A SURVEY TO DETERMINE THE PERCEPTIONS THAT EXIST AMONGST PREGNANT ADULTS TOWARDS THE USE OF HOMOEOPATHY DURING PREGNANCY

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This mini-dissertation was submitted in partial compliance with the requirements for the Master's Degree in Technology: Homoeopathy, in the Faculty of Health Sciences at the Durban Institute of Technology.

I, Fatima Paruk, do hereby declare that this dissertation represents my own work, both in conception and execution.

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DEDICATION

To all those people in my life that tread this path alongside me, your support and encouragement proved invaluable, - thank you.

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ABSTRACT

This study sought to determine the perceptions that currently exist amongst pregnant women towards homoeopathy, in light of the fact that drug use during pregnancy is limited. This study aimed at identifying myths and misconceptions that currently exist towards homoeopathy by looking at the attitudes and perceptions held by this target group. This information can be used to develop future homoeopathic education initiatives for this target group.

This study was carried out using the survey method with a questionnaire as the measurement tool. The “Perceptions in Pregnancy” questionnaire was adapted from Moys (1996), and administered to pregnant adults attending private antenatal facilities. The questionnaire was divided into three sections: A) Demographic data; B) Knowledge and attitudes towards homoeopathy; C) Previous health care experience. This sample was obtained from private antenatal facilities through convenience sampling.

Antenatal class instructors within the greater Durban area were approached and briefed about the study. Willing instructors were asked to sign a “Letter of Permission” (see Appendix A) agreeing to allow the study to be conducted within their classes. Instructors were asked to hand out copies of the “Participant Information Letter” (see Appendix B) within the class informing potential candidates of the study. Subjects willing to participate were then given a copy of

the “Informed consent form” (Appendix C) and the “Perceptions in Pregnancy” questionnaire (see Appendix D) to complete and return to the class instructor. The “Perceptions in Pregnancy” questionnaire was adapted from Moys (1998) in order to make it more suited to pregnant women.

Data obtained was analysed using the SPSS for Windows® statistical package. Descriptive statistics, T-tests, and ANOVA tests were used to study the data. The results of this survey are only generaliseable to relatively high socio-economic status women, since participants were sampled from private ante-natal clinics, and are in no way a reflection of the population in general.

This study concluded that, although people are aware that homoeopathy exists, a lack of knowledge and understanding of its methods and principles prevents them from seeking homoeopathic treatment. Despite this lack of knowledge, almost all respondents indicated that homoeopathy should be made available for most medical conditions and that it should be made available in hospitals and clinics. This indicates their desire to learn more about homoeopathy and possibly use it as an adjunct or alternative to mainstream medicine.

A need to provide basic homoeopathic education to the public exists. Education initiatives should aim to differentiate homoeopathy from other alternative therapies, in order to eliminate misconceptions about homoeopathy. Results

indicate that by educating the public on homoeopathy, more individuals would be likely to seek homoeopathic treatment.

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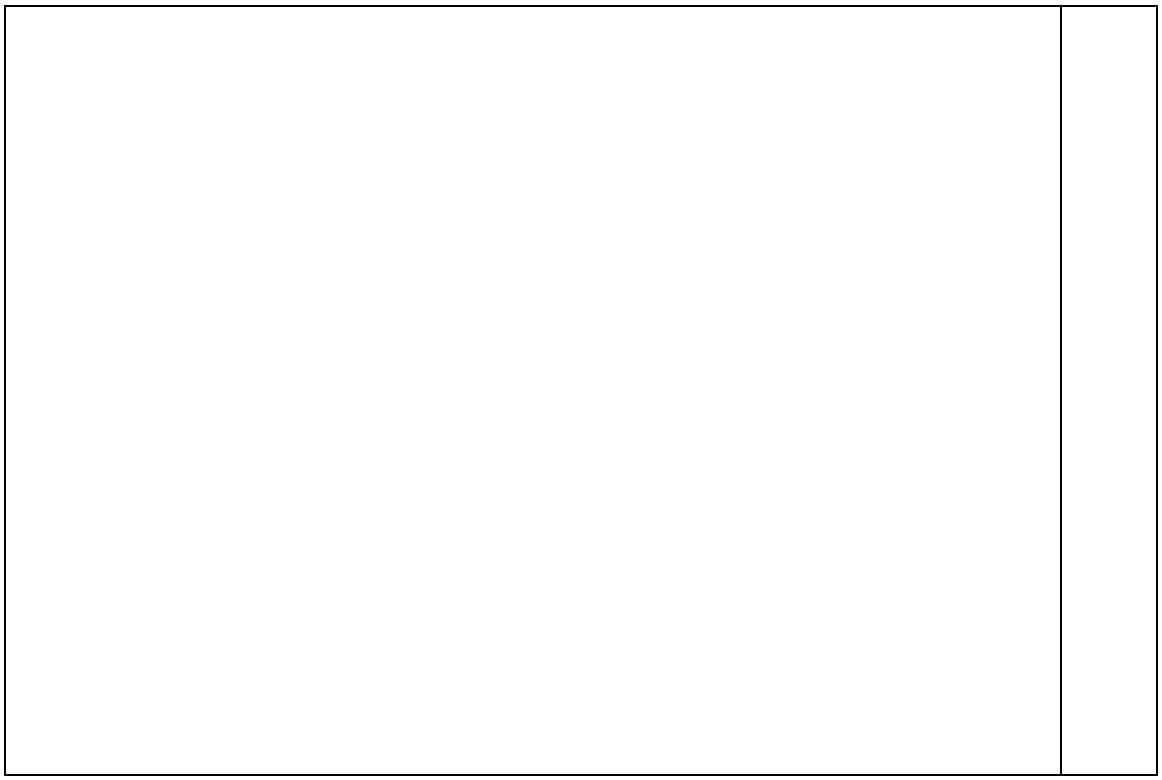

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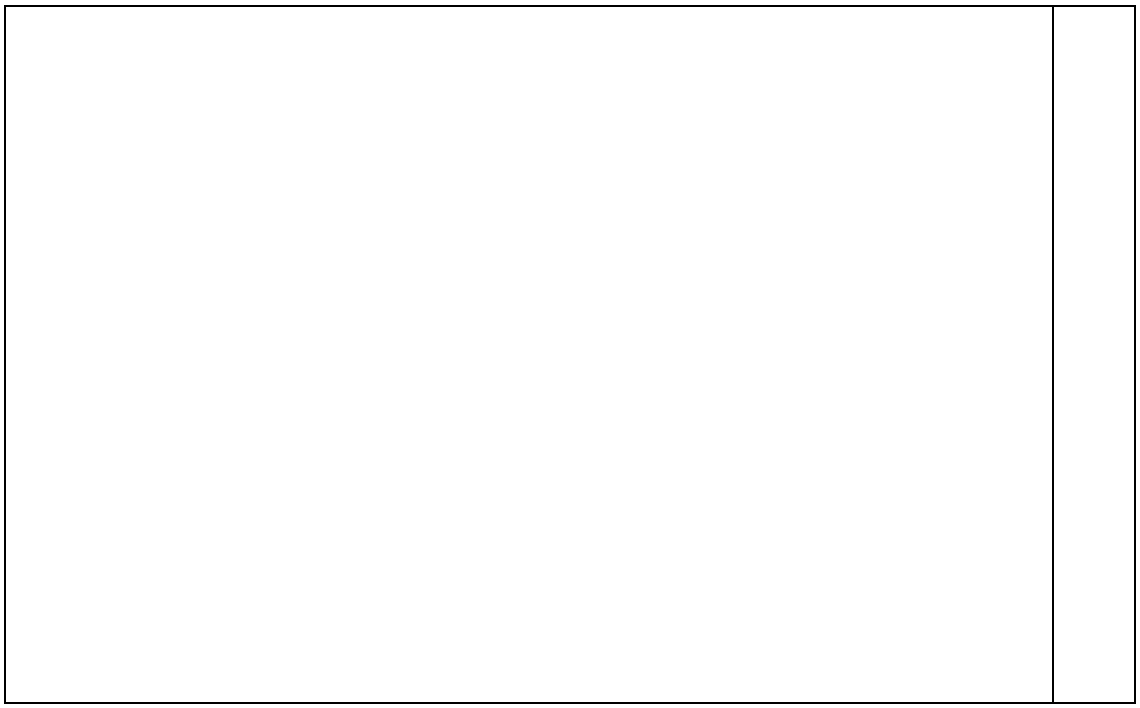

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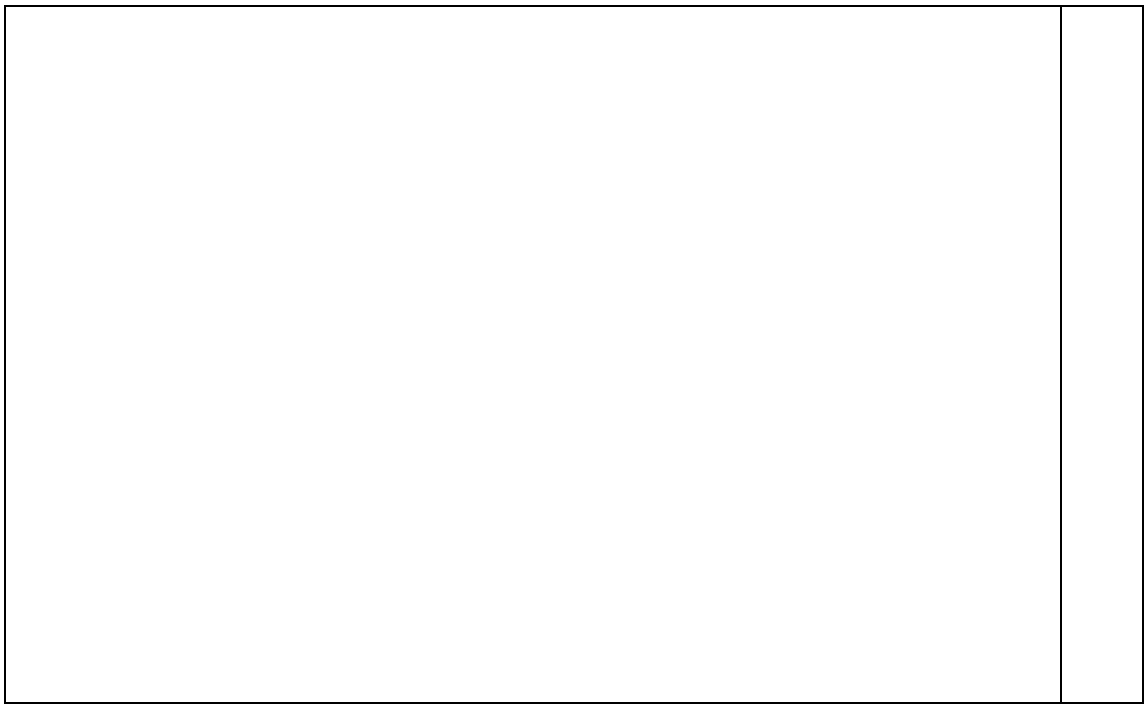

DEFINITIONS

ALLOPATHIC MEDICINE: A therapeutic system that treats disease by using medicines whose effects are different from those of the disease being treated and which have no relationship to the disease symptoms (Yasgur, 1998:9).

CHRONIC DISEASE: An illness whose onset is usually gradual and whose course is of long duration with no certain prospect of recovery, may consist of recurrent acute episodes, and often involves more than one organ system (Swayne, 1998:208)

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COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM): A term given to the group of nonorthodox therapeutic disciplines implemented to complement other orthodox procedures, rather than to replace them (Kayne, 2003:47).

HOMOEOPATHY: A therapeutic system based on the Law of Similars. Disease processes are treated with substances that are able to produce, in a healthy person, symptoms similar to those displayed when ill (British Homoeopathic Association, 1992:1).

INFINTESIMAL DOSE: A generic concept that embraces both ultrahigh and ultramolecular doses; it was used to described the extreme dilutions introduced

by Hahnemann in order to avoid the unwanted effects of primary drug action (Swayne, 1998:211).

MATERIA MEDICA: A list of remedies with associated descriptions of their characteristics, the source material being obtained from provings, toxicology and cured cases (Leckridge, 1997:265).

MIASMS: Postulated basis of chronic disease. Either acquired or inherited (Leckridge, 1997:265).

OTITIS: An inflammation of the ear, usually as a result of an infection (Beers and Berkow,1999:673).

PLACEBO: A substance with no active biological properties, knowingly or unknowingly used to exert a beneficial therapeutic effect (Swayne, 1998:213).

POTENCY: The strength or dilution of the remedy. Decimal scale, denoted by X or D, is a series of 1:9 dilutions and succussion. Centesimal scale, denoted by C, is a series of 1:99 dilutions and succussion. LM scale is a 1:50 000 dilutions series used by Hahnemann (Leckridge, 1997:265). The degree of dilution of a homoeopathic remedy, expressed as the number of serial dilutions and the proportionate dilution (decimal, centesimal, etc.) used in series (Swayne, 1998:214).

POTENTISATION: A method of preparation of homoeopathic remedies made up of alternating steps of dilution and succussion, in order to enhance the medicinal capabilities of the substance (Lockie and Geddes, 2001:15).

PROVING: Testing of a substance on healthy volunteers in order to determine its medicinal capability (Leckridge, 1997:265).

SUCCUSSION: A process of vigorous shaking of the solution at each stage of dilution that is used in the preparation of homoeopathic remedies (Leckridge, 1997:265).

TERATOGEN: An agent that is capable of disturbing the development of the embryo or foetus. A teratogen can halt the pregnancy or, alternately, permit the pregnancy to proceed but produce birth defects.[3]

TERATOGENESIS: Is defined as the malformation of foetal organs as evidenced either structurally or functionally (Koren, Pastuszak and Ito. 1998).

TINCTURE: The raw material consisting of powdered dried plant materials or crushed materials of animal origin (bees, ants etc.). 90-60% alcohol is used to extract the drug constituents (Koehler.1989:32). The original medicinal substance is dissolved in alcohol but undiluted (Leckridge, 1997:265).

VITAL FORCE: The force or energy responsible for the healthy running of the body, coordinating its defences against disease. Also recognized by orthodox medicine as the body's own healing power (Lockie and Geddes, 2001:18).

CHAPTER ONE

INTRODUCTION

1.1. OVERVIEW

Uncertainty regarding the understanding of homoeopathy and the use of homoeopathic medicines exists to a large degree amongst the South African public. Although homoeopaths are aware that a basic lack of education exists, little is being done to bridge this gap thus far. A possible reason for this being the lack of availability of definitive data regarding what is actually known about homoeopathy and what misconceptions currently exist regarding homoeopathy amongst the general public.

This study aimed to determine the perceptions that existed amongst pregnant adults attending private facilities. Pregnant adults were identified as a target group because of their potential as consumers due to the fact that pregnancy limits the use of allopathic drugs. It was presumed that their opinions on the subject would provide a useful indicator of the general knowledge and understanding that currently exists towards homoeopathy, and provide a basis for future homoeopathic education initiatives in this and other target groups. It is hoped that the information gathered will be used in a concerted effort by the

homoeopathic profession to develop an education initiative aimed at providing homoeopathic education to the South African public.

The study took the form of a survey, using self administered questionnaires as a method of data collection. A questionnaire was adapted from Moys (1998), and amended to better suit this target group. Respondents were approached in private facilities like antenatal classes. Questionnaires were handed out to respondents and recollected by the antenatal class instructor. To avoid the possibility of interviewer bias, the researcher was not present at any time.

1.2. PROBLEM STATEMENT

The purpose of this study was to determine what perceptions exist amongst pregnant adults with regards to their understanding of homoeopathy and the use of homoeopathic treatment during pregnancy.

1.3. HYPOTHESES

- It is hypothesized that pregnant women will not have any knowledge about homoeopathy.
- The alternate hypothesis is that pregnant women will have knowledge about homoeopathy.

1.4. DELIMITATIONS

1. This survey was conducted amongst pregnant females only.
2. This survey was conducted amongst pregnant females over the age of 18.
3. This survey was conducted in private facilities (e.g. private antenatal classes or private gynaecologists' waiting rooms).
4. Subjects were required to be literate in English.

1.5. RATIONALE

1. There are certain restrictions to the use of allopathic medicines during pregnancy (Koren, Pastuszak and Ito, 1998:1990-1194).
2. Homoeopathy provides a safe and effective form of alternate therapy during pregnancy used either solely, or in conjunction with allopathic medicine (Castro, 1992: xii).
3. Homoeopathy offers safe treatment and is able to address a wide range of conditions typically associated with pregnancy (Castro, 1992:79-104).
4. This study aimed to assess the degree of understanding of the use of homoeopathy during pregnancy as an alternative to allopathic medicines.
5. A survey of this kind has not been conducted before.

CHAPTER TWO

REVIEW OF LITERATURE

2.1. OVERVIEW

This chapter reviews pregnancy, the allopathic management of pregnancy and its limitations; homoeopathic theory and management of pregnancy; an outline of other studies regarding perceptions towards homoeopathy and complementary medicine; and myths and misconceptions regarding homoeopathy.

2.2. PREGNANCY

Pregnancy begins when a sperm fertilises an egg. For about nine months, a pregnant woman's body provides a protective, nourishing environment in which the fertilised egg can develop into a foetus. A normal pregnancy ends at delivery, when a baby is born (Beers, Fletcher, Jones, and Porter, 2003:1453).

Pregnancy is a very special time for mothers, yet it is routinely associated with a host of ailments. Pregnancy is not a disease, but the changes that the body undergoes during pregnancy may lead to certain discomforts. If these are left untreated they may be distressing to the mother, and may become a cause for concern later in the pregnancy thereby making it necessary for her to seek

medical intervention. Common discomforts of pregnancy include morning sickness, oedema (especially of the legs), varicosities of the legs and vulva, haemorrhoids, backache, fatigue (especially in the first and last trimesters), heartburn, and urinary frequency (Beers and Berkow, 1999).

Those women that do seek medical intervention usually refute the treatment offered to them due to lack of evidence regarding drug safety during pregnancy. Although drugs undergo extensive research and trials before being released onto the market, drug safety during pregnancy is not established due to ethical aspects associated with clinical trials involving pregnant women (Rubin, 1998).

2.3. ALLOPATHIC TREATMENT IN PREGNANCY

2.3.1. INTRODUCTION

Drug use in pregnancy is of concern because of the effect drugs may have on the developing foetus. According to Rubin (1998) “evidence from large clinical trials doesn’t exist for drug treatment during pregnancy”. He goes on to say that information regarding many drugs include non-specific warnings like “not to be used in pregnancy unless the benefits outweigh the risks” even though the risks are not specified and the benefits have not been confirmed. Concerns regarding foetal congenital malformations often result in pregnant women refuting drug treatment during pregnancy (Koren, Pastuszak and Ito, 1998).

2.3.2. BIOCHEMICAL PATHWAY BETWEEN MOTHER AND FOETUS

The use of drugs in pregnancy is complicated because of the changing biochemical dynamics between the mother and her foetus. Drugs reach the foetus by circulating along the same pathway that carries substances for growth and development. It is also via this same pathway that waste removal from the foetus occurs. Drugs may affect the foetus by producing lethal, toxic, or teratogenic effects on the embryo or foetus. Foetal age, drug potency, and the dose taken largely determine a drug's effect on the foetus. If taken before the 20th day after fertilisation, they may have an all-or-nothing effect, either killing the embryo or having no apparent effect. During this stage of development, teratogenesis is unlikely. Organogenesis is the period between the 3rd and 8th week, in which the foetal organs begin to develop and it is this period that is critical for teratogenesis. Drugs taken after organogenesis, during the second or third trimester, are unlikely to be teratogenic, but may still alter the growth and function of otherwise normal foetal organs and tissues (Beers and Berkow, 1999:2022-2023). With side effects including neural tube, skeletal, CNS, craniofacial, cardiovascular, and internal organ defects, as well as anomalies of teeth and bone, and growth retardation, physicians are faced with great difficulty in making these decisions regarding drug use in pregnancy (Koren, Pastuszak and Ito, 1998).

2.3.3. DRUG SAFETY DURING PREGNANCY

The Food and Drug Association (FDA) classifies drugs into five universally accepted categories of safety for use during pregnancy. This categorisation is helpful in making “risk-benefit” decisions when prescribing drugs during pregnancy and are as follows:

A. Controlled human studies have demonstrated no foetal risks; these drugs are the safest.
B. Animal studies show no risk to the foetus, and no controlled human studies have been conducted, or animal studies show a risk to the foetus but well controlled human studies do not.
C. No adequate human or animal studies have been conducted, or adverse foetal effects have been shown in animals but no human data is available.
D. Evidence of human foetal risks exists, but benefits may outweigh risks in certain situations (e.g. life-threatening conditions or serious diseases for which safer drugs cannot be used or are ineffective).
X. Proven foetal risks outweigh any possible benefit.

