A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations.

By

Kate Couchman

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 University of Technology.

I, Kate Couchman, do hereby declare that this mini-dissertation is representative of my own work, both in conception and execution.

…….. ……..

Signature of student Date

APPROVED FOR FINAL SUBMISSION

…….. ……..

Signature of supervisor Date

Dr C.M. Korporaal

M.Tech:Chiropractic (D.I.T.)

…….. ……..

Signature of co-supervisor Date

Dr I.M.S. Couchman

M.Tech:Homoeopathy (D.I.T)

TO MY FAMILY

AND

FRIENDS

FOR YOUR INFINITE LOVE AND SUPPORT

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ABSTRACT

Introduction

This descriptive, quantitative perception survey aimed to determine the opinions and treatment regimes of registered South African homoeopaths, regarding childhood vaccinations.

Purpose / Aim

The purpose of this survey was to determine if there is a coherent treatment protocol amongst homoeopaths when dealing with childhood vaccinations.

Methodology

The researcher used a questionnaire (Appendix B), aimed at homoeopaths registered with the Allied Health Professions Council of South Africa (AHPCSA), as primary health care practitioners, to view their patient management techniques regarding vaccinations. This study aimed to document the intervention protocols offered concurrently or as an alternative to orthodox vaccinations.

A participant information letter (Appendix A) and a questionnaire (Appendix B) were faxed or e-mailed to all homoeopaths. After a two week time lapse, an independent third party contacted the participants who had not returned the questionnaires to ensure they had received the questionnaire. A further 2 weeks were allowed to lapse for the return of the outstanding questionnaires, after which time the non-complying candidates were excluded from the study.

Anonymity was maintained as the 93 completed questionnaires were returned to the third party. All personal details were removed before the researcher was allowed access to the questionnaires.

The data accumulated was evaluated and statistically analyzed using Pearson's chi-square tests, frequency tables, bar charts, analysis of variance (ANOVA) and Bonferroni post hoc multiple comparison tests. A p-value <0.05 was considered as statistically significant.

Results

Polio was the only disease that participants felt should be vaccinated against (40%) and only 10.1% of participants rated vaccinations as very important.

Half (55.3%) of the participants thought there was not enough scientific proof that vaccinations prevent infectious disease. The participants rated improved sanitization (82.9%); nutrition (72%); access to healthcare (65%); healthcare (64.6%) and education (64.2%) as the most important interventions contributing to the decline of infectious diseases.

Conclusions

The assumption that most homoeopaths disagree with vaccinations held true as 72% of the participants were not in favor of vaccinations. However, 44.4% felt that the risks of vaccinations did not outweigh the benefits.

Results indicate that the majority of participants did not support the use of vaccinations although their treatment protocols and general opinions regarding vaccinations varied tremendously.

In conclusion, the homoeopathic profession can use this information to decide what steps should be taken to rectify any misconceptions, improve general knowledge and attitudes regarding homoeopaths' opinions and intervention protocols with regards to childhood vaccinations.

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LIST OF DEFINITIONS

Allied Health Professions Council of South Africa (AHPCSA): This is a statutory council for Natural Health, responsible for the promotion and protection of the health of the population of South Africa and will affect this by regulating and setting standards for our registered profession, under act 63 of 1982 (Kotze, 2008).

Allopathic medicine: A therapeutic system in which a disease is treated by producing a second condition that is incompatible with or antagonistic to the first (Stedman's, 2005).

Attenuation: The act of thinning or weakening, as the alteration of virulence of a pathogenic micro-organism by passage through another host species, decreasing the virulence of the organism for the native host and increasing it for the new host (Dorland, 2008).

Booster: One or more vaccine doses given after the initial dose to increase the immune response to the components in the original vaccine dose (Cave, 2004).

Complementary and Alternative Medicine (CAM): A general term for therapeutic methods, some ancient and widely practiced, to treat non-emergency conditions from a holistic and non-invasive approach. Examples of complementary practices include acupuncture, chiropractic, osteopathy, homoeopathy to name a few (Stedman's, 2005).

Cross-sectional surveys: These surveys are used to gather information on a population at a single point in time. These are primarily used to determine prevalence. Prevalence equals the number of cases in a population at a given point in time (Fink and Kosecoff, 1985).

Curative: That which heals or cures (Stedman's, 2005).

Descriptive survey: A descriptive research is a study that attempts to describe that which exists as accurately as possible. The purpose of a descriptive or observational survey is to count, descriptive surveys chiefly tell us what proportion of a population has a certain opinion or characteristic (Fink, 1995).

Homoeopathic Association of South Africa: The current body representing Homoeopaths and Homoeopathic students (Razlog, 2007).

Homoeopathy: Homoeopathy is a system of therapy developed by Samuel Hahnemann based on the "law of infinitesimal doses" in *similia similibus curantur* (likes are cured by likes), which holds that a medicinal substance that can evoke certain symptoms in healthy people may be effective in the treatment of illnesses having symptoms closely resembling those produced by the substance given to healthy people – derived from the Greek words *homoios*, meaning like or similar and *pathos*, meaning suffering (Stedman's, 2005).

Holistic: The principle of regarding organisms and systems as a whole; as more than the sum of their parts (Swayne, 2000).

Homoeoprophylaxis: The systematic use of homoeopathically potentised substance to prevent the development of the characteristic symptoms of infectious disease (Golden, 2005).

Immune system: An intricate complex of interrelated cellular, molecular and genetic components, which provides a defence (immune response) against foreign organisms or substances and aberrant native cells (Stedman's, 2005).

Immunization: Stimulating immune response, via use of an infectious agent; the process of rendering a subject immune, or of becoming immune (Dorland, 2008).

Isopathy: Derived from the Greek words *isos* meaning equal and *pathos*, meaning disease or suffering. Therefore it is a method of treating disease using a producer or product of the disease (O'Reilly, 1997).

Life force: The force / power / energy which enlivens the human body. In health, it keeps all parts of the organism functioning vitally and harmoniously to enable our indwelling, rational spirit to freely avail itself for the higher purposes of our existence (O'Reilly, 1997).

Mother tincture: Liquid preparations resulting from the extraction of suitable source material in water-ethanol mixtures, which form the starting point for the production of most homoeopathic medicines (Swayne, 2000).

Minute doses: The smallest dose of a homoeopathic medicine that will produce the desired therapeutic effect (Swayne, 2000).

Nosodes: Disease substances that are diluted to the point where only the "energy" of the disease is left (O'Reilly, 1997).

Orthodox medicine: Also called allopathic medicine, conventional medicine, mainstream medicine, and western medicine. A therapeutic system in which a disease is treated by producing a second condition that is incompatible with or antagonistic to the first (Stedman's, 2005).

Pearson's chi-square tests: Statistical method to test whether two (or more) variables are: (1) independent or (2) homogeneous. The chi-square test for independence examines whether knowing the value of one variable helps to estimate the value of another variable. The chi-square test for homogeneity examines whether two populations have the same proportion of observations with a common characteristic. Though the formula is the same for both tests, the underlying logic and sampling procedures vary (Esterhuizen, 2010).

Potentization: A multi-step process developed by Hahnemann (O'Reilly, 1997) by which the medicinal power (potency) of a homoeopathic medicine is released or increased, involving serial dilution with succussion, or using trituration or fluxion (Swayne, 2000).

Preventative medicine: A branch of medical science concerned with the prevention of disease and with promotion of physical and mental health, through study of the aetiology and epidemiology of disease processes (Stedman's, 2005).

Primary health care: This is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work. It should form an integral part of the national health services, and the other levels of health care services should be designed to support the primary health care services (Chan, 2009).

Psora: The homoeopathic term for the disease which underlies all chronic illness. (O'Reilly, 1997).

Qualitative survey: A qualitative research survey has an undefined scope and procedures are not strictly formalised, the approach is of a rather philosophical nature. Thus is characterised by open-ended questions requiring personal input and opinions (Mitchell and Jolley, 1992).

Quantitative survey: Quantitative data collection is highly formalized, explicitly controlled, and has exactly defined range. Thus questions are of a precise nature (Mitchell and Jolley, 1992).

Remedy: Homoeopathic remedies are prepared from plants, minerals and animal products. Offered as pills, powders, granules, tablets and liquid these remedies are prepared in stages involving repeated dilution and succussion over a period of time. This is to avoid toxicity of the remedies made for human consumption (Shealy, 1998).

Serial dilution: A sequence of separate and equal dilutions from the same stock, each accompanied by succussion or trituration, comprising the separate steps in the potentization of a homoeopathic medicine (Swayne, 2000).

Similia similibus curentur: Latin phrase meaning "Let like be cured by like." It expresses the fundamental principle of homoeopathy, the "similia" principle, which states that substances may be used to treat disorders whose manifestations are similar to those which they will themselves induce in a healthy subject (Swayne, 2000).

Succussion: Vigorous shaking, with impact or 'elastic collision,' carried out at each stage of dilution in the preparation of a homoeopathic potency (Swayne, 2000).

Suppressive: The palliative treatment of a symptom or condition so that it is relieved but not resolved. It may remain dormant, or manifest in another, possibly more serious or deep-seated disorder (Swayne, 2000).

Vaccine: Cave (2004) defines a vaccine as "a preparation that stimulates an immune response that can create resistance to, or prevent infection."

Vaccination: The South African Government Gazette (2003) state vaccinations involve the administration of a vaccine into the body of a healthy person to stimulate a protective immune response that will prevent disease in the vaccinated person if contact subsequently occurs with the corresponding infectious agent.

Vaccinosis: This term dates back to Burnett (1884) as he stated it was a homoeopathic term for chronic adverse vaccine reactions. Vithoulkas (1998) stated it is a chronic disease state vaccinations impress onto susceptible patients, as the vaccinated person is poisoned by the vaccine virus.

Vital force: Described by Hahnemann (O'Reilly, 1997) as the spirit-like life force that enlivens the material organism as dynamis, governs without restriction and keeps all parts of the organism in admirable, harmonious, vital operation (Swayne, 2000).

CHAPTER ONE

INTRODUCTION

1.1 Introduction

Discussion among homoeopaths in South Africa provides the impression that there is a negative attitude towards the use of orthodox vaccinations to prevent childhood diseases (Schmidt and Ernst, 2003). However, very little empirical evidence exists, either in South Africa or internationally, to substantiate this impression. In order to address this issue, a survey was conducted amongst the registered South African homoeopaths to assess their opinions and treatment regimes, regarding childhood vaccinations.

Within the literature, there is a debate on whether vaccinations are essential treatments or whether they are detrimental. This study aimed to assess the perception of the South African homoeopath on this subject, in order to elucidate whether there is a consensus on this matter. This in turn will assist homoeopaths in guiding their patients with respect to the pros and cons regarding vaccinations within the South African context.

The main benefit of vaccinations is seen as the elimination of childhood diseases (WHO, 2005) whereas the main disadvantage is seen as the side effects caused by the vaccination itself (Offit and Jew, 2003).

Due to this controversy and the fact that homoeopaths are often consulted with as complementary health care practitioners with regards to vaccination, this study aimed to assess whether the perceptions of homoeopaths in South Africa were in congruence with

the current literature, as well as whether there is a consensus within the profession that can then be utilised as a source of information for the public.

