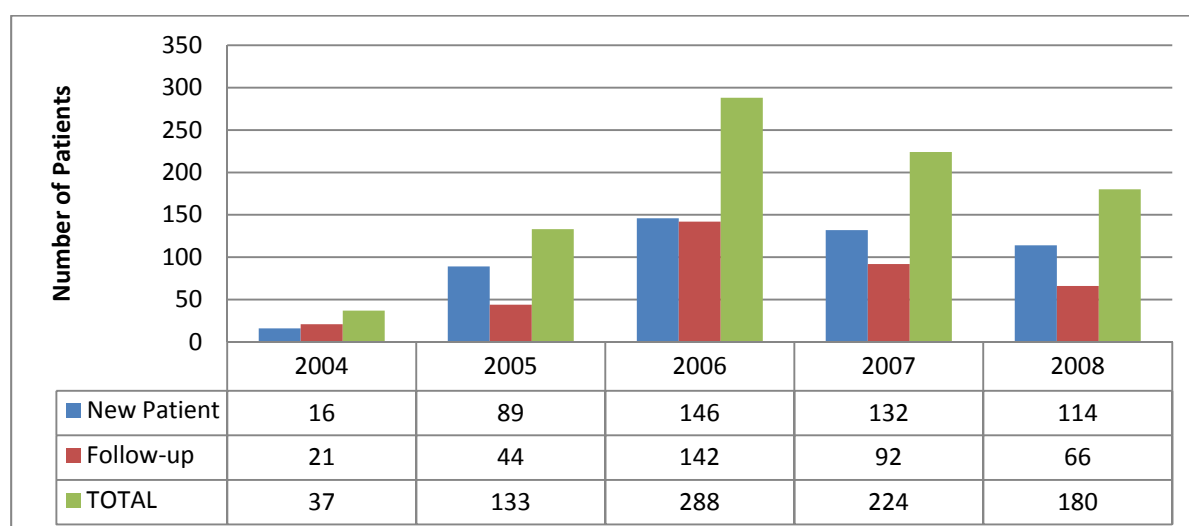


Figure 1: Number of new and follow up patients attending UNHC from June 2004 – June 2008.

The above graph reflects that the total number of patients increased by 46% from 2005 to 2006. 2006 showed the highest number of patients including the highest number of follow up patients for the duration of the study.

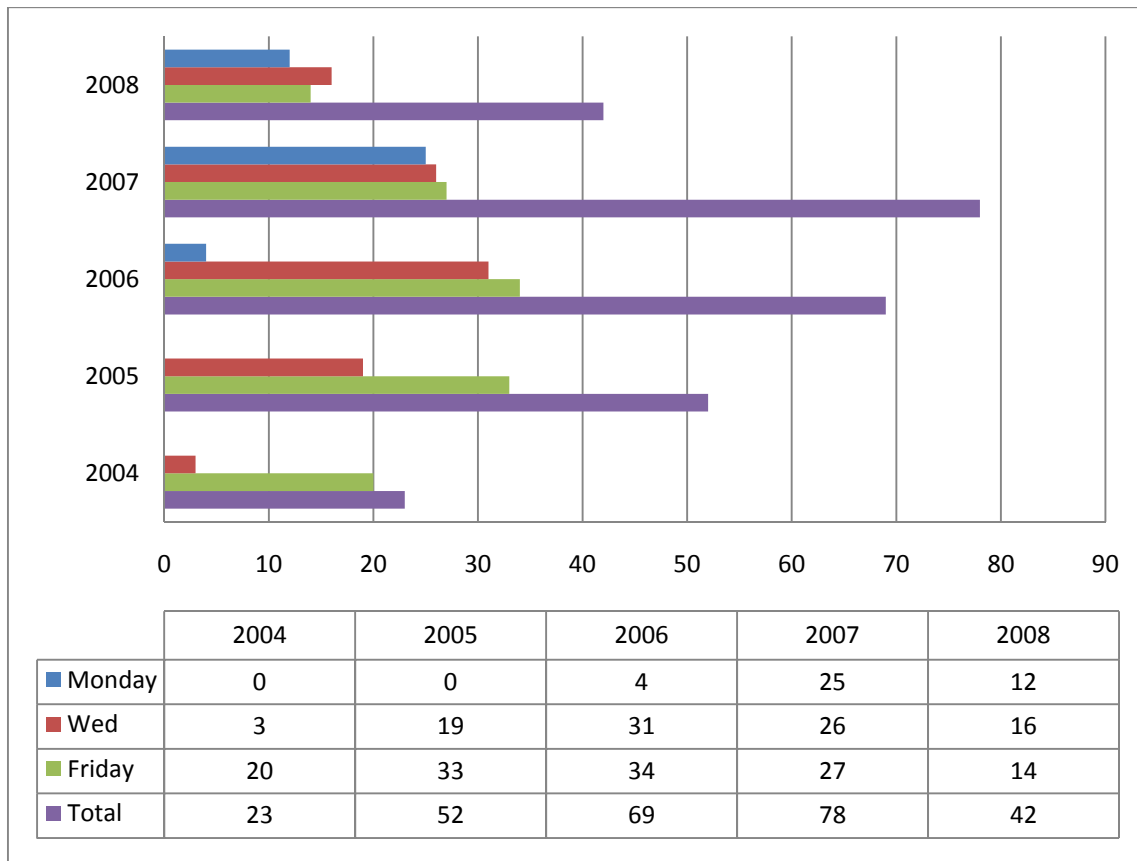


Figure 2: Number of days the clinic was open for each year from June 2004 - June 2008.

UNHC was operational only on Wednesdays and Fridays in 2004 and 2005, Monday operating hours were partially introduced in 2006 and as of 2007 UNHC was operational three days a week, as a result thereof the total consultation days increased significantly.

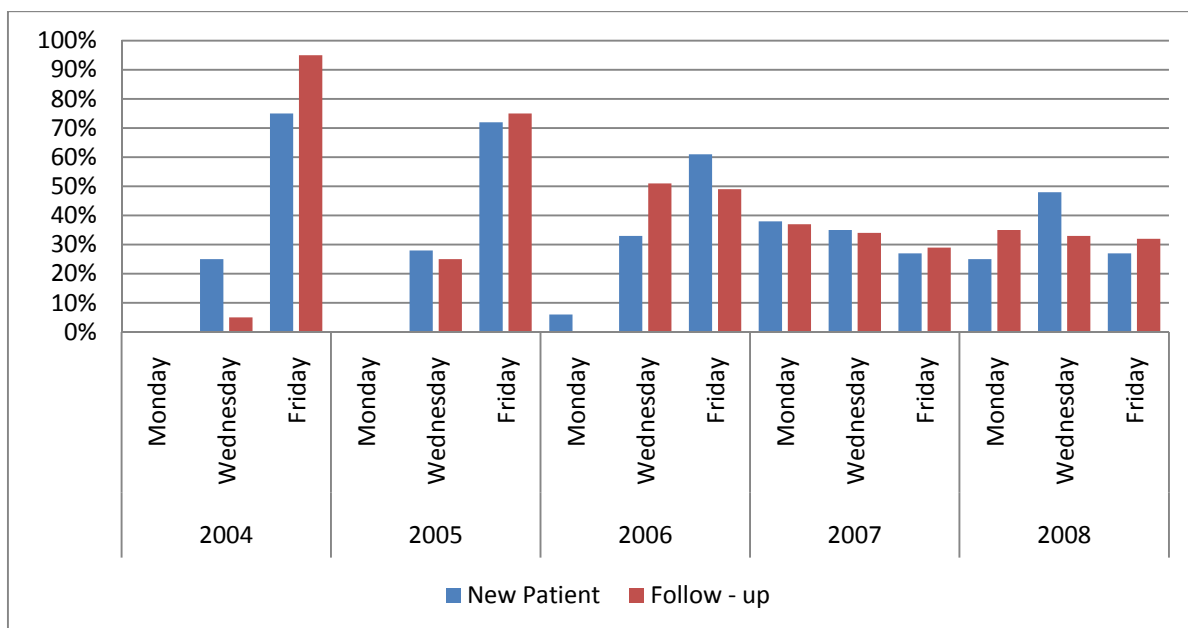


Figure 3: The distribution of consultations over the respective consulting days of the week

The above chart shows the highest demand for consultations at UNHC was on Fridays over the first two years but since Monday consultations were introduced the demand has been evenly spread across all three consultation days.

Table 1: The averages of the busiest day of the week and busiest month of the year from June 2004 – June 2008.

Busiest day of the week (on average)				
2004	2005	2006	2007	2008
Friday	Friday	Friday	Monday	Wednesday
Busiest month of the year (on average)				
2004	2005	2006	2007	2008
August	June/Oct	March	March	April

The permanent introduction of Monday consultations in 2007 significantly reduced the demand for consultations on Fridays, Monday becoming the busiest day in 2007.

The latest data reveals that March/April were the busiest months of the year at UNHC.

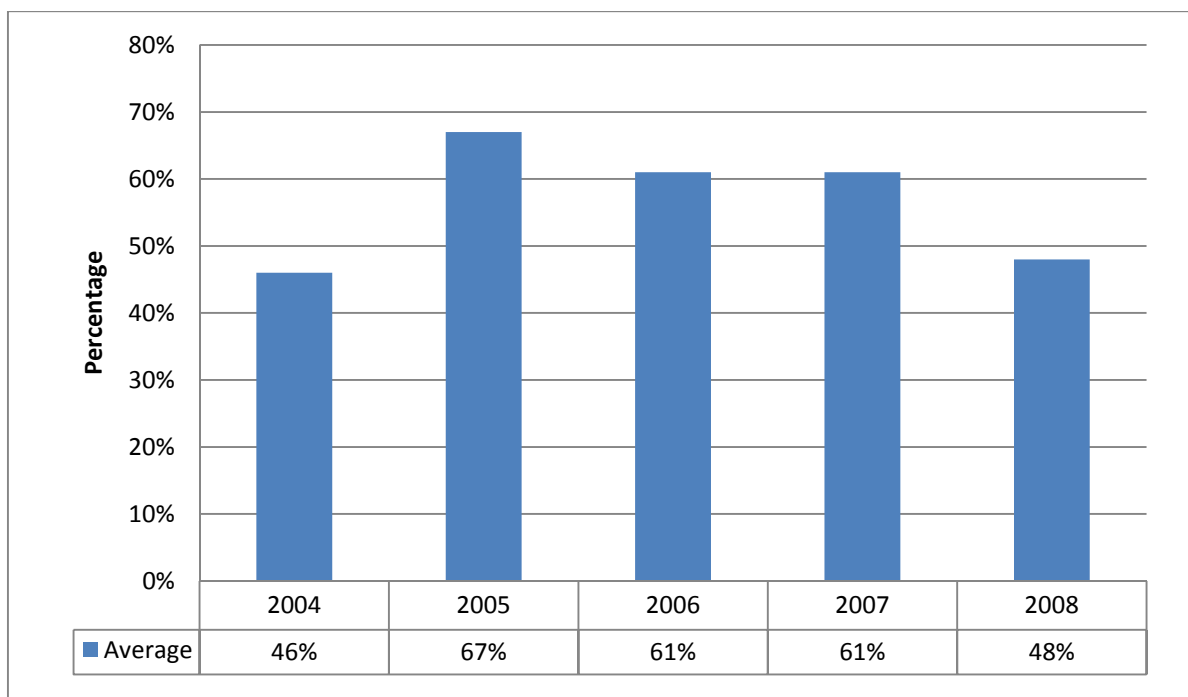


Figure 4: Percentage of patients who came back to UNHC for more than one follow up consultation from June 2004 – June 2005.