(Beers and Berkow, 1999:2032)

2.3.4. TERATOGENESIS

Teratogenesis may be defined as the malformation of foetal organs as evidenced either structurally or functionally. Abnormalities vary in severity depending on the teratogenic agent, and major malformations may be life threatening and require major surgery or may have serious cosmetic or functional effects (Koren, Pastuszak and Ito, 1998).

The thalidomide disaster of the 1960's shed new light on drug use in pregnancy, and lead many to question the safety of drugs used in pregnancy, accentuating the possibility that every drug had the potential to be 'another disaster waiting to happen'. Thalidomide was introduced in the early 1960's in the treatment of morning sickness amongst pregnant females, and has since been approved for use in the treatment of erythrema nodosum leprosum (a painful skin condition associated with leprosy). Despite malformation rates as high as 20-30%, as well as characteristic patterns of malformations, teratogenicity was not suspected for many years. It was later determined that foetal exposure to the drug during critical periods of development resulted in severe limb defects and other forms of organ malformation and that as little as a single dose could cause this. Subsequently, research into human tetratogenicity and drug safety during pregnancy increased, as did awareness amongst the general public (Koren, Pastuszak and Ito, 1998).

Virtually all illegal drugs, such as marijuana (causes decreased birth weight), heroin (increased risk of preterm delivery and decreased birth weight) and cocaine (causes constriction of placental vessels), pose dangers to a pregnant woman. Legal substances, such as alcohol and tobacco, are also dangerous, and even medical drugs, both prescription and over-the-counter, can be harmful. As a general rule drugs must only be used in pregnancy if the benefits outweigh the risks to the foetus (van der Spuy and Anthony, 2002:86-91).

Some drugs that are identified as threatening to pregnant women are summarized in this paragraph. Isotretinon (Accutane), used in the treatment of acne may cause chronic malformations during the stage of foetal development. Anticonvulsants like phenytion (Dilantin) and carbamazapine (Tegratol) used to treat epilepsy are associated with mental retardation and defects of the heart and face. Antimigraine medications like ergotamine and methysergide used to prevent or treat migraines may increase the risk of premature labour.
Pain killers like aspirin and ibuprofen, as well as other non-steroidal anti-inflammatory drugs (NSAID's) interfere with blood clotting mechanisms and increase the risk of uncontrolled bleeding in the mother and baby. When taken later in pregnancy they pose the threat of delaying labour. Anticoagulant drugs (coumarin) used in the treatment of heart disease or stroke to slow blood clotting cause mental retardation and facial malformations when taken early in pregnancy, and increase risks of uncontrolled bleeding when taken in later stages of pregnancy. Antineoplastic drugs are also dangerous because

embryonic tissues grow rapidly, resembling neoplastic tissues and thus are sensitive to these drugs. Vaccines containing live-virus should be avoided if pregnancy is suspected. Other drugs that are considered threatening to pregnancy include: Ace-inhibitors used in the treatment of high blood pressure; Alcohols ingested chronically or in binges; Antibiotics (tetracycline, doxycycline and streptomycin); Antidepressants (lithium); Antirheumatic agent and metal binder (penacilamine) used in the treatment of arthritis and joint pains; Antithyroid drugs (carbimazole/thiouracil) used in the treatment of thyroid problems (Beers and Berkow, 1999:2032-2027)[3].

This raises questions regarding the management of patients who require chronic treatment for conditions like depression, thyroid problems, high blood pressure, epilepsy and heart conditions. Potential risks to these individuals are great, yet they are faced with the decision on whether to discontinue treatment for the duration of their pregnancy.

2.3.5. ETHICAL LIMITATIONS ON CLINICAL TRIALS

Many new drugs are approved and released into the market each year, having gone through extensive series of clinical trials involving thousands of people, mostly male. As a result definitive data about effects on foetal development are not available at the time of drug release (Koren, Pastuszak and Ito, 1998).

This is further exacerbated by the fact that clinical trials cannot be performed amongst pregnant females for obvious ethical reasons, which in turn leads to the lack of definitive evidence of drug safety during pregnancy (Rubin, 1998).

Although fewer than 30 drugs have proven teratogenic effects, few drugs have sufficient evidence to render them “safe” (Koren, Pastuszak and Ito, 1998). Consequently many medications are labelled “not to be used in pregnancy unless potential benefits outweigh the risks,” even though the benefits may not have been confirmed and the risks are not specified (Rubin, 1998).

2.3.6. CONCLUSION

The uncertainty associated with the safety of drug use during pregnancy, often causes pregnant mothers to refute medical treatment for the duration of their pregnancy, forcing them to seek alternate therapies for common and chronic ailments.

2.4. HOMOEOPATHIC THEORY

2.4.1. INTRODUCTION

Homoeopathy is a system of medicine founded by the German physician Dr. Samuel Hahnemann (1755-1843) (Sankaran,1999:3). Hahnemann formulated

the laws and principles upon which homoeopathy is based, and according to which homoeopathic physicians practice today (De Schepper, 2001:26-43). The defining characteristic of homoeopathic treatment is based on the similarity between the drug picture and the clinical presentation of the patient (*Law of Similars*) (Swayne, 1998:214).

In homoeopathy, disease is viewed as an underlying imbalance that presents itself in the body as symptoms (Ullman and Reichenberg-Ullman, 1995:10-11). Sankaran (1999:8) elaborates on this concept saying that a central disturbance occurs and is followed by various changes in other organ systems depending on the individual's pathological tendencies. He explains that the pathological tendencies grow on the central disturbance as a creeper grows on a stick, and as such, homoeopathic treatment aims to remove the central disturbance thereby eliminating the associated pathology.

Disease symptoms represent the commencement of the bodies healing process, and the medicine capable of generating these symptoms is the one that is able to carry this healing process through to the next stage of recovery, or cure (Coulter, 1980:22). Homoeopathy thus aims to treat the imbalance itself by using the presenting symptoms as a guide to selecting the appropriate remedy. Homoeopathic treatment acts by stimulating the body's own immune and defence systems, in order to stimulate the healing process. Homoeopathy is widely recognised to be safe and free from side effects (Ullman, 1991:xxix-11).

The practice of homoeopathy is governed by the following laws: (1) The law of similars, (2) Single remedy, (3) Provings, (4) Minimum potentized dose, (5) Herring's Law, and (6) Individualization (De Schepper, 2001:43).

2.4.2. LAW OF SIMILARS

The *Law of Similars* forms the basic principle of homoeopathy, "similia similibus curentur", or let "like cure like". This means that any substance that can produce symptoms of disease in a healthy person when given in large doses, can cure those same symptoms in a sick person when given in very small doses (De Schepper, 2001.26-27). The principle that "like cures like", makes up the fundamental pillar of the science of homoeopathy (Vithoulkas, 1998:91-93).

Swayne (1998:17-18) describes the *law of similars* as the defining principle of homoeopathy explaining that substances which are able to cause disorder, symptomatic, functional or pathological, physical or psychological, in healthy subjects can be used in the treatment of similar patterns of disorder amongst people who are ill. These patterns of disorder are obtained in drug trials called provings, in which repeated doses of a diluted substance are administered to healthy volunteers. He correctly clarifies that it is not the degree of dilution that makes medicines homoeopathic, but rather the likeness of the patients suffering to the medicinal effects of the substance (like cures like).

According to Ullman (1999:9-18), “Homoeopathy’s use of the principle of *similars* is an important safeguard against disease suppression because it mimics the wisdom of the body rather than suppresses its’ symptoms”. She explains that practical application of this law demonstrates its ability to heal and evokes a respect for the body’s inherent wisdom, teaching us to avoid suppressive therapies and seek curative ones.

2.4.3. SINGLE REMEDY

Another fundamental principle of homoeopathy is that of prescribing a single remedy at a time. The use of a single remedy allows unambiguous evaluation of any beneficial or adverse effects that may be produced following administration of the remedy to the patient (Vithoulkas, 1998:217). Hahnemann recognized the inability to predict the effect of several drugs administered simultaneously, and thus advocated the use of a singe remedy at a time (Coulter, 1980:67).

The single remedy that represents the most accurate match between the clinical characteristics of the patient and the drug picture portrayed in the materia medica is called the *similimum* (Swayne, 1998:216-217). The *similimum* is the remedy that best matches the patient’s symptoms and is most likely to cure those symptoms based on the principle of ‘like cures like’ (Ullman and Reichenberg-Ullman, 1995:13-14).

2.4.4. PROVINGS

Provings are experiments conducted to determine what a homoeopathic substance is able to cure (Ullman, 1991:9). *Provings* investigate the effects of repeated doses of homoeopathic medicines in healthy volunteers (provers) in order to reveal their properties and therapeutic capabilities (Swayne, 1998:170-171).

The symptoms of each remedy, as experienced by the provers, are meticulously recorded (Sankaran, 1991:3-5). Information obtained form these drug trials are used to compile Materia Medicas (encyclopaedias of drug effects) (Ullman, 1991:10). “Together with the study of toxicology and clinical experience, provings provide the Materia Medica of homoeopathic medicines” (Swayne, 1998:170). In practice, the symptoms of the patient are matched to the symptoms in the Materia Medica, and the remedy with symptoms that most resemble the symptoms of the patient is prescribed (like cures like) (Sankaran, 1999:3-5).

2.4.5. MINIMUM POTENTIZED DOSE

According to Hahnemann, the physician should employ the ‘minimum dose’ capable of eliciting the desired response. Only the ‘minimum dose’ will produce cure without a worsening of the patient’s symptoms (Coulter, 1980:22;52).

Hahnemann found that most potentially useful substances were highly toxic. In his attempt to overcome this problem, he diluted the substances reducing their toxicity, which consequently reduced their therapeutic effect. Hahnemann then discovered the technique of shaking the dilutions (called succussion), imparting kinetic energy to them. This process of succussion and serial dilution was called 'potentization' (Vithoulkas.1998:101-102).

The more a homoeopathic remedy is diluted and shaken (potentized), the stronger it's therapeutic effect. Although the substance is chemically more dilute, clinical observation showed that the more the substance was potentized, the deeper and longer lasting was its effect (Ullman and Reichenberg-Ullman, 1995:47). As a result of this intense process of dilution, homoeopathic remedies are harmless when used correctly, and safe to use in pregnancy (Ullman, 1991:10-12), and have no side effects (Ullman and Reichenberg-Ullman, 1995:35).

2.4.6. HERRING'S LAW

Herring's Law reveals that as a disease passes from an acute to a chronic state, the symptoms of the disease move from the surface of the body to the interior, from the lower parts of the body to the upper, and from the less vital organs to the more vital ones. In order to cure disease, homoeopathy aims to reverse this process (Coulter, 1980:23-24). Herring's Law is extremely useful to

homoeopathic practitioners in order to measure the progress of chronic disease states, and is described below (Leckridge, 1997.32).

The direction of cure is said to have four axes:

1. From most important organs to less important organs.
2. From inside out.
3. From top to bottom.
4. Disappearance of symptoms in reverse order of their appearance.

Progress within the above mentioned parameters is taken as evidence that the remedy is having a positive effect. Any changes in the patient's condition that opposes this law is taken as evidence of a negative effect of the remedy, at which point the homoeopath will re-evaluate the case and consider another more suitable remedy (Leckridge, 1997.32).

2.4.7. INDIVIDUALIZATION

In the practice of homoeopathy, diagnosis is simply the recognition of the drug which can cause, and therefore cure a particular *totality of symptoms*. The advantage of this form of diagnosis is that it focuses exclusively on the symptoms of the individual patient, using them to find an appropriate cure (Vithoulkas, 1987:70-72). According to De Schepper (2001:42), "the homoeopath does not treat disease, he treats sick individuals, and no two patients with the same disease are ill in exactly the same way".

Accuracy of homoeopathic prescribing is dependant upon the similarity between the characteristics of the medicine and the individual characteristics of the patient's illness. Homoeopathic prescriptions are thus individualized to the patient (Swayne, 1998:23).

The *totality of symptoms* encompasses all the elements in the current course of illness including physical signs, pathological states, subjective symptoms; local, general and mental features; and all aggravations and ameliorations. The collection of these characteristics ensures a uniquely individual clinical picture (Swayne, 1998:87-88). "Although the homoeopathic physician is guided by the patient's symptoms, he is not prescribing symptomatically. He treats, not the patient's symptoms, but his whole organism – whose needs are made manifest through the *totality* of his symptoms", (Coulter, 1980:22).

The theory of totality of symptoms is of extreme value with regards to homoeopathic treatment in pregnancy. In conjunction with the obvious changes in physical aspects of the body, major mental and emotional changes also occur. Homoeopathy thus provides a considerable service to pregnant females, which is capable of attending to the patient's needs on all levels, and not just the physical symptoms in isolation.

2.5. SCOPE OF HOMOEOPATHIC TREATMENT IN PREGNANCY

The scope of homoeopathic treatment includes pre-conception, conception and pregnancy, labour, birth and beyond. Pregnancy is by far the best and most rewarding time to treat both the mother and the unborn child. Complaints that are successfully treated using homoeopathy during pregnancy include: vaginal bleeding, breast pain, breathlessness, breech presentation, carpel tunnel syndrome, colds, constipation, cramps, cystitis, diarrhoea, dizziness, eclampsia and pre-eclampsia, emotional disturbances, exhaustion, food cravings, headaches, heartburn, genital herpes, hypertension, incontinence, indigestion, insomnia, hypotension, morning sickness, oedema, pain, palpitations, piles, sinusitis, rash, spider veins, vaginal thrush, varicose veins, vomiting and much more. Homoeopathy also treats a host of complaints related to labour and the post-natal period. It offers pregnant women an extremely useful system of medicine, at a time when anxiety about the side effects of orthodox medicines often leads them to suffer rather than seek medical help for minor aches and pains (Castro, 1992).

According to Ullman (1991:73-82) the relative safety of homoeopathic medicines makes them invaluable during pregnancy, labour, and the postpartum period. Unlike allopathic drugs, which must be given with extreme caution during pregnancy, homoeopathic remedies are safe and effective making them an ideal treatment for the pregnant woman. Pregnant women manifest symptoms of the

remedy they require very clearly while pregnant, making prescribing of the similimum relatively simple. Furthermore, homoeopathic treatment during pregnancy addresses any underlying disease tendencies, resulting in a much healthier child (De Schepper, 2001:202).

2.6. OTHER SURVEYS DONE ON PERCEPTIONS TOWARDS HOMOEOPATHY IN SOUTH AFRICA

2.6.1. OPINION SURVEY CENTRE, (1983)

In 1983, the Opinion Survey Centre of the Human Sciences Research Council conducted a survey to determine the attitudes, extent of knowledge, and experience with chiropractic and homoeopathy amongst the white population of South Africa. A total of 3000 subjects were randomly chosen from the voters' roll, and a sample size of 2206 was achieved (n=2206). The study was conducted as a mail survey using a questionnaire as a measurement tool.

It was found that 12.9% of respondents had consulted with a homoeopath within the preceding 12 months. Of these respondents, 49,4% stated they had been completely cured or helped very much, 21.6% stated that homoeopathic treatment did not help their ailment, and there was no report of worsening of ailment by homoeopathic treatment. Patients that consulted with a homoeopath or chiropractor displayed a positive attitude towards them, and gave reasons for

consulting with them as: “medical practitioners could no longer help” (27.9%); or because they felt “desperate” (30.3%). Although most of the patients that consulted with homoeopaths and chiropractors also consulted medical doctors for their complaints, 19.2% had not, thus indicating that their homoeopath or chiropractor was their primary health care provider. Of those that had never consulted with a homoeopath or chiropractor, the most common reason given for this was that they had “ never required their services” (Steenkamp, 1985:5-10).

The questionnaire used was very comprehensive as it not only obtained demographic data, but also valuable information regarding past experience with homoeopathy and chiropractic, which no other survey had done at the time. Although an excellent response rate (76.25%) resulted in a substantial sample size (n=2206), the sample is by no means a representation of the South African population as the study was targeted at whites only and excluded other racial groups. It should however be noted that the sample was drawn from voters that had previously agreed to participate periodically in mail surveys, and this may have contributed to the favourable response rate.

2.6.2. FERRUCCI, L (1994)

Ferrucci conducted a survey amongst homoeopathic practitioners in private practice and senior students at the Homoeopathic Day Clinic at Technikon Natal. The aim was to evaluate and compare data regarding patient demographics,

clinical conditions treated and clinical methods employed, in terms of patient perception, in order to highlight any differences between the groups as well as areas of possible improvement which could lead to increased efficiency and patient satisfaction at the Homoeopathic Day Clinic. A sample of 160 practitioners and 140 students was obtained (n=300) over a four month period, using a questionnaire as the measurement tool.

Analyses of responses showed that more females than males consulted homoeopaths and that more patients sought treatment for chronic complaints namely arthritis and hypertension, in both groups. Patients going to private homoeopaths tended to be over 25 years of age; consulted more frequently with the homoeopath because of better follow through of cases; a broader selection of conditions were treated in private practice; and the use of more treatment modalities suggested increased patient satisfaction compared to patients receiving treatment at the Homoeopathic Day Clinic. Treatment modalities, as pertaining to this study, include homoeopathy, acupuncture, electrotherapy, massage and other. Patients receiving treatment at the Homoeopathic Day Clinic tended to be less than 25 years of age; a limited number of conditions were being treated; and modalities mentioned above were not being used at the Homoeopathic Day Clinic. Yet clinical methods employed such as clinical examination and blood pressure measurement, were more thorough as compared to those used in private practice.

The focus of this study leaned more towards comparison of treatment methods used and patient satisfaction between the two groups. Information about patients understanding of homoeopathy and perceptions towards homoeopathy would have been valuable, but was not collected in this study. The sample was drawn from private patients in the Witwatersrand area (now Gauteng), and senior students at the Technikon Natal (now Durban Institute of Technology) using convenience sampling. Information regarding the proportion of registered homoeopaths and homoeopathic students are not provided, thus there is uncertainty as to whether this is a fair representation of the target group. This study does prove that the misconception that homoeopathy is mainly for chronic conditions is prevalent, or understandable, as the majority of cases being treated in this sample group were chronic.

2.6.3. WORTMANN, L (1997)

Wortmann conducted a survey amongst veterinary surgeons in South Africa to determine their perceptions towards the role of acupuncture and homoeopathy in veterinary medicine using a questionnaire as the measurement tool (n=251). 10% of respondents admitted to using acupuncture for less than five years and 26% admitted to using homoeopathy for less than five years.

The main limitation of the use of these therapies was identified as being a lack of knowledge about the therapies. A need for clinical trials and proof of efficacy of

the therapies was stressed by veterinary surgeons before they would consider the use of these therapies in their practice. Practitioners already using these therapies would continue to do so, and those not using these therapies showed interest in a short course in these disciplines. Over 70% of respondents agreed that both therapies had a role to play in veterinary medicine.

This study differs because it sought to determine perceptions towards the use of acupuncture and homoeopathy in veterinary medicine, and not the perception of veterinarians towards homoeopathy itself. A shortcoming of this study is that information regarding the perceptions of veterinarians towards homoeopathy, as well as their understanding of the use of homoeopathy was not obtained. Information of this kind would have proved valuable in terms of identifying misconceptions and attitudes that exist towards homoeopathy and addressing them as part of future education initiatives in this and other target groups.

2.6.4. DAPHNE, A (1997)

Daphne conducted a survey to determine the perceptions of pharmacists towards the role of complementary medicine in the context of health care in South Africa. Analysis of data showed that very few pharmacists had been instructed in complementary medicine during their pharmaceutical education, and 84.4% agreed that complementary medicine should be incorporated into their curriculum. Although most pharmacists knew nothing or very little about

ayurveda, osteopathy, chiropractic, acupuncture, reflexology, herbalisim, aromatherapy, the majority of pharmacists knew an average to substantial amount about homoeopathy and thought it was more effective than any other complementary therapy. The main reason respondents held this perception towards homoeopathy was that homoeopathic remedies contained herbal ingredients, and that patients had "faith" in it. It was also found that majority of pharmacists viewed complementary medicine as a supportive therapy. Daphne concluded that although pharmacists had a positive attitude towards complementary medicine, they had limited knowledge and may thus be hesitant to prescribe complementary medicine to the patient.