1.2 Aims and objectives of this study

This descriptive, quantitative, perception study was conducted, by means of a self-administered questionnaire, to determine the opinions of homoeopaths with regards to childhood vaccinations and their approach, as primary health care practitioners, to patient management regarding the use of childhood vaccinations.

This study aimed to document the intervention protocols offered by homoeopaths concurrently or as an alternative to allopathic vaccinations.

The objectives of this research were to

1. Develop a profile of homoeopaths in terms of demographic factors including but not limited to gender, age, language, ethnicity and education.

2. Determine the opinions homoeopaths have regarding childhood vaccinations.

3. Investigate the current intervention protocols followed by homoeopaths prior to, post, or as an alternative to, recommended allopathic childhood vaccination protocols within South Africa.

4. Examine the associations between the opinions and current intervention protocols used by homoeopaths with regards to childhood vaccinations in order to determine whether any significant associations are present.

5. Determine whether the mode of intervention regarding childhood vaccinations by homoeopaths differs, according to the appropriateness of individual patients with regards to the patient's socio-economic, educational and nutritional status as well as their accessibility to sanitation, sewage disposal, basic healthcare and distribution of food and water.

1.3 Rationale for the study

1. According to Ernst (2001) there is a shift from allopathic treatment towards more complementary options, making more homoeopaths primary contact practitioners. Thus homoeopaths are dealing with more questions regarding vaccinations. This study aimed to investigate whether there is consensus amongst the profession or not.

2. Coulter (1990) and Neustaedter (1991) state that the administration of childhood vaccinations are a controversial topic within society as a whole, as well as within homoeopathy. Offit et al. (2002) state there are many concerns regarding not vaccinating children. In addition, there is a debate with regards to whether orthodox vaccinations are the only option available to the public (Sinclair, 2002) as there are homoeopathic alternatives to vaccination (Curtis, 2004 and Golden, 2005). This research aimed to investigate the viewpoint of South African homoeopaths.

3. At present, there is no literature regarding the opinions of homoeopaths in South Africa on the use of childhood vaccinations. Considering homoeopaths are primary contact physicians, they could either enable or disable the policies of the government. This research therefore aimed to investigate the generalized opinions and treatment regimes of homoeopaths with regards to childhood vaccinations and to therefore determine whether a consensus on this topic exists, within the homoeopathic profession in South Africa.

4. This study aimed to establish a basis from which a cohesive opinion amongst registered homoeopaths could exist within the unique South African context with regards to their opinions and intervention protocols regarding childhood vaccinations and the possible alternatives.

1.4 Limitations

1. Only South African homoeopaths who were registered with the AHPCSA participated in this study.

2. Only practitioners that had a full complement of contact details were considered for the study.

3. Only correctly completed questionnaires were analysed.

1.5 Benefits

1. This study will provide a basic idea of what the current opinion and treatment regime is within the homoeopathic profession of South Africa.

2. This study may highlight problem areas with regards to homoeopathic treatment and childhood vaccinations.

3. The general public stand to benefit from the study as the information gathered may provide further “food for thought”.

4. The pharmaceutical, medical and complementary field all stand to benefit from the information obtained from this study as well as the public who are directly affected by these fields.

1.6 Conclusion

In order to elaborate on the study, Chapter Two will be utilized to give an overview of relevant literature, with Chapter Three indicating the materials and methods applicable to this study. Chapter Four presents the results attained from the statistical analysis of the data. Chapter Five discusses the results as well as the trends observed in the results and Chapter Six completes the dissertation with the conclusions of this study and recommendations for future studies in this field.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Dorland (2008) defines a vaccine as a "suspension of attenuated or killed micro-organisms administered for prevention or treatment of disease". Vaccinations work by presenting a foreign antigen to the immune system in order to evoke an immune response (Feder, 2007), according to various methods. According to Coulter (1990), the three main types are as follows:

2.1.1 Inactivated vaccines – these are made from viruses and bacteria that have been killed through physical or chemical processes (National Center for Immunization and Respiratory Diseases, 2006). The virus particles are destroyed and cannot replicate, but the virus capsid proteins are sufficiently intact to be recognised by the immune system and evoke a response although booster shots are required periodically to reinforce the immune response (Ernst, 2001).

2.1.2 Attenuated vaccines – these contain a live virus which is weakened through chemical or physical processes in order to produce an immune response without causing the severe effects of the disease (National Center for Immunization and Respiratory Diseases, 2006). They will reproduce, but very slowly therefore boosters are required less often (Ernst, 2001). There is a risk of

reversion to virulence (Cave, 2004) and therefore cannot be used in immuno-compromised individuals (Department of Health, 2005).

2.1.3 Subunit vaccines - these present an antigen to the immune system without introducing viral particles (National Center for Immunization and Respiratory Diseases, 2006). One method of production involves isolation of a specific protein from a virus and administering this by itself (O'Shea, 2002). A second method is the recombinant vaccine, which involves putting a protein gene from the targeted virus into another virus (O'Shea, 2002) so the second virus will express the protein, but will not present a risk to the patient.

Vaccines typically contain one or more adjuvants added to the antigen in order to boost the immune response (Ernst, 2001). Neustaedter (1996) states vaccines may also contain other ingredients, including thimerosal (ethyl mercury / preservative), aluminum (promotes antibody response), formaldehyde (disinfectant / preservative), phenol (disinfectant / dye), ethylene glycol (antifreeze), benzethonium chloride (antiseptic) and methylparaben (anti-fungal and preservative). Appendix J shows the revised EPI schedule, listing the proposed vaccination schedule for infants in South Africa. Appendix K shows a list of thimerosal-free vaccines available in South Africa.

2.2 History of vaccinations

The South African Department of Health (1997), stated that if the Director General felt there was adequate scientific grounds to suspect the Republic or any part of the population's health may be affected by a communicable disease against which a vaccination was available, he may do the following -

(a) Demarcate an area for compulsory immunization of all inhabitants.

(b) Designate the government body and / or persons that must carry out the immunization and the period it must be done in.

(c) The designated persons can authorize medical practitioners, nurses and immunization officers to carry out the immunization.

(d) No person may disregard or fail to comply with an order.

(e) Any person who cannot or will not be vaccinated may be placed in quarantine.

The Republic of South African Government Information Bill of Rights (2009) later stated that informed consent is required for any medical procedure, including vaccinations.

Although vaccinations are not compulsory by law in South Africa (van den Heever, 2008), they are intrinsically entrenched in the Constitution, in accordance with the United Nations Convention on the Rights of the Child (1997 White Paper for the Transformation of the Health System in the Republic of South Africa). On the other hand, Van den Heever (2008) states that "The Department of Education has gazetted that children must be fully immunised before being allowed into schools". This appears to conflict with the Constitution and the Rights of the Child and therefore may cause difficulty for health care providers in advising parents with regards to childhood vaccinations.

2.3 The viewpoints on vaccinations

Bhatia (2006) states that vaccination - be it conventional or homoeopathic - has always remained controversial as they carry certain risks, yet there are also many concerns regarding not vaccinating infants. WHO (2005) acknowledges that the safety of existing vaccines has created a climate of concern, as risks accompany every vaccination. Cave (2004) states there are an increasing number of parents who question the safety, effectiveness and necessity of vaccines. Neustaedter (1991) suggests that parents should be offered literature to assist them in making an informed decision with regards to the safety and efficacy of vaccinations, although he states the literature is "confusing and contradictory."

Given the complexity of this matter (Coulter, 1990 and Neustaedter, 1991), many parents turn to their health care provider for advice and Zotti, Silvaplana, Ditommaso, Russo and Ruggenini (2002) state parents are greatly influenced by what their practitioner recommends. Maayan-Metzger, Kedem-Friedrich and Kuint (2005) surveyed mothers and noted that those who prevented the administration of routine vaccinations to their newborn infants had a higher income level, were more educated and expressed more knowledge about vaccines than the remaining women. The reasons mainly given by the complying mothers were "to protect the baby" and "trust in the doctors". Therefore, anecdotal evidence shows that the practitioner is seen as a vital member of the health team and suggests their role is critical for patient health.

Considering the conditions unique to South Africa, such as the social structure and health conditions, this research aimed to determine whether South African homoeopaths are

congruent in their opinions of vaccinations whilst disclosing the opinions and interventions of South African homoeopaths, as health care providers, with regards to childhood vaccinations.

2.4 The pro vaccination stance

McTaggart (2005) states that most doctors believe vaccines are one of medical science's greatest success stories, responsible for eliminating many potentially deadly infectious diseases.

WHO (2005) estimated 1.4 million deaths among children under 5 years old, were due to diseases that could possibly have been prevented by routine vaccination. This represents 14% of global total mortality in children of this age-group. Vaccinations remain one of the most cost effective health interventions, as opposed to treating the severe chronic effects the ailments may produce (Department of Health, 2005).

Various pro-vaccination parties believe they are beneficial and state:

2.4.1 Vaccinations save lives - Since being introduced, rates of diseases have declined by 90% (Department of Health, 2005). According to WHO (2005), vaccination currently saves three million lives per year world-wide.

2.4.2 Vaccinations prevent the spread of disease – Vaccinations not only protects the individual but also curbs the spread of disease within the community – that is provides herd immunity (Department of Health, 2005). Thus, a non-vaccinated child has a reduced chance of contracting a communicable disease when in a

community where most of the population has been vaccinated. Therefore, vaccine promoters encourage everyone to comply with government recommendations or it is thought that the diseases will return.

2.4.3 Vaccinations are safe – The Department of Health (2005) states that vaccinations are safe and getting safer and more effective, due to medical research and ongoing review by medical scientists. However, Gale et al. (1990) found a positive association between severe acute neurological illnesses and vaccine administration. This was confirmed by Miller et al. (2008) who found that after 10 years, significantly more children die or suffer behavioural or neurological deficits than non-vaccinated children.

2.4.4 Vaccinations save money – Vaccinations are one of the most cost effective health interventions as WHO (2005) estimates that every R10 spent on vaccines saves R70 in medical costs and R250 in overall costs. Bloom et al. (2005) conclude vaccines are regarded as an effective and cheap tool for improving health.

2.4.5 Vaccinations offer effective protection - A recent study showed that children who had not received the measles vaccine were 35 times more likely to get the disease. However, Neustaedter (1996) states that 90% or more of measles cases occur in previously vaccinated people and this therefore questions the efficacy of vaccines.

2.5 The anti-vaccination stance

Morrell (2000) states that the decline in infectious diseases was due to better methods of sanitation, sewage disposal and distribution of food and water as well as access to safe drinking water and basic healthcare. Weil (2004) therefore concludes that scientific medicine has taken undue credit for advances in health.

With regards to the vaccination schedule (Appendix J) Smits (2006) states that:

2.5.1 Vaccinations are carried out too early - Noble et al. (1987) showed that there was an 85-90% reduction in severe reactions and deaths when vaccines were administered after age two.

2.5.2 Too many vaccines are administered together - Hirsch et al. (1981) and Jaber et al (1988) show concern regarding the number of vaccines which may be administered simultaneously as it may create more of a burden on the system and therefore cause a greater likelihood of adverse reactions than giving the vaccinations individually. This has been confirmed by Neustaedter (1996) and Offit et al. (2002).