From the total number of follow up patients, 46-67% of patients returned to the clinic for more than one follow-up consultation over the four year period, the average follow up rate over the study period being 56%.

4.2.2 Demographic data

4.2.2.1 Gender

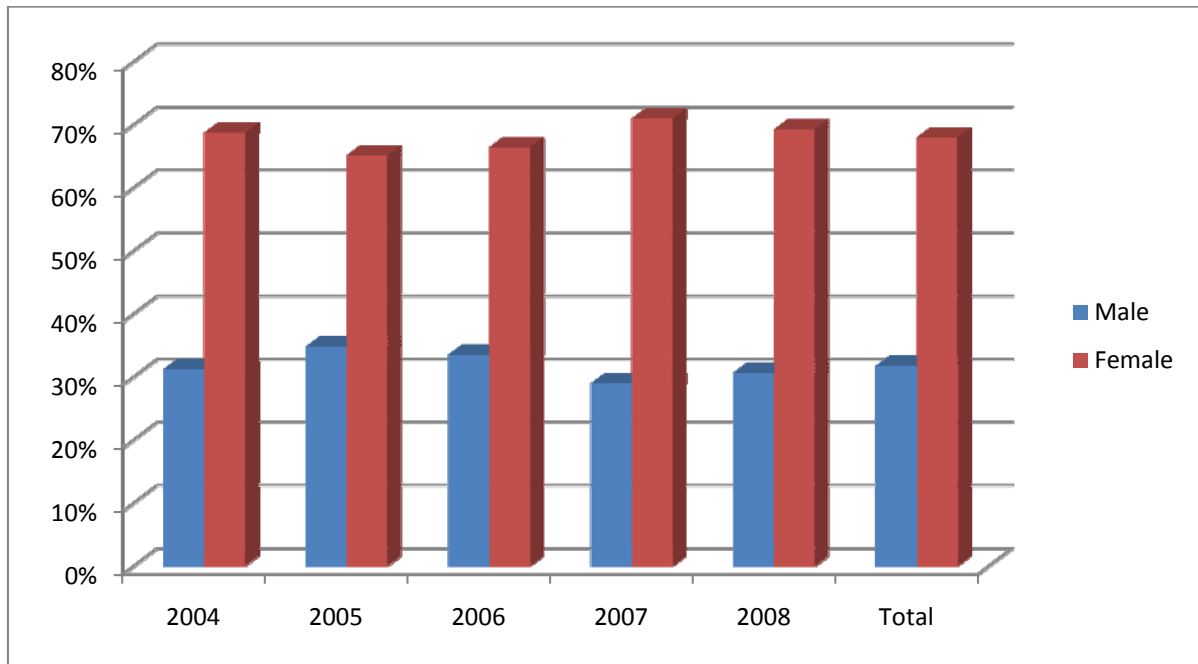


Figure 5: Gender distribution of patients attending UNHC during the study period

Figure 5 shows that the majority of patients during the study period were females (68%). The data also reflects that the annual gender distribution at UNHC was relatively unchanged over the 5 year period.

4.2.2.2 Employment

Table 2: Employment June 2004 – June 2008

	2004	2005	2006	2007	2008	Total
Unemployed	38%	46%	39%	30%	54%	41%
Employed	31%	37%	41%	32%	36%	36%
Pensioner	6%	6%	8%	8%	6%	7%
Student	25%	9%	10%	27%	4%	14%
Child	0%	2%	2%	3%	0%	2%

During the study period a large portion of the patients seen at UNHC were unemployed (41%), (36%) were employed and the balance (23%) were pensioners (7%), students (14%) or children (2%).

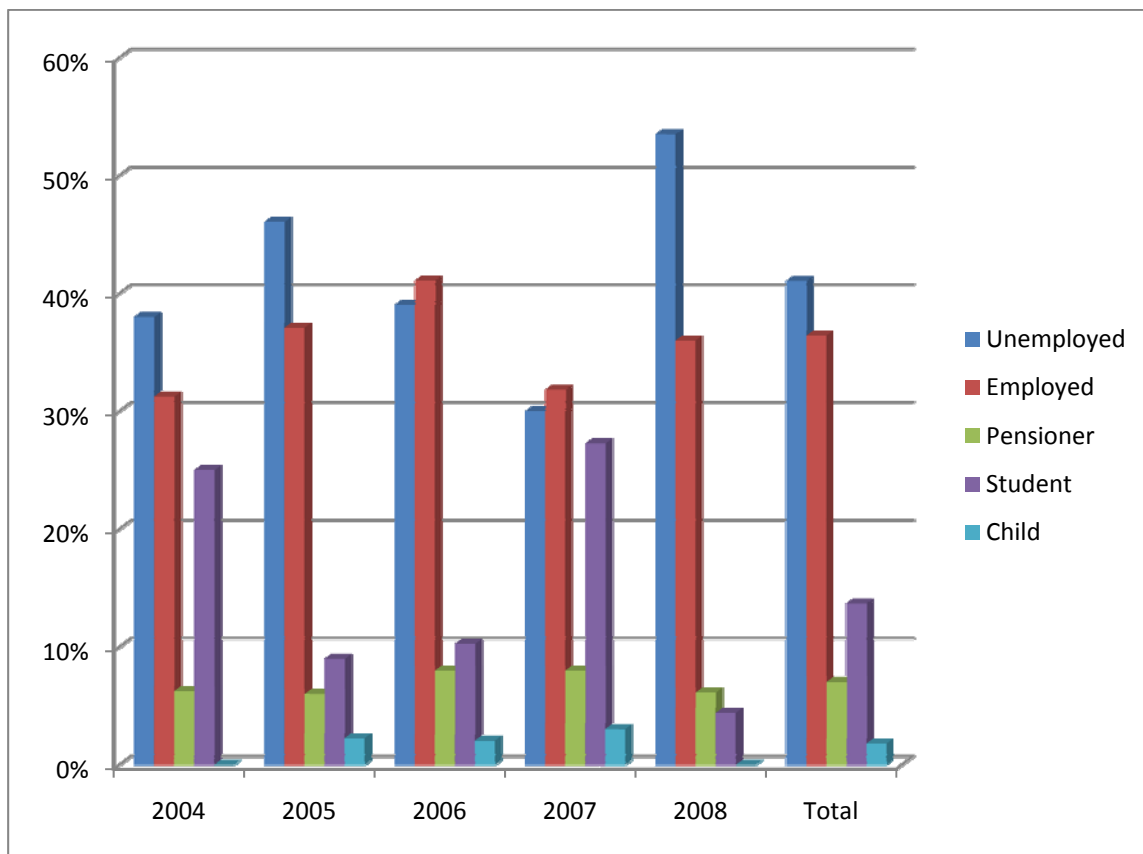


Figure 6: Employment status of patients attending UNHC during the study period

4.2.2.3 Age

Table 3: Age (Years): Average

	2004	2005	2006	2007	2008	Total
0-18	0%	7%	6%	7%	3%	5%
18-24	38%	7%	12%	36%	7%	17%
25-39	38%	47%	42%	25%	23%	34%
40-64	25%	35%	32%	21%	60%	36%
65>	0%	4%	8%	11%	8%	8%

The data represented in Table 3 and Figure 7 show that during the study period those patients within the age group of 40-64 years were the most prevalent (36%) at UNHC the next most prevalent age group was that of patients 25-39 years (34%).

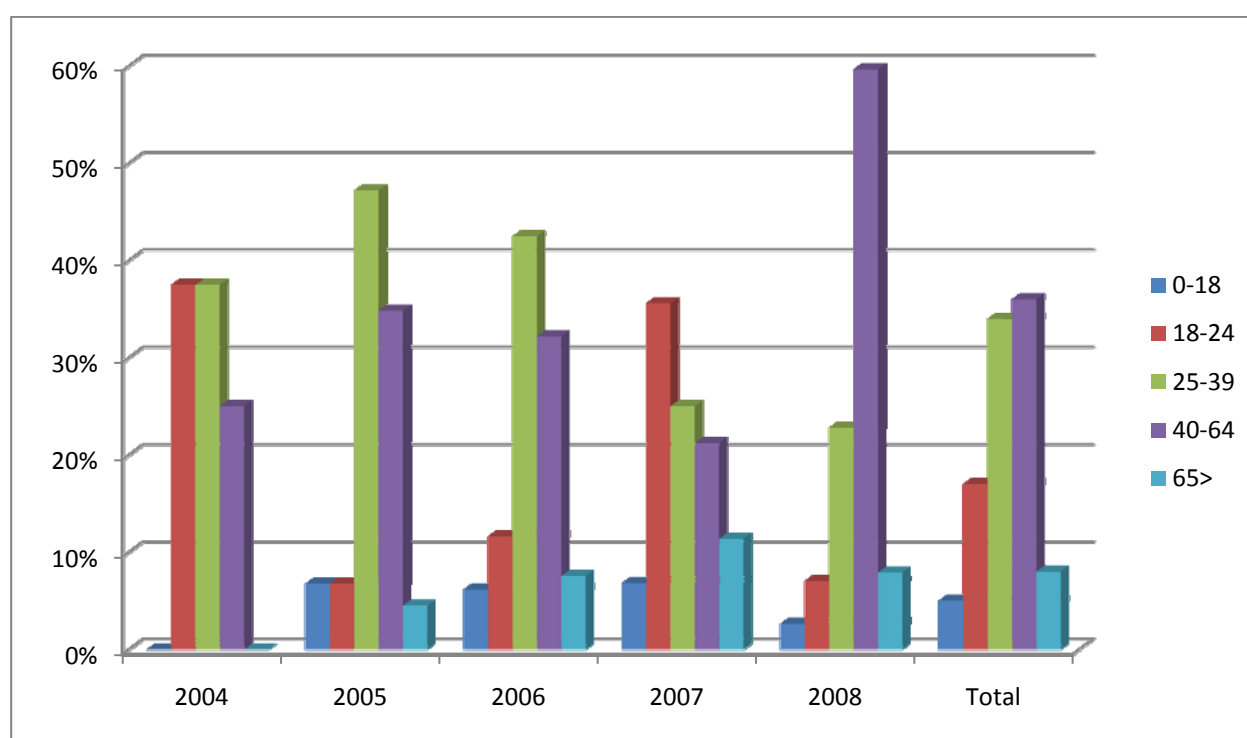


Figure 7: Age distribution of patients attending UNHC during the study period

4.2.2.4 Marital status

Table 4: Marital Status

	2004	2005	2006	2007	2008	Total:
Single	69%	47%	48%	45%	46%	47%
Married	19%	37%	38%	35%	32%	35%
Widowed	13%	12%	10%	14%	19%	13%
Divorced	0%	3%	3%	2%	4%	3%
Separated	0%	0%	1%	5%	0%	2%

The demographic data represented in Table 4 and Figure 8 show percentages with regard to marital status; the highest category being single (47%). For 2004 the data is skewed due to the fact that it was not a full clinical year and only a small number of patients were included for data analysis.