A total of 160 (n=160) questionnaires were collected of the 725 questionnaires that were distributed to pharmacies in Durban, Cape Town, Johannesburg, Bloemfontein, Port Elizabeth, East London and Pietermaritzburg. Daphne attributed this low response rate to a lack of knowledge on the subject, and the perception that complementary medicine is useless and not worthy of time spent in answering the questionnaire. As such, the study is not representative of pharmacists in South Africa, and the findings may represent a distorted view of the knowledge of complementary medicine amongst pharmacists.

This study differs because it does not investigate the attitudes and perceptions towards homoeopathy itself, but rather the role of a group of complementary therapies in the context of health care in South Africa. This study highlights the

myth that homoeopathy is a form of herbalism, as most pharmacists thought that homoeopathic treatment contained herbs, and attributed the effectiveness of homoeopathic remedies to this. Information regarding the understanding of homoeopathy, and its principles, as well as perceptions towards homoeopathy was not directly evoked. This information was necessary in order to determine exactly what pharmacists know about homoeopathy, and how they feel about it as a treatment option, in order to develop some sort of basis for addressing problem areas and developing some sort of education initiative in this target group.

2.6.5. SUKDEV, R (1998)

This study sought to determine the perception amongst medical practitioners towards the role of complementary medicine in health care in South Africa. The attitudes, experience with, and knowledge of complementary medicine were investigated. In this study 'complementary therapies' refers to homoeopathy, chiropractic, acupuncture, reflexology, ayurveda, herbalism, aromatherapy and osteopathy. Questionnaires were posted to a list of medical practitioners working in the central urban areas of Johannesburg, Cape Town, Durban, Bloemfontein, East London and Port Elizabeth. Of the 1000 questionnaires sent out, a response rate of 32.2% was obtained.

Analysis of data showed that medical practitioners had limited knowledge of individual complementary therapies, and that very few practitioners make use of complementary medicine in their practice. Lack of knowledge and poor efficacy seem to be limitations that, if overcome, may encourage the use of complementary medicine amongst medical practitioners, majority (75.5%) of which see complementary medicine as a supportive therapy and a minority (14%) that actually view it as a form of primary therapy.

Again, as in the study by Daphne, this study sought to determine perceptions towards complementary medicine and not homoeopathy directly. Perceptions towards homoeopathy, and the understanding of homoeopathic principles and its use were not investigated. Conclusions merely showed a general lack of knowledge about complementary medicine, and a need for educating this target group, clarifying legal aspects, and providing proof of efficacy. An encouraging finding is that most medical practitioners have no problem with complementary medicine playing an active role in health care in South Africa, with 56.52% of respondents agreeing that complementary medicine should be included into the syllabus for undergraduates in the medical profession, and 22.98% disagreeing.

2.6.6. MOYS, E (1998)

In 1998 Moys conducted a survey to determine the perceptions of affluent White and Indian communities, in the Westville and Reservoir Hills areas towards

homoeopathy. A total sample group of 1000 was used, 500 for each area. The aim was to find out what perceptions existed towards homoeopathy, what was known about homoeopathy, as well as their personal experience of homoeopathy in order to determine what the needs in these communities are, and how the homoeopathic profession may be able to address these needs.

Results showed that knowledge of homoeopathy and its principles was very general in both groups. Both groups perceived chronic conditions to respond to homoeopathy. With regards to the effectiveness of homoeopathic medicine, 34% of Westville and 44% of Reservoir Hills respondents answered “don’t know”, with the remainder finding homoeopathic medicine to be as effective as allopathic medicine. The Westville group reported more experience with homoeopathy than the Reservoir Hills group (Westville 39%, Resevoir Hills 18.2%). In both groups respondents first heard of homoeopathy from friends or relatives, found the homoeopathic treatment they received to be effective in varying degrees (Westville 82.6%, Reservoir Hills 61.5%), and a significant number of those that had never consulted with a homoeopath, answered ”Yes” when asked if they would consider doing so in the future. Results showed that homoeopathy had a definite place in providing health care to these groups, and highlighted an urgent need for educating them on the principles, use and benefits of homoeopathic treatment.

When compared to other studies this study stands out because it was able to obtain information specifically regarding homoeopathy and not complementary medicine in general. It provided useful information about current perceptions towards homoeopathy, understanding of homoeopathic principles and the use of homoeopathy, which other studies failed to do. This provides a better understanding of how people view homoeopathy, how they think it works, and what they think it is useful for. It also provided information on current health care providers, how respondents viewed their services and how satisfied they were with their current health care provider. Information regarding reasons for not previously consulting with a homoeopath, likelihood to do so in the future and for what likely reason, provide valuable information that is of use for the homoeopathic profession to assess and address in order to draw these communities.

A criticism is that in gathering the data, the researcher was present during the filling out of questionnaires by respondents. Interviewer bias is important as it influences the responses of the subjects. This survey was targeted at upper-middle class White and Indian populations and excluded other racial groups, and is thus not representative of the general population.

2.6.7. SMALL, D (2004)

This study was based on an initial perception that a great deal of ignorance regarding homoeopathy exists within the South African population. Public secondary schools within the Durban area were selected, and the study took the form of a self-administered, descriptive, qualitative / quantitative survey. A questionnaire was compiled and administered to Grade 12 learners who completed and returned it to the researcher immediately (n-1597). A short presentation about homoeopathy, the course offered at Durban Institute of Technology, and its appeal as a career and treatment option followed the collection of questionnaires (Small, 2004: ii).

Data analysis confirmed the initial perception that a great deal of ignorance about homoeopathy exists amongst the public, namely, 76% of respondents had never heard of homoeopathy. Only 3.7% of respondents had ever been treated homoeopathically. Respondents also had little knowledge regarding its safety and efficacy, where 57.7% and 64.4% respectively would not offer an opinion. More than half the respondents believed that the public does not generally accept homoeopathy as a medical therapy, where 76% of these respondents attributed this to a lack of knowledge on the subject. More than 80% of respondents with no previous experience with homoeopathy, showed interest in learning more about it. Also, those with previous experience with homoeopathy, displayed positive

perceptions towards homoeopathy and satisfaction with the therapy (Small, 2004:ii-iii).

Although this method of administration of questionnaires ensured a high return of questionnaires (n=1597), responses were subject to interviewer bias, as the researcher was present at all times during the data collection. This study did seek to determine current perceptions towards homoeopathy, but due to the fact a significant number of respondents were unable to offer an opinion, very minimal information was attained. This serves to again highlight the degree of lack of knowledge regarding homoeopathy, and emphasises the need for a concerted effort by the profession to undertake public education initiatives (Small, 2004:76-88).

2.7. INTERNATIONAL SURVEYS ON PERCEPTIONS TOWARDS HOMOEOPATHY AND COMPLEMENTARY AND ALTERNATIVE MEDICINE

2.7.1 PERCEPTIONS OF COMPLEMENTARY / ALTERNATIVE MEDICINE HELD BY THE MEDICAL FIELD

2.7.1.1 Obstetricians and midwives

In February 2004, an article titled “Use of complementary therapies in pregnancy: The perceptions of obstetricians and midwives in South Australia” was published in the Australian and New Zealand Journal of Obstetrics and Gynaecology. The aim of this study was to determine attitude’s towards the use of complementary and alternative medicines (CAM) during pregnancy amongst South Australian obstetricians and midwives. It sought also to examine their referral patterns and their views on the usefulness and safety of these therapies during pregnancy (Gaffney and Smith, 2004).

The study showed a 78% response rate to this postal questionnaire, with over 90% of midwives and obstetricians thought they should have some knowledge about CAM. 72% of obstetricians also held the opinion that there needs to be an evidence base as compared to 26% of midwives who shared the same opinion. Only 14 % of the obstetricians considered CAM as a threat to public health. Majority of obstetricians (68%) and midwives (78%) had previously referred a patient for one of the complementary therapies. It was also found that a large proportion (over 70%) of obstetricians and midwives found massage, vitamins, acupuncture, yoga, meditation and hypnosis to be useful and safe for use in pregnancy (Gaffney and Smith, 2004).

2.7.1.2 Paediatricians

Despite the widespread increasing use of complementary / alternative medicine (CAM), literature regarding risks and adverse drug reactions (ADRs) pertaining to childhood populations are scarce. This study aimed to review literature in the paediatric field and summarise what is known about ADRs and the risks of CAM. Some interesting aspects emerged: (1) the extent of CAM use in the paediatric field is increasingly sought by parents of children with chronic illnesses; (2) most parents that choose CAM medicine for their children believe that these therapies are “natural” and thus “safe”; and (3) physicians often feel they know too little about CAM and wish to learn more for different reasons including “to decide whether the alternative method is unsafe and / or ineffective”. They concluded that paediatricians should be prepared to discuss CAM therapies, in an attempt to minimise risks and to restrain parental misconceptions and doubts. They suggest education interventions for parents should be conducted, to increase awareness with regards to CAM (Cuzzolin, Zaffani, Murgia, Gangemi, Meneghelli, Chameniti, and Benoni, 2003).

2.7.1.3 Pharmacists

A survey was conducted by the American society of health-system pharmacists (ASHP) in 1998, to assess awareness of alternative medicines amongst pharmacists. Patients’ usage, patients’ misconceptions, the need for patients’ to

inform physicians of alternative medicines usage, and drug interactions between prescription and alternative medicines was investigated. Analysis of responses showed that 89% of pharmacists surveyed were aware that patients in their health system were using alternative medicines. 91% of the pharmacists who had previously discussed alternative medicines with their patients' reported that their patients' had misconceptions about the use of alternate medicines. 88%of pharmacists surveyed believe that interactions between alternative and prescription medicines can cause serious problems and 84% believed that alternative medicines can have potentially serious side effects. 78% of pharmacists went on to admit that they believed that the use of alternate medicines will increase over the next five years (Joudrey and Gough, 2003).

2.7.1.4 Physicians

In 1995, a survey was conducted amongst family physicians in the Chesapeake region of Baltimore, USA. It aimed to explored attitudes towards complementary or alternative medicine, and gather information regarding their knowledge, use of, and training in complementary medicine. Responses showed that 70-90% of the physicians considered therapies such as diet and exercise, behavioural medicine, counselling, psychotherapy, and hypnotherapy to be legitimate medical therapies. Complementary medical therapies that were not favoured as legitimate medical practice included homoeopathy, Native American medicine, and traditional Oriental medicine. 70% of physicians expressed an interest in training

in multiple areas of complementary medicine (Berman, Singh, Lao, Sing, Ferentez, and Hartnoll, 1995).

Lewith, Hayland and Gray (2001) conducted a mail survey amongst specialist physicians of the Royal College of Physicians in the United Kingdom. The study aimed to evaluate attitudes and use of complementary and alternative medicines (CAM) in the U.K. Results showed that 32% of respondents practiced CAM, and that CAM was used more frequently in private practice, although only 13% of respondents had received training in CAM. Results of this study were obscured by a poor response rate (23%). It was concluded, assuming that those practitioners who failed to respond to the questionnaire were disinterested in CAM, that one in every ten specialist physicians in the U.K are actively involved in CAM (Lewith, Hayland, and Gray, 2001).

2.7.1.5 General practitioners (GP'S)

Verhoef and Sutherland (1995) conducted a survey to investigate the opinions and behaviour of general practitioners (GPs) in Ontario and Alberta, Canada. Results showed that 54% of GPs referred to alternative practitioners, and 16% practised alternative medicine. A total of 56% of GP's believed that conventional medicine could benefit from ideas and methods employed in alternative medicine. They found that GPs considered acupuncture, chiropractic and hypnosis to be most useful, and homoeopathy, reflexology and naturopathy to be

least useful. They concluded that although acceptance and integration of alternative therapies extended only to certain therapies, the use of alternative medicine in general practice cannot be discounted.

2.7.1.6 Nurses and medical students

In 2001, a study was conducted in the United States to identify the perceptions of nurses towards the effectiveness and safety of complementary and alternative medical therapies. A random sample of 1000 nurses was obtained by employing three-wave mailing in the U.S. Half of these respondents perceived that there was conclusive evidence that five of the therapies were effective: bio-feedback, chiropractic, meditation / relaxation, multivitamins and massage. With regards to safety, the same amount of nurses found five therapies to be definitely safe: hypnotherapy, chiropractic, acupressure, acupuncture, and healing touch (Brolinson, Price, Ditmyer, and Reis, 2001).

In 2005 a survey was conducted to gauge the understanding, interest and knowledge of CAM amongst medical students at a local university in Singapore. Students were asked to complete a questionnaire designed to assess their knowledge, beliefs and attitudes to CAM in general and 16 CAM therapies. 57 % of students claimed to know something about acupuncture, and no students claimed to know anything about chiropractic, osteopathy, ayurvedic medicine, homoeopathy and naturopathy, with many students admitting that they had never

heard of these therapies before. 86% of students wished to know more about CAM, 91% stated their belief that CAM would play an important role in their future medical practice, and 92% believed that CAM includes ideas and methods from which conventional medicine can benefit. The main barrier to implementation of CAM was thought to be a lack of scientific support (Yeo, Yeo, Yeo, Lee, Lim, and Lee, 2005).

In 2001, Wilkinson and Simpson conducted a survey amongst nursing, pharmacy, and biomedical science students in order to determine students' attitudes towards the use of complementary therapies using a self-administered questionnaire. Results showed that students held favourable attitudes towards complementary therapies. With 78% of them having used complementary therapies within the past 12 months, and 56% of which had visited a complementary therapy practitioner.

2.7.2 PERCEPTIONS OF COMPLEMENTARY / ALTERNATIVE MEDICINE HELD BY PATIENTS

2.7.2.1 Consumer survey

A study was conducted by the American society of health-system pharmacists (ASHP) in 1999, to gauge public attitudes towards alternative medicine.

Analysis of responses showed that 58% of consumers surveyed believed alternative medicines could have potentially serious side effects, yet 34% felt it safe to take alternative medicines while taking prescription drugs. 70% of consumers agreed with the following statement: “Alternative medicines are safe to use since they are made from plants, herbs and other natural products.” 57 % agreed with the following statement: “Because alternative medicines are made from natural ingredients, side effects from such products are relatively minor.” 85% of consumers also believed that it was important for people using alternative medicines to inform their pharmacist, doctor, or other heath care professional of their use alternative medicines (Joudrey and Gough, 2003).

2.7.2.2 Trends in use of homoeopathy

A study to document trends in alternative medicine use in the United States between 1990 and 1997 was conducted after a national survey done in 1990 showed high prevalence and costs of alternative medicine use in the United States. This study suggested a 47.3% increase in visits to alternative medicine practitioners, thereby exceeding total visits to all US primary care physicians. Use of at least 1 of 16 alternate therapies within the last year increased from 33.8% in 1990 to 42,1% in 1997. Homoeopathy was recognised as one of eight therapies shown to increase the most between 1990 and 1997. It was concluded that the use and expenditures of alternate medicine increased substantially between 1990 and 1997, and that this was primarily attributed to an increase in

the proportion of the population seeking alternative therapies, as opposed to an increase in visits per patient (Eizenberg, Davis, Ettener, Appel, Wilkey, Rompay, and Kessler, 1998).

Another survey aimed to determine prevalence, costs, and patterns of alternative medicine use in Canada. Respondents were questioned with regard to their attitudes towards both conventional and alternate health care. 50% of respondents admitted to using at least one alternate therapy in the previous 12 months, 73% to having used at least one alternate therapy in their lifetime. 81% of respondents gave the reason for using alternate therapies as either to prevent future illness from occurring, or to maintain health and vitality. Of those that had made use of alternate therapies only 44.3% of them had discussed doing so with their doctor (Ramsey, Walker, and Alexander, 1999).

2.7.3 BARRIERS TO ACCEPTANCE: AN EXPLORATORY STUDY OF COMPLEMENTARY / ALTERNATIVE MEDICINE DISUSE

In 2001 Jain and Astin conducted a survey to determine why the majority of patients and individuals fail to make use of complementary and alternative therapies. A two page survey was mailed to a random sample of Stamford University alumni (n=601). Disuse of CAM was found to be associated to: being male; having high confidence levels; being healthy; lack of physician support; and believing that CAM therapies are ineffective or inferior. It was shown that lack of

physician support predicted disuse of all therapies except acupuncture and homoeopathy. Lack of knowledge of CAM predicted disuse of herbs, chiropractic and homoeopathy. The perception that CAM providers were not in accessible locations predicted disuse of all CAM therapies except homoeopathy and meditation.

2.7.4 CONCLUSION

It is evident from the literature that although the perceptions towards complementary and alternative medicine have been investigated, there is a lack of sound evidence regarding homoeopathy specifically. Perceptions and attitudes regarding homoeopathy, as well as myths and misconceptions associated with homoeopathy, have not been adequately evaluated. A need for further studies aimed specifically at investigating knowledge, attitudes, perceptions, myths and misconceptions regarding homoeopathy definitely exists.

2.8. MYTHS AND MISCONCEPTIONS REGARDING HOMOEOPATHY

2.8.1. INTRODUCTION

An impression that myths and misconceptions regarding homoeopathy are rife lead to the topics discussed below. These myths and misconceptions are thought

to originate from a basic lack of awareness and understanding of homoeopathic principles, methods and uses.

2.8.2. HOMOEPATHY IS A FORM OF HERBALISM

The association of homoeopathy as being a form of herbalism is common, and results of this study as well as that of Moys (1998), verifies this. According to Swayne (1998:210-211), homoeopathy is often confused with herbal medicine because of the plant origin of its many medicines. Leckridge (1997:15) also acknowledges this as a common misconception, explaining that about 70% of homoeopathic remedies originate from plants.

Both herbalism and homoeopathy make use of plant extracts usually in tincture or crude form, and emphasis of prescriptions is based on the symptoms of the individual, yet the principles that govern these two therapies are quite different. Herbalism utilizes plant extracts exclusively and is based on empirical evidence that certain plants have certain healing properties. Many herbs may be combined for an individual complaint. Homoeopathy does not exclusively use plant extracts, but also animal and mineral substances. Homoeopathy adheres to the principles set out as previously mentioned, such as the *law of similars* and the *infinitesimal dose*. Homoeopaths usually prescribe a single remedy rather than complex remedies. (Castro, 1992:11).

2.8.3. HOMOEOPATHY IS A FORM OF VACCINATIONS

It is assumed that people associate homoeopathy with vaccinations in order to try to better understand how remedies work. According to Ullman (1991:6), both the use of immunizations and the use of homoeopathic remedies are based on the principle of like cures like *(law of similars*), hence the common association.

Vaccinations contain live or attenuated strains of disease, and when administered stimulate the immune system directly to produce anti-bodies, as if the patient had contracted the actual disease. Vaccinations are not administered orally, thereby bypassing the body's natural defence system, and in doing so, they stress the immune system. Vaccinations are first tested on animals, and later on humans in order to verify their safety, yet children and adults may still suffer serious side effects. Homoeopathic remedies work quite differently. Firstly, homoeopathic remedies are prepared in dilute forms, containing none of the original substance. They are administered orally, and stimulate the body's own innate life force to produce a response that is precise and individual for the specific needs of the patient being treated. Homoeopathic remedies undergo trials (proving) using human volunteers (provers), and when used correctly do not have side effects (Castro,1992:10-11).

According to Vithoulkas (1998:113), it is only superficial reflection that likens homoeopathy to vaccinations, because small amounts of material capable of

producing disease in normal people is administered. Deeper reflection into the laws of homoeopathy indicate otherwise. Vaccinations are administered to populations without consideration of individuality or individual sensitivity, clearly contradictory to the laws of homoeopathy.

2.8.4. HOMOEOPATHIC REMEDIES ARE PLACEBO

Placebo is defined as “A substance with no active biological properties knowingly or unknowingly used to exert a beneficial therapeutic effect. (Origin: Latin: ‘I shall please’) (Swayne, 1997:213). The concept of placebo effect implies that any observed effects are not attributed to the substance that was administered, thus further implying that the substance has no pharmacological effects. Sceptics consider homoeopathic medicines as a placebo and consider its action to be attributed to the context in which it was prescribed (Swayne, 1997:2-4). According to Ullman (1999:14) 20% of people that are treated homoeopathically for chronic diseases experience a slight aggravation followed by significant improvement of the chronic disease and overall state of health which does not occur in people given placebo.

Sceptics insist that homoeopathy only works if you believe in it, implying that the workings of homoeopathy are merely ‘placebo’. The fact that homoeopathy is able to achieve dramatic results when used on infants and animals dispels this myth. Placebo effect does not apply to both infants and animals because they are

not capable of being influenced by the prescriber. An adult on the other hand might very well be influenced by what he/she is told by the prescriber about the medication and about their recovery (Digby, 1997:4-5).