2.5.3 Vaccinations are carried out too frequently and repeated too often - In South Africa, it is currently advised to have up to 25 vaccines before the age of 14 weeks (Appendix J). Elminger, as cited by Smits (2007), found that economic considerations had dictated for several years that an increasing number of vaccinations were given at the same time. However, administering

2.5.4 Vaccines cultivated on animal proteins contain chemical additives that can excite allergies - Offit and Jew (2003) state that there are potential health damages from the chemicals and preservatives within vaccines.

2.5.5 Concerns regarding the route of administration - Moskowitz (1983) states vaccinations short circuit important primary responses to disease as the virus is placed directly into the blood. Swift (2004) states that no such exposure occurs in nature and therefore questions whether a normal immune reaction can occur following vaccinations.

2.5.6 Concerns regarding the use of live vaccines - Levy (1992) states that live vaccines are banned in Scandinavian countries due to their detrimental effects and potential of causing the very disease they are designed to protect one against, yet they are found in the measles, rotavirus, rubella, varicella and yellow fever vaccines currently utilised in South Africa (Stannard, 2001).

2.5.7 Concerns regarding chronic impact - Secondary and long-term effects on the immune system from introducing immunogens and immunologic adjuvants directly into the body are not fully understood. Moskowitz (1983), concludes that it is dangerously misleading to claim that a vaccine makes us 'immune' or protects us against an acute disease, if it drives the disease deeper into the interior and causes one to harbour it chronically. Neustaedter (1996) uses the

terms *vaccinate* and *vaccination* as opposed to *immunize* and *immunization* as he believes that vaccines do not produce a true *immunity*, but are potentially *immunosuppressive*.

2.6 Circumstances pertaining to South Africa

Considering Morrell (2000) states that the decline in infectious diseases was not due to vaccinations, but rather due to better methods of sanitation, sewage disposal and distribution of food and water as well as access to safe drinking water and basic healthcare, which a large portion of the South African population do not have access to (Lehohla, 2007), there may be a different dimension to this already complex topic.

2.6.1 Poverty - Mbeki (2008) and Manuel (2008) stated that fighting poverty is a central objective of the South African Government's Programme of Action as a significant portion of the country survives on less than $1 per day. Muller (2004) states that only a quarter of black South Africans have electricity, running water and modern sanitation.

2.6.2 Education - According to the 2001 General Population Census, a mere 52% of the population within South Africa have completed grade nine or more. Of the remainder, 32% have not completed grade seven and 16 % have no schooling at all. The need for literacy and basic education interventions therefore continues.

2.6.3 Nutrition - Collins (2002) states the most common meal in South Africa is a plate of maize meal and a cup of tea which contain minimal nutritional value.

2.6.4 Sanitation – Leatt and Berry (2006) state basic sanitation is essential for safe and healthy childhoods. Puoane et al. (2003) revealed that 80 % of residents in Khayelitsha live in shacks and an average of 105 people share each toilet. Leatt and Berry (2006) state that the use of buckets or open fields has detrimental consequences for water quality and leads to the spread of diseases.

2.6.5 Water - Muller (2004) states that 12 million people in South Africa did not have access to any kind of safe water in 1994 and that only 30 countries out of 180 in the world have less water per person than South Africa.

2.6.6 Health Care - Modisane (2005) states the South African government spends R33,2 billion on health care for 38 million people while the country's private sector spends R43 billion servicing seven million people. There is also a severe shortage of qualified staff as 88% of doctors work in metropolitan areas, resulting in a shortage of doctors in remote areas (with a ratio of 1:30 000 in parts of the Eastern Cape). Lehohla (2007) states the average life expectancy is decreasing by up to 14% with the average male life expectancy in Kwa-Zulu Natal being as low as 44 years of age.

2.7 The homoeopath's role as a primary care physician

Razlog (2007) states that homoeopathy is currently in full expansion therefore it is important to analyze the viewpoints of homoeopaths with regards to vaccinations to see if there is a correlation to the above arguments, and what homoeopaths are telling their patients. If there is congruence in the perceptions of homoeopaths within South Africa on this subject, and on the way they deal with the issue of vaccinations, then this could be used as a spring board for the development of an official policy regarding homoeopathy and childhood vaccinations.

Flanagan-Klygis et al. (2005) conducted a survey to identify reasons paediatricians cite for both parent refusal of vaccinations and consequent family dismissal from their practice. A total of 54% faced total vaccine refusal and paediatricians cited safety concerns as a top reason for this. However, 39% would discontinue care for a family for refusing all vaccinations whilst 27% would dismiss a family for refusing select vaccines. Ernst (2001) stated Complementary and Alternative Medicine (CAM) practitioners are hesitant about the use of vaccinations and therefore may serve as alternative practitioners to oversee these families health yet allow the parents their freedom of choice.

2.8 Homoeopath's viewpoints on vaccinations

Anecdotally, homoeopaths are against vaccines as they go against the homoeopathic principles and may lead to vaccinosis (Burnett, 1884).

Ullman (1992) states homoeopathy is a medical approach that utilizes medicines that stimulate the body's own immune and defence systems to initiate the healing process. Based on this, some schools of thought believe homoeopathy and allopathic vaccinations apply the same principles in that they both induce the body's natural response to an infection through administration of a minute dose of the required constituent/s. However, Vithoulkas (1998) states the concept of vaccination is almost the opposite of the principles of homoeopathy as it is an indiscriminate administration of a foreign substance to everyone, regardless of the state of health or individual's sensitivity as well as the following reasons:

- For any given disease, vaccination uses the same *identical* disease to try to prevent it. Homoeopathy uses substances with a *similar* sphere of action, not an *identical* substance.
- Vaccinations use physical quantities of disease material, whereas homoeopathic remedies are diluted beyond Avogadro's limit (i.e. do not contain any molecules of the original substance).
- Vaccinations contain foreign substances (e.g. egg albumin, formaldehyde, mercury) necessary in the production of the vaccine plus excipients and preservatives. Homoeopathic remedies do not.
- Vaccinations are injected directly into the body, bypassing several of the body's defence mechanisms. Homoeopathic remedies do not.

- Vaccinations have the potential for allergic reaction. Homoeopathic remedies do not.

It can therefore be extrapolated from O'Reilly (1997) that the homoeopathic method of prescribing medicines (giving the smallest possible dose - after serial dilution and succussion - according to individual susceptibility) are not met by vaccination. Vithoulkas (1998) states vaccination has nothing to do with homoeopathy - no more than surgery, the contraceptive pill or beta blockers have.

In the homoeopathic field, the term "vaccinosis" dates back to Burnett in 1884 and has been summarised by Vithoulkas in 1998. He stated vaccinations can impress a chronic disease state onto susceptible patients, as the vaccinated person is poisoned by the vaccine virus. Phillips (2001) elaborates by stating evidence links vaccination practice to dozens of chronic immunological and neurological diseases. Furthermore, Swift (2004) states that once vaccinosis develops, there is a disturbance in the body's vital force that leads to symptoms of chronic disease that can be very difficult (or impossible) to cure.

Vithoulkas (1998) states that vaccinations are disease agents which shock the vital force in a similar way as a severe illness or allopathic drugs do. He describes three possible reactions to vaccinations: mild, strong and very strong reactions.

- The mild reaction or no reaction means the vital force is not strong enough to resist the shock.
- The strong reaction suggests that the vital force is able to successfully overcome the shock of the vaccine but is then not "protected" by the vaccination (although this

"protection" consists of an artificial suppression of the person's natural susceptibility to a disease agent).

- The very strong reaction means that there is a great susceptibility, but that the vital force is not strong enough to overcome the shock and serious damage occurs.

Saxton (2005) states there is a crucial difference between vaccinosis and a vaccine reaction, which can have significant clinical implications. A vaccine reaction, if properly managed, need have no adverse effects, but failure to recognise it and act accordingly can cause vaccinosis.

2.9 Homoeopathic alternatives to vaccination

Considering McTaggart (2005) states that vaccines are responsible for eliminating many potentially deadly infectious diseases and Vithoulkas (1998) states vaccines may cause vaccinosis, it is logical that an alternative must be offered.

Anecdotal evidence shows there are numerous ways of approaching vaccinations within the homoeopathic profession. These methods may be more extensive, but according to Curtis (1994) and Golden (2005), can be summarised as follows:

- Stand-alone alternative to vaccination (homoeoprophylaxis).
- Adjunct, to quieten the side effects of vaccination.
- Disease treatment, once established.
- Prescribing on the rubric “vaccination, effects of”.
- Altering the body’s susceptibility to diseases (fortifying the immune system).
- Using it to effect changes if the child presents with adverse reactions.

Anecdotal evidence suggests that homoeopaths' dealings and opinions with regards to vaccination varies tremendously. Some of the suggestions according to Coulter (1990), Curtis (1994), Feder (2007), Golden (2005), Levy (1992) and Scheibner (2006) include:

- Avoid all vaccinations.
- Use homoeoprophylaxis.
- Selective vaccines only.
- Vaccinate, but support the body with a concurrent homoeopathic remedy.
- Vaccinate, but later and / or
- Vaccinate, but treat any symptoms which may develop.

Golden (2005) stimulates the immune system to produce antibodies with the use of homoeopathic nosodes "as they accomplish immunity yet do not have the other contaminants which cause the damage we see." Scheibner (2006) points out that if nosodes are given immediately after exposure to a known disease, they can prevent the development of clinical disease. However, Scheibner (2006) believes homoeopathic nosodes have limitations as they essentially put a "band-aid" over a susceptibility which will need to be dealt with at some stage. O'Reilly (1997) states that homoeopaths should prescribe a single remedy, based upon the totality of the individual's symptoms to strengthen the immune system and assist the defence mechanism in overcoming the disease. This method offers greater protection than the nosodes, as it works from the inside out, rather than pasting a "band-aid" over the top.

2.10 Other studies of practitioners perceptions

Anecdotal evidence suggests there is no single opinion across the board regarding vaccinations from practitioners.

Lehrke, Nuebling, Hofmann and Stoessel (2001) conducted a survey to clarify whether homoeopathic physicians recommend or apply vaccinations as frequently as their allopathic colleagues. The study revealed that homoeopathic physicians view vaccines within a specific hierarchy and therefore apply the “classical” vaccines against tetanus, diphtheria and poliomyelitis to nearly the same degree as their non-homoeopathic colleagues. Contradictorily, other vaccines were applied and accepted with more restraint by homoeopaths.

Research conducted by Schmidt and Ernst (2003) revealed that no homoeopaths and 0.06% of chiropractors advised in favour of specific vaccinations. Posfay-Barbe et al. (2005) surveyed physicians and found 93% agree with the current official allopathic vaccination recommendations.

It is undeniable that there are, amongst the CAM healing professions, those who adopt a reserved, cautionary or even totally negative position on the subject of vaccinations (Loibner, 2008).

2.11 Conclusion

This study is vital as vaccination remains a debatable subject - not only in South Africa, but also globally. As more patients are becoming aware of complementary medicine, so an increasing amount of them are debating whether vaccinations are necessary. It is imperative to ascertain the viewpoints of the homoeopaths in South Africa to see whether there is cohesion within the profession on this subject. If there is, then a policy on how to deal with vaccinations can be established and made readily available for the public so that an alternative approach to vaccinations can be formalized.

Deciding not to vaccinate or to use the homoeopathic nosodes can be difficult. Even the nosodes, as free from side-effects as they are, do not guarantee absolute freedom from disease (Golden, 2005). So making a decision implies taking more responsibility for your health, which involves nutritional support, as well as alternative methods of dealing with viral and bacterial infections, should they arise.