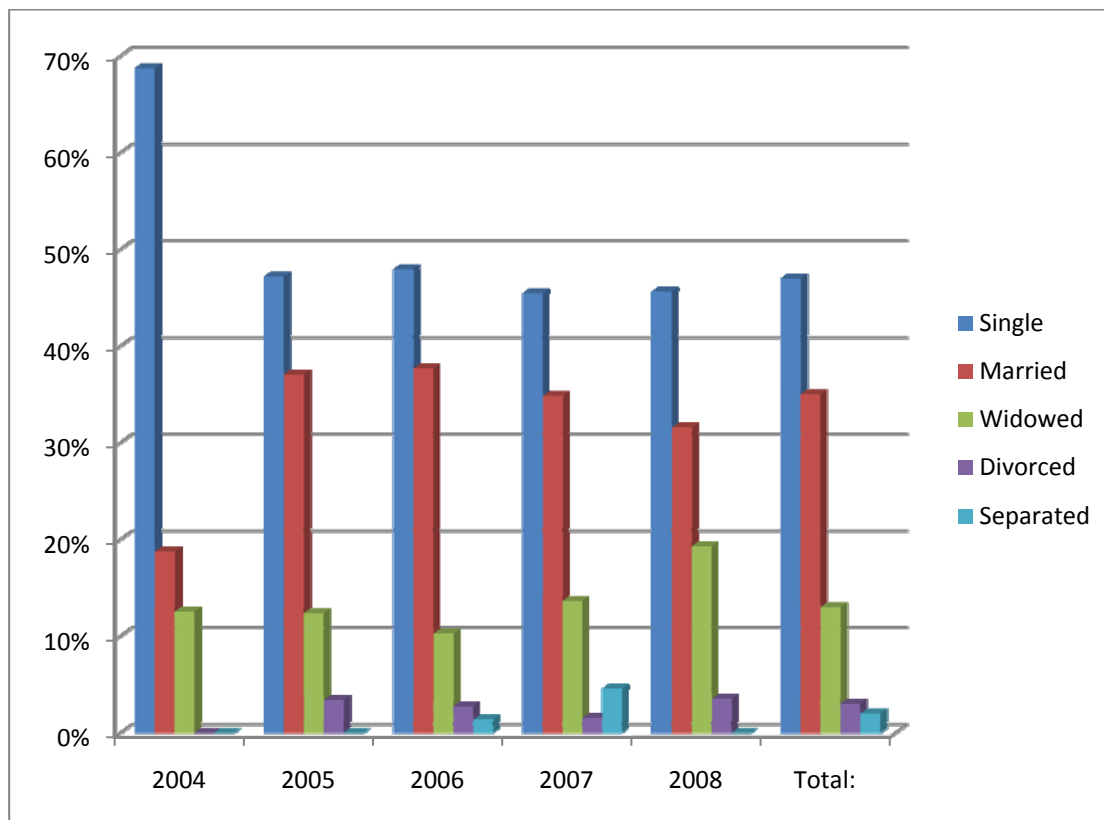


Figure 8: Marital status of patients attending UNHC during the study period

4.2.2.5 Race

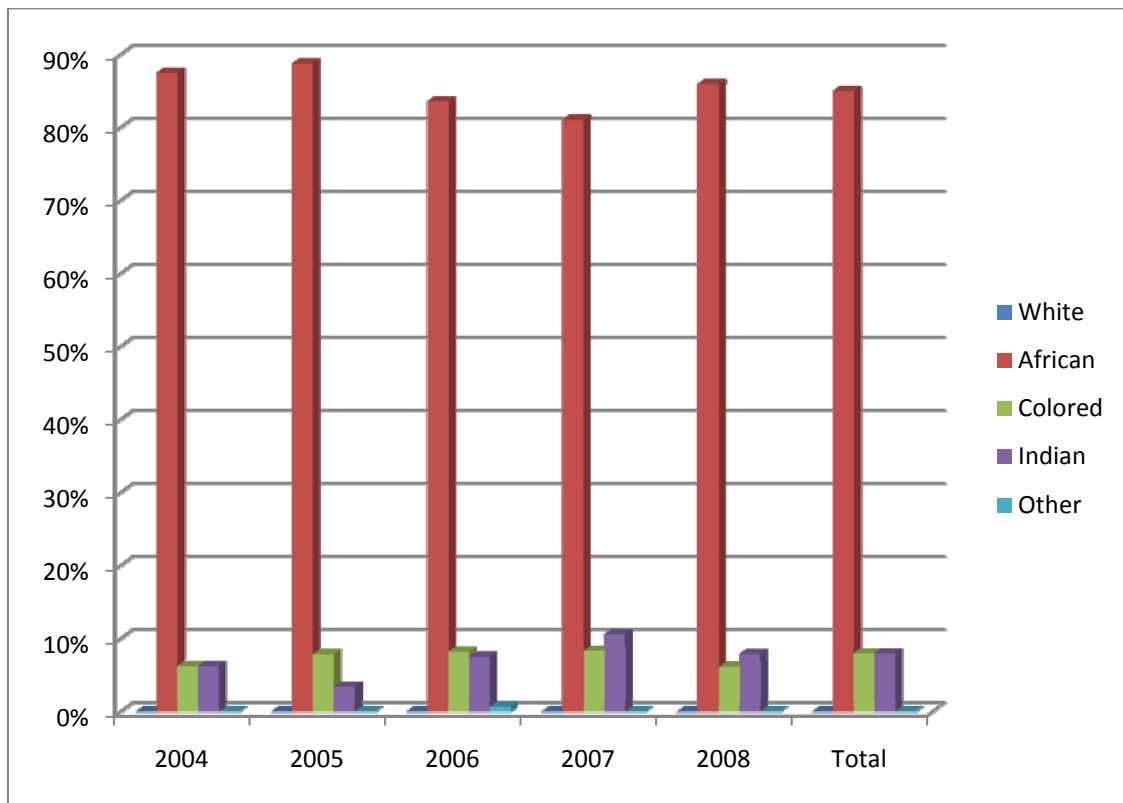


Figure 9: Averages of the race of patients from June 2004 - June 2008.

Over 80% of the patients attending UNHC during the study period were African, only a small percentage (20%) were Coloured and Indian, the clinic was not visited by White patients.

4.2.3 Referrals

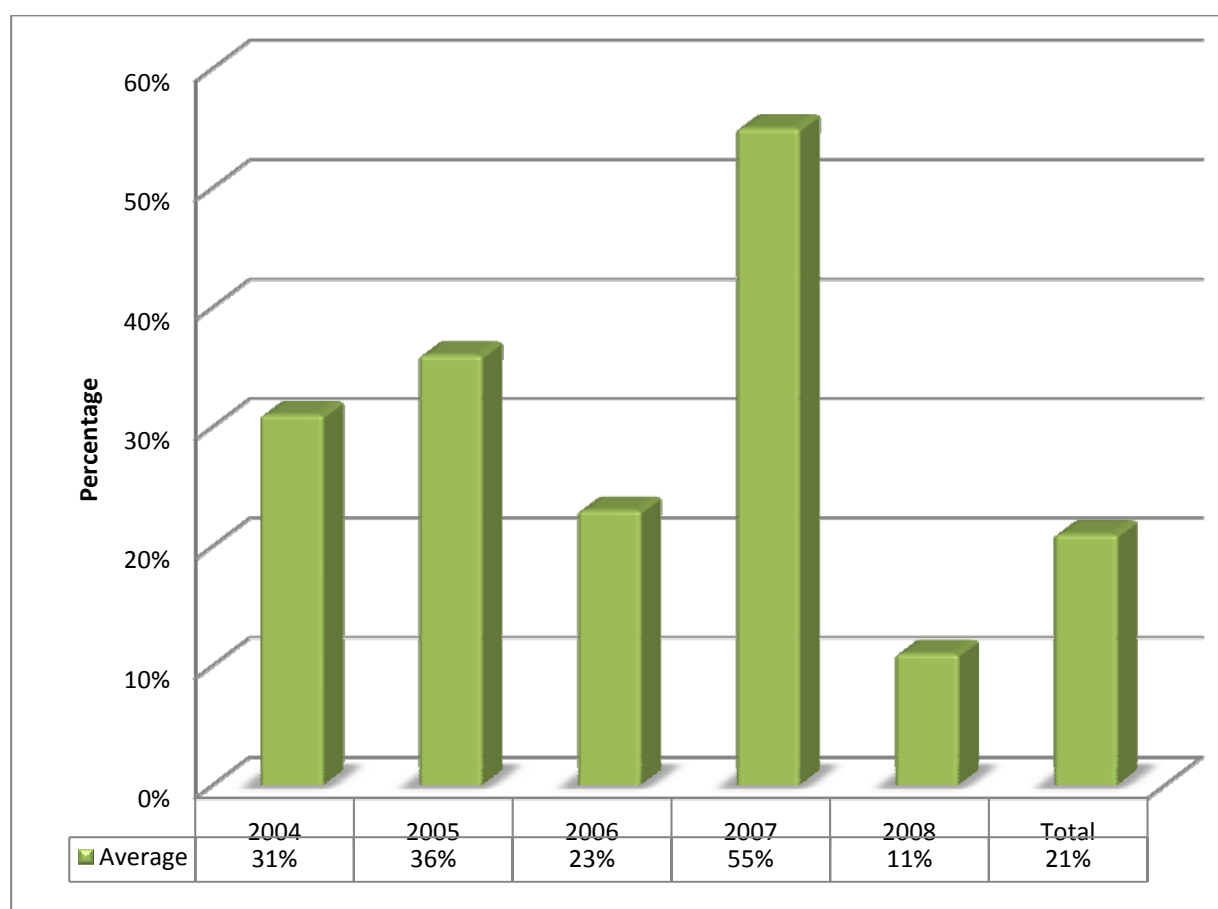


Figure 10: Percentage of patients referred at UNHC during the study period

An average of 21% of the total number of patients seen at UNHC during the study period were referred for various reasons. Of the patients referred 28% were referred for HIV and 22% for TB diagnostic testing.

Table 5: Referrals made per category from June 2004 – June 2005

Reason for referral	Count
HIV test	39
TB test	30
Pregnancy test	19
Blood glucose test	14
Suspected heart disease (ECG)	10
Back pain	8
Abdominal pain	6
Ultrasound	4
Chest X-ray	2
Appendicitis	2
Contraception	2
Mammogram	1
Hypertension management	1
Epilepsy	1
Total	139

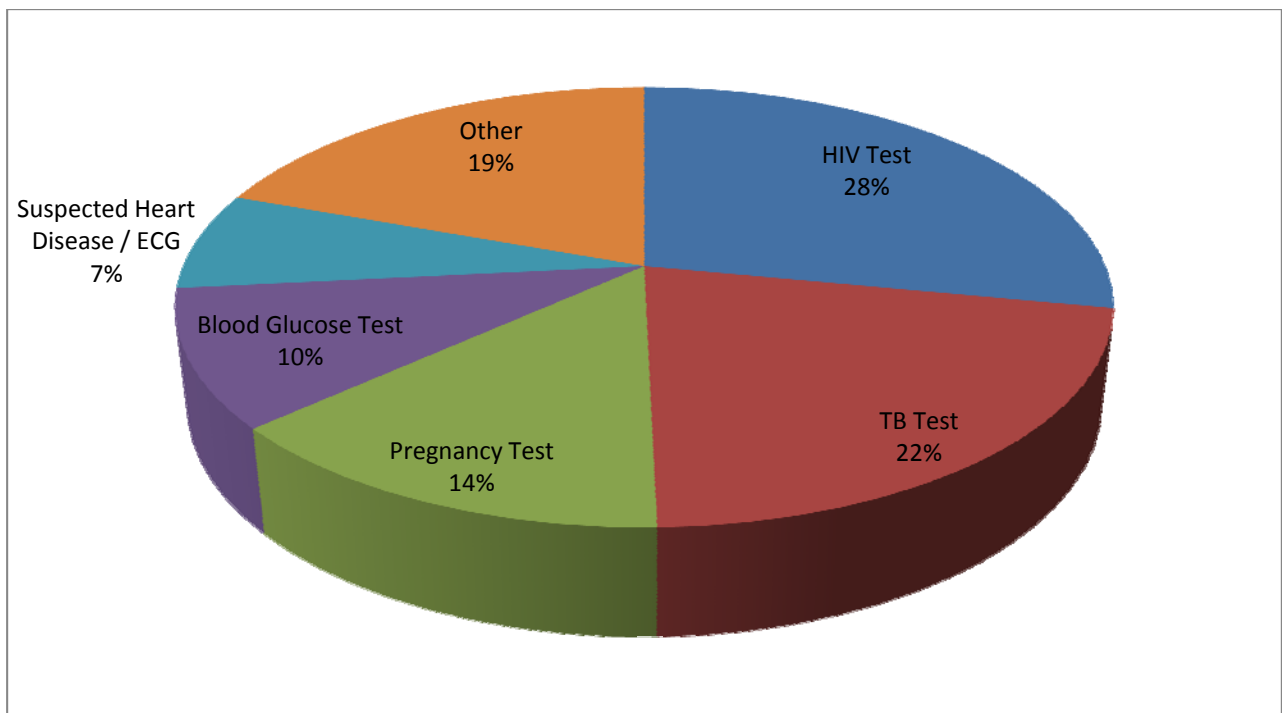


Figure 11: Reasons for referral of patients at UNHC during the study period

The above pie chart shows HIV (28%) and TB (22%) to be the highest reason for patients being referred to other relevant medical facilities from UNHC.