2.8.4.1. Current literature on homoeopathy and placebo

A recent article by Shang, Huwiler-Muntener, Nartey, Juni, Dorig, Sterne, Pewsner, and Eggerin published in the *Lancet* medical journal titled “Are the clinical effects of homoeopathy placebo effects? Comparative study of placebo-controlled trials of homoeopathy and allopathy”, as well as an editorial titled “The end of homoeopathy”, has aroused much debate regarding the efficacy of homoeopathy.

The study reviewed 19 electronic databases between 1995 and 2003 and compared results between 110 trials of homoeopathic remedies against placebo, and 110 trials of allopathic medicines also tested against placebo. Results of this study found homoeopathy to be ineffective, and likened it to placebo. Scrutiny of the methodology used in this recent study revealed that the conclusions reached were based on only eight (statistically insignificant) conspicuously selected homoeopathic trials (Shang, Huwiler-Muntener, Nartey, Juni, Dorig, Sterne, Pewsner, and Egger, 2005). A similar study published in the Lancet in September of 1997 titled; “Are clinical effects of homoeopathy placebo effects?: A meta-analysis of placebo controlled trials” analysed 189 studies and disproved

the hypothesis that the clinical effects of homoeopathy are completely due to placebo, called for further research on homoeopathy provided it is “rigorous and systematic” (Linde, Clausius, Ramirez, Melchart, Eitel, Hedges, and Jonas, 1997). The editorial indicated that no further studies are necessary at this point in time, and requested that doctors be honest with their patients about the “lack of benefit” of homoeopathy (Sboros, 2005).

Not surprisingly, this followed a research study published in June this year in the Complementary Therapeutic Medicine Journal, titled “Outcome and costs of homoeopathic and conventional treatment strategies: A comparative cohort study in patients with chronic disorders.” This study concluded that patients seeking homoeopathic treatment had a better overall outcome when compared with patients on conventional treatment, whereas costs in both groups were similar. It also included a report (still in draft form) prepared by an office of the World Health Organization which states that most of the studies published over the past 40 years have shown homoeopathic remedies to be superior to placebo and “equivalent to conventional medicines in the treatment of illnesses, in both humans and animals” (Homoeopathic Association of South Africa, 2005).

Responses to this article indicated that many professionals viewed the study to be biased, and found the 8 articles used to be unsuitable for use in evaluating homoeopathic medicine (Homoeopathic Association of South Africa, 2005).

2.8.4.2. Other literature on homoeopathy and placebo

In 1986 an article titled ‘Is Homoeopathy a placebo response?’ was published in *The Lancet* by David and Morag Taylor Reilly of the Glasgow Homoeopathic Hospital. They compared the effects of a homoeopathic preparation of grass pollen against the effects of placebo, using a standard randomised, double blind control trial with crossover. They were able to demonstrate significant superiority of the homoeopathic preparation over the placebo (Reilly, Taylor, McSharry, and Aitchison, 1986). The same team then went on to repeat this study using a randomised, double blind control trial, and once again demonstrated the superiority of the homoeopathic preparation over placebo. The article was titled ‘Is evidence for homoeopathy reproducible?’ and was published in *The Lancet* in 1994. This alarmed a great many people as it proved either that homoeopathy worked, or that the ever popular randomised control trial did not (Reilly, Taylor, Beattie, Campbell, McSharry, Atchison, Carter, and Stevenson 1994).

A review of 108 clinical trials in homoeopathy was published in The British Medical Journal in 1991. Of these, 81 showed a positive result for homoeopathy. The study also showed that the greater the scientific merit of the papers, the more likely the trial was to show the positive effect of homoeopathy. They went on to conclude that the evidence presented in this review was sufficient for establishing homoeopathy as a main stream treatment for certain conditions (Kleijnen, Knipschild and ter Riet, 1991).

2.8.5. HOMOEOPATHY WORKS VERY SLOWLY

This seems to be a common misconception, and people seem to think that it takes several months of homoeopathic treatment before one is able to perceive any positive change in one's condition. As a general rule, the pace of reaction to a homoeopathic medicine depends on the nature of the illness, the vital force of the patient, and the accuracy of the prescription (Ullman, 1991).

Although the response time may be longer when treating chronic diseases, many patients find initial relief within a few days to a week of taking homoeopathic medication (Ullman, 1991). Vithoulkas (1987: 54) outlines a guide to determining the time required for a positive similimum response, saying that an allowance of one month for every year the condition was experienced is an acceptable estimate for resolution to occur.

Provided that the correct remedy is chosen and given in the correct potency, homoeopathic treatment works very rapidly, especially in acute inflammations and infections (e.g. tonsillitis, otitis, which comes on very suddenly and with great intensity), often a lot faster than antibiotics. With regard to chronic conditions, the homoeopath may need to spend time treating the root of the disease, which is the basis of the disease symptoms, and patience may be required in this regard. Suppressive treatment (palliative) may temporarily relieve the symptoms, and offer fast relief, but it fails to address the underlying disease process responsible

for the symptoms. Thus after a short period of relief other symptomology will be produced by the ensuing disease. (Digby.1997:4-5).

2.8.6. HOMOEOPATHY IS ONLY FOR CHRONIC CONDITIONS

Possible confusion regarding the use of homoeopathy for chronic conditions may have arisen as a result of the success of homoeopathy in the treatment of chronic conditions. Homoeopathic treatment is not limited to chronic conditions, and is safe and effective for acute conditions as well. Its use in first aid is also noted, and results are often felt within an hour of two. Common examples of everyday first aid remedies include Arnica Montana for bruises and trauma, or Cantharis for burns (Ullman, 1999).

2.8.7. HOMOEOPATHS ARE QUACKS AND HAVE NO FORMAL MEDICAL TRAINING

Many courses around the world offer certificates and diplomas in homoeopathy. Such courses provide basic training in homoeopathy and lack medical and clinical exposure. As such, homoeopaths are thought to have no legitimate medical training.

In South Africa, legitimate homoeopathic training is offered at the Durban Institute of Technology's Department of Homoeopathy and the University of

Johannesburg. These are intensive full-time courses that run for five years. The programme consists mainly of main-stream medical courses up until the fourth year, at which point the focus shifts towards homoeopathy. Medical courses include biology; physiology; physics; chemistry; anatomy; histology; pharmacology; pathology; systemic pathology and diagnostics. Homoeopathic subjects include homoeopathic philosophy, principles and history; materia medica; homoeopharmaceutics; and clinical homoeopathy. The majority of the subjects listed contains both theoretical and practical aspects, and are annual courses. Clinical exposure is introduced at fifth year level as part of the clinical homoeopathy programme. Subsequent to this, students are required to submit a research dissertation for completion of the Master's degree. Homoeopaths are thus adequately trained, with the medical curriculum amounting to roughly half of the formal training. Students qualifying from this institution receive a Master's Degree in Technology: Homoeopathy (Durban Institute of Technology. Dept. of Homoeopathy; Rule Book, 2005).

In other parts of the world, homoeopathy is practiced mainly by medical doctors. India boasts 200 homoeopathic medical colleges, and there are about 500 such colleges in other parts of the world, offering post graduate studies in homoeopathy. At present there are about 200 000 trained homoeopaths in India and at least half a million across the globe. [2]

2.8.8. HOMOEOPATHS PRESCRIBE STRICT DIETS

Often a homoeopath will ask patients to abstain from certain substances for the duration of their treatment. This is not prescribed as a diet but rather due to the fact that certain aromatic or fragrant substances may antidote or alter the action of the homoeopathic medicine. These substance include coffee, garlic, tea, tobacco, alcohol, camphor, eucalyptus, and menthol.[2]

2.8.9. HOMOEOPATHY IS AN UNPROVED SCIENCE

Over the last 200 years, homoeopathy has been studied to determine the efficacy and indications of homoeopathic medications. Homoeopathy is thus based on experimental pharmacological and clinical data, and clinical studies have been carried out in several countries including India and Germany. Although many people find the physical basis of homoeopathic medicines to be unclear, there is sufficient clinical data available to prove its efficacy.[2]

2.8.10. HOMOEOPATHY CAN TREAT ANY CONDITION

Because homoeopathy treats symptomatically, it has the potential to treat any disorder based on the presenting symptoms. Like all other fields of medicine, homoeopathy too has limitations. Homoeopathy is not effective in conditions where surgery is unavoidable.[2]

2.9. MEASUREMENT TOOLS

Conducting a survey is a method of gathering information from a specified target group (Fink and Kosecoff.1985). Surveys are most often used to measure the prevalence of attitudes, beliefs and behaviour (Weisberg, Krosnick and Bowen, 1996:16). The data collection process may take one of three forms, i.e. face to face interviewing, telephone interviewing , or self-administered questionnaires (Weisberg, Krosnick and Bowen, 1996:103).

Face-to-face interviewing was once considered to be the best way of obtaining high quality data. The problem with this form of data collection is that the success of the survey is in the hands of the interviewers. Data collection and interpretation is entirely dependant on the skills and abilities of the interviewers who ask the questions and record the responses (Weisberg, Krosnick and Bowen, 1996:103-129). Face-to face surveys also tend to be expensive and time consuming, but response rates achieved via this method tend to be better than those obtained by other methods of data collection. Mail surveys are usually faster and cheaper, but response rates are generally poorer (Reid and Boore.1990:38). Telephone surveys are now more commonly used because they are fast, cheap, and can be recorded and supervised (Weisberg, Krosnick and Bowen, 1996:103-129).

The use of self administered questionnaires involves the handing out of questionnaires to respondents to fill out. When using this method, questionnaires

may be distributed in one of the following ways: (1) they can be mailed or delivered to homes or workplace ; (2) people can be approached in the street or public places and asked to complete questionnaires on the spot; (3) people assembled in groups can be approached and asked to fill out the questionnaire, as was done in this study (Weisberg, Krosnick and Bowen, 1996:103-129).

A survey usually makes use of questionnaires as the research instrument. All respondents are asked the same questions in the same format, and are required to provide responses in a predetermined form, i.e. by ticking from lists of possible responses (Reid and Boore, 1990:34-42). The type of questions used is important as they impact on the resultant information that is obtained (Fink and Kosecoff, 1985). Questions used should be simple, straight foreword and easy to understand. Questions used should be written specifically for the target group being interviewed, and should be structured with the purposes of the survey in mind (Weisberg, Krosnick and Bowen, 1996:84-101).

For the purposes of this survey, a questionnaire was adapted from Moys (1998). The questionnaire consists of three sections: (1) demographic data; (2) knowledge and understanding of homoeopathy; (3) past experience with homoeopathy. The questionnaire was adapted to focus on the specified target group. As a result questions were altered to be more specific to pregnancy and pregnancy related issues. A pilot study was conducted using 8 questionnaires.

No problems were encountered with the questionnaire, and the study was approved for completion.

CHAPTER THREE

METHODS

3.1. RESEARCH METHODOLOGY

This study took the form of a self-administered, descriptive, qualitative survey. The researcher was not present at any time during the data collection thus eliminating the possibility of interviewer bias.

3.1.1. THE PARTICIPANTS

3.1.1.1. The population

The target population for this survey was pregnant females over the age of 18 years, who were currently attending a private facility within the greater Durban area.

3.1.1.2. The sample

A listing of antenatal class instructors as advertised in 'The Expectant Mother/Fathers Guide' for 2004 was used as the main reference for private antenatal class instructors in the Durban area. Instructors were contacted telephonically in January of 2004 and informed about the study. Instructors who

were willing to conduct the survey within their classes were then approached in person, and briefed regarding the aims, format, and process of data collection associated with this survey. They were asked to sign a “Letter of Permission” (Appendix A) and given the appropriate number of documents, relative to the size of their class. Instructors were thus recruited strictly on a voluntary basis. Of the 20 instructors that were contacted, 7 responded positively.

3.1.2. THE QUESTIONNAIRE

The questionnaire used was adapted from Moys (1998). The questionnaire was specifically chosen from Moys because of its previous success in gathering valuable data regarding perceptions towards homoeopathy, and knowledge and understanding of homoeopathy. It also provided information with regards to the participant’s previous experience with homoeopathy. The questionnaire was modified to suit pregnant women, in consultation with statistician Kavanaal Thomas (Durban Institute of Technology), and Drs. I. Couchmann, and M. Maharaj, in 2003. A pilot study was conducted using 8 questionnaires. No problems were encountered and the study was approved for completion.

3.1.3 ADMINISTRATION OF THE QUESTIONNAIRE

Antenatal instructors were asked to inform their classes about the study. Interested individuals were given a copy of each of the following: (1) Participant

information letter (Apendix B); (2) Informed consent form (Appendix C); (3) Perceptions in Pregnancy questionnaire (Appendix D). These were completed and returned immediately or at a later stage to the class instructor. Questionnaires were checked by instructors, and those that were incorrectly filled out or incomplete, were returned to the participant at the next class for correct completion. Completed questionnaires were collected from antenatal instructors after an 8-week period. Data collection took place between February and October 2004. Of the 130 questionnaires printed 60 were correctly completed, 23 were discarded due to being incorrectly completed and 47 were not returned.

3.2. DATA ANALYSIS

Raw data was captured onto an Excel spread sheet and later processed using the SPSS for Windows® statistical package. Further statistical analysis was conducted by a statistician. Descriptive statistics were attained with frequency tabulations and bar charts for categorical variables, and summaries of quantitative variables were presented as means and standard deviations. Data was analyzed using both tables to summarize the data and graphs were used to graphically emphasize prevalent trends.

Knowledge of homoeopathy was scored as a percentage correct out of 24 questions, for which one mark each was allocated. The questions used to compile the knowledge score were Q2.1 (13 items), Q2.4 (10 items) and Q3.12

(1 item). Factors affecting knowledge score were compared using independent t-tests in the case of two groups and ANOVA in the case of >2 groups.

Questions 2.2, 2.3, 2.5, 2.6, 3.10, 3.11 were identified as attitudes questions. These questions were first analyzed descriptively, and thereafter compared with the knowledge scores as a percentage, using the ANOVA test.

3.2.1. STATISTICAL TESTS USED

Descriptive statistics were attained with frequency tabulations and bar charts for categorical variables, and summaries of quantitative variables were presented as means and standard deviations. Factors affecting knowledge score were compared using independent t-tests in the case of two groups and ANOVA in the case of >2 groups.

The *t*-test tells us if the variation between two groups is "significant". This analysis is used when comparing the means of two groups. When there are three or more levels for the nominal variable, a simple approach is to run a series of t tests between all the pairs of levels. A more powerful approach is to analyze all the data in one go. The model is the same, but it is referred to as ANOVA (one way analysis of variance), and the test statistic is the F ratio. The major difference between a t-test and ANOVA is that, where the t-test measures the difference between the means of two groups, an ANOVA tests the difference

between the means of two or more groups. A *one-way ANOVA*, or single factor ANOVA, tests differences between groups that are only classified on one independent variable. You can also use multiple independent variables and test for interactions using factorial ANOVA. The advantage of using ANOVA rather than multiple t-tests is that it reduces the probability of a *type-I error.* Making multiple comparisons increases the likelihood of finding something by chance—making a *type-I error*. An ANOVA controls the overall error by testing all means against each other at once, so *alpha* remains at .05. One potential drawback to an ANOVA is that you lose specificity: all an *F* tells you is that there is a significant difference between groups, not which groups are significantly different from each other. [3]

A factorial ANOVA can examine data that are classified on multiple independent variables. You can use more than two independent variables in an ANOVA (e.g., three-way, four-way). A factorial ANOVA can show whether there are significant main effects of the independent variables and whether there are significant interaction effects between independent variables in a set of data. Interaction effects occur when the impact of one independent variable depends on the level of the second independent variable. The computations of these tests have been done on statistical software in consultation with statistician Tonya Esterhiuzen (Esterhiuzen, T.2005. Dept of Medical Bioethics, Nelson Mandela School of Medicine, Durban, July 2005).

CHAPTER FOUR

RESULTS

4.1. INTRODUCTION

Sixty pregnant women (n=60) were included in this survey. Their responses to the “Perceptions in Pregnancy" (Appendix C) questionnaire are evaluated statistically in this chapter using the SPSS for Windows® statistical package. Categories that were not selected by participants (n=60) in the questionnaire were omitted from analyses.

4.2. DATA

4.2.1. CRITERIA GOVERNING ADMISSIBILITY OF DATA

Questionnaires had to be completed in full.

4.2.2. RESPONSE RATE

Participation in this study was strictly voluntary. The response rate is shown in Table 4.1.

Table 4.1: Response Rate (n=60)

Questionnaires	Frequency	Percent
Completed in full	60	46%
Incomplete	23	18%
Not returned	47	36%
Total	130	100%

4.3. DEMOGRAPHICS AND HEALTH

4.3.1. AGE (Q.1.1)

The age distribution of study participants is shown in Table 4.2 and illustrated by the pie chart in Figure 4.1. The age group ’45 years and above’ was omitted from this analyses as none of the participants (n-60) fell into this category. Age did not have a significant effect on the knowledge score of the sample (p=0.174).

Table 4.2: Age distribution of study participants (Q1.1) (n=60)

	Frequency	Percent
18-24 yrs	15	25.0
25-34 yrs	38	63.3
35-44 yrs	7	11.7
Total	60	100.0

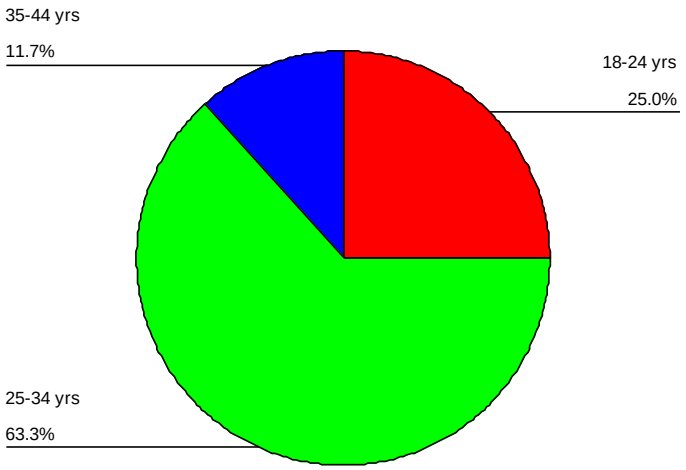


Figure 4.1: Pie chart of age group distribution of participants (Q1.1) (n=60)

4.3.2. POPULATION (Q.1.2)

The percentage of participants' population groups is shown in Table 4.3 and illustrated by the pie chart in Figure 4.2. The 'Black' population group was omitted from this analyses as none of the participants (n=60) fell into this category. Population had no significant effect on the knowledge score of the sample (p=0.460).

Table 4.3: Population group of participants (Q.1.2) (n=60)

	Frequency	Percent
Coloured	1	1.7
Indian	22	36.7
White	36	60.0
Other	1	1.7
Total	60	100.0

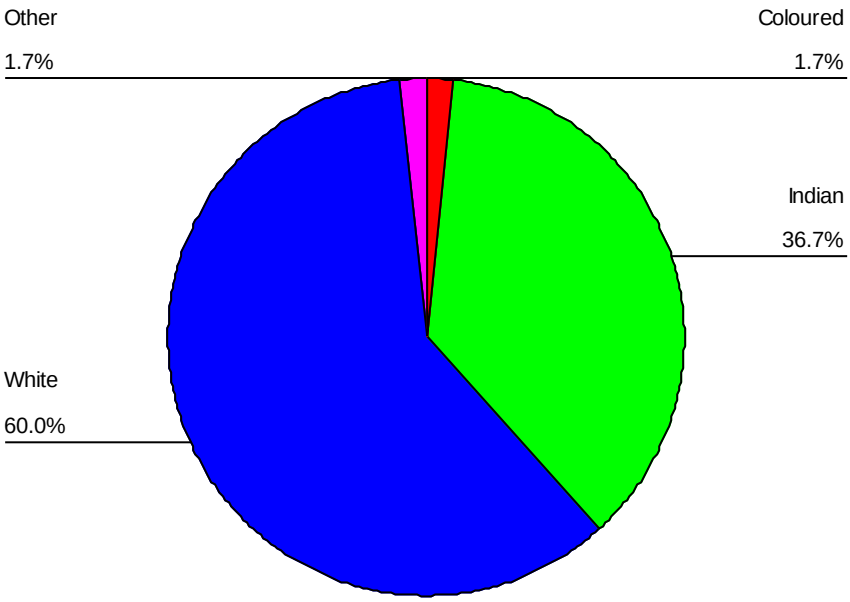


Figure 4.2: Pie chart of population group distribution of participants (Q.1.2) (n=60)

4.3.3. HOME LANGUAGE (Q.1.3)

Home language spoken by participants is shown in Table 4.4. These results may have been influenced by the fact that one of the requirements of this study was for participants to be literate in English, and that antenatal classes are conducted using the English language as a medium of communication.