This topic is especially complicated in countries such as South Africa because of the lack of basic needs available to some of the population. Therefore, if Morrell (2000) is correct in his statement that the decline in infectious diseases was due to better methods of sanitation, sewage disposal and distribution of food and water as well as access to safe drinking water and basic healthcare, the above information reveals some of the South African population may still be at risk and may contribute to the lack of cohesion in practitioners opinions.

Anecdotal evidence suggests that homoeopaths' dealings and opinions with regards to vaccination varies tremendously. Currently, no literature regarding the opinions of homoeopaths in South Africa on the use of childhood vaccinations can be found. Considering the abovementioned research, one can see that physicians have a marked influence on decision making. This study therefore aimed to quantify the response of South African homoeopaths with regards to childhood vaccinations and whether the anecdotal evidence correlates.

CHAPTER THREE

MATERIALS AND METHODS

3.1Study Design

This survey took the form of a descriptive, quantitative perception study method (Fowler, 1993) to investigate the opinions and intervention protocols of registered South African homoeopaths, regarding childhood vaccinations by means of a questionnaire.

In this study, a self-administered anonymous questionnaire was designed and sent to practitioners registered with the Allied Health Practitioners Council of South Africa (AHPCSA).

3.2 Study population

In this study, it was deemed feasible to contact the entire population group as the number of participants was small enough to be contacted. The total number of homoeopaths registered with the AHPCSA as at 14/12/2008 was 549. However, only 296 homoeopaths had the full complement of contact details required.

3.2.3 Inclusion criteria

- Participants were all homoeopaths who were registered with the AHPCSA, up until the end of 2008. All participants were required to have a full complement of contact details (including e-mail address and / or fax numbers as well as a contact telephone number).

3.2.4 Exclusion criteria

- The members of the pilot study and focus group were excluded from the main study to prevent bias from any of the participants in the main study as set out by Morgan (1997).

3.3 Ethics

Homoeopaths were free to choose not to participate in this study.

Confidentiality and anonymity were maintained in the following way:

a) To ensure complete confidentiality, the questionnaires were not returned directly to the researcher, instead they were received by an independent party, within the Faculty of Health Sciences – the D.U.T. Department of Basic Medical Sciences.
b) The names on the questionnaires were ticked off by the independent party against a list of practitioners so that a response rate could be determined.
c) Thereafter any part of the questionnaire containing personal details was discarded.
d) Only then were the researcher and her supervisors allowed access to the completed questionnaires.

3.4 Methodology

3.4.1 Research design

A self-administered, descriptive, quantitative questionnaire (Appendix B), which was drawn up as discussed in Chapter Two formed the basic measurement tool of this study.

As a questionnaire of this nature had never been previously conducted specific to homoeopathic intervention protocol with regards to childhood vaccinations, the questionnaire was compiled from a number of different sources as below. Questionnaires that had been utilized in similar research were reviewed for ideas, layout and concepts but

were not adapted nor adopted (Babaletakis, 2006, Page et al., 2006, Flanagan-Klygis et al., 2005, Jelleyman and Ure, 2004, Busse et al., 2002, Bovier et al., 2001, Lehrke et al., 2001, Zimmerman et al. 1998). The questionnaire was then formulated using generally accepted guidelines as set out by Bernard (2000), Eckhardt and Ermann (1997), Hall and Hall (1996) and Mouton and Marais (1990). A focus group and pilot study were then conducted prior to the distribution of the questionnaires.

The focus group consisted of eight participants.

- Two qualified homoeopaths
- Two homoeopathic research students
- Two qualified complementary and medical health care practitioners
- Two members of the public with a university degree

The purpose of the focus group is to ensure that the proposed questions were correctly gathering or measuring the required information and are in terms of the outcomes the researcher set out to achieve.

The final questionnaire was modified as a result of discussions from the focus group. As stated by Khoosal (2007), the participants of both the focus group and pilot study were excluded from the main study to prevent any bias responses.

The pilot study was then completed by four registered homoeopaths. The purpose of the pilot study was to answer the following questions:

1) Are questions clearly understood?

2) Are instructions clear?

3) Is the order of questions appropriate?

4) Are the questions relevant to the topic being researched?

5) To further assess the questionnaire for clarity and relevance once alterations had been suggested by the focus group.

3.4.2 Measurement tools

The questionnaire was essentially broken down into three main questions and each main question had further sub-questions.

Question One gathered personal and demographic information about the homoeopath. Question Two requested information about the homoeopath's opinion on the recommended childhood vaccination schedule used within South Africa and Question Three focussed on the homoeopaths' personal experience with regards to vaccinations.

However to ensure that the questionnaire had validity within the South African context the questionnaire was subjected to both a focus group and pilot study prior to being sent out to the participants.

There was no need to translate the questionnaire to any language other than English, as all homoeopaths within South Africa were required to complete their training in which the medium of instruction was English.

3.4.3 Administration of and distribution and collection of questionnaires

The researcher obtained a list of registered homoeopaths and their contact details, from the AHPCSA (Kotze, 2008). Each homoeopath who met with the inclusion criteria, was contacted by the researcher either via e-mail or fax.

A two week time lapse from the time of initial contact was allowed for a response. After this time, the participants were contacted by the third party to confirm whether they had received the questionnaire and as a reminder to complete and return the document.

After a further two weeks, non-complying candidates were excluded from the study.

3.4.3 Data capture and analysis

Data was captured using Excel® XP™, and took place once 93 (31,4%) questionnaires were received. This was more than the minimum of 30% required for such a survey to have statistical relevance (Korporaal, 2008). Statistical analysis was done using SPSS® for Windows™ version 15.0.

CHAPTER FOUR

RESULTS

4.2 Introduction

Following the methodology described in the previous Chapter, this study produced raw data in the form of completed questionnaires. All completed questionnaires were then analysed to fulfil the aims and objectives of the study.

SPSS version 15.0 (SPSS Inc., Chicago, Illinois, USA) was used to analyse the data. Descriptive analysis involved the use of frequency tables and bar charts for categorical variables while summary statistics such as mean, standard deviation and range were used for quantitative variables. Pearson's chi square tests were used to show associations between categorical variables. Analysis of variance (ANOVA) testing was used to compare means of quantitative variables between groups. This was followed by Bonferroni post hoc multiple comparison tests in order to compare the mean differences in the all combinations of pairs of groups. The p value was Bonferroni adjusted in order to control for an increase in type 1 error rate. A p value <0.05 was considered as statistically significant. (Esterhuizen, 2010).

4.2 Demographics

To develop a profile of homoeopaths in terms of demographic factors including but not limited to gender, age, language, ethnicity and education.

4.2.1 Gender distribution

There were 93 participants, of which, 84 had valid responses to this question. Of these, 53 were female (63.1%) and 31 were male (36.9%) as shown in Figure 1.

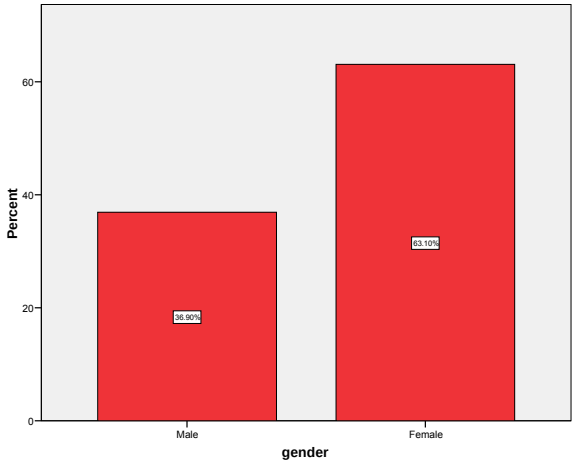

Figure 1: Graph showing gender distribution of participants

4.2.2 Age distribution

The mean age of the sample group was 37.8 years with a range from 24 to 89 years and a standard deviation of 12 years as shown in Table 3 and in Figure 2.

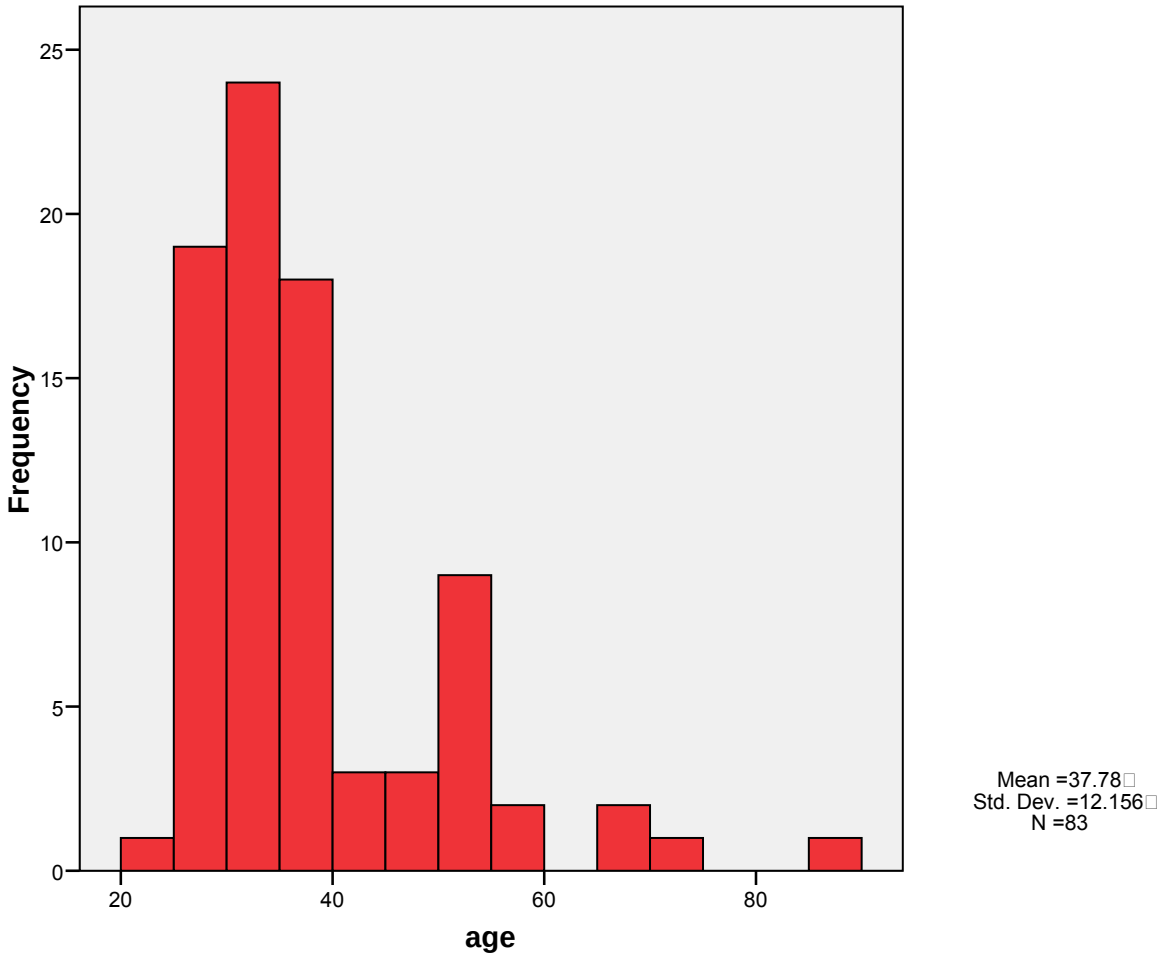

Figure 2: Graph showing age distribution of participants

4.2.3 Racial distribution

The majority of the sample group was white (89%) with the total racial distribution shown in Table 1.