Table 6: Represents the location to which the patients were referred during the study period

Year	Location	Count
2004	Addington Hospital	3
	Lifeline building in Warwick Junction	2
2005	Prince Mshiyeni Memorial Hospital	11
	Lifeline building in Warwick Junction	9
	Addington Hospital	8
	Chiropractor - DUT Clinic	3
	McCord Hospital	1
2006	Lifeline building in Warwick Junction	14
	Chiropractor - DUT Clinic	5
	Addington hospital	4
	Family Planning Clinic	2
	To Patients GP	1
2007	Addington Hospital	20
	Pharmacy / clinic	16
	Prince Mshiyeni Memorial Hospital	16
	Lifeline building in Warwick Junction	11
2008	Pharmacy / clinic	5
	Lifeline building in Warwick Junction	3
	Addington Hospital	3
	Prince Mshiyeni Memorial Hospital	1

4.2.4. Urine dipstick tests

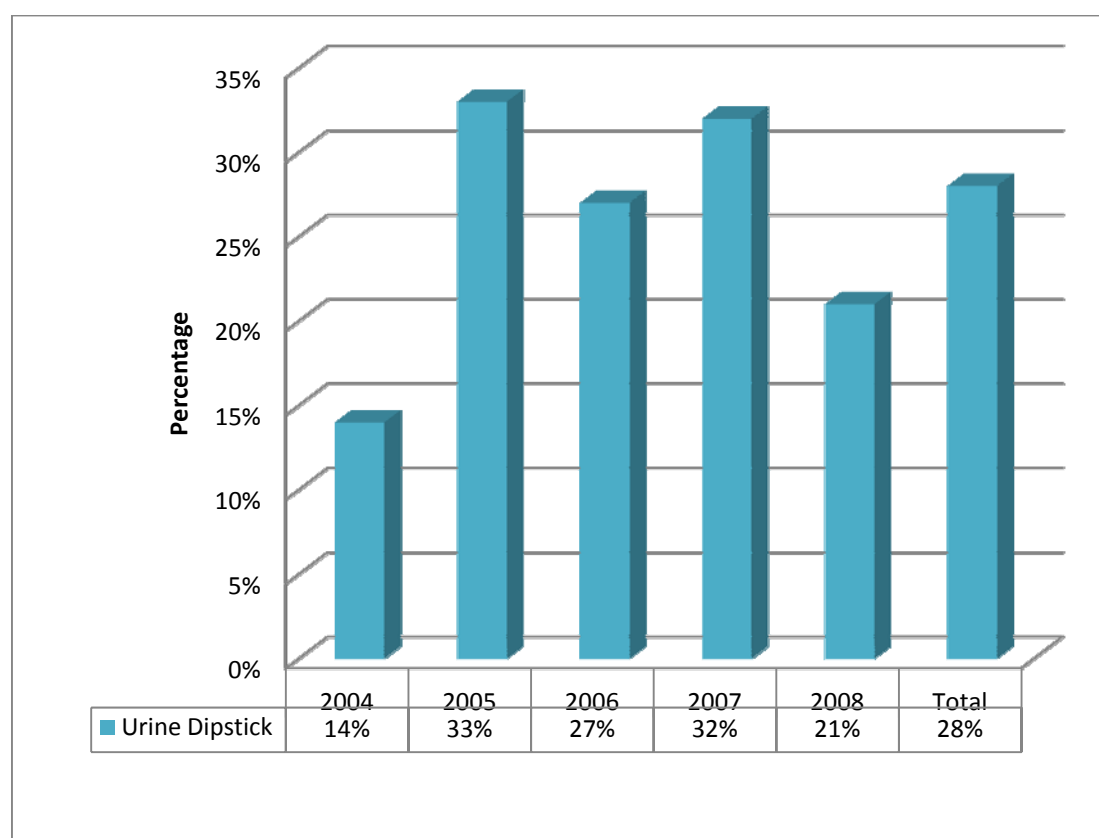


Figure 12: Percentage of patients who underwent urine analysis during the study period at UNHC

Urine analysis using the dipstick technique was extensively utilised at UNHC during the study period; 28% of patients over the study period were assessed using this diagnostic tool. Results were skewed slightly by data derived from 2004 and 2008 due to the lower patient numbers (6 month periods only).

4.2.5 Main complaints

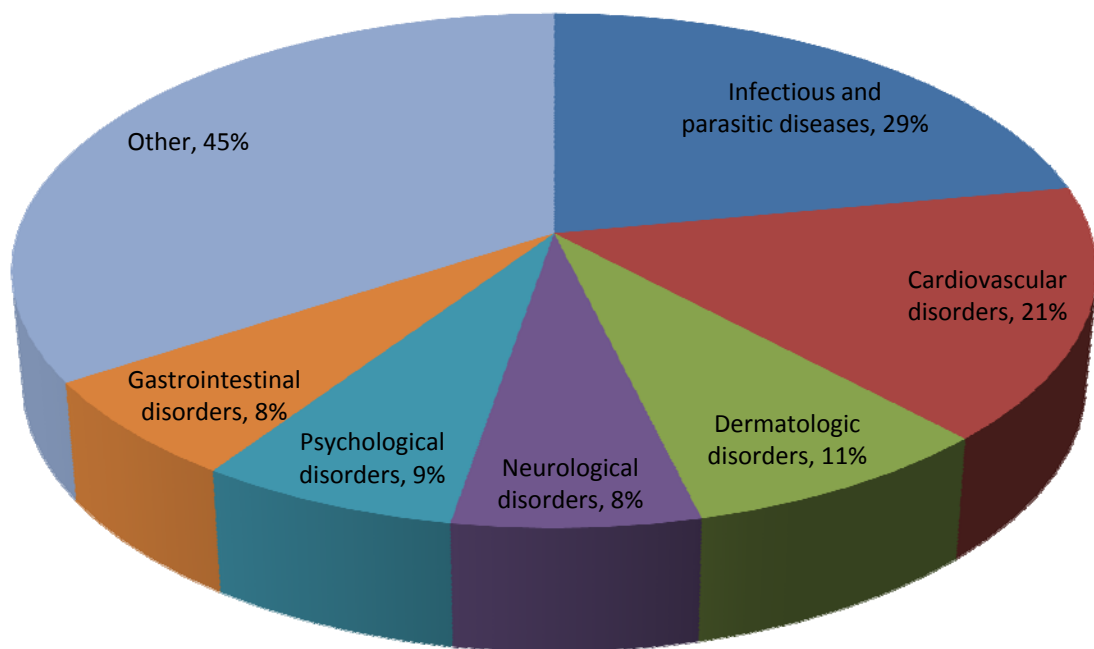


Figure 13: Overall diagnostic distribution per system of patients at UNHC during the study period

A number of complaints are seen and treated at UNHC with infectious and parasitic diseases being the highest at 29% from June 2004 – June 2008.

Table 7: The most prevalent diagnoses per most prevalent pathology

System	Percentage	Specific diagnosis per system
Infectious disease	29%	Influenza (8%) HIV / AIDS (6%) Sexually transmitted diseases (4%) Other (11%)
Cardiovascular diseases	21%	Hypertension (13%) Blood pressure checkup (3%) Arrhythmia (2%) Other (3%)
Dermatological disorders	11%	Dermatitis (5%) Eczema (3%) Acne (1%) Other (2%)
Psychological disorders	9%	Emotional trauma from domestic violence (2%) Anxiety (2%) Rape trauma (1%) Other (4%)
Musculoskeletal disorders	9%	Rheumatoid Arthritis (3%) Osteoarthritis (2%) Lumbar pain (1%) Other (3%)

The most prevalent infectious diseases formally diagnosed included influenza (8%) and HIV/AIDS (6%). With regards to the cardiovascular diseases seen at UNHC there was a high incidence of hypertension (13%). Dermatitis was the most prevalent dermatological diagnosis (5%) as was emotional trauma from domestic violence (2%) the most prevalent psychological disorder encountered, rheumatoid arthritis (3%) was the most prevalent musculoskeletal diagnosis made.

4.2.6 Medicines prescribed

Table 8: The most frequently prescribed homoeopathic remedies at UNHC during the study period

Homoeopathic remedies prescribed	Frequency	Mean
<i>Natrum muriaticum</i>	66	8%
<i>Sepia officinalis</i>	43	5%
<i>Aconitum napellus</i>	43	5%
<i>Staphysagria delphinium</i>	40	5%
<i>Pulsatilla nigricans</i>	39	5%
<i>Allium cepa</i>	35	4%
<i>Phosphorus</i>	32	4%
<i>Sulphur</i>	29	4%
<i>Stramonium</i>	28	4%
<i>Ignatia amara</i>	27	3%

A range of 94 different homoeopathic remedies were prescribed at UNHC during the study period, of these the most frequently prescribed remedy was *Natrum muriaticum* (8%) followed by *Sepia officinalis* (5%), *Aconitum napellus* (5%), *Staphysagria delphinium* (5%), and *Pulsatilla nigricans* (5%).

Table 9: Prescription count per remedy kingdom at UNHC during the study period

Kingdom	Remedy	Count
Plants	<i>Aconitum napellus</i>	43
	<i>Staphysagria delphinium</i>	40
	<i>Pulsatilla nigricans</i>	39
	<i>Allium cepa</i>	35
	<i>Datura stramonium</i>	35
	<i>Ignatia amara</i>	28
		27
Minerals	<i>Natrum muriaticum</i>	66
	<i>Phosphorus</i>	32
	<i>Sulphur</i>	29
	<i>Calcarea carbonica</i>	26
	<i>Silica</i>	21
	<i>Stannum metallicum</i>	16
Animals	<i>Sepia officinalis</i>	43
	<i>Cantharis</i>	11
	<i>Lachesis mutas</i>	6
	<i>Lac caninum</i>	4
	<i>Lac delphinium</i>	2
	<i>Bufo rana</i>	1
Nosodes	<i>Tuberculinum</i>	18
	<i>Carcinosin</i>	11
	<i>Psorinum</i>	8
	<i>Medorrhinum</i>	5
	<i>Bacillinum</i>	1

The plant kingdom and the mineral kingdom were the most frequently prescribed at 44%. The most frequently prescribed remedy per kingdom was *Aconitum napellus* (plant kingdom), *Natrum muriaticum* (mineral kingdom), *Sepia officinalis* (animal kingdom) and *Tuberculinum bovinum* (nosodes).