Table 4.4: Home language of participants (Q.1.3) (n=60)

	Frequency	Percent
English	58	96.7
Afrikaans	2	3.3
Total	60	100.0

4.3.4. PREGNANCY STATUS (Q.1.4)

Pregnancy trimester of participants is indicated in Table 4.5 and illustrated by the pie chart in Figure 4.3.

Table 4.5: Pregnancy status of participants (Q.1.4.) (n=60)

	Frequency	Percent
First trimester	3	5.0
Second trimester	7	11.7
Third trimester	50	83.3
Total	60	100.0

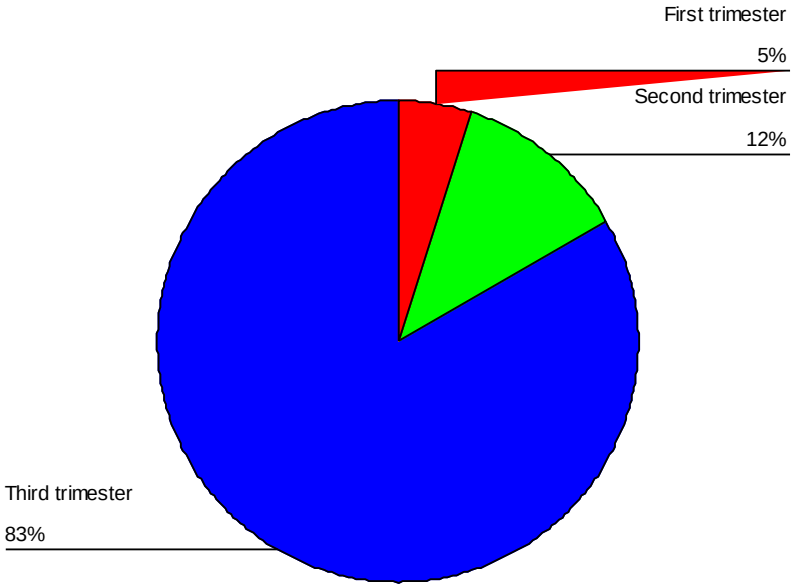


Figure 4.3: Pie chart of pregnancy status of participants (Q.1.4) (n=60)

4.3.5. OCCUPATIONAL STATUS (Q.1.5)

Occupation of participants is shown in Table 4.6 and illustrated by the bar chart in Figure 4.4.

Table 4.6: Occupational status of study participants (Q.1.5) (n=60)

	Frequency	Percent
Unemployed	4	6.7
Employed part time	7	11.7
Employed full time	27	45.0
Self employed	10	16.7
Housewife	9	15.0
Student	2	3.3
Other	1	1.7
Total	60	100.0

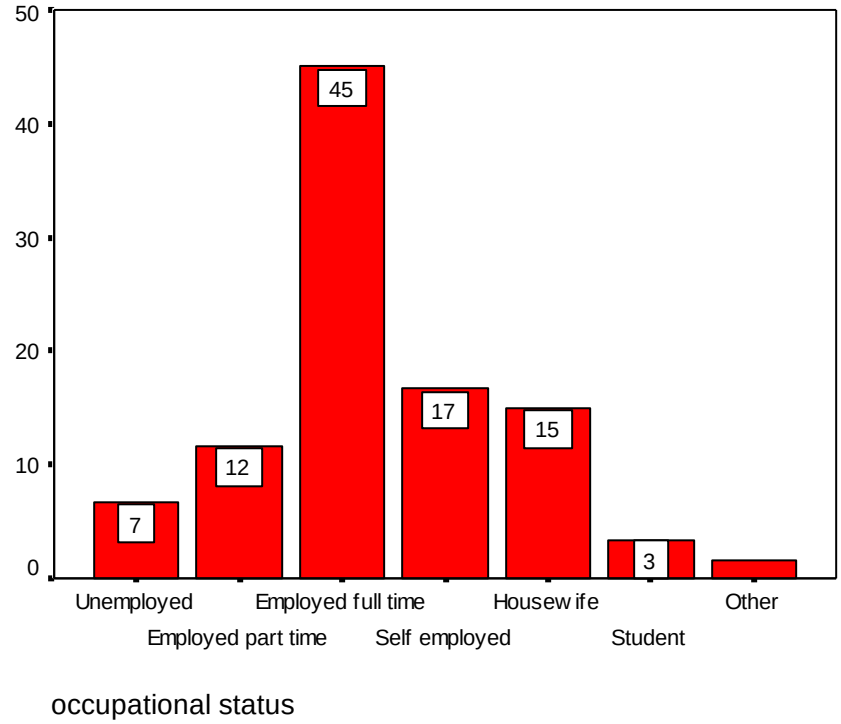


Figure 4.4: Bar chart of occupational status of participants (Q.1.5) (n=60)

4.3.6. HIGHEST EDUCATION LEVEL (Q.1.6)

Education level of participants is shown in Table 4.7 and illustrated by the pie chart in Figure 4.5.

Table 4.7: Highest education level of study participants (Q.1.6) (n=60)

	Frequency	Percent
<Standard 10	1	1.7
Std 10	17	28.3
Diploma/degree	35	58.3
Post grad diploma/degree	7	11.7
Total	60	100.0

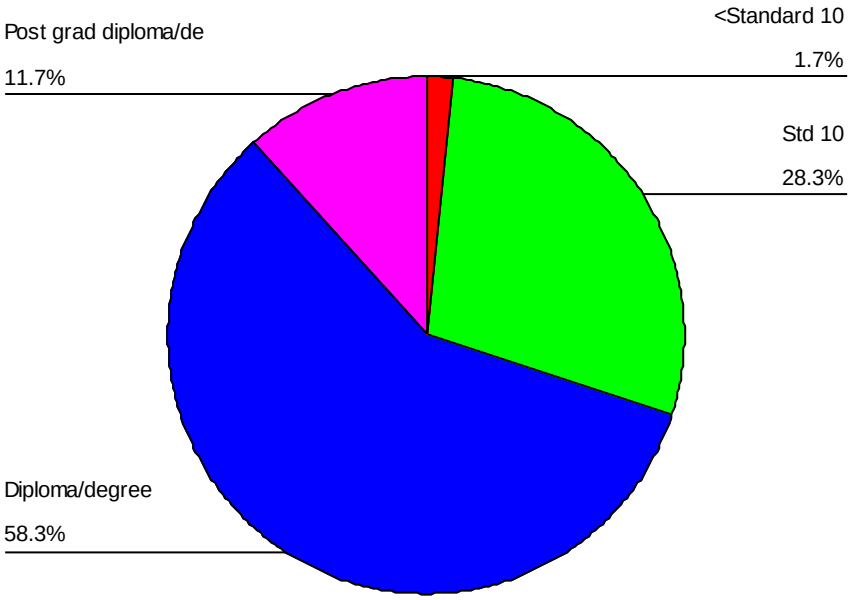


Figure 4.5: Pie chart of highest education level of participants (Q.1.6) (n=60)

4.3.7. ANNUAL INCOME (Q.1.7)

Annual income distribution of participants is shown in Table 4.8 and illustrated by the bar chart in Figure 4.6.

Table 4.8: Annual income of study participants (Q.1.7) (n=60)

	Frequency	Percent
<R16000	5	8.3
R16000-R29999	7	11.7
R30000-R49999	8	13.3
R50000-R69999	14	23.3
R70000-R99999	12	20.0
R100000-R299999	11	18.3
>=R300000	3	5.0
Total	60	100.0

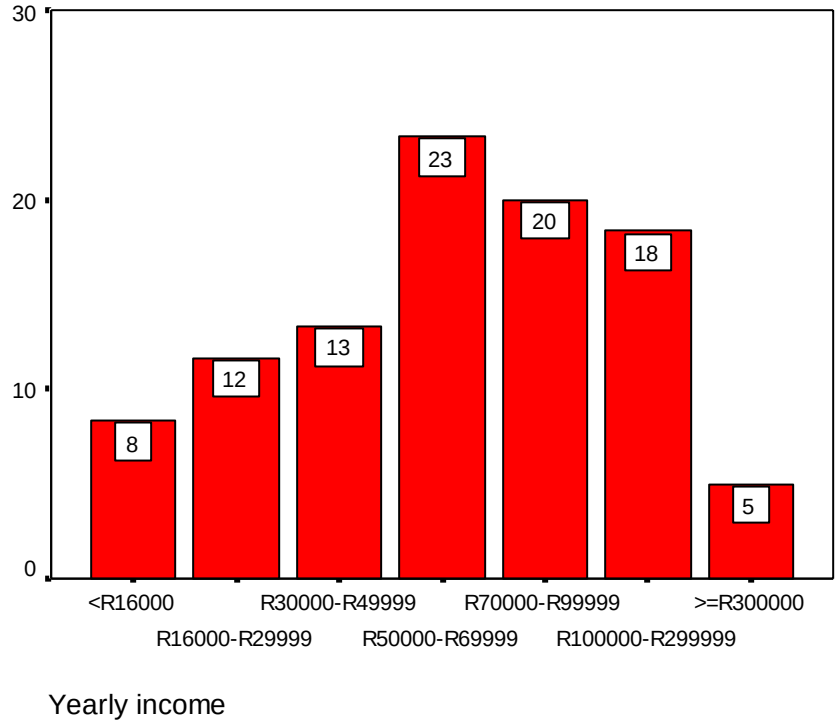


Figure 4.6: Bar chart of annual income of study participants (Q.1.7) (n=60)

4.3.8. GENERAL HEALTH STATUS (Q.1.8)

General health status of participants is depicted in Table 4.9 and illustrated by the pie chart in Figure 4.7. The category for 'Poor' general health status was omitted from this analyses as none of the participants (n=60) fell into this category.

Table 4.9: General health status of study participants (Q.1.8) (n=60)

	Frequency	Percent
Excellent	29	48.3
Good	30	50.0
Reasonable	1	1.7
Total	60	100.0

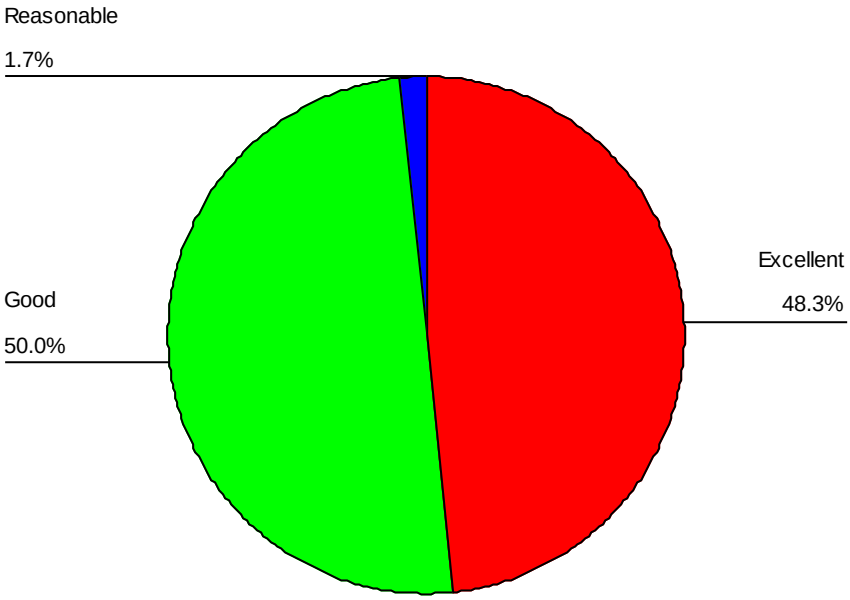


Figure 4.7: Pie chart of general health status of participants (Q.1.8) (n=60)

4.3.9. PREGNANCY HEALTH STATUS (Q.1.9)

The pregnancy health status of participants is depicted in Table 4.10 and illustrated by the pie chart in Figure 4.8.

Table 4.10: Pregnancy health status of study participants (Q.1.9) (n=60)

	Frequency	Percent
Excellent	17	28.3
Good	34	56.7
Reasonable	8	13.3
Poor	1	1.7
Total	60	100.0

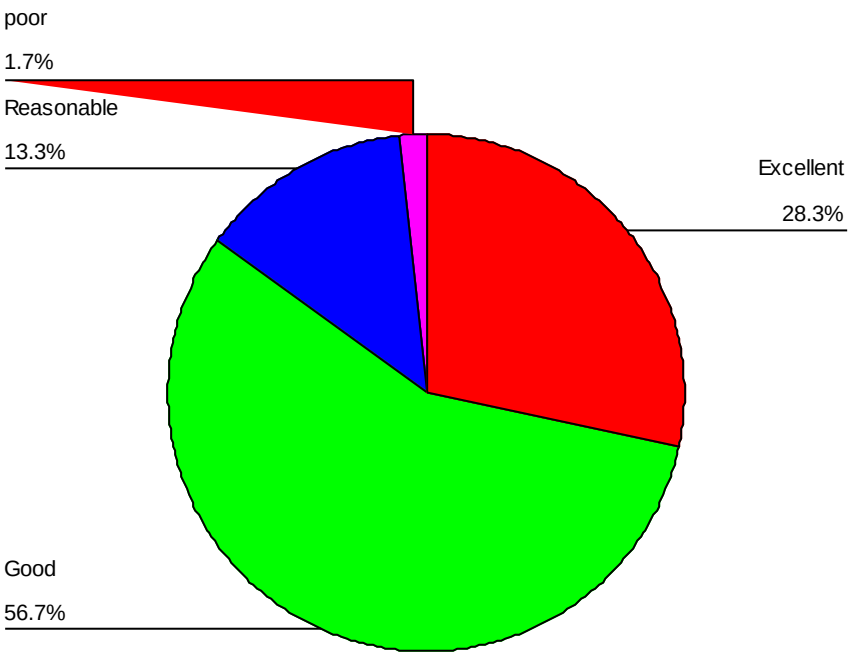


Figure 4.8: Pie chart of pregnancy health status of participants (Q.1.9)

(n=60)

4.3.10. MEDICATIONS BEING TAKEN AT PRESENT (Q.1.10)

Medications that were being taken by participants are shown in Tables 4.11-15 and are summarized and illustrated by the bar chart in Figure 4.9. Categories for medications being taken at present by participants have been analyzed individually because more than one category could be selected.

Table 4.11: Percentage of participants taking supplements (Q.1.10) (n=60)

	Frequency	Percent
Yes	53	88.3
No	7	11.7
Total	60	100.0

Table 4.12: Percentage of participants taking natural remedies (Q.1.10) (n=60)

	Frequency	Percent
Yes	5	8.3
No	55	91.7
Total	60	100.0

Table 4.13: Percentage of participants taking homoeopathic remedies (Q.1.10) (n=60)

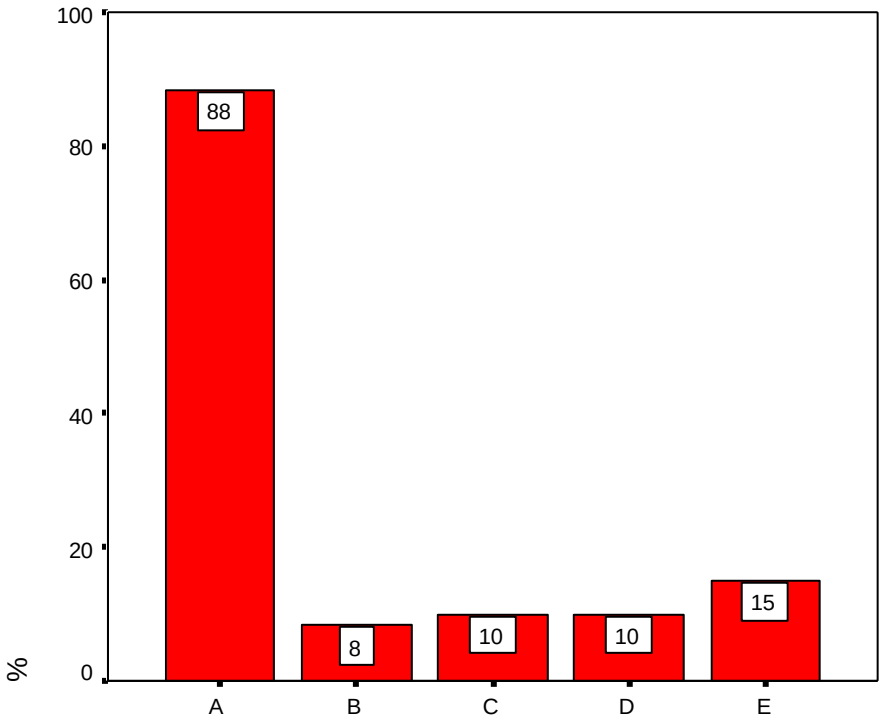
	Frequency	Percent
Yes	6	10.0
No	54	90.0
Total	60	100.0

Table 4.14: Percentage of participants taking over-the-counter medicines (Q.1.10) (n=60)

	Frequency	Percent
Yes	6	10.0
No	54	90.0
Total	60	100.0

Table 4.15: Percentage of participants taking prescribed medicines (Q.1.10) (n=60)

	Frequency	Percent
Yes	9	15.0
No	51	85.0
Total	60	100.0



A = Supplements
B = Natural medicines
C = Homoeopathic remedies
D = Over the counter\non-prescription medications
E = Prescription medications

Figure 4.9: Bar chart of medication taken at present by study participants (Q.1.10) (n=60)

4.4. KNOWLEDGE OF HOMOEOPATHY

4.4.1. KNOWLEDGE OF HOMOEOPATHY

Questions 2.1, 2.4, and 3.12 were identified as *knowledge* questions and allocated one point for each correct answer. Scores for respondents' individual knowledge score percent are shown in Figure 4.10. Table 4.16 shows statistics for knowledge score percent of the sample. The category '9 years or more' in question 3.12 was omitted from analysis as it was not selected by any of the participants (n=60). The knowledge score was expressed as a percentage out of the maximum possible score (24). Responses to individual knowledge questions are shown in Tables 4.17-19. These responses are further illustrated by bar charts in Figures 4.11-13. The mean score for all participants was 54.9% (n=60), with a standard deviation of 14.6% and a range of 25-83%. This indicated a mediocre level of knowledge about homoeopathy in the sample group.