Table 1: Ethnicity of the sample (n=82)

	Frequency	Percent
Asian	1	1.2
Black	1	1.2
Indian	7	8.5
White	73	89.0
Total	82	100.0

4.2.4 Qualification distribution

Most of the participants (47%) obtained their qualification through D.U.T. whilst 33 (39.8%) participants obtained it through the University of Johannesburg and only eleven (13.3%) participants obtained their qualification elsewhere.

Table 2: University of qualification of the sample (n=83)

	Frequency	Percent
DUT	39	47.0
University of Johannesburg	33	39.8
Other	11	13.3
Total	83	100.0

4.2.5 Year of qualification and registration with AHPCSA

The median year of qualification was 2002 with a range from 1971 to 2008, whilst the median year of registration was also 2002 with a range from 1976 to 2008, as shown in Table 3.

4.2.6 Age on qualification

The mean age on qualification was 29.2 years with a range from 22 to 56 years old and a standard deviation of 7.4 years as seen in Table 3. The duration of the course is 5 years and so the youngest cannot be below 22 years.

Table 3: Summary statistics for age, year of qualification and registration, age on qualification and number of years practicing

		Age	Year of qualification	Year of registration	Age on qualification	Years practicing
N	Valid	83	82	80	86	85
	Missing	3	4	6	0	1
Mean		37.78	2002	2002	29.16	8.72
Std. Deviation		12.156	7.579	6.131	7.383	8.920
Minimum		24	1971	1976	22	0
Maximum		89	2008	2008	56	37

4.2.7 Additional qualifications other than homoeopathy

Twenty participants had one or more other qualification which included mainly medicine (n=6), acupuncture (n=4), chiropractic. (n=2), education (n=3), law (n=2) and many more, as shown in Table 4.

Table 4: Qualifications obtained other than homoeopathy

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	44	51.2	51.2	51.2
	Acupuncture	4	4.7	4.7	55.8
	Ayurveda	1	1.2	1.2	57.0
	Botany	1	1.2	1.2	58.1
	Bowen technology	1	1.2	1.2	59.3
	Chiropractic	2	2.3	2.3	61.6
	Commerce	1	1.2	1.2	62.8
	Defeat Autism Now practitioner	1	1.2	1.2	64.0
	Education	3	3.5	3.5	67.4
	Graphic design	1	1.2	1.2	68.6
	Integrative science	1	1.2	1.2	69.8
	Journalism	1	1.2	1.2	70.9
	Kinesiology	1	1.2	1.2	72.1
	Law	2	2.3	2.3	74.4
	Management	1	1.2	1.2	75.6
	Marketing	1	1.2	1.2	76.7
	MBU	1	1.2	1.2	77.9
	Medicine	6	7.0	7.0	84.9
	Microbiology	1	1.2	1.2	86.0
	Midwifery	1	1.2	1.2	87.2
	Ministry	1	1.2	1.2	88.4
	Modern languages	1	1.2	1.2	89.5
	Music performance	1	1.2	1.2	90.7
	Pharmacy	1	1.2	1.2	91.9
	Psychology	1	1.2	1.2	93.0
	Reflexology	1	1.2	1.2	94.2
	Reiki	1	1.2	1.2	95.3
	Somatology	2	2.3	2.3	97.7
	TCM	1	1.2	1.2	98.8
	Zoology	1	1.2	1.2	100.0
	Total	86	100.0	100.0	

4.2.8 Duration of practice

The mean duration that the participants had been practicing was 8.72 years (standard deviation of 9 years) with a range from 0 to 37 years as shown in Table 3 above and Figure 3 below. As one can see, the vast majority of participants have been practising for 13 years or less, predominantly less than three years.

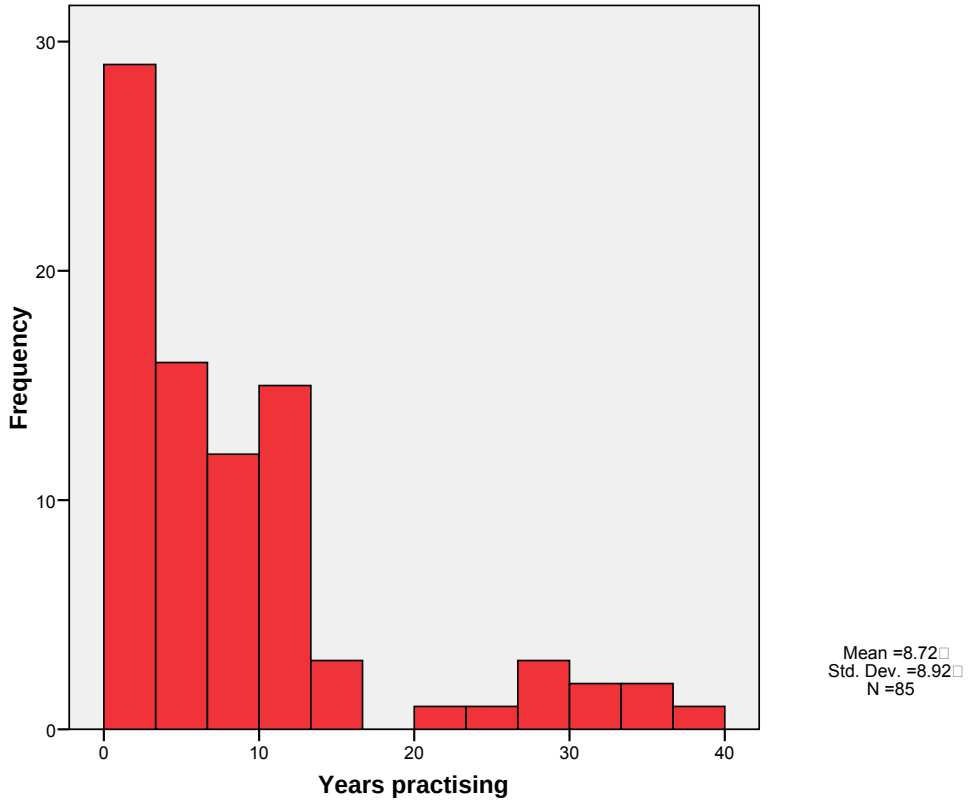

Figure 3: Graph showing the duration of participants in practice, in years.

4.2.9 Children of their own

More than half of the participants (n=47) had children of their own (56%).

4.3 Opinions of homoeopaths regarding the vaccination schedule, as suggested by the South African government

To investigate the opinions homoeopaths have regarding childhood vaccinations.

4.3.1 Administration of specific vaccinations

Table 5 shows that polio was the only disease that most participants agreed with vaccinating against (40%) whereas the most frequent response for chickenpox, DPT, Hepatitis A, Hib, measles, MMR and pneumococcal was “strongly disagree”.

Table 5: Participants opinions with regards to specific vaccinations

	Strongly agree		Agree		Neutral		Disagree		Strongly disagree		Insufficiently informed to comment	
	n	%	n	%	n	%	n	%	n	%	N	%
BCG	3	3.5%	17	20.0%	20	23.5%	20	23.5%	21	24.7%	4	4.7%
Chicken-pox	0	.0%	5	5.9%	8	9.4%	22	25.9%	47	55.3%	3	3.5%
DPT	3	3.5%	15	17.6%	18	21.2%	23	27.1%	23	27.1%	3	3.5%
Hepatitis A	1	1.2%	8	9.4%	25	29.4%	22	25.9%	25	29.4%	4	4.7%
Hepatitis B	5	5.9%	14	16.5%	23	27.1%	20	23.5%	19	22.4%	4	4.7%
Hib	3	3.6%	11	13.1%	20	23.8%	22	26.2%	22	26.2%	6	7.1%
Measles	1	1.2%	13	15.3%	13	15.3%	24	28.2%	31	36.5%	3	3.5%
MMR	1	1.2%	7	8.4%	8	9.6%	25	30.1%	39	47.0%	3	3.6%
Polio	8	9.4%	34	40.0%	16	18.8%	17	20.0%	7	8.2%	3	3.5%
Pneumoc occal	3	3.5%	16	18.8%	15	17.6%	20	23.5%	23	27.1%	8	9.4%

4.3.2 Timing of specific vaccinations

With regards to the timing of each vaccination, most participants thought that they were either too close together, or recorded that they were insufficiently informed to comment. This is shown in Table 6.

Table 6: Participants opinions with regards to the timing of vaccinations

	Too close together		Timing is appropriate		Too far apart		Uncertain		Repeat too often		Insufficiently informed to comment	
	n	%	n	%	n	%	N	%	N	%	n	%
BCG	18	23.7%	13	17.1%	0	.0%	11	14.5%	12	15.8%	22	28.9%
Chickenpox	19	25.7%	4	5.4%	0	.0%	12	16.2%	11	14.9%	28	37.8%
DPT	28	35.4%	9	11.4%	0	.0%	7	8.9%	13	16.5%	22	27.8%
Hepatitis A	16	21.1%	8	10.5%	0	.0%	14	18.4%	9	11.8%	29	38.2%
Hepatitis B	18	23.1%	12	15.4%	0	.0%	12	15.4%	8	10.3%	28	35.9%
Hib	18	24.0%	9	12.0%	0	.0%	11	14.7%	12	16.0%	25	33.3%
Measles	20	26.0%	13	16.9%	0	.0%	10	13.0%	14	18.2%	20	26.0%
MMR	26	34.2%	6	7.9%	0	.0%	8	10.5%	15	19.7%	21	27.6%
Polio A	21	27.6%	15	19.7%	0	.0%	10	13.2%	10	13.2%	20	26.3%
Polio B	0	.0%	0	.0%	0	.0%	0	.0%	4	100.0%	0	.0%
Pneumococcal	18	24.3%	6	8.1%	1	1.4%	15	20.3%	9	12.2%	25	33.8%

4.3.3 Optimal duration prior to administering initial vaccination

Figure 4 shows that the majority of participants either thought that children should wait a few months before being vaccinated, or they should not be vaccinated at all (28.2% each). Nearly one quarter of the participants (22.4%) felt that years should elapse before being vaccinated, while only 5.9% felt it should be a matter of days.