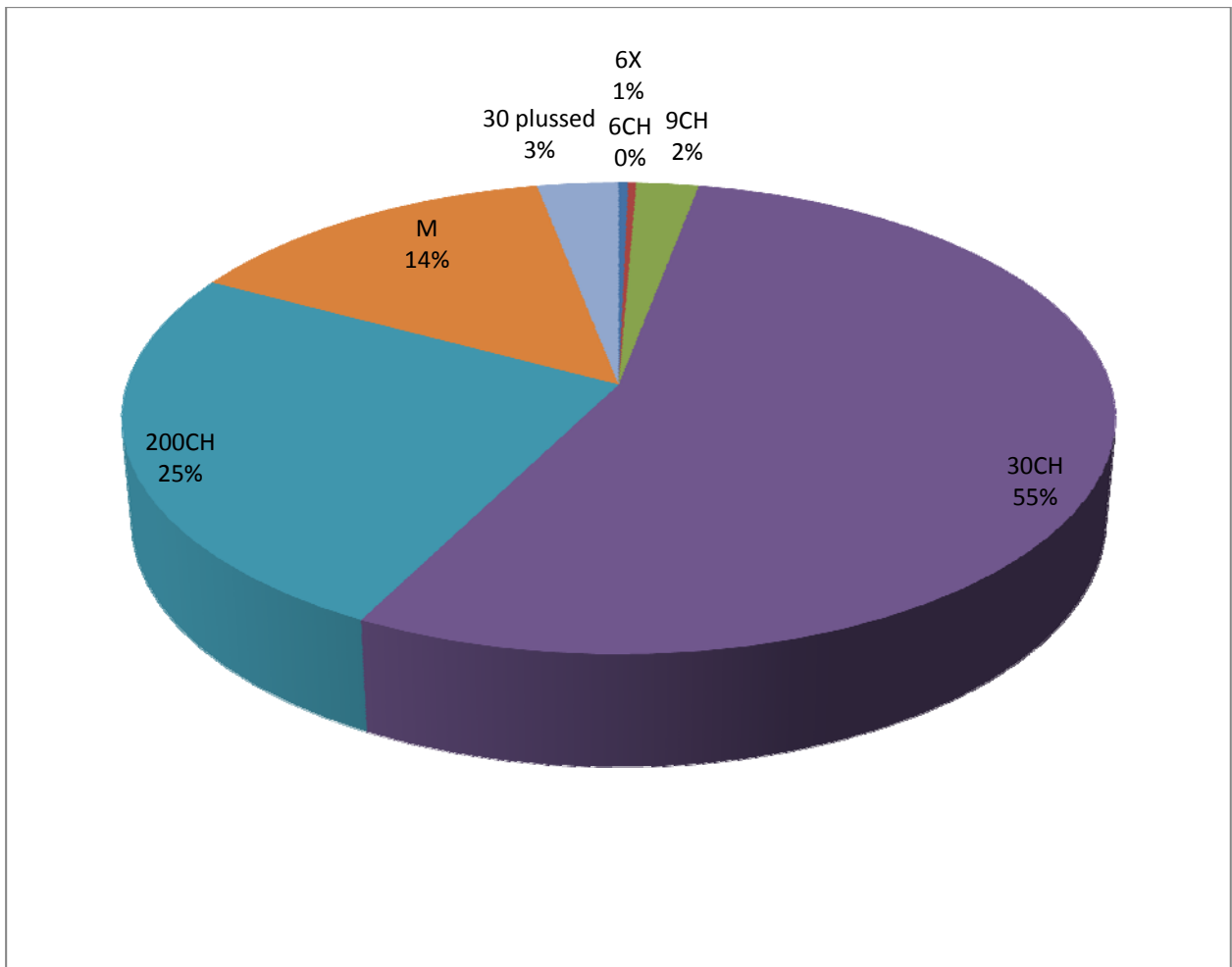


Figure 14: Potency distribution at UNHC during the study period

The above chart shows that the most frequent potency utilized at UNHC during the study period was 30CH (55%) followed by the 200CH (25%).

In addition to the primary prescription of homoeopathic medicine adjunctive prescriptions for phytotherapeutic medicines, Bach Flower Remedies and Tissues salts were made.

Table 10: The most commonly prescribed phytotherapeutic interventions

Phytotherapeutic intervention	Frequency	Mean
<i>Calendula officinalis</i>	157	18%
<i>Crataegus oxyacantha</i> and <i>Rawolfia serpentina</i>	90	10%
<i>Calendula officinalis</i> and <i>Hypericum perforatum</i>	54	6%
<i>Arnica montana</i>	46	5%
<i>Passiflora incarnata</i> & <i>Valeriana officinalis</i>	39	5%
<i>Ruta graveolens</i>	38	4%
<i>Syzygium cumini</i>	33	4%
<i>Urtica urens</i>	32	4%
<i>Echinacea purpurea</i>	31	4%
Combination of <i>Arnica</i> and <i>Ruta graveolens</i> gel 50ml	29	3%

The above table shows *Calendula officinalis* (18%) was the most commonly prescribed phytotherapeutic intervention with a combination of *Crataegus oxyacantha* and *Rawolfia serpentina* being the second most prevalent prescription (10%).

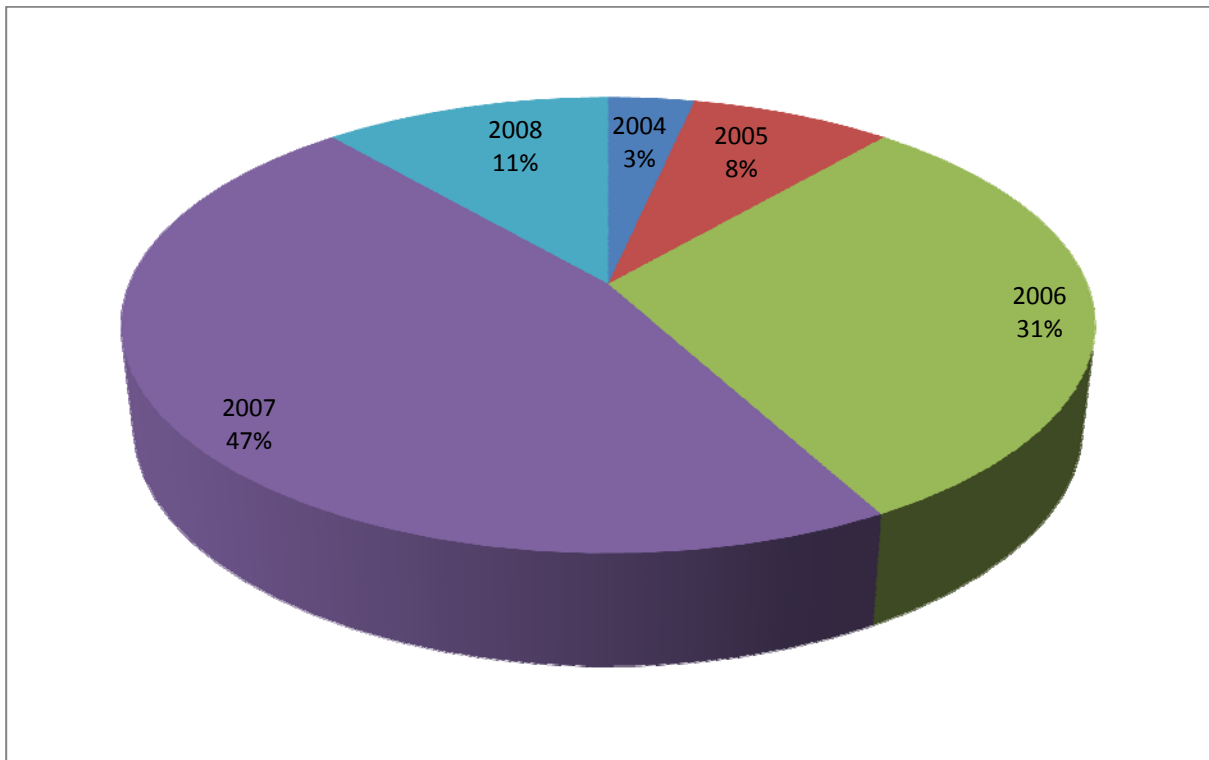


Figure 15: Chart representing the percentage of patients which were prescribed Rescue remedy during the study period

In 2007 Rescue remedy was prescribed to a significant portion (47%) of patients attending UNHC. 2004 and 2008 were only half years and thus the data is skewed accordingly.

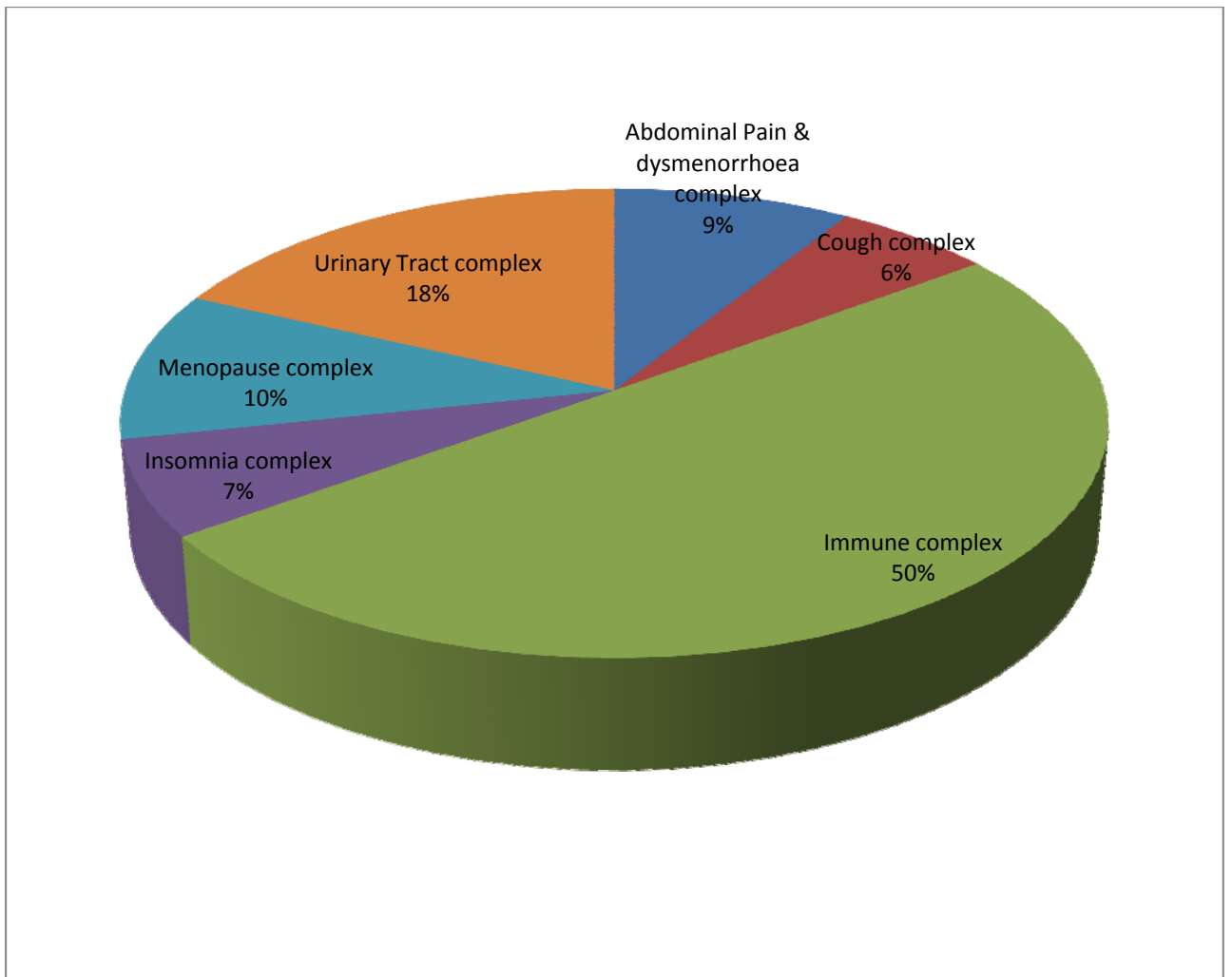


Figure 16: Chart representing the most frequently prescribed phytotherapeutic complexes from June 2004 - June 2008

The chart above shows the immune complex to have been prescribed 50% of the time during this period and the cough complex being the least often prescribed at 6%.