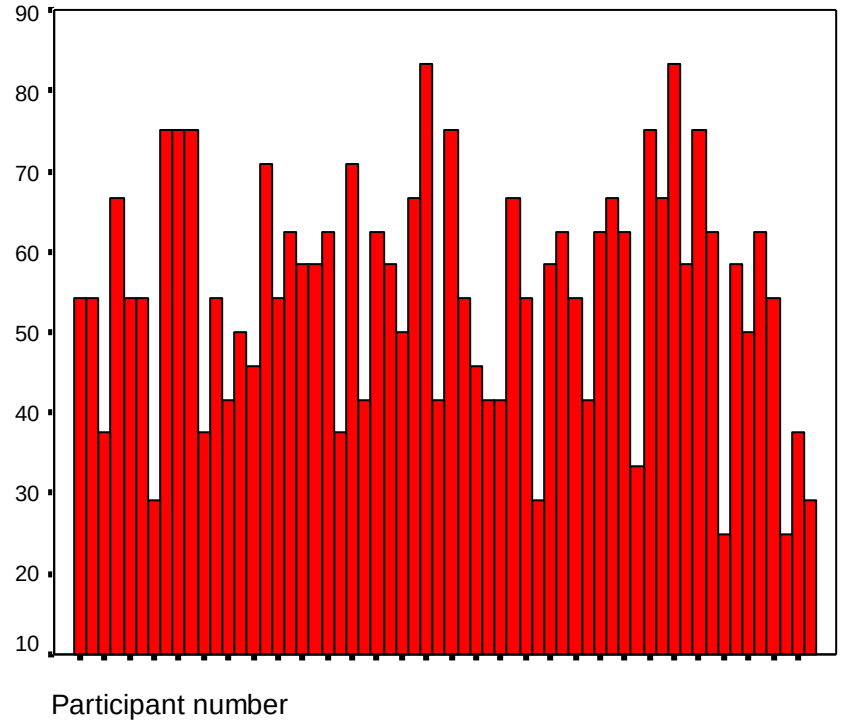


Figure 4.10: Individual knowledge percent scores per participant number (n=60)

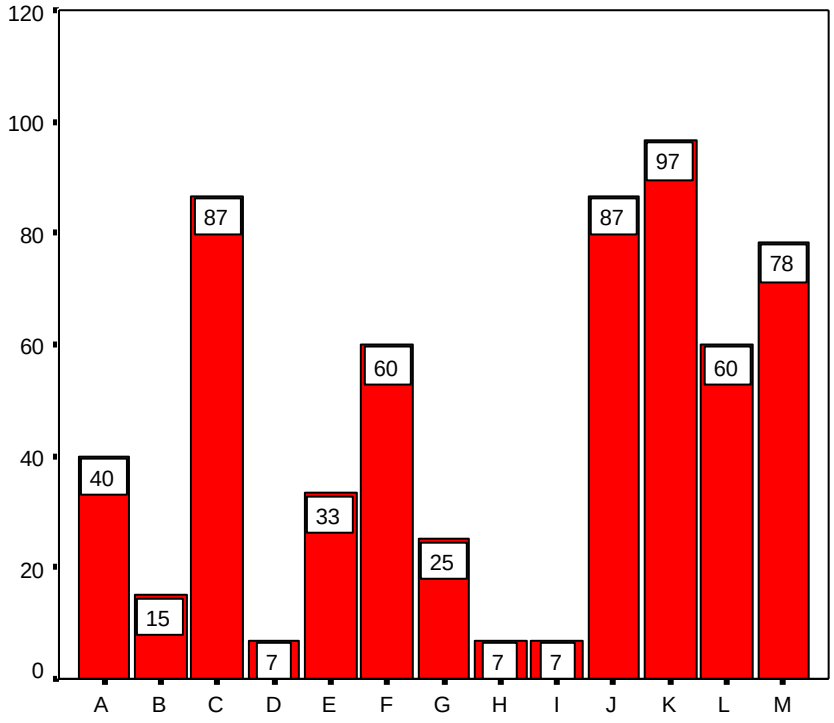
Table 4.16: Sample statistics for knowledge score percent (n=60)

N	Valid	60
	Missing	0
Range	Minimum	25
	Maximum	83
Mean		54.93
Standard Deviation		14.565

Table 4.17: Responses to individual questions regarding knowledge about what a homoeopath does (Q.2.1) (n=60)

		Frequency	%
Takes blood pressure	Yes	24	40.0%
	No	21	35.0%
	Not sure	15	25.0%
Stimulates skin with needles	Yes	9	15.0%
	No	43	71.7%
	Not sure	8	13.3%
Boosts immune system	Yes	52	86.7%
	No	3	5.0%
	Not sure	5	8.3%
Prescribes pain killers	Yes	4	6.7%
	No	45	75.0%
	Not sure	11	18.3%
Prescribes medicines that are diluted and shaken	Yes	20	33.3%
	No	23	38.3%
	Not sure	17	28.3%
Can diagnose majority of diseases	Yes	36	60.0%
	No	8	13.3%
	Not sure	16	26.7%
Use medicines that can cause same symptoms	Yes	15	25.0%

	No	21	35.0%
	Not sure	24	40.0%
Uses antibiotics	Yes	4	6.7%
	No	45	75.0%
	Not sure	11	18.3%
Looks into people's eyes to make diagnosis	Yes	4	6.7%
	No	42	70.0%
	Not sure	14	23.3%
Prescribes plant extracts	Yes	52	86.7%
	No	1	1.7%
	Not sure	7	11.7%
Emphasizes a healthy lifestyle	Yes	58	96.7%
	No	2	3.3%
	Not sure	0	.0%
Usually prescribes a diet	Yes	36	60.0%
	No	10	16.7%
	Not sure	14	23.3%
Can treat majority of diseases	Yes	47	78.3%
	no	0	.0%
	Not sure	13	21.7%



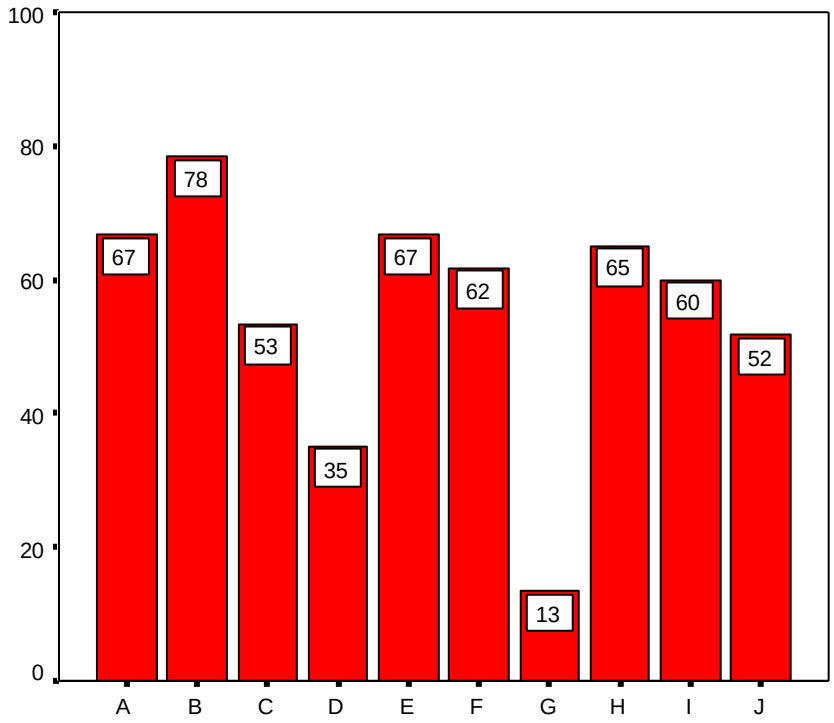
A = Takes blood pressure
B = Stimulates the skin with sharp needles
C = Boosts the immune system
D = Usually prescribes pain killers
E = Prescribes medicines that are diluted and shaken
F = Can diagnose the majority of diseases
G = Makes use of medicines that can cause the same symptoms
H = Makes use of antibiotic treatments
I = Looks into peoples eyes to make a diagnosis
J = Prescribes plant extracts
K = Emphasizes a healthy lifestyle
L = Usually prescribes a diet
M = Can treat the majority of diseases

Figure 4.11: Bar chart of percentage of "yes" responses to knowledge statements (Q.2.1) (n=60)

Table 4.18: Responses to individual questions towards statements regarding homoeopathy (Q.2.4) (n=60)

		Frequency	%
Has a scientific base	Yes	40	66.7%
	No	4	6.7%
	Not sure	16	26.7%
Medicines do not contain chemicals	Yes	47	78.3%
	No	3	5.0%
	Not sure	10	16.7%
Medicines made from plants only	Yes	32	53.3%
	No	11	18.3%
	Not sure	17	28.3%
Must believe in it for medicines to work	Yes	21	35.0%
	No	31	51.7%
	Not sure	8	13.3%
Medicines tested through trial and error	Yes	40	66.7%
	No	5	8.3%
	Not sure	15	25.0%
Medications have undergone clinical trials	Yes	37	61.7%
	No	6	10.0%

	Not sure	17	28.3%
Works only if not treatable by conventional medicine	Yes	8	13.3%
	No	43	71.7%
	Not sure	9	15.0%
Safe during pregnancy	Yes	39	65.0%
	No	3	5.0%
	Not sure	18	30.0%
Safe in newborns and infants	Yes	36	60.0%
	No	4	6.7%
	Not sure	20	33.3%
Safe to use in labour	Yes	31	51.7%
	No	2	3.3%
	Not sure	27	45.0%



A = Homoeopathy has scientific base
B = The medicines do not contain chemical or drug substances
C = Medicines are made from plants only
D = For medicines to work you must believe in it
E = Medicines have been tested through trial and error over many years
F = Homoeopathic medicines have undergone clinical trials
G = Homoeopathy works only on conditions that are not treatable by conventional medicine
H = Homoeopathic medicine is safe to use in pregnancy
I = Homoeopathic medicines are safe to use in newborns and infants
J = Homoeopathic medicines can be used during the labour process safely and effectively

Figure 4.12: Bar chart of percentage of "yes" responses to statements regarding homoeopathy (Q2.4) (n=60)

Table 4.19: Responses to question on how long it takes to qualify as a homoeopath (Q.3.12) (n=60)

	Frequency	Percent
1-2 years	5	8.3
3-4 years	16	26.7
5-6 years	26	43.3
7-8 years	13	21.7
Total	60	100.0

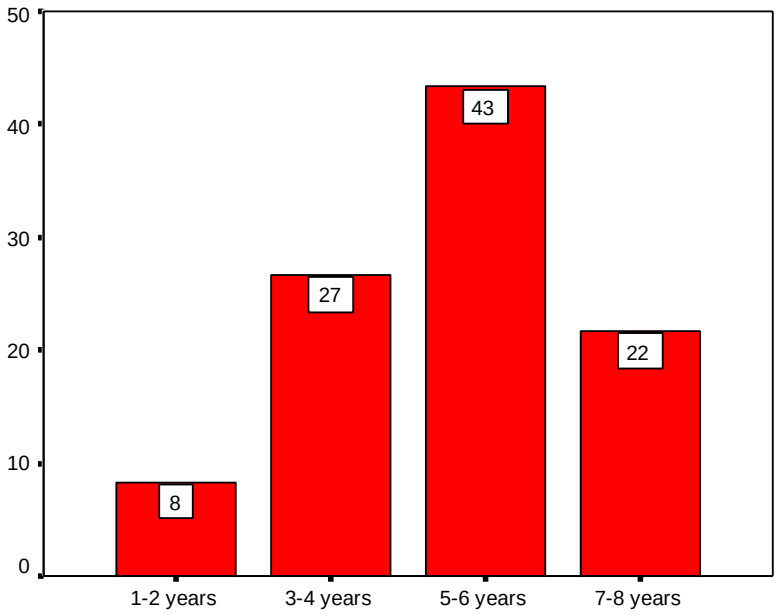


Figure 4.13: Bar chart of responses to question on how long it takes to qualify as a homoeopath (Q.3.12) (n=60)

4.4.2. FACTORS AFFECTING KNOWLEDGE OF HOMOEOPATHY

4.4.2.1. Demographics

Age, population, education and income groups were considered to influence participant's knowledge of homoeopathy. These factors were compared with the mean knowledge score of participants using the ANOVA test. Results of these tests are shown in 4.4.2.1.1 – 4.4.2.1.4 below.

4.4.2.1.1. Age

Results for the comparison of mean knowledge score between age groups are depicted in Table 4.20. The age group '45 years and above' was omitted from this analyses as none of the participants (n=60) fell into this category.

Table 4.20: ANOVA results for comparison of mean knowledge score between age groups (n=60)

AGE	Mean knowledge score percent	N	Std. Deviation	P value
18-24 yrs	51.11	15	17.919	0.174
25-34 yrs	57.57	38	13.064	
35-44 yrs	48.81	7	12.664	
Total	54.93	60	14.565	

4.4.2.1.2. Population

Results for the comparison of mean knowledge score between population groups are depicted in Table 4.21.

Table 4.21: T-test results for comparison of mean knowledge score between two population groups (n=60)

Population group	Mean	N	Std. Deviation	P value
Indian	57.39	22	15.427	0.460
White	54.51	36	13.524	
Total	55.60	58	14.212	

4.4.2.1.3. Education level

Results for the comparison of mean knowledge score between education levels are depicted in Table 4.22 below. Education level had no significant effect on the knowledge score of the sample (p=0.702).

Table 4.22: ANOVA results for comparison of mean knowledge score between education levels (n=60)

Highest education level	Mean	N	Std. Deviation	P value
Std 10	52.70	17	16.267	0.702
Diploma/degree	56.31	35	14.762	
Post graduate diploma/degree	55.95	7	8.284	
Total	55.23	59	14.508	

4.4.2.1.4. Income Groups

Results for the comparison of mean knowledge score between income groups are depicted in Table 4.23 below.

Table 4.23: ANOVA results for comparison of mean knowledge score between income groups (n=60)

Yearly income	Mean	N	Std. Deviation	P value
<R16000	60.83	5	18.305	0.396
R16000-R29999	62.50	7	11.785	
R30000-R49999	59.38	8	14.391	
R50000-R69999	49.11	14	16.840	
R70000-R99999	53.47	12	11.491	
R100000-R299999	52.27	11	13.612	
>=R300000	58.33	3	16.667	
Total	54.93	60	14.565	

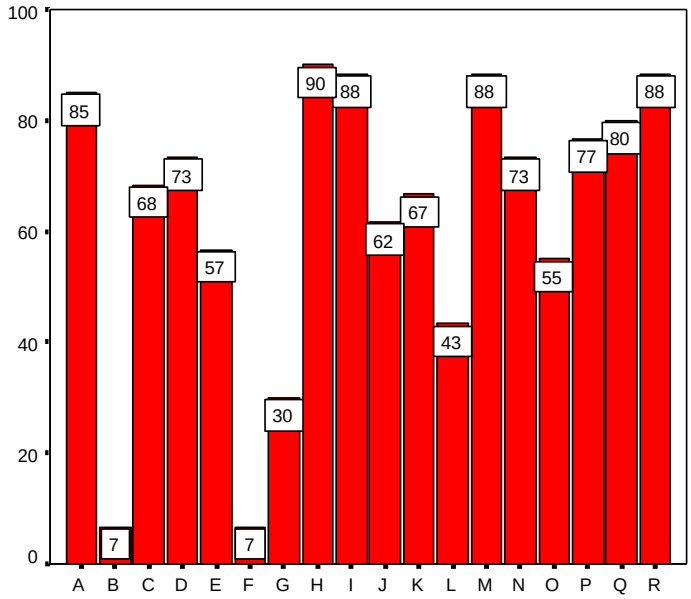
4.5. ATTITUDES TOWARDS HOMOEOPATHY

4.5.1. ATTITUDES TOWARDS HOMOEOPATHY

Questions 2.2, 2.3, 2.5, 2.6, 3.10, 3.11 were identified as attitudes questions. These questions were first analyzed descriptively, and thereafter compared with the knowledge scores as a percentage, using the ANOVA test.

4.5.1.1. "Yes" responses to conditions for which participants would seek homeopathic treatment during pregnancy (Q.2.2)

Analysis of "Yes" responses to question 2.2 are illustrated by the bar chat in Figure 4.14 below.

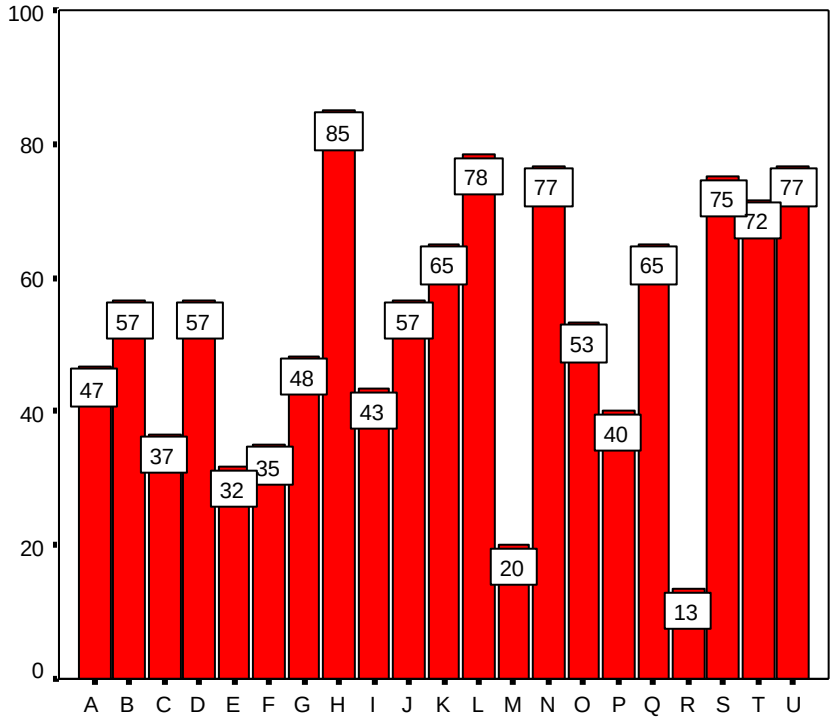


A = Allergies
B = Aids
C = Arthritis
D = Asthma
E = Blood pressure problems
F = Broken bones
G = Cancer
H = Colds and flu
I = Coughs
J = Childhood complaints
K = Complaints of pregnancy
L = Diabetes
M = Headaches
N = Hot flushes
O = Mental illness
P = Menstrual problems
Q = Skin conditions
R = Weakness, Tiredness, Loss of energy

Figure 4.14: Bar chart of percentage of "yes" responses to conditions for which participants would seek homoeopathic treatment during pregnancy (Q2.2) (n=60)

4.5.1.2. "Yes" responses to pregnancy related symptoms for which participants would seek homoeopathic treatment (Q2.3)

Analysis of "Yes" responses to question 2.3 is illustrated by the bar chart in Figure 4.15.



A = Breast pain
B = Sore, cracked nipples
C = Mastitis
D = Problems with milk production
E = Induction of labour / Progression of labour
F = Incontinence
G = Varicose Veins
H = Skin complaints
I = Piles
J = Pain
K = Swelling
L = Morning sickness
M = inverted nipples
N = insomnia

O = Bladder infection /Urinary tract infection
P = Hypertension
Q = Emotional changes
R = Breech baby
S = Constipation
T = Muscle pain or cramping
Q = Heartburn

Figure 4.15: Bar chart of percentage of "yes" responses to pregnancy related symptoms for which participants would seek homoeopathic treatment (Q.2.3) (n=60)

4.5.1.3. Homoeopathic treatment of acute conditions (Q.2.5)

The perceptions of participants towards the effect of homoeopathic medicines in the treatment of acute conditions are depicted in Table 4.24. Individual categories of responses to this question are compared with the mean knowledge score using the ANOVA test, which is shown in Table 4.25.

Table 4.24: Participants' perceptions of homoeopathy in the treatment of acute conditions (Q.2.5) (n=60)

	Frequency	Percent
Not effective	2	3.3
More effective than orthodox	3	5.0
Less effective than orthodox	13	21.7
As effective as orthodox	18	30.0
Don't know	24	40.0
Total	60	100.0

Table 4.25: ANOVA results for comparison of mean knowledge score between the categories of responses to the question on the homoeopathic treatment of acute conditions

Knowledge score percent

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	983.136	4	245.784	1.172	.333
Within Groups	11533.936	55	209.708		
Total	12517.072	59			

4.5.1.4. Homeopathic treatment of chronic conditions (Q.2.6)

The perceptions of participants towards the effect of homoeopathic medicines in the treatment of chronic conditions are depicted in Table 4.26. Individual categories of responses to this question are compared with the mean knowledge score and are depicted in Table 4.27. The first category (not effective) was omitted from analysis since there was only one response and thus ANOVA could not be performed.

Table 4.26: Participants' perceptions of homoeopathy in the treatment of chronic conditions (Q.2.6) (n=60)

	Frequency	Percent
Not effective	1	1.7
More effective than orthodox	11	18.3
Less effective than orthodox	6	10.0
As effective as orthodox	21	35.0
Don't know	21	35.0
Total	60	100.0

Table 4.27: ANOVA results for comparison of mean knowledge score between the categories of responses to the question on the homoeopathic treatment of chronic conditions

Knowledge score percent

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1928.200	3	642.733	3.357	.025
Within Groups	10530.604	55	191.466		
Total	12458.804	58			

4.5.1.5. Availability of homoeopathic treatment for most medical conditions (Q.3.10)

Opinions on availability of homoeopathic treatment for most medical conditions are shown in Table 4.28. Comparisons of responses to this question with the mean knowledge score are shown in Table 4.29.

Table 4.28: Participants' opinion on whether homoeopathic treatment should be offered as treatment for most medical conditions (Q.3.10) (n=60)

	Frequency	Percent
Yes	54	90.0
No	6	10.0
Total	60	100.0

Table 4.29: Comparison of mean knowledge score between participants who thought that homoeopathic treatment should be offered as treatment for most medical conditions and those who did not (n=60)

Should homoeopathic treatment be offered as option for most medical conditions	N	Mean	Std. Deviation	Std. Error Mean	P value
Yes	54	55.86	14.423	1.963	0.138
No	6	46.53	14.293	5.835	

4.5.1.6. Availability of homoeopathic treatment in hospitals and clinics (Q.3.11)

Opinions on availability of homoeopathic treatment in hospitals and clinics are shown in Table 4.30. Comparison of responses to this question with the mean knowledge score are shown in Table 4.31 below.