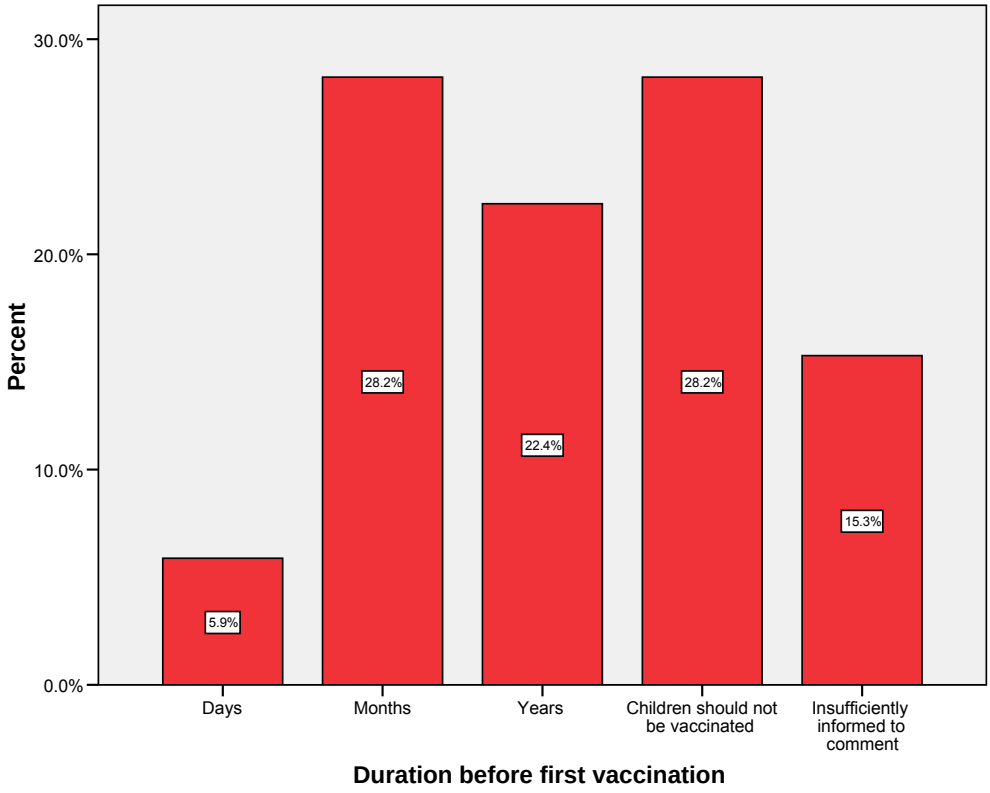

Figure 4: Graph showing perceived optimal duration prior to administering initial vaccination

Table 7 shows the median and range of responses to Question 2.3 where participants stipulated the number of days, months or years they thought was appropriate to elapse before children are vaccinated. Only two participants stipulated a number of days that should elapse, one responding one day and the other seven days. The median number of months reported was six, with a range from one to ten months. The median number of years was two (range one to five years).

Table 7: Perceived optimal duration prior to administering initial vaccination

		Days	months	Years
N	Valid	2	22	16
	Missing	84	64	70
Median		4.0000	6.00	2.00
Minimum		1.00	1	1
Maximum		7.00	10	5

4.3.4 Optimal duration between vaccinations

Most participants (30%) felt that children should not be vaccinated at all, whilst 27.5% felt that there should be a number of months (median of three, range one to six months - Table 8) between vaccinations. This is shown in Figure 5.

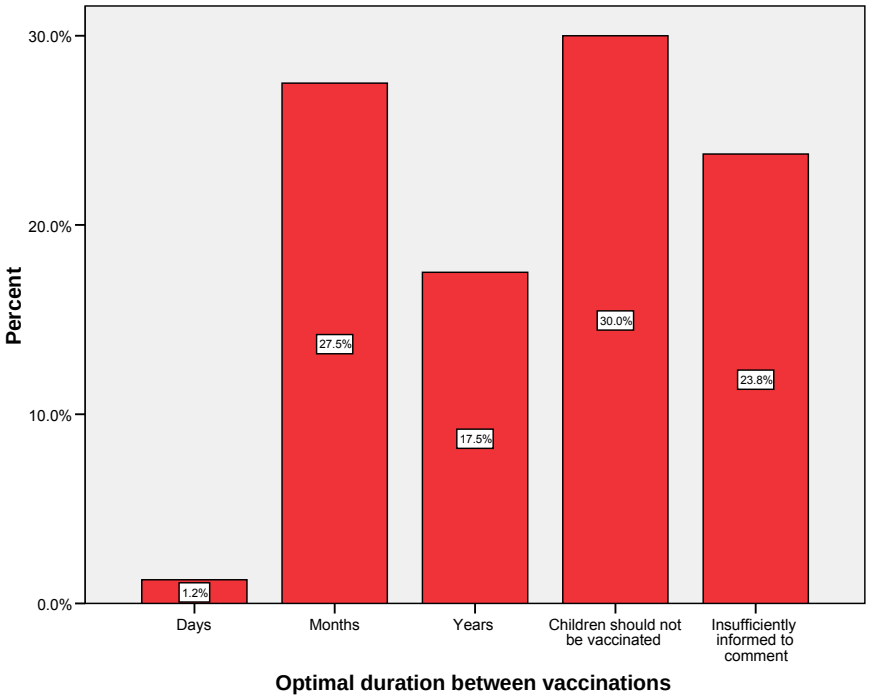

Figure 5: Graph showing perceived optimal duration between vaccinations

Table 8: Perceived optimal duration between vaccinations

		Days	months	Years
N	Valid	1	20	11
	Missing	85	66	75
Median		10.0000	3.00	1.00
Minimum		10.00	1	1
Maximum		10.00	6	3

4.3.5 Factors contributing to the decline of infectious diseases

The participants rated improved sanitization (82.9%), followed by improved nutrition (72%), improved access to healthcare (65%), improved healthcare (64.6%) and improved education 64.2%) as the most important interventions contributing to the decline of infectious diseases. Only 10.1% of participants rated vaccinations as very important, as in Table 9.

Table 9: Perceived factors contributing to declining infectious diseases

	Very important		Important		Hardly important		Uncertain		No influence		Insufficiently informed to comment	
	N	%	n	%	N	%	n	%	n	%	n	%
Decreased virulence of organism	12	15.6%	11	14.3%	15	19.5%	20	26.0%	15	19.5%	4	5.2%
Improved education	52	64.2%	24	29.6%	2	2.5%	1	1.2%	0	.0%	2	2.5%
Improved nutrition	59	72.0%	19	23.2%	0	.0%	1	1.2%	1	1.2%	2	2.4%
Improved sanitization	68	82.9%	12	14.6%	0	.0%	0	.0%	1	1.2%	1	1.2%
Improved healthcare	53	64.6%	19	23.2%	3	3.7%	4	4.9%	1	1.2%	2	2.4%
Improved access to healthcare	52	65.0%	19	23.8%	4	5.0%	2	2.5%	1	1.3%	2	2.5%
Vaccination	8	10.1%	20	25.3%	29	36.7%	11	13.9%	9	11.4%	2	2.5%

4.3.6 Poly-vaccinations

Table 10 shows 11.8% of participants supported the use of poly-vaccinations whilst 82.4% disagree with it.

Table 10: Opinions regarding poly-vaccinations

	Frequency	Percent
Yes	10	11.8
No	70	82.4
Insufficiently informed to comment	5	5.9
Total	85	100.0

4.3.7 General support of vaccinations

Table 11 shows 22.1% of the participants were in favour of vaccinations in general.

Table 11: Opinions regarding the general support of vaccinations

	Frequency	Percent
Yes	19	22.1
No	62	72.1
Insufficiently informed to comment	5	5.8
Total	86	100.0

4.3.8 Adequate scientific proof

Table 12 shows that 55.3% of participants thought that there was not enough scientific proof that vaccinations prevent infectious disease.

Table 12: Responses regarding proof of vaccination prevention

	Frequency	Percent
Yes	27	31.8
No	47	55.3
Insufficiently informed to comment	11	12.9
Total	85	100.0

4.3.9 Common side effects of vaccinations

The vast majority of participants (90.6%) agreed that fever was a common side effect of vaccinations, whilst local inflammation (87.1%), pain and discomfort (85.9%), irritability (84.7%) and rash (78.8%) were also reported commonly, as shown in Table 13.

Table 13: Common side effects of vaccinations

	Yes		No		Unsure		Insufficiently informed to comment	
	n	%	n	%	n	%	N	%
ADD/ADHD	41	48.8%	13	15.5%	22	26.2%	8	9.5%
Anaphylaxis	38	45.2%	14	16.7%	22	26.2%	10	11.9%
Anorexia	20	24.7%	16	19.8%	31	38.3%	14	17.3%
Autism	54	63.5%	9	10.6%	16	18.8%	6	7.1%
Encephalitis	32	40.0%	12	15.0%	26	32.5%	10	12.5%
Fever	77	90.6%	0	.0%	3	3.5%	5	5.9%
Headaches	58	69.0%	7	8.3%	12	14.3%	7	8.3%
Irritability	72	84.7%	1	1.2%	6	7.1%	6	7.1%
Joint pains	52	61.9%	7	8.3%	17	20.2%	8	9.5%
Local inflammation	74	87.1%	3	3.5%	3	3.5%	5	5.9%
Lymphadenopathy	64	75.3%	6	7.1%	8	9.4%	7	8.2%
Neurological disorders	43	51.2%	12	14.3%	20	23.8%	9	10.7%
Non-infectious rash	67	78.8%	4	4.7%	8	9.4%	6	7.1%
pain and discomfort	73	85.9%	0	.0%	7	8.2%	5	5.9%
Stiff neck	31	36.5%	11	12.9%	33	38.8%	10	11.8%
Thrombocytopenia	21	25.3%	11	13.3%	33	39.8%	18	21.7%

4.3.10 Vaccinations effect on the incidence of infectious diseases

Table 14 shows that most participants (65.5%) believed that vaccinations had changed the incidence of polio. However, for the other diseases mentioned, most participants were unsure or did not believe that vaccinations had changed the incidence of the disease.

Table 14: Responses regarding vaccinations effect on the incidence of infectious diseases.

	Yes		No		Unsure		Insufficiently informed to comment	
	n	%	n	%	N	%	n	%
Chickenpox	13	15.5%	53	63.1%	12	14.3%	6	7.1%
Diphtheria	33	39.8%	28	33.7%	18	21.7%	4	4.8%
Hib	11	13.3%	50	60.2%	15	18.1%	7	8.4%
Hepatitis A	15	18.1%	37	44.6%	24	28.9%	7	8.4%
Hepatitis B	19	22.9%	33	39.8%	24	28.9%	7	8.4%
Measles	27	31.8%	40	47.1%	14	16.5%	4	4.7%
Mumps	21	25.0%	42	50.0%	17	20.2%	4	4.8%
Pertussis	26	31.0%	38	45.2%	15	17.9%	5	6.0%
Pneumococcal	10	12.2%	43	52.4%	20	24.4%	9	11.0%
Polio	55	65.5%	13	15.5%	13	15.5%	3	3.6%
Rubella	25	29.8%	40	47.6%	15	17.9%	4	4.8%
Tetanus	38	44.7%	27	31.8%	16	18.8%	4	4.7%
TB	10	11.9%	52	61.9%	17	20.2%	5	6.0%

4.3.11 Risk of vaccinations versus their usefulness in preventing diseases

There was an almost equal positive and negative response to Question 2.11 with 40.7% saying “yes” and 44.4% saying “no” while 14.8% were unsure (Figure 6).