Table 11: Phytotherapeutic complex ingredients

Name of complex	Ingredients
Insomnia complex	<i>Melissa officinalis; Valeriana officinalis ; Passiflora incarnata; Humulus lupulus; Avena sativa</i>
Urinary tract complex	<i>Agathosma betulina; Petroselinum crispum; Equisetum hiemale; Arctostaphylus uva ursi; Sarsaparilla</i>
Immune complex	<i>Echinacea purpurea; Phytolacca americana; Baptisia tinctoria; Myrrh; Pulsatilla nigricans</i>
Abdominal pain & Dysmennorhoea complex	<i>Matricaria chamomilla; Mentha piperita; Dioscorea villosa; Viburnum opulus Zingiber officinalis</i>
Menopause complex	<i>Dioscorea villosa ; Agnus castus ; Cimicifuga racemosa</i>
Cough complex	<i>Verbascum thapsus; Rumex crispus; Drosera rotundifolia</i>

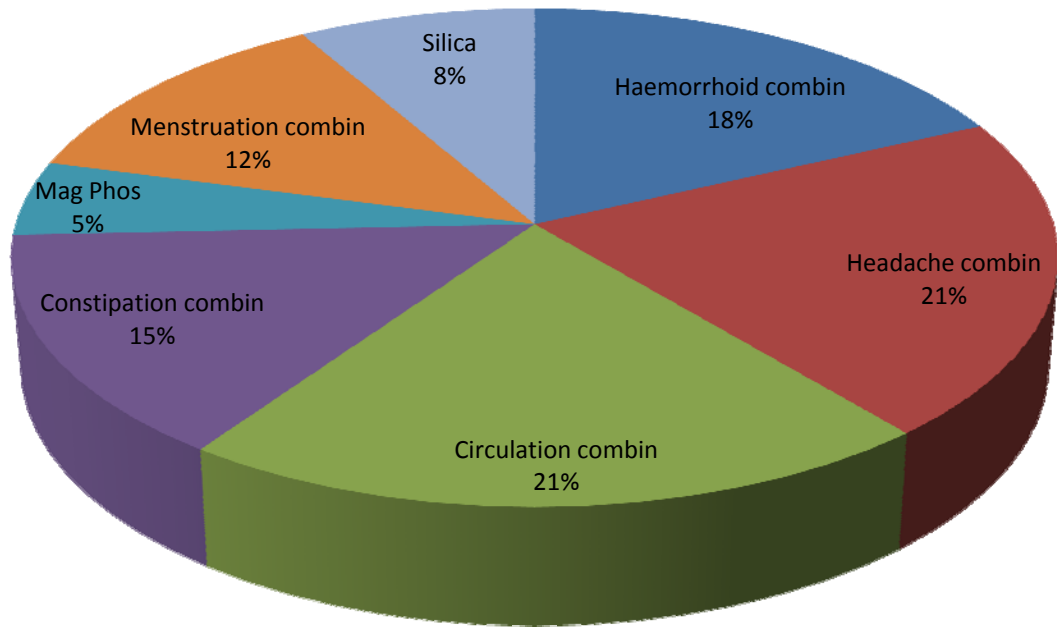


Figure 17: Tissue salt combinations prescribed during the study period.

The above chart shows circulation and headache combin to be the highest prescribed over the given period at 21%.

Table 11: Tissue salt ingredients

Tissue Salt	Ingredients
Haemorrhoid combin	6x: Calc Fluor, Ferrum phos, Kali mur, Kali phos
Headache combin	6x: Ferrum phos, Kali phos, Mag phos, Nat mur, Silicea
Circulation combin	6x: Calc fluor, Calc phos, Ferrum phos, Kali mur, Kali phos
Constipation combin	6x: Kali mur, Nat mur, Silicea
Mag Phos	6x
Menstruation combin	6x: Calc phos, Ferrum phos, Kali phos, Kali sulph, Magnesium phos
Silica	6x

CHAPTER FIVE – DISCUSSION

5.1 INTRODUCTION

In the following chapter, the results from Chapter four will be discussed.

The outline of the chapter is as follows:

- Sample characteristics
- Consultations
- Demographics
- Referrals
- Examinations and Urine dipstick tests
- Main complaints
- Prescribed medicines

These will be described according to how they related to and affect one another. All relevant issues will be explored incorporating statistical data obtained from Chapter four.

5.2 SAMPLE CHARACTERISTICS

The population that the research aimed to describe comprised of patients who attended UNHC over an exact four year period from the month of June 2004 to June 2008. There were 497 new and 365 follow-up patients seen at UNHC during this time period.

As the sample comprised the entire population (all files during the study period) and the study period included data from UNHC since its inception in 2004 for four consecutive years only excluding the half of 2004 and 2008 one can assume that the data is valid and representative of the clinical activity at UNHC.

5.3 CONSULTATIONS

UNHC operated for 3 hours per day which took place in the afternoons 2-3 times per week.

The number of patients has steadily increased from 16 (the year the clinic opened in 2004, 6 month period) to 114 (the end of the study period 2008, 6 month period) as the years progressed. There were, on average, more new patients for each year than patients coming back for follow ups. In 2005, 2006, 2007, and 2008 there was an indication that on average 40% of the patients returned for follow-ups consultations. These results suggest that UNHC has grown significantly since its inception in 2004.

The number of days the clinic was open for each year ranged from 23 in 2004 (6 month period), 52 in 2005, 69 in 2006, 78 in 2007, and 42 in 2008 (6 month period). The reason for the fluctuations in the number of days the clinic was open is due to the fact that UNHC could only commence activity once all the respective students had been registered for the year at DUT; usually this process is only completed in February of each year.

Additional factors which impact on the number of consulting days included public holidays, DUT vacation periods, strikes, and routine closures during midterm and end of year exam periods. UNHC was open Wednesdays and Fridays for all five years and began operating on Monday's as of 2007. There was a direct correlation between the number of days the clinic was open and the number of patients seen; the higher the number of consultation days the higher the number of patients seen. Over the 4 years there was a steady increase in patient numbers hence the decision to open UNHC for an additional consulting day of the week (Mondays). Over the four year period the clinic was averaging one and a half patients a day when open twice a week in its inception in 2004 this increased to 3 patients a day in 2005 (open 2 days a week); in 2007 UNHC began operating on 3 days of the week this resulted in an increase in the average number of consultations per day to 4 patients a day which remained the case until 2008. Based on the latest data (2008) it was calculated that the average consultation took approximately 45 minutes to complete based on 4 patients over a 3 hour clinical session.

Figure 4. shows that between 2005 and 2007 an average of 63% of patients returned for more than one follow up consultation. Data from 2004 and 2008 was excluded from this calculation as they comprised 6 monthly periods only, 2004 was also the first year of operating for UNHC and due to the clinic not being fully established within the community consultation numbers were very low, inclusion of these data sets would thus skew the total data. A return rate of 63% is a positive sign and although not formally measured suggests that the majority of patients were satisfied with the service/treatment they obtained from UNHC.

Table 1 shows that for three of the years within the study period (2004 – 2006) Friday's were the busiest day of the week on average, this was replaced by Monday's in 2007 and Wednesday's in 2008. Mondays were only introduced in 2007 which ties in with Monday being the busiest day in 2007 and not any other year. Fridays are overall a more convenient day to attend UNHC as people leave work earlier on this day and are thus able to attend UNHC within the designated clinic times in addition being within a commuter zone; weekly workers go home for the weekends and therefore this may result in more people frequenting the area in general around that time.

With regards to the busiest month of the year depicted in Table 1 the variable data makes it difficult to define a particular trend; the most recent data suggests that the March/April period appears to be becoming the busiest months at UNHC, this could be due to the fact that it is change of season and people tend to suffer more with allergies and cold and flu during this time. Further data collection and monitoring is necessary to accurately calculate this variable though. Factors which may have influenced the data obtained include that the beginning months were not as busy due to the community still getting to know the clinic hours; the clinic tends to become more utilized as the year progresses and referral by word of mouth takes place in addition UNHC usually only becomes operational in February of each academic year and in the latter months of the year i.e. November and December UNHC is usually not operational due to academic closure and exams.

5.4 DEMOGRAPHICS

The majority of patients who attended UNHC during the study period were African (80%) females (60%) between 40-64 years of age (40%) who were unemployed (40%) and single (40%).

5.4.1 Gender

This research supports the evidence shown in Figure 5 which shows there is a greater proportion (more than 60%) of female patients who attend the clinic than male patients. This supports the findings of Ferrucci (1994) who found in her study that females dominated the patient samples for both private clinics and patients of the Homoeopathic Day Clinic at Technikon Natal. Verhoogt (2003) found a predominance of female patients within homoeopathic practices in KwaZuluNatal (KZN); this is also consistent with IIPOS-01 study (Heger et al, 2001) in Europe and the USA (66.7% female). A new study carried out by Experian Simmons Research (2007) shows that woman are more health conscious than men, this could be a reason as to why more females attended UNHC than males.

5.4.2 Employment

Throughout all five years of the study period the patient's seen at UNHC were predominantly unemployed (41%). Those who were employed accounted for only 36% of patient seen; 14% of patients were students, 8% pensioners and 2% children. In 2008, having only included 6 months of clinical data up to June almost 60% of patients were unemployed. As stated in Chapter two the poverty and unemployment rates in KZN are above the national averages and is a major contributing factor to patients being drawn to clinics which offer primary healthcare free of charge. Ferrucci (1994) states that of the patients who attended the Technikon Natal Homoeopathic Day Clinic 33% were employed and 29% were unemployed.

One of the factors which may have attributed to the low number of children (5%) seen at UNHC could be due to the fact that a number of patients who attend UNHC do so spontaneously i.e. pamphlets are distributed outside the doors on the street to passersby and no prior arranged appointments are taken, thus it is possible that their respective children are not present during working hours (most likely at school or crèche).

5.4.3 Age

The two major age groups seen at UNHC during the study period were 40-64 (36%) and 25-39 (34%) with 18-24 (17%) coming third and lastly >65 (8%) and 0-18 (5%). In Ferruccis' study (1994) the age of the patients varied between research groups; at the Homoeopathic Day Clinic the majority (29%) of patients were between 18 and 25 years of age and in the private sector the largest age group being 26-55 (20%). A larger middle aged group of patients at UNHC could be due to the fact that there are many small businesses and markets in the surrounding area and UNHC being located in Warwick Junction, a major commuter zone (one of the largest bus and taxi depots in Durban) could explain the larger number of patients within the working age group.

5.4.4 Marital status

The study shows that over 40% of the patients who attended UNHC during the study period were single (47%), 35% were married, 13% widowed, 3% divorced and 2% separated. This demographic variable remained relatively constant during the study period. It was mentioned earlier in chapter one that Ukuba Nesibindi is intended for the impoverished community and 'youths at high risk' such as runaways and prostitutes who find themselves in Warwick Junction, this could be the reason for the high incidence of single patients due to their history and lifestyle such committed relationships (marriage) may not occur.