Table 4.30: Participants' opinion on whether homoeopathic treatment should be available in hospitals and clinics (Q.3.11) (n=60)

	Frequency	Percent
Yes	54	90.0
No	6	10.0
Total	60	100.0

Table 4.31: Comparison of mean knowledge score between participants who thought that homoeopathic treatment should be available in hospitals and clinics and those who did not (n=60)

Should homoeopathic treatment be offered in hospitals	N	Mean	Std. Deviation	Std. Error Mean	P value
Yes	54	55.94	14.806	2.015	0.107
No	6	45.83	8.333	3.402	

4.6. PARTICIPANTS HEALTH CARE PROVIDERS

4.6.1. HEALTH CARE PROVIDER WHEN ILL OR INDISPOSED (Q.3.1)

The health care providers that participants consult when feeling ill or indisposed are shown in Table 4.32.

Table 4.32: Health care providers who participants usually consult when ill or indisposed (Q.3.1) (n=60)

	Frequency	Percent
General Practitioner	43	71.7
Medical Specialist	4	6.7
Homoeopath	12	20.0
Healer	1	1.7
Total	60	100.0

4.6.2. PRESENT PRIMARY HEALTH CARE PROVIDER (Q.3.2)

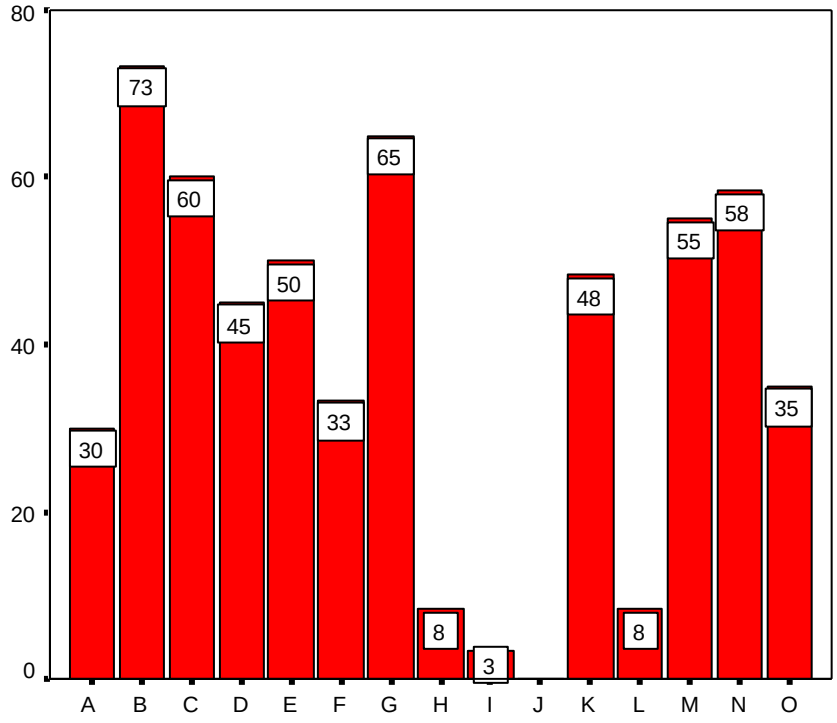
Participants' present primary health care providers are shown in Table 4.33.

Table 4.33: Primary health care providers (Q.3.2) (n=60)

	Frequency	Percent
General Practitioner	32	53.3
Medical Specialist	19	31.7
Homoeopath	8	13.3
Other	1	1.7
Total	60	100.0

4.6.3. OPINIONS REGARDING HEALTH CARE PROVIDER (Q.3.3)

Opinions regarding participants' health care providers are illustrated by the bar chart in Figure 4.16 below.



A = Prescribes medicines that make me feel better
B = Listens to all I have to say about my illness or indisposition
C = Treats me as his or her equal
D = Soon finds out what is wrong with me
E = Sympathizes with my problems
F = knows the best treatment fro my illness or indisposition
G = Puts me at ease
H = Prescribes medicines too easily
I = Prescribes too many medicines
J = Makes me feel as if he or she is hiding something from me
K = Examines me thoroughly
L = merely wants to make money
M = Discusses with me the treatment he or she has in mind
N = Is interested in me as an individual
O = Diagnoses the majority of ailments correctly

Figure 4.16: Bar chart of percentage of "yes" responses to statements about health care providers (Q.3.3)

4.7. PRIOR EXPERIENCE WITH HOMOEOPATHY

4.7.1. PREVIOUS CONSULATATION WITH A HOMOEOPATH (Q.3.4.)

Participants who had previously consulted with a homoeopath and those who had not are shown in Table 4.34.

Table 4.34: Percentage of participants who had previously consulted with a homoeopath (Q3.4) (n=60)

	Frequency	Percent
Yes	23	38.3
No	37	61.7
Total	60	100.0

4.7.2. NUMBER OF TIMES PARTICIPANTS CONSULTED WITH A HOMOEOPATH (Q.3.5)

The number of times a homoeopath was consulted by participants who answered "Yes" to question 3.4 above, is illustrated by the bar chart in Figure 4.17.

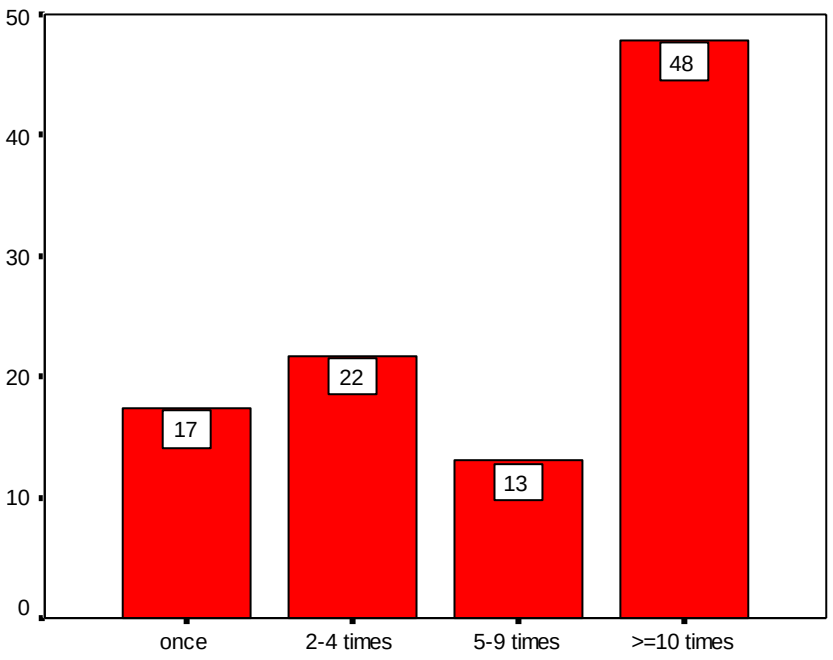
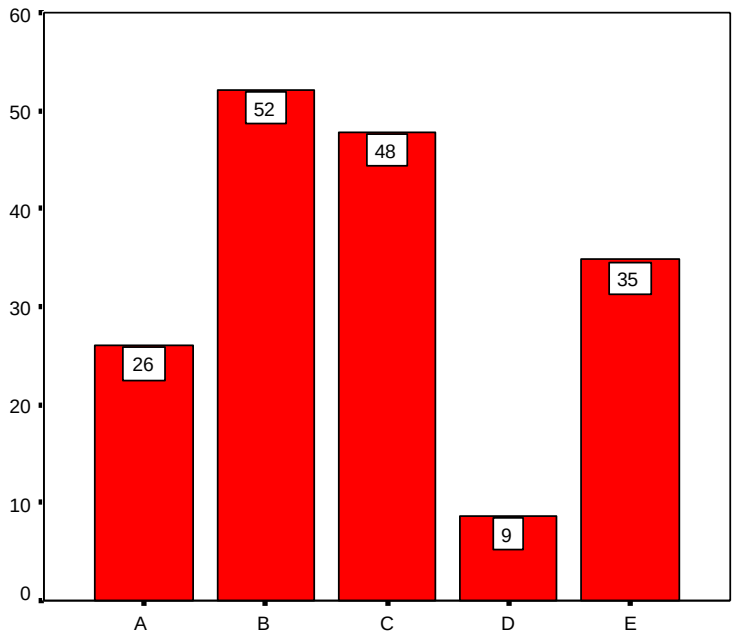


Figure 4.17: Bar chart of number of times homoeopath was consulted (Q.3.5) (n=23)

4.7.3. REASONS FOR CONSULTING A HOMOEOPATH (Q.3.6)

Reasons given for having consulted with a homoeopath are illustrated by the bar chart in Figure 4.18.



A = Conventional medicine failed
B = Homoeopathy is natural
C = Personal recommendation
D = During pregnancy
E = Homoeopathic medicines are safe and have minimal side effects

Figure 4.18: Reasons given for consulting homoeopaths (Q.3.6) (n=23)

4.7.4. FIRST SOURCE OF HOMEOPATHIC INFORMATION (Q.3.7)

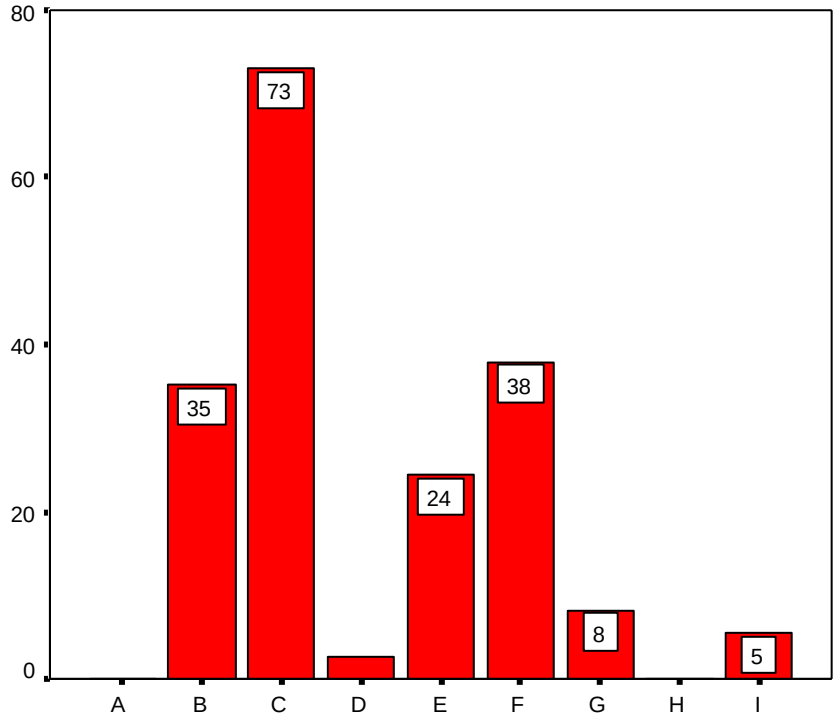
Responses to question on where participants first heard about homoeopathy are shown in Table 4.35.

Table 4.35: Where did you first hear about homoeopathy (Q.3.7) (n=23)

	Frequency	Valid Percent
Relative/friend	18	78.3
Media	1	4.3
Doctor	1	4.3
Other	3	13.0
Total	23	100.0

4.7.5. REASONS FOR NOT CONSULTING A HOMOEOPATH (Q.3.8)

Reasons for participants not having consulted with a homoeopath are illustrated in Figure 4.19.



A = Never heard of homoeopathy
B = Have never needed their service
C = Know too little about them
D = Too expensive
E = My medical aid scheme does not cover them
F = I am unsure of their methods
G = I have heard of their failures
H = They are nothing but quacks
I = Their training is not up to standard

Figure 4.19: Reasons for not consulting a homoeopath (Q.3.8) (n=37)

4.7.6. EFFECT OF PREVIOUS CONSULTATION WITH HOMOEOPATH ON THE KNOWLEDGE SCORE

Results for effect of previous consultation with a homoeopath on the knowledge score is shown in Table 4.36.

Table 4.36: T-test results for comparison of mean knowledge score between those who have consulted with a homoeopath before and those who had not (n=60)

Have you ever consulted a homoeopath?	N	Mean	Std. Deviation	Std. Error Mean	P value
Yes	23	62.68	15.048	3.138	0.001
No	37	50.11	12.127	1.994	

4.7.7. LIKLEYHOOD TO CONSULT A HOMEOPATH AMONGST PARTCIPANTS WHO HAD NEVER PREVIOUSLY CONSULTED A HOMOEOPATH (Q.3.9.1)

Responses to question 3.9.1 are shown in Table 4.37.

Results to question 3.9.1 are compared with mean knowledge score and shown in Table 4.38.

Table 4.37: Results for question on likelihood to consult with homoeopath amongst those who have not consulted a homeopath before (Q.3.9.1) (n=37)

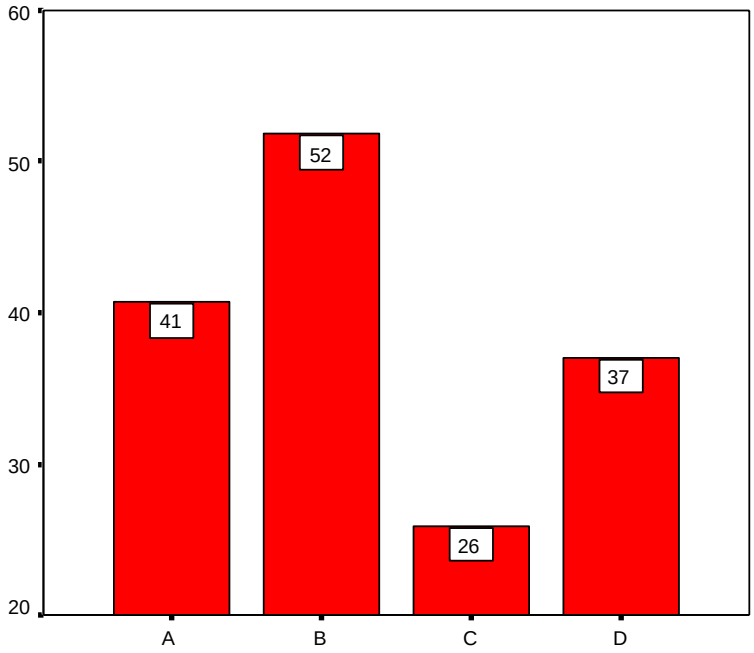
Would you be likely to consult with a homoeopath	Frequency	Percent
Yes	27	73
No	10	27
Total	37	100

Table 4.38: T-test results for comparison of mean knowledge score between those participants who would be likely to consult with a homoeopath and those who would not , amongst participants who had never previously consulted with a homoeopath (n=37)

Would you be likely to consult with a homoeopath	N	Mean	Std. Deviation	Std. Error Mean	P value
Yes	27	52.47	11.800	2.271	0.051
No	10	43.75	11.154	3.527	

4.7.8. REASONS FOR BEING LIKELY TO CONSULT A HOMOEOPATH AMONGST PARTICIPANTS WHO HAD NEVER CONSULTED A HOMOEOPATH BEFORE (Q.3.9.2)

Reasons for being likely to consult with a homoeopath, amongst participants who had never consulted with a homoeopath before are illustrated by the bar chart in Figure 4.20 below.



A = If conventional medicine failed
B = Homoeopathy is natural
C = During pregnancy
E = Homoeopathic medicines are safe and have minimal side effects

Figure 4.20: Reasons given for being likely to consult a homoeopath

(Q.3.9.2) (n=27)

CHAPTER FIVE

DISCUSSION

5.1. INTRODUCTION

The results of the statistical analysis of responses to the 'Perceptions in Pregnancy' questionnaire (Appendix C), from Chapter Four will be analyzed and evaluated further in this chapter. The information obtained is specific for this target group (pregnant adults attending private facilities) and is in no way representative of the general population of the Durban area.

5.2. RESPONSE RATE

A total of 130 questionnaires were handed out to potential participants. 83 (64%) questionnaires were returned, of which 60 (46%) were viable. The remaining 47 (36%) were not returned (Table 4.1). Poor response rate may be attributed to improper instruction, misunderstanding of instruction, and lack of willingness to participate in the study by most antenatal instructors in the Durban area which directly affected the sample size. It is assumed that had more antenatal instructors been willing to participate in the study a sample twice or three times this size could have been obtained. The researcher feels that being present during completion of the questionnaire would have positively affected the

compliance of participants and more completed questionnaires would have been obtained. Had the researcher been present, proper instruction could have been given and any misunderstanding could have been addressed immediately. The researcher also feels that a larger sample group could have been obtained by seeking permission from private gynaecologists to approach patients in their waiting rooms.

5.3. DEMOGRAPHIC DATA

The age distribution of the sample was predominantly in the 25-34 year age group (63%) and a further 25% of the sample was between the ages of 18 and 24 years (Table 4.2 and Figure 4.1). This portrays the predominant child bearing age of this target group, and gives a rough estimate of the age group of these potential consumers. Consideration must be given to the fact that most pregnant women only attend antenatal classes in their first pregnancy, and are unlikely to attend these classes in subsequent pregnancies. Thus it is presumed that the age group represents majority of women in their first pregnancy. Age did not have a significant effect on the knowledge score of the sample (p=0.174).

The majority of the sample group was 'White' (60%), and 'Indian' (37%). A shortfall of this survey is the under representation of 'Black', 'Coloured' and 'Other' population groups, which may be attributed to the fact that the survey was conducted amongst women attending private facilities in central areas of Durban.

Had the survey been conducted amongst private facilities in peripheral areas of Durban and public facilities, one would assume that there would have been a greater representation of ‘Black’, ‘Coloured’, or ‘Other’ population groups. It was interesting to note that the private antenatal classes that responded to this study catered more to the white and Indian population groups. Population had no significant effect on the knowledge score of the sample (p=0.460).

96.7% of the sample was English speaking, with two Afrikaans speaking participants (Table 4.4). These results may have been influenced by the fact that one of the requirements of this study was for participants to be literate in English, and that the antenatal classes are conducted using the English language as a medium of communication. It is assumed that further studies in semi-private and public settings within the Durban area would yield different results, with a greater portion of respondents speaking Zulu as a home language.

Private antenatal classes instruct women with regards to the labour and birthing process, and as a result the majority of women prefer to attend these classes during the latter half of their pregnancy. The data obtained verifies this observation, showing that 83% of participants were in their third trimester of pregnancy at the time that they completed the “Perceptions in Pregnancy” questionnaire. The researcher feels that this question rendered data that is of no value, and that a more appropriate question to ask would be “How many pregnancies have you had previously?”. This information could be used to

determine if individuals that have had previous pregnancies are more likely to have a better knowledge about homoeopathy from prior experiences. This information would also be useful as it would reflect directly on the age group of the sample, providing more insight on whether the predominant age group is mainly representative of first time mothers or not, as is assumed above.

Almost half the participants (45%) were employed full time followed by 16.7% of participants that were self employed (Table 4.6 and Figure 4.4). This indicates that majority of participants were working and thus able to afford private homoeopathic care, confirming the view that they represent potential consumers to the homoeopathic profession. Responses showed that a fairly high level of education existed amongst this sample with 58% possessing a degree or diploma (Table 4.7 and Figure 4.6), yet education level was shown to have no significant effect on the knowledge score of the sample ($p=0.702$).

Most (23%) participants earned between R50 000 and R70 000 annually. 43.3% of the sample earned more than R70 000, and 56.6% earned less than R70 000. Although this question implied annual house-hold income, it is unclear whether participants answered according to their individual income, or combined annual income. The researcher feels that this question (Q.1.7) was incorrectly worded and requests that if this questionnaire is to be used in the future, this question (Q.1.7) should be altered to indicate ‘annual house-hold income’. For purposes of this study it is assumed that subjects indicated combined house-hold income

(Table 4.8 and Figure 4.6). Income was shown to have no significant effect on the knowledge score of the sample (p=0.396).

Responses to the question regarding participants state of health revealed the following: 48.3% of respondents indicated that their health was ‘excellent’, 50% indicated that their health was ‘good’ and only one participant (1.7%) reported ‘reasonable health’ (Table 4.9 and Figure 4.7). Most participants were healthy during pregnancy with 56.7% of the sample indicating good health, and 28.3% indicating excellent health (Table 4.10 and Figure 4.8). This study focused on the private sector in which the overall state of health was found to be excellent. Further studies are necessary in order to determine if this trend is prevalent amongst pregnant women in the public sector.

The majority of participants were taking supplements (88%) which is understandable considering they were in the latter half of their pregnancies at which point pregnancy multivitamins are routinely prescribed. This indicates that besides supplements (Table 4.11) and prescription medications (Table 4.15) that are prescribed by gynaecologists, very few other medications were being taken. It can thus be concluded that pregnant women exercise caution with regards to the medication they take and are not very likely to take medicines that are not prescribed to them. This may also be attributed to the fact that the sample was generally healthy (4.3.8.1) and experienced good health in pregnancy (4.3.8.2) and thus did not have a need for further medications. Alternately it may indicate

that the sample is cautious in their use of medication during pregnancy because of uncertainty regarding the effects of various medications on the developing foetus. The researcher feels that this aspect of the questionnaire should have been more in specific. Questions regarding conditions for which participants are required to take medications , and if they are continuing treatment during pregnancy should have been included.