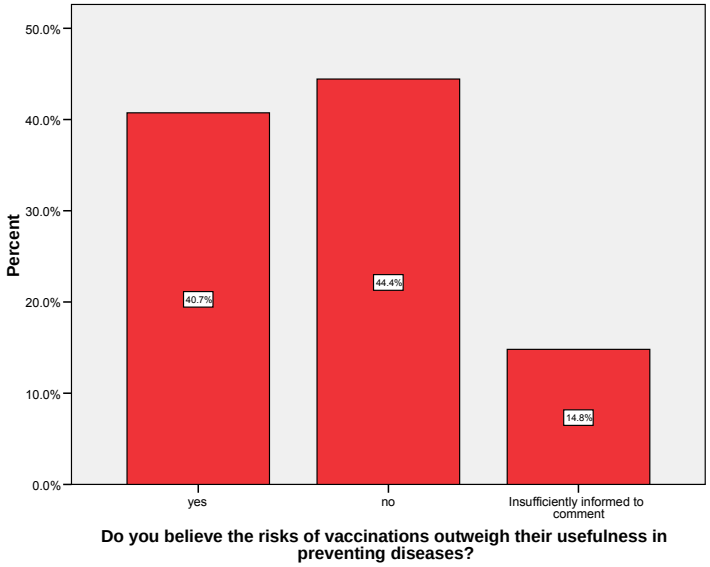

Figure 6: Graph showing perceived risks versus benefits of vaccinations

4.3.12 Risk of adverse reactions versus “herd immunity”

Table 15 shows that 62% of participants did not believe that the risk of adverse reactions was acceptable if the majority of the population was protected against infectious disease.

Table 15: Risks of adverse reactions versus “herd immunity”

	Frequency	Percent
Yes	22	27.8
No	49	62.0
Insufficiently informed to comment	8	10.1
Total	79	100.0

4.3.13 Safety of natural contraction of infectious disease versus vaccination

Table 16 shows that the majority of participants felt that contracting chickenpox (84.5%), measles (73.8%) and mumps (75.6%) was safer than being vaccinated against them. To a lesser extent, they felt the same about rubella (61.4%) and pertussis (51.8%).

Table 16: Natural contraction of disease versus vaccination

	Yes		No		Unsure		Insufficiently informed to comment	
	n	%	N	%	n	%	n	%
Chickenpox	71	84.5%	11	13.1%	1	1.2%	1	1.2%
Diphtheria	25	31.3%	37	46.3%	16	20.0%	2	2.5%
Hib	46	54.8%	20	23.8%	15	17.9%	3	3.6%
Hepatitis A	32	39.0%	31	37.8%	17	20.7%	2	2.4%
Hepatitis B	17	21.0%	44	54.3%	17	21.0%	3	3.7%
Measles	62	73.8%	17	20.2%	4	4.8%	1	1.2%
Mumps	62	75.6%	14	17.1%	5	6.1%	1	1.2%
Pertussis	43	51.8%	27	32.5%	12	14.5%	1	1.2%
Pneumococcal	30	36.1%	32	38.6%	18	21.7%	3	3.6%
Polio	9	11.0%	62	75.6%	10	12.2%	1	1.2%
Rubella	51	61.4%	19	22.9%	12	14.5%	1	1.2%
Tetanus	14	16.9%	50	60.2%	18	21.7%	1	1.2%
TB	19	22.9%	47	56.6%	15	18.1%	2	2.4%

4.3.14 Desire of administration of vaccines to homoeopaths own children

Table 17 shows responses to Question 2.14 and are ranked from most to least frequently selected. Polio was the most commonly selected response (52.3%), followed by 42% who responded that they will not use orthodox vaccines. Tetanus was selected in 37.2% and Hepatitis B in 24.4%. Only 5.8% said they would vaccinate against chickenpox.

Table 17: Diseases which homoeopaths would vaccinate their own children against

	Count	%
Polio	45	52.3%
I wont use orthodox vaccines	36	41.9%
Tetanus	32	37.2%
Hepatitis B	24	27.9%
TB	21	24.4%
Diphtheria	20	23.3%
Hepatitis A	16	18.6%
Pertussis	16	18.6%
Rubella	15	17.4%
Pneumococcal	13	15.1%
Measles	10	11.6%
Mumps	10	11.6%
Hib	9	10.5%
Chickenpox	5	5.8%

4.3.15 Basis for opinions on vaccinations

Table 18 shows that the concern of adverse effects (77.9%) was the foremost concern of homoeopaths with regards to forming their opinions with regards to orthodox vaccinations whereas homoeopathic training accounted for 67.4%, while personal beliefs or experiences accounted for 55.8%.

Table 18: Basis for opinions of vaccinations

	Count	%
Concern of adverse effects	67	77.9%
Homoeopathic training or literature	58	67.4%
Personal beliefs or experience	48	55.8%
Concern of suppression	44	51.2%
Scientific literature	43	50.0%
Concern of infectious diseases	27	31.4%
Government stipulations	13	15.1%
Antenatal classes	11	12.8%
Government campaigns	7	8.1%
Other	2	2.3%
Religion	0	0%

4.3.16 Indication of whether the intervention protocol would differ according to the appropriateness of individual patients

The vast majority of homoeopaths (80.5%) indicated that their intervention protocols would differ depending on individual circumstances, as in Figure 7.

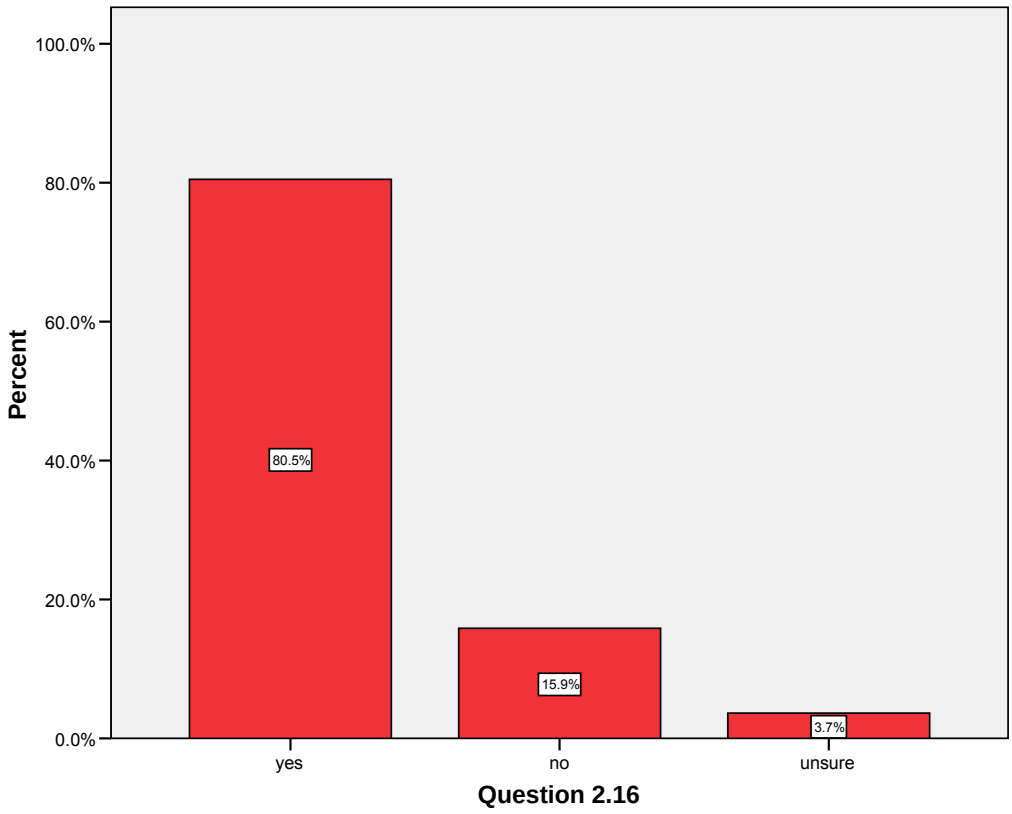

Figure 7: Graph showing whether homoeopaths' intervention protocol is individualised

4.4 Homoeopaths experience with regards to childhood vaccinations

To investigate the treatment regimes followed by homoeopaths prior to, post, or as an alternative to recommended allopathic childhood vaccination treatment within South Africa.

4.4.1 Preferred "vaccination" method

Sixty percent of participants preferred to use a combination of both homoeopathic remedies and orthodox vaccinations. Almost equal proportions of participants avoided orthodox vaccines (23.3%) and used only homoeopathic remedies (24.4%). A mere 4.7% used orthodox vaccinations only, as seen in Figure 8.

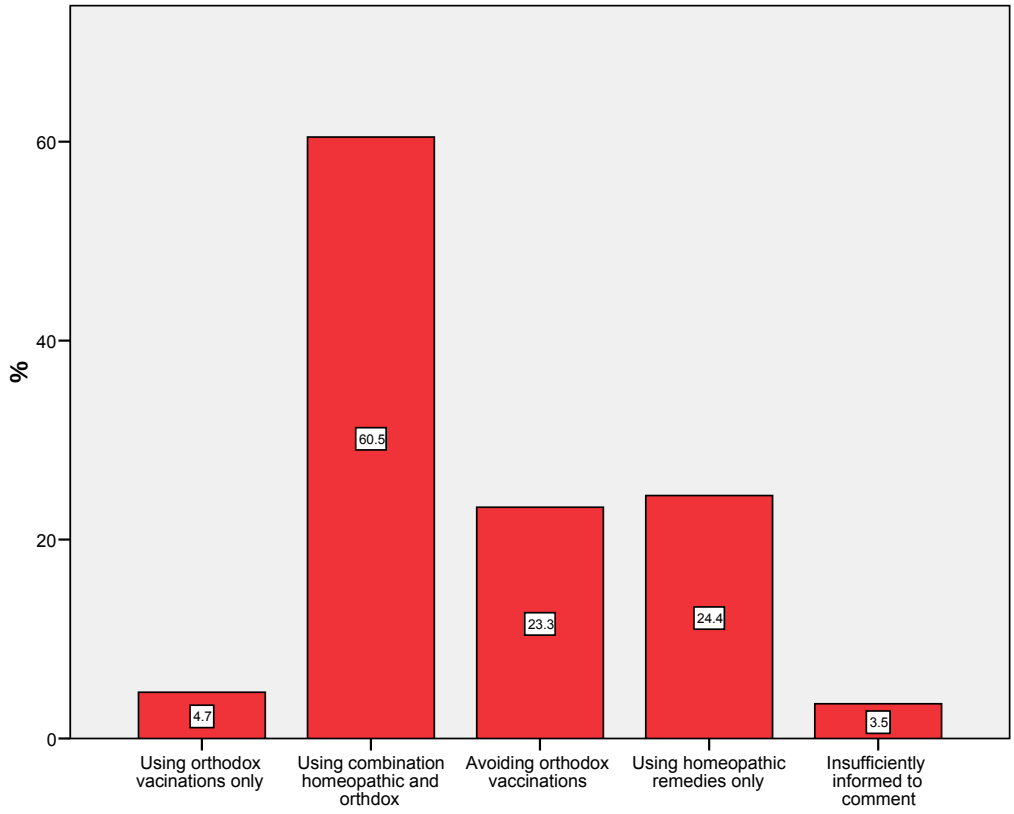

Figure 8: Graph showing participants preferred method of "vaccination"

4.4.1.1 Elaboration of the use of orthodox vaccines

Table 19 shows that 22.1% of homoeopaths would use orthodox vaccinations if the disease was life threatening. Only 3.5% would use them if there was a family history of the disease.