5.4.5 Race

The results showed that throughout the study period the majority of patients attending UNHC were African (85%), it is noteworthy that no White patients were seen at UNHC. These findings differ vastly from those of Verhoogt (2003) whose study was done in the private sector; she stated that homoeopathy appealed more to the White (61%) and Indian (22.2%) population. Jacobs *et al.* (1998) compared the demographics of patients using homoeopathic medicine as compared with patients of physicians using conventional medicine in the USA. They found that the former saw a higher percentage of White (91%) and Asian patients (5.5%).

The majority of the patients seen at UNHC are African due to the specific location and history of Warwick Junction as well as by the official provincial population demographics i.e. that there are approximately 69% African people, 20% Indian people, 8% White people, and 3% coloured people in KZN.

Apartheid was a system of legal racial segregation enforced by the National Party government in South Africa between 1948 and 1994, under which the rights of the majority Black inhabitants of South Africa were curtailed and minority rule by Whites was maintained (Marais, 1989).

According to Chazan (2007) the end of apartheid in South Africa has led to political-economic transition, the deregulation of cities, and increased population mobility, with growing numbers of people living and working in sub-standard and 'informal' urban conditions.

With the imminent collapse of apartheid, people previously denied access to the city began to stake claims. Minibus taxis 'invaded,' and Warwick Junction became the site of intense trade and taxi activity and is today the largest trading hub in Durban, KwaZulu-Natal.

Most street traders came into the city with the end of apartheid and as a result of rising unemployment and political violence in their home areas. The majority maintain patterns of circular migration with their homes in the surrounding rural areas. Many have been drawn to Warwick Junction as a matter of survival, as it offers livelihood opportunities, however meagre such as selling goods and services to thousands of commuters each day.

The implications of the racial demographics directly influence the operating of the UNHC. The majority of homoeopathic students who work at UNHC do not speak an African language and in most cases translation is necessary in order to communicate effectively with patients. In addition to performing clinical supervision duties the head clinician (who is first language Zulu speaking) of UNHC also serves as the main translator when required. The need for constant translation poses significant challenges for operation at UNHC as often there is more than one patient having a consultation simultaneously and needing translation. Students have recently taken Zulu as another subject to aid in this regard but more funding would allow a translator which would allow more patients to be seen to as well as more effective case taking due to a decrease in misinterpretation which would ultimately affect the remedy selection.

5.5 REFERRALS

A total of 21% of all patients seen at UNHC during the study period were referred to other medical facilities for various reasons.

In situations when patients required medical interventions which extended beyond the homoeopathic scope of practice or where specialised resources and equipment were necessary patients were referred to various public health facilities described in Table 6. Patients with complex medical needs and where specialised diagnostic interventions were warranted such as ECG's, mammograms and ultrasounds were referred to Addington, McCord and Prince Mshiyeni hospitals. UNHC as stated in Chapter 2 is located in the Lifeline building in Warwick Junction, it is here where patients are referred for HIV testing (28% of UNHC patients), and pre and post test counselling from well trained nurses is provided free of charge.

The data also shows that patients are directed to family planning clinics/ pharmacies for pregnancy and glucose finger prick tests. Referral letters were written by Homoeopathic students under supervision of the clinician and issued to the respective patients, the letters also requested feedback from the respective medical facilities allowing for continued patient management thereafter. The need for referral for simple procedures such as pregnancy testing, and glucose tests would be significantly decreased by improving the diagnostic resources at UNHC.

5.6 URINE DIPSTICK TESTS

An average of 28% of all patients (862) (new and follow up) who came to UNHC during the study period had a urine dipstick test carried out. This test provides a valuable, time and cost effective diagnostic tool for the students and supervisors to screen patients for the presence of leucocytes, nitrites, blood, or protein in the urine which may indicate urinary tract infections or other conditions. Suspected diabetics with glucose or ketones in their urine could be referred with just cause for further tests at a more advanced facility.

5.7 MAIN COMPLAINTS

Of the 5 most prevalent system disorders encountered at UNHC (Figure 13) infectious disorders were the most frequent along with cardiovascular, dermatological, psychological and musculoskeletal disorders. Table 7 describes the most common specific ailments diagnosed at UNHC.

Of the infectious diseases (29% of all disease treated at UNHC) cold and flu accounted for 8%, HIV/AIDS 6%, and sexually transmitted infections 4%. In the cardiovascular system one of the major diagnosed disorders was hypertension (13%). Often this was diagnosed incidentally on a routine blood pressure assessment which is carried out on all patients seen at UNHC.

With respect to patients being informed of the seriousness of mismanaged hypertension, as well as, aetiology, contributing factors and the importance of regular blood pressure assessments, which were done free of charge at UNHC, it linked up with the 3% of patients who visited UNHC for their blood pressure monitoring. Some patients presented with pre-existing arrhythmias, these patients were referred for specialised cardiovascular management and ECG assessments. With respect to dermatological complaints many forms of dermatitis (5%) were seen, diagnosed and treated as well as eczemas (3%) and acne (1%).

UNHC being situated in the Lifeline building resulted in a fair number of patients being seen who had also presented for counselling and often during the routine case history of the patient the psychological trauma of past or recent experiences was revealed. A survey for the period 1998 – 2000 compiled by the United Nations Office on Drugs and Crime ranked South Africa second for a very high incidence of violent crimes including murder, rape and domestic abuse. Poverty stricken areas force a high number of sex workers from all ages onto the streets this includes Warwick Junction with a 'nightclub/tavern' situated directly next door to the LifeLine building. Skinner (2008) states that approximately 8 000 street traders, most of whom are Zulu women, sell goods and services to about 450 000 daily commuters in Warwick Junction. Most traders are not protected by social security and labour legislation, and the majority earn well less than ZAR 1 000 per month. Many work long hours in hazardous conditions such as cooking on open fires, inhaling exhaust fumes, avoiding harassment from security workers and customers, and enduring flare-ups of crime and violence earning barely enough for their families to survive.

The survivalist nature of most street-trading, the precariousness of traders' working conditions, their low education levels, limited negotiating power, lack of access to resources and information, and their lack of social protection combine to increase their vulnerabilities to HIV and AIDS and could be cause for such a high percentage seen at UNHC as well as a reason for LifeLine to place a HIV centre in this area.

Homoeopathy being a holistic practise of medicine is able to offer supportive treatment to these patients at the emotional level. With formal Lifeline training obtained by homoeopathic students in their fourth year of study, students were able to provide counselling for patients when required, though difficult and particularly sensitive patients were referred to more experienced homoeopathic practitioners, counsellors, or psychologists.

With regards to the musculoskeletal system, rheumatoid arthritis (3%), osteoarthritis (2%), and lumbar pain (1%) were the three of the most common conditions encountered at UNHC. The results of the study show that the highest percentage of patients seen at UNHC (36%) were between the ages of 40 – 64 which may be a contributing factor to the high incidence of musculoskeletal system diagnoses at UNHC.

The Verhoogt (2003) study which audited private homoeopathic practices in KwaZulu Natal revealed that gastro-intestinal tract pathology accounted for the largest diagnostic group at 12.7% of respondents. Dermatology was also prevalent at 11% as seen in the UNHC study.

Depression and psychological complaints were very high ranking 3rd in Verhoogt's study and 4th in the UNHC study respectively. In contrast with the previous similarities in the two studies was that of infectious diseases which were uncommon (3.2%) and in the Verhoogt study however the highest in the UNHC study, this could be due to the fact that UNHC clinic is situated in a HIV testing facility where more HIV and TB patients are likely to be seen and the patients come from a poorer socio-economic background and education levels in this area are low. In the Ferrucci study (1994), dermatological and gynaecological complaints were the most prevalent, dermatological complaints ranked within the five major categories of complaints at UNHC.

Although UNHC is a free public facility and Verhoogt examined private homoeopathic practice, there were still similarities seen such as the remedy selections, but there were also clear differences in terms of race and main complaints diagnosed and treated, which could be due to the socio-economic factors involved in both studies. International studies showed similarities in terms of diagnoses with eczema, arthritis, and depression being most prevalent regardless of the fact that these studies took place in first world countries.

The Jacobs et al. study (1998, USA) lists ten most common diagnoses made by homoeopaths of which three are in common with this study. These are depression (3.5%), eczema (2.6%), and arthritis (2.5%). Likewise in the Jansen and Koster (1995, Netherlands) study four of their most common diagnoses were listed as eczema (19.2%), anxiety (8.6%), depression (8.6%), and arthritis (6.2%).

5.8 MEDICINES PRESCRIBED

Calendula officinalis was the most frequently prescribed phytotherapeutic medicine (18%). This herb is used commonly by homoeopaths topically and orally as a mild bactericide, antiseptic and anti-inflammatory, this most likely explains the frequency of its prescription at UNHC at which high incidences of infectious and dermatological disorders were noted. A combination of *Crataegus oxyacantha* and *Rawolfia serpentina* accounted for 10% of herbal medications prescribed this correlates with the relatively high incidence of hypertension at UNHC, as hypertension is usually a chronic disease patients returned on a number of occasions to obtain repeat medications for this disorder further contributing to the high incidence of this prescription. *Arnica montana* (5%) acts as an anti-inflammatory, local antibiotic, analgesic herb excellent for bruises and sprains as well an effective treatment for the musculoskeletal disorders which were seen to be one of the more prevalent diagnoses at UNHC. The high incidence of psychological trauma which often results in bring anxiety and insomnia, most likely is accountable for the high incidence of prescriptions for *Passiflora incarnate* and *Valeriana officinalis* (5%) for their carminative effects.

Overall the most frequently prescribed phytotherapeutic prescriptions correlate with the most prevalent disorders seen and treated at UNHC i.e. infectious disease, psychological, dermatological and musculoskeletal disease respectively.

At UNHC the most frequently prescribed homoeopathic remedy was *Natrum muriaticum*. Jansen and Koster (1995) reported *Calcarea carbonica* as most prescribed along with *Natrum muriaticum* (3rd), as well as *Pulsatilla pratensis*, *Sepia officinalis* and *Sulphur* within their 10 most commonly prescribed remedies. Dempsey and Swayne (1990) reported *Natrum muriaticum* (4th), *Sulphur*, and *Sepia officinalis* as some of the most frequently prescribed remedies. Verhoogt (2003) reported that *Calcarea carbonica* ranked 19th in frequency of prescription and interestingly the most frequently prescribed medicine in the homoeopathic private sector was also *Natrum muriaticum* and the 10 most frequently prescribed remedies included *Aconitum napellus*, *Pulsatilla pratensis*, *Sulphur* and *Sepia officinalis*. At UNHC *Calcarea carbonica* was the 11th most frequently prescribed remedy. A retrospective study of 4 years of prescribing trends at the Glasgow Homoeopathic Hospital (Kayne and Beattie, 1998) showed that in all four years *Natrum muriaticum* was the most frequently prescribed medicine. *Pulsatilla pratensis*, *Sulphur* and *Sepia officinalis* also fell consistently into the top ten medicines prescribed.

From the above comparisons it is clear that generally the prescriptions at UNHC are in line with trends reported from other studies both regionally and internationally. What is noteworthy was the fact that *Lycopodium clavatum*, which ranked high in other studies, was not commonly prescribed at UNHC. The frequent prescription of *Aconitum napellus* at UNHC coincides with the high crime rate and degree of violence and psychological complaints experienced by patients attending UNHC, *Aconitum napellus*, being used to treat states on shock and fright (Vermeulen, 1994:13).

The high prescription rate of *Natrum muriaticum* is not surprising considering that one of the most frequent conditions seen were cardiac complaints aggravated by emotional upsets and suppressed grief (Vermeulen, 1994:1116) which could further correlate with the high rate of psychological traumas and the high number of cardiovascular presentations of hypertension seen at UNHC.