In keeping with the study conducted by Moys (1998), this study did not find income or education level to have any significant influence on the knowledge of homoeopathy amongst participants.

5.3.1. CONCLUSION

Demographic results indicate that the sample is not representative of the general population. Participants were predominantly English speaking, healthy, educated, employed, women under the age of 35 years, in the latter half of their pregnancy, White or Indian, and of the upper-middle class socio-economic group. None of the demographic variables (age, population and education level) significantly affected knowledge score.

Data obtained did not provide a representative cross-section of the target group. This is mainly due to the specific nature of the sample and the fact that other private facilities in non-central areas of Durban were not included in this study.

Size and specific nature of this target group warrants repetition of this study on a broader scale, involving a variety of private hospitals, antenatal facilities, and waiting rooms of private gynaecologists. A specific attempt should be made to include private antenatal classes in non-central areas of Durban and amongst Black residential areas, which the researcher failed to do in this study. The researcher feels that this would render data that would better represent this target group and the general population. Also a need to repeat this study in semi-private and public facilities exists, with the possibility of comparative studies between these different groups.

5.4. KNOWLEDGE OF HOMOEOPATHY

Knowledge was calculated by allocating a score for each of the knowledge questions. The knowledge questions were made up of questions 2.1, 2.4, and 3.12. They were expressed as a percentage out of the maximum possible score (24), for which one mark was allocated for each correct answer.

The mean score for all participants was 54.9% (n=60), with a standard deviation of 14.6% and a range of 25-83%. This indicated a average level of knowledge about homoeopathy in the sample group signifying the need for a concerted education initiative by the homoeopathic profession.

60% of respondents indicated that homoeopaths are able to diagnose the majority of diseases and 78% indicated that homoeopaths are able to treat the majority of diseases. This shows that most of the sample was aware that homoeopaths are trained to diagnose and treat the majority of diseases, thus disproving the misconception that homoeopaths are ‘quacks’ and indicating a general awareness of the capabilities of homoeopaths.

Almost half (43.3%) of the sample were aware that it takes between 5 and 6 years to qualify as a homoeopath, proving that many people are aware that becoming a homoeopath requires a fair amount of tertiary study.

Almost all (93%) of the respondents were aware that homoeopaths do not ‘usually prescribe pain killers’ or ‘make use of antibiotics’, indicating that they are aware that homoeopaths do not prescribe main stream drugs. 87% of respondents indicated that homoeopaths prescribe plant extracts, which indicates that the myth that homoeopathy is a form of herbalism, does in fact exist (see 2.6.1). These results are in keeping with those obtained by Moys (1998:60-63), who found that the majority of participants indicated that homoeopaths ‘prescribe plant extracts’ (84.4% for Westville and 79% for Reservoir Hills), and do not ‘usually prescribe painkillers’ (80.6% for Westville and 64% for Reservoir Hills), or ‘make use of antibiotics’ (78.2% for Westville and 18.6% for Reservoir Hills). No significant confusion between homoeopathy and iridology or acupuncture was noted in this study, as compared to Moys (1998:63)

who found that 26% of respondents in both groups were of the opinion that homoeopaths used iridology to diagnose disease. 53% of the sample was not aware that homoeopathic medicines are made from substances other than plants. This further reiterates the fact that, as highlighted above, homoeopathy is often confused with herbalism. A need definitely exists to address this common misconception.

The majority (97%) of respondents thought that homoeopaths 'emphasizes a healthy lifestyle' and a further 60% thought that homoeopaths 'usually prescribe a diet'. This finding is also in keeping with that obtained by Moys (1998) who found that most participants felt that homoeopaths 'emphasize a healthy lifestyle' (91.8% for Westville and 89.2% for Reservoir Hills), and 'usually prescribes a diet' (60% for Westville and 75% for Reservoir Hills). These findings prove that the myth that homoeopaths prescribe strict diets is rife and highlights possible confusion between homoeopaths and naturopaths, dieticians and nutritionists.

Homoeopathic principles like the *Law of Similars* and *Infintesimal dose* were presented in the following statements regarding what a homoeopath does: 'Prescribes medicines that are diluted and shaken'; and 'Uses medicines that can cause the same symptoms'. Only 33% of the sample indicated correctly that homoeopaths use medicines that are diluted and shaken, and only 25% knew that homoeopaths make use of medicines that can cause the same symptoms,

indicating a poor level of knowledge of homoeopathic principles. These findings are in keeping with those obtained by Moys (1998).

87% of the respondents were aware that homoeopaths boost the immune system. This indicates that most of the sample is aware that homoeopathic medicines have a positive effect on the individuals' immune system.

67% of respondents were aware that homoeopathy has a scientific base, a further 78% were aware that homoeopathic remedies do not contain chemical or drug substances, 62% knew that homoeopathic medicines have undergone clinical trials. It was interesting to note that 67% of respondents thought that homoeopathic medicines have been tested through trial and error over many years, indicating that they are unaware that all homoeopathic medicines have undergone drug provings.

This indicates that the myth that homoeopathy is an unproved science exists. It is likely that respondents may have confused homoeopathy with age old traditional healing methods which have established their medicinal materials and uses over many years. Confusion between homoeopathy and other healing methods does exist, and basic homoeopathic education in this regards is necessary.

65% of the sample indicated correctly that homoeopathy was safe to use in pregnancy, and 62% indicated that homoeopathy is safe for use in infants and newborns. This indicates that roughly one third of the sample were aware of the

uses of homoeopathy. Only half (52%) of respondents were aware that homoeopathy is safe for use during labour, indicating the need to make people aware of the uses and benefits of homoeopathy during the birthing process.

35% of respondents thought that you have to believe in homoeopathy for it to work, indicating that the misconception that the effect of homoeopathic remedies is due to the 'placebo effect' does exist. Fortunately the greater majority (65%) of respondents did not agree with this statement, indicating that they did not attribute the workings of homoeopathy with 'placebo'.

5.4.1. CONCLUSION

Responses to questions regarding homoeopathy (Q.2.4) and what a homoeopath does (Q.2.1) indicate that although respondents have some knowledge of homoeopathy, education regarding the uses of homoeopathy as well as its methods and principles is necessary. It was assumed that participants who were unable to offer an opinion had done so due to a lack of knowledge regarding homoeopathy.

Further analysis revealed a need for the following points to be addressed:

•Provision of basic homoeopathic knowledge regarding history, principles and practice of homoeopathy.

•Information regarding the training and capabilities of homoeopathic practitioners,

and the scope of homoeopathy.

•The association with homoeopathy as being ‘natural’ and homoeopathic remedies being made from ‘plants’, emphasizes the need for differentiation between herbalism and homoeopathy.

• Provision of basic knowledge regarding homoeopathic methods of remedy preparation, selection and action.

• The association of homoeopathy with lifestyle and dietary changes warrants differentiation between homoeopathy and naturopathy, nutrition, and dietetics.

• Provision of basic knowledge of the uses, benefits and scope of homoeopathy during pregnancy, labour and birth.

• Differentiation of homoeopathy from other age old practices with emphasis on the sound scientific nature of homoeopathy and the many clinical studies that have been conducted in this regard.

•Symptomatic approach of homoeopathy to illness, and its ability to treat diseases based on the presenting symptoms.

•Homoeopathic approach to acute and chronic conditions with emphasis that homoeopathy is effective for both.

Relative similarity in the findings obtained in this study and those obtained by Moys (1998) clearly indicated that public awareness of homoeopathy and its principles have not changed significantly. This proves that little has been done over the past few years to educate and inform the public about homoeopathy.

The researcher feels that homoeopathic practitioners in South Africa should take up education initiatives within their respective communities to try to increase the level of education amongst the general public. The researcher feels that the best way to do this would be to provide short talks, lectures and first aid courses in homoeopathy. The above mentioned topics should be addressed to try to increase public knowledge of homoeopathy and dispel common myths. A further suggestion would be to provide talks on various common conditions (specific to individual communities) outlining their homoeopathic management.

The researcher feels that emphasis be placed on talks and lectures as a more effective means of educating the public on homoeopathy, as opposed to advertising, because a deeper understanding and sense of homoeopathy is achieved through person to person communication, which cannot be achieved by means of advertising.

5.5. ATTITUDES TOWARDS HOMOEOPATHY

Questions 2.2, 2.3, 2.5, 2.6, 3.10, and 3.11 which were identified as attitudes questions were first analyzed descriptively, and thereafter compared with the knowledge score as a percentage using the ANOVA test.

The responses to questions on which conditions participants were likely to seek homoeopathic treatment reflects an association between with the morbidity of the illness, and individual responses. The majority of respondents were more likely to

seek homoeopathic treatment for less debilitating conditions like coughs headaches, allergies, tiredness, colds and flu. Respondents were less likely to seek homoeopathic treatment for conditions like diabetes, AIDS and cancer which are associated with high levels of debility. With regards to pregnancy related symptoms, although most individuals are fairly keen to try homoeopathy for most conditions, they were less likely to use homoeopathy for more serious pregnancy related conditions like breech, varicose veins, piles and hypertension. Once again it was assumed that participants who were unable to offer an opinion had done so due to a lack of knowledge regarding homoeopathy. This outlines further lack of knowledge regarding homoeopathic practices, indicating that few individuals are aware that homoeopathic prescriptions are symptom based and homoeopaths are thus able to treat any condition, no matter how serious, based on the presenting symptoms.

The majority of the participants were undecided (40%) when it came to their perceptions in the use of homoeopathy for treatment of acute conditions. 30% found homoeopathic medicines to be as effective as orthodox medicines in the treatment of acute conditions. There was no significant difference in mean knowledge score between the categories of response to the question ($p=0.333$), indicating that participants knowledge of homoeopathy did not significantly influence their response to this question. For the treatment of chronic conditions, equal proportions of participants were unsure (35%) and felt it was as effective as orthodox treatment (35%). There was a significant difference in the mean

knowledge score between the categories of response to this question (p=0.025), indicating that participants knowledge of homoeopathy influenced their response to this question. Although a large percentage of the sample was not able to offer an opinion, more respondents were aware of the effect of homoeopathy on chronic conditions than acute conditions which may indicate an association to the myth that homoeopathy is mainly for chronic conditions.

90% of participants reported that homoeopathy should be offered as a treatment option for most medical conditions. 90% of participants also reported that homoeopathic treatment should be available at hospitals and clinics. This reveals that even though the participants may have a poor knowledge of homoeopathy, they welcome homoeopathy as a mainstream form of medicine.

5.6 PARTICIPANTS' HEALTH CARE PROVIDERS

71.7% of respondents seek medical advice from a general practitioner (G.P.) when ill or indisposed. It is encouraging to note that 20% of the sample consults with a homoeopath when feeling ill or indisposed. Most participants (53.3%) were being treated by a G.P., a further 31.7% were being treated by a medical specialist, and 13.3% were seeing a homoeopath.

The overall difference between responses to question 3.1 and 3.2 is that larger number of participants were seeing a medical specialist at present. This becomes obvious when one considers that most women attending private

facilities would be likely to consult with a gynaecologist instead of a G.P. for the duration of their pregnancy.

Responses indicate that participants are satisfied with the treatment they recieve from their health care providers, and that they find them to be competent in their management, approach and treatment of disease.

5.6.1. CONCLUSION

Due to the responses to questions 3.1 and 3.2 above, it is assumed that the responses to this question (Q.3.3) are mainly reflective of G.P.'s and medical specialists who accounted for roughly 80% of the health care providers in each question (Q.3.1.and Q.3.2). The researcher also feels that the nature of such a question naturally evokes a protective response and thus participants may have been biased in their account of the quality of the treatment they receive, so as not to discredit their primary health care provider. This question could be amended to try to determine what participants feel are the shortcomings of health care providers in general. Alternately if this study is to be repeated, the researcher feels that this question could be omitted, as it provides information that does not directly affect the outcome of the study or satisfy the aims of this study.

5.7. PRIOR EXPERIENCE WITH HOMOEOPATHY

Only 38.3% of respondents had consulted with a homoeopath in the past. Almost half of the respondents who had consulted with a homoeopath in the past (n=23), had been to a homoeopath more than 10 times (48%). 83% of those participants that had been to a homoeopath previously (n=23), had been there more than once, indicating that having been to a homoeopath, there is a strong likelihood of subsequent visits. Just over half of the respondents (n=23) had visited a homoeopath because they considered homoeopathy to be 'natural' (52%). 48% had visited a homoeopath due to personal recommendation, 35% did so because they considered homoeopathy to be safe and have minimal side effects, 26% did so because conventional medicine had failed, and 9% did so during pregnancy. Again, the association of homoeopathy with being "natural" may indicate some confusion between homoeopathy and herbalism, further indicating a need to dispel this myth through basic homoeopathic education.

The majority of respondents (78.3%) had first heard of homoeopathy through a friend or relative, indicating that people that have been to homoeopaths usually recommend them to others. Very few respondents had heard of homoeopathy through media (4.3%). This indicates that there is insufficient homoeopathic exposure in the media, and the little exposure that there may be is not very effective. It also reiterates the point made previously by the researcher that person to person interaction is a more effective way of communicating

information regarding homoeopathy, because it affords a better understanding and sense of homoeopathy.

Most of the respondents that had not previously consulted with a homoeopath (n=37), had not done so because they felt that they knew too little about them (73%), and because they were unsure of their methods. This clearly shows that the main reason for not consulting with a homoeopath was due to a lack of knowledge about homoeopathy, and this highlights the need for homoeopathic education in this and other groups, as pointed out previously. It is however encouraging to note that not one of the respondents had indicated that they had never heard of homoeopathy before.

Having consulted with a homoeopath previously significantly influenced the knowledge score (p=0.001). The group who had never previously consulted with a homoeopath had a lower mean score than the group who had consulted previously. Thus those participants who had consulted with a homoeopath before have a better knowledge and understanding of homoeopathy.

73% of those who had never consulted previously with a homoeopath reported that they would consider consulting with a homoeopath in the future (n=27). There was a borderline significant difference in knowledge score between those who said they would consider consulting with homoeopaths in future, and those who said they would not (p =0.051). Table 4.37 shows that the mean score for

knowledge was higher in those who would be likely to consult with a homoeopath in future.

Almost half (52%) the participants indicate that they are likely to consult with a homoeopath because homoeopathy is natural. 41% would consult with a homoeopath if convention medicine failed, 37% would visit a homoeopath because they considered homoeopathy to be safe and have minimal side effects, and 26% would do so during pregnancy. A further association with homoeopathy as being “natural” emphasizes the likelihood of confusion between homoeopathy and herbalism, and again indicates the need to address this misconception and provide a basic homoeopathic education to the public, as previously discussed. The fact that more individuals were likely to visit a homoeopath because homoeopathy is natural as opposed to homoeopathy being safe and having minimal side effects indicates a lack of basic homoeopathic knowledge.

5.8. POSSIBLE SHORTFALLS AND IMPROVEMENTS ON THE STUDY DESIGN – AN OVERALL VIEW

5.8.1. THE TARGET GROUP

The researcher feels that other private facilities in non central areas of Durban should have been included in this study. The inclusion of facilities in these areas would have provided a better representation of the target group and the sample

population would be more representative of the general population, thus yielding more reliable results. A larger sample size, and possibly a barrier response rate could have also been achieved. The possibility of semi private and public facilities being included in this study should also be considered, with a possible comparison of results between in these different groups.

5.8.2. SURVEY METHOD

The following points were recognized as shortcomings of this study by the researcher. In the event of this study being repeated, the amendments discussed below should be considered.

1. Data collection should be conducted by the researcher who should be present during the completion of questionnaires by participants so as to address any misinterpretation and to increase compliance of participants. This method would also eliminate reliance on antenatal class instructors and ensure a greater return of questionnaires. Although this increases the possibility of interviewer bias, it is believed that the overall compliance and response rate will be significantly greater.
2. The following changes should be made to the “Perceptions in Pregnancy” questionnaire (Appendix D):
    i. Question 1.7 should be altered to indicate ‘annual household income’.

ii. Questions 1.10, 3.6, and 3.8, should be altered to permit either “yes” or “no” responses.

iii. Instruction to question 2.2 should be altered as follows: Which of the following conditions are you likely to seek homoeopathic treatment for?

iv. A question regarding satisfaction with homoeopathic treatment amongst participants who have previously consulted with a homoeopath should be included.

v. Question 3.3 should be amended to try to determine what participants feel are the shortcomings of health care professionals in general. Alternately the researcher finds that this question could be omitted as it provides information that does not directly affect the outcomes of this study, or satisfy its aims.

vi. Question 1.4 should be amended to determine how many previous pregnancies the participant has had. The researcher feels that this question is more appropriate than determining the trimester of the participant, as it may reflect differences in knowledge between participants who have had previous pregnancies and those who had not.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1. CONCLUSIONS

It was assumed that, although most people are aware of homoeopathy, a lack of knowledge and understanding regarding homoeopathy and its uses exists, and that myths and misconceptions regarding homoeopathy are rife.

This study was undertaken in order to determine the knowledge, attitudes and misconceptions that currently exist, regarding homoeopathy. The study targeted pregnant women attending private facilities in particular because they represent potential consumers, and it was presumed that their opinions would provide a useful indicator of the knowledge and understanding of homoeopathy in general. The results obtained are thus generaliseable to educated, high socio-economic status women.

Results of this study show that the assumptions were justified. Although all participants had heard of homoeopathy, the main reasons for not having sought homoeopathic treatment were identified as being due to a lack of knowledge of homoeopathy, and uncertainty regarding its methods.

The sample possessed a mediocre knowledge of homoeopathy and responses to questions regarding homoeopathy and what a homoeopath does, verifies this. Further analysis revealed that the following misconceptions exist within this sample: homoeopathy is a form of herbalism (natural); homoeopaths prescribe strict diets; homoeopaths emphasise a healthy lifestyle; homoeopaths prescribe plant extracts. A false impression that homoeopathy is mainly for chronic conditions was also identified.

Previous consultation with a homoeopath (n=23) significantly increased knowledge and understanding of homoeopathy, and increased likelihood of subsequent visits. Amongst those participants who had never consulted with a homoeopath before (n=37); those who had a greater knowledge of homoeopathy were more likely to do so (n=27) than others. This further highlights lack of homoeopathic knowledge as being a limiting factor amongst participant inhibiting them from seeking homoeopathic treatment.

Attitudes towards homoeopathy indicated that participants were more likely to seek homoeopathic treatment for minor and common ailments, and less likely to seek homoeopathic treatment for more serious or debilitating conditions.

Interestingly, despite the lack of knowledge and understanding of homoeopathy, almost all respondents were of the opinion that homoeopathy should be made available for the treatment of most medical conditions and be offered in hospitals

and clinics. This indicates that participants are open and keen to the use of homoeopathy as an adjunct or alternative to mainstream medicine.

The researcher concludes with conviction that provision of basic homoeopathic knowledge to the public will prompt individuals to seek homoeopathic treatment in the future.

6.2. RECOMMENDATIONS

•There is a definite need for a concerted education initiative by the homoeopathic profession to provide the public with a basic homoeopathic education so that they are able to understand what homoeopathy is, how it is used, and its potential as an alternative to mainstream medicine.

•The researcher feels that the best way to educate the public on homoeopathy (as outlined in chapter five) is for homoeopathic practitioners to offer short talks or lectures on homoeopathy within their respective communities.

•There is a need for advertising via the media (radio talk shows, short advertisements) to increase exposure of the public to homoeopathy, indicating to them that homoeopathy is available as a form of medical treatment.

•Small size and specific nature of this target group warrants repetition of this study on a broader scale, involving a variety of private hospitals, antenatal facilities, and waiting rooms of private gynaecologists. The researcher feels that this would render data that would better represent this target group.

•This study could be repeated amongst private facilities in other provinces of South Africa, and results be compared to those obtained in this study.

•This study could be repeated in semi-private and public facilities, and the results be compared with those obtained in this study.

•This study could be repeated in private and semiprivate facilities, and the results be compared between the two groups.

•In the event of this study being repeated, the amendments discussed in chapter five of this study should be considered.

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APPENDICES

8.1. APPENDIX A: LETTER OF PERMISSION

8.2. APPENDIX B: PARTICIPANT INFORMATION LETTER

8.3. APPENDIX C: INFORMED CONSENT FORM

8.4. APPENDIX D: PERCEPTIONS IN PREGNANCY QUESTIONNAIRE