Statistics with regard to posology revealed that with respect to the 5 most commonly prescribed remedies 30CH, 200CH and M potencies were the most prevalent in prescription (see Figure 14). There are many different approaches with respect to potency selection which are ever changing as Homoeopathy evolves. The choice of posology lies with the practitioner and their training. The most likely reason why 30CH, 200CH and M potency selection were most prevalent at UNHC is directly as a result of how the students are trained at DUT.

As stated by Ernst (2002) Bach Flower Remedies are dilutions of flower material developed by Edward Bach in the 1930's. The remedies are mainly to aid with emotional conditions. The remedies contain a very small amount of the original flower material in a 50:50 solution of water and alcohol. Rescue remedy was prescribed frequently in 31% of patients in 2006 and in 47% of patients in 2007. Rescue remedy is a combination of various single Bach flower remedies and not a homoeopathic remedy due to the fact that it does not follow fundamental homoeopathic precepts such as the law of similar's and "succussion". According to Stein (1990) Rescue remedy aids with emotional conditions such as grief, anxiety, stress and insomnia as well as soothing various stress induced skin conditions such as eczema.

Figure 13 shows the high number of Psychological disorders and Dermatological disorders which together account for 20% of all patients diagnosed at UNHC hence the reason for the frequency of prescription of Rescue remedy.

Various combinations of homoeopathic mother tinctures were prescribed at UNHC; the Immune Complex was prescribed to 50% of patients during the study period and the Urinary Tract Complex (UTI complex) to 18% of patients. Most of the patients seen at UNHC experienced some degree of lowered immune function as a result of from daily stress, anxiety, poor nutrition and HIV furthermore the most prevalent disease treated at UNHC was influenza which further explains the high prescription rate of the Immune Complex which is prescribed to fortify the immune system and assist the patient to overcome their respective infection. A significant number of patients attending UNHC were diagnosed with urinary tract infections (8%) this correlates with the frequency at which the UTI complex was prescribed.

According to Henderson (2009), Tissue Salts can be an effective supportive therapy in parallel with the prescribed homoeopathic remedies. The two most frequently prescribed tissue salts were the *Homeoforce* Headache Combin and the *Homeoforce* Circulation Combin as depicted in Figure 17 With 13% of patients suffering from hypertension and headaches being a common symptom of hypertension (Kahan and Smith ,2004).This could be an indication as to why the Headache Combin Tissue Salt was prescribed more regularly than the others during the study period.

The influence of socio-economic status is seen as a major contributing factor to the significantly different disease profile between UNHC and private homoeopathic practice as described by Verhoogt (2003). Conditions such as HIV, TB, worms, scabies, fungal infections, rape, emotional trauma, UTI, and hypertension are conditions which did not feature significantly in the private sector within KZN but were frequently encountered at UNHC.

CHAPTER SIX – CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

UNHC has grown significantly with respect to patient numbers since it opened in 2004. This degree of significant growth is suggestive of the clinic's success and the positive impact the service provided has had on the surrounding community. The steady year on year increase in the number of patients who attended UNHC as well as the high proportion who returned for more than one follow-up (more than 60%) are in addition positive signs suggesting the viability and success of the clinic.

The study showed that demographically the majority of patients were unemployed, middle aged, single African females. The most common illnesses encountered at UNHC were those of an infectious nature (colds, influenza, HIV, STI's) although cardiovascular, dermatological disorders and psychological trauma were also frequently treated. Referrals which occurred were mainly for HIV and TB diagnostic screening.

The location of UNHC, as a primary healthcare facility in the LifeLine building was advantageous as HIV testing could be carried out on site. Patients were treated using homoeopathic remedies and complexes, phytotherapeutic remedies, rescue remedy and tissue salts.

Although outcome measures were not applied the statistics derived from this study suggest that the practice of homoeopathy as a form of primary healthcare in an impoverished community is feasible if one considers the growth rate and rate of return of patients to UNHC. These findings may serve to motivate for the inclusion of homoeopathy as a contributing discipline to the high demand for primary health care in South Africa and may facilitate the further expansion of UNHC or justify the establishment of more such clinics in South Africa. Further community homoeopathic clinics such as UNHC will, in addition to providing a valuable primary healthcare service, aid significantly in the expansion of knowledge of this profession.

6.2 RECOMMENDATIONS

6.2.1 Recommendations to enhance the service provided by UNHC

The following are recommended in order to improve service delivery at UNHC:

- The provision of additional basic diagnostic equipment such as a glucometer and pregnancy kits will eliminate the need for referral for such basic assessments.
- Consultation times may be shortened if dedicated translators are available on an ongoing basis as UNHC, this will ultimately result in more patients being seen per day.
- Computer aided repertorisation software will further streamline the process of finalizing the respective prescriptions and negate the need for manual repertorisation entirely.
- Currently all filing and record keeping is done manually resulting in a demand for a significant degree of filing space and time spent completing paperwork. In addition labels for medicines are completed by hand, such administrative demands result in more time being required to process the prescription and ultimately result in fewer patients being seen to. A computerised filing and labelling system will significantly refine the current process.
- Currently UNHC is located on the 3rd floor of the respective building, this poses limitations for disabled patients and those who cannot walk up stairs, ideally a ground floor consulting facility should be sought to cater for such patients.

- In addition to supervising the respective students, the head clinician often has to dispense prescribed medicines as well as translate consultations; an additional clinician and/or assistant who are able to assist with administrative requirements at UNHC would facilitate the supervision process significantly.
- UNHC officially starts consulting in February due to registration of students being completed in late January. It is recommended that UNHC commence operating as early as possible in January so as to minimize the impact of December holidays on service provision, an expedited, early registration for clinical students would facilitate this process.

6.2.2 Recommendations for future studies

This study was conducted solely in the quantitative paradigm; an additional qualitative study which aims to determine the patient's perception of the service provided is warranted. Future studies should include a measurement of patient benefit in response to treatment in the form of a patient benefit survey; this would formally quantify the effectiveness of homoeopathy as a form of medicine in primary healthcare. The running costs of UNHC were not quantified in this study, future studies should attempt to determine the actual running costs of UNHC so as to facilitate comparisons with those of orthodox primary healthcare clinics.

According to the National Health Act (Act No 61 of 2003) of South Africa everyone has the right of access to health care and where most PHC's throughout South Africa do their best to provide such health care, high demands and limited resources ultimately limit such rights. UNHC is a suitable example of the plausibility of a homoeopathic PHC clinic, with additional research quantifying patient benefit at such facilities; the likelihood of formally establishing homoeopathy within the public health sector may be improved. The introduction of government funded homoeopathic based primary care clinics in disadvantaged areas may ultimately improve access to healthcare in general and therefore decrease the pressure placed on existing orthodox PHC's in South Africa.

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APPENDIX A

Tracey Smillie
11 St. Andrews Drive
Durban North
4051

Dear Dr A. H. Ross,

Re: Permission to conduct a survey

I am currently registered for a Masters Degree at the Durban Institute of Technology: Homoeopathy. In order to obtain my degree I am required to complete a mini-dissertation. My mini-dissertation is a clinical audit of the DUT homoeopathic satellite clinic, Ukuba Nesibindi.

Purpose of audit:

The aim of this retrospective, exploratory, descriptive study is to determine a patient demographic and disease prevalence profile, describe the various treatment protocols applied as well as the resultant treatment outcomes, it is anticipated that the establishment of such formal data may define the feasibility and viability of homoeopathic care in the primary healthcare sector as well as external funding obtained to aid the clinic setting further.

In order to carry out my research I need to access patient files at the clinic. I would like to request permission to do so, noting that patient confidentiality will be maintained as no names need to be used, no copies of patient files will be made nor shall any of the files be removed from Ukuba Nesibindi Homoeopathic Clinic. Clinician in charge and co-supervisor Dr Jabulile Ngobese will be present at all times and overseeing this exercise.

Your participation will be greatly appreciated.

Many thanks,

Tracey Smillie
Research student

HOD Homoeopathy (DUT)
Dr. A. H. Ross

APPENDIX B

Tracey Smillie
11 St. Andrews Drive
Durban North
4051

Dear Dr J. Ngobese,

Re: Permission to conduct a survey

I am currently registered for a Masters Degree at the Durban Institute of Technology: Homoeopathy. In order to obtain my degree I am required to complete a mini-dissertation. My mini-dissertation is a clinical audit of the DUT homoeopathic satellite clinic, Ukuba Nesibindi.

Purpose of audit:

The aim of this retrospective, exploratory, descriptive study is to determine patient demographics, disease prevalence, numbers of consultations (and follow-ups), reasons for referrals, and evaluate medicine consumption and other medical costs involved. Establishment of such formal data may define the feasibility and viability of homoeopathic care in the primary healthcare sector as well as external funding obtained to aid the clinic setting further.

In order to carry out my research I need to access patient files at the clinic. I would like to request permission to do so, noting that patient confidentiality will be maintained as no names need to be used, no copies of patient files will be made nor shall any of the files be removed from Ukuba Nesibindi Homoeopathic Clinic. I would also like to request from you as clinician in charge and co-supervisor of my research to be present at all times and to oversee this exercise.

Your participation will be greatly appreciated.

Many thanks,

Tracey Smillie
Research student

Head clinician Ukuba Nesibindi Homoeopathic day clinic
Research Co-Supervisor
Dr J. Ngobese

APPENDIX C

Tracey Smillie
11 St. Andrews Drive
Durban North
4051

Dear Dr D. F. Naude,

Re: Permission to conduct a survey

I am currently registered for a Masters Degree at the Durban Institute of Technology: Homoeopathy. In order to obtain my degree I am required to complete a mini-dissertation. My mini-dissertation is a clinical audit of the DUT homoeopathic satellite clinic, Ukuba Nesibindi.

Purpose of audit:

The aim of this retrospective, exploratory, descriptive study is to determine a patient demographic and disease prevalence profile, describe the various treatment protocols applied as well as the resultant treatment outcomes, it is anticipated that the establishment of such formal data may define the feasibility and viability of homoeopathic care in the primary healthcare sector as well as external funding obtained to aid the clinic setting further.

In order to carry out my research I need to access patient files at the clinic. I would like to request permission to do so, noting that patient confidentiality will be maintained as no names need to be used, no copies of patient files will be made nor shall any of the files be removed from Ukuba Nesibindi Homoeopathic Clinic. Clinician in charge and co-supervisor Dr Jabulile Ngobese will be present at all times and overseeing this exercise.

Your participation will be greatly appreciated.

Many thanks,

Tracey Smillie
Research student

Research Supervisor
Dr. D. F. Naude

APPENDIX D

1. File Number			
1.1 Gender:			
	Male		
	Female		
1.2 Race:			
	White		
	African		
	Indian		
	Coloured		
	Other		
1.3 Age:			
	0-18years		
	18-24 years		
	25-39 years		
	40-64 years		
	65 years and above		
1.4 Employment:			
	Employed		
	Un-Employed		
1.5 Year of First Consultation at the Clinic			
	2004		
	2005		
	2006		
	2007		
	2008		
1.6 Number of follow ups			
	0		
	1		
	2		
	3		
	4		
	5		
	6		
	7		
	8		
	9		
	10		
	more than 10 (specify):		
1.7 Clinical Diagnosis including date of diagnosis			
1	Date:	7	Date:
2	Date:	8	Date:
3	Date:	9	Date:
4	Date:	10	Date:
5	Date:	11	Date:
6	Date:		Date:

1.8 Diagnostic Tools utilised			
	Full physical examination		
	Urine Dipstick		
1.9 Patient Referred			
	Yes (If so state reason for referral) Y =Yes N = No		
	Reason:		
	Where was patient referred:		
1.10 Medication			Potency /Strength
	Homoeopathic remedy		
	Phytotherapeutic tincture		
	Phytotherapeutic complex		
	Rescue remedy		
	Tissue Salt		