Table 19: Participants use of orthodox vaccinations

	Count	%
Using certain life threatening vaccines only	19	22.1%
Using all vaccinations but delaying administration	8	9.3%
As stipulated by SA government	6	7.0%
Using vaccines to which individual is susceptible	6	7.0%
If family history use orthodox vaccine	3	3.5%

4.4.1.2 Elaboration of combining homoeopathic and orthodox vaccines

Those who preferred using a combination of orthodox and homoeopathic remedies opted mainly to treat adverse reactions homoeopathically (47.7%) while 36% administered the standard remedy prior or post to orthodox vaccinations.

Table 20: Trends used when combining principles

	Count	%
Treat adverse reactions homoeopathically	41	47.7%
Administering standard remedy	31	36.0%
Administering constitutional remedy	20	23.3%
Using homoeopathic nosodes as well as orthodox	19	22.1%
Administering vaccination complex	16	18.6%
Using homoeopathic vaccines as well as orthodox	9	10.5%

4.4.1.2.1 Standard concurrent single remedy, stipulation of remedy and potency scale

Table 21 shows that 46.5% of homoeopaths used Thuja as a concurrent standard remedy. The median potency used was 30CH.

Table 21: Standard remedies administered concurrently and potency scale

	Count	%	Median	Minimum	Maximum
Thuja	40	46.5%	30	1	1000
Silica	17	19.8%	200	1	200
Belladonna	6	7.0%	18	0	200
Other	6	7.0%	200	30	1000
Sulphur	4	4.7%	18	6	30
Nux vomica	3	3.5%	115	30	200

4.4.1.2.2 Standard concurrent remedy complex

For those who administered a vaccination complex, the constitution of their remedies is shown in Table 22.

Table 22: Tabulation of concurrent remedy complexes administered

	Frequency	Percent
apis, cham, variolinum, morbillinum etc 30CH	1	8.3
apis, hep-s, merc, …3-30CH	1	8.3
bell, thuja, sil	1	8.3
carc, maland, mur-ac, tub 200/M	1	8.3
echinacea, sil, thuja	1	8.3
ledum--30CH	1	8.3
MMR-30CH	1	8.3
Nosodes	1	8.3
nux, sil, sulph, thuja 30CH	1	8.3
puls, thuja, sil, hyp 9CH	1	8.3
sulph, sil, thuja 30 day b4, of & post	1	8.3
vaccininum, thuja, med, tub 30CH	1	8.3
Total	12	100

4.4.1.3 Treatment protocol if orthodox vaccinations are avoided

Of those who preferred avoiding orthodox vaccines, their preferred alternative method of intervention was treating symptoms according to the law of similars (30.2%). Treating symptoms according to the clinical picture was preferred in 18.6% of participants (Question 3.2.1).

Table 23: General protocol used if orthodox vaccinations are avoided

	Count	%
Treating symptoms according to law of similars	26	30.2%
Using constitutional remedy	16	18.6%
Treating symptoms according to clinical picture	16	18.6%
Using homoeopathic nosodes	13	15.1%
Giving constitutional remedy with symptoms	12	14.0%
Using homoeoprophylaxis	10	11.6%
Treating symptoms according to aetiology	8	9.3%
Using homoeopathic vaccines	6	7.0%

4.4.2 Standard treatment protocol pre and post-vaccinations

Of the participants, 61.8% had a standard protocol for treating children prior to or following their orthodox vaccinations.

Table 24: General treatment protocol before and after vaccinations

	Frequency	Percent
Yes	47	61.8
No	18	23.7
Have not been required to address this issue in practice yet	11	14.5
Total	76	100.0

Of those who had a standard protocol for treating children prior to orthodox vaccinations, administration of a standard remedy was the most common practice, followed by constitutional remedy and own combination. For those who administered it post orthodox vaccinations, the standard remedy was also the most common, followed by own combination and nosodes (Figures 9 and 10).

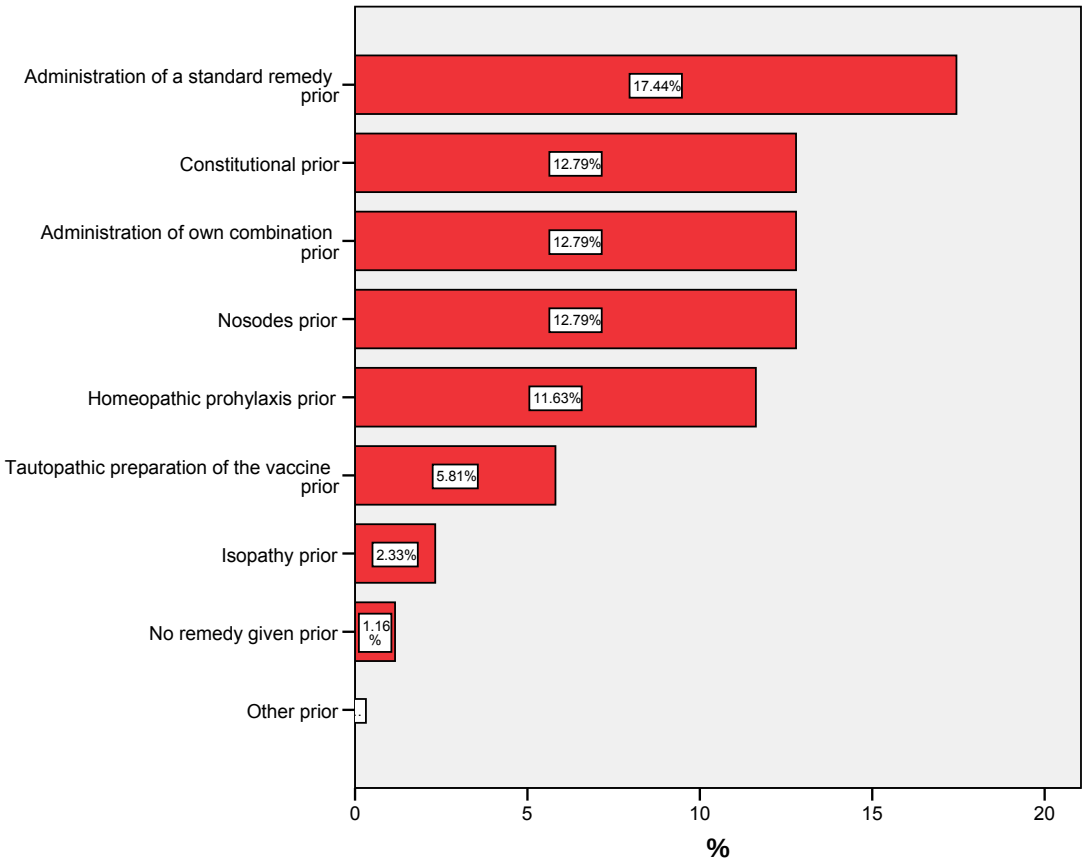

Figure 9: Graph showing treatment protocol prior to orthodox vaccinations

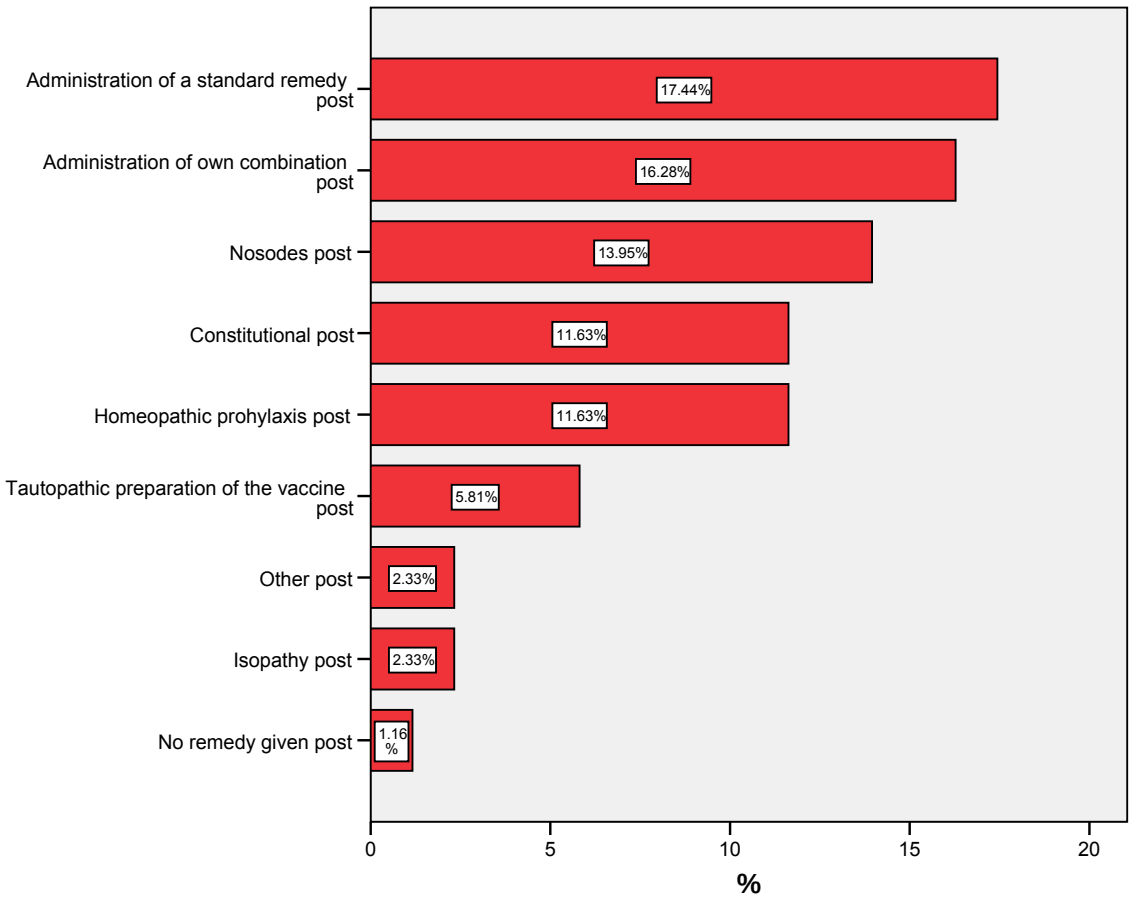

Figure 10: Graph showing the treatment protocol post orthodox vaccinations

4.4.3 Preferred treatment alternatives

Of the participants, 60.8% recommended other preventative strategies to treat children as opposed to using orthodox vaccinations (Table 25)

Table 25: Recommendation of alternative preventative strategies

	Frequency	Percent
Yes	48	60.8
No	22	27.8
Insufficient information to comment	9	11.4
Total	79	100.0

4.4.3.1 Method

Table 26 shows that the most common strategies were constitutional, followed by administration of remedy according to presenting disease, and nosodes.

Table 26: Types of alternative homoeopathic strategies used

	Count	%
Constitutional	24	27.9%
Administration of remedy according to presenting disease	17	19.8%
Nosodes	16	18.6%
Homoeopathic prophylaxis	14	16.3%
Administration of own combination	9	10.5%
Administration of a standard remedy	6	7.0%
Other	6	7.0%
Tautopathic preparation of the vaccine	4	4.7%
Isopathy	3	3.5%

4.4.4 Noted adverse effects in patients

Figure 11 shows that 76.5% of homoeopaths had seen adverse reactions that they believed to be caused from vaccinations, in their patients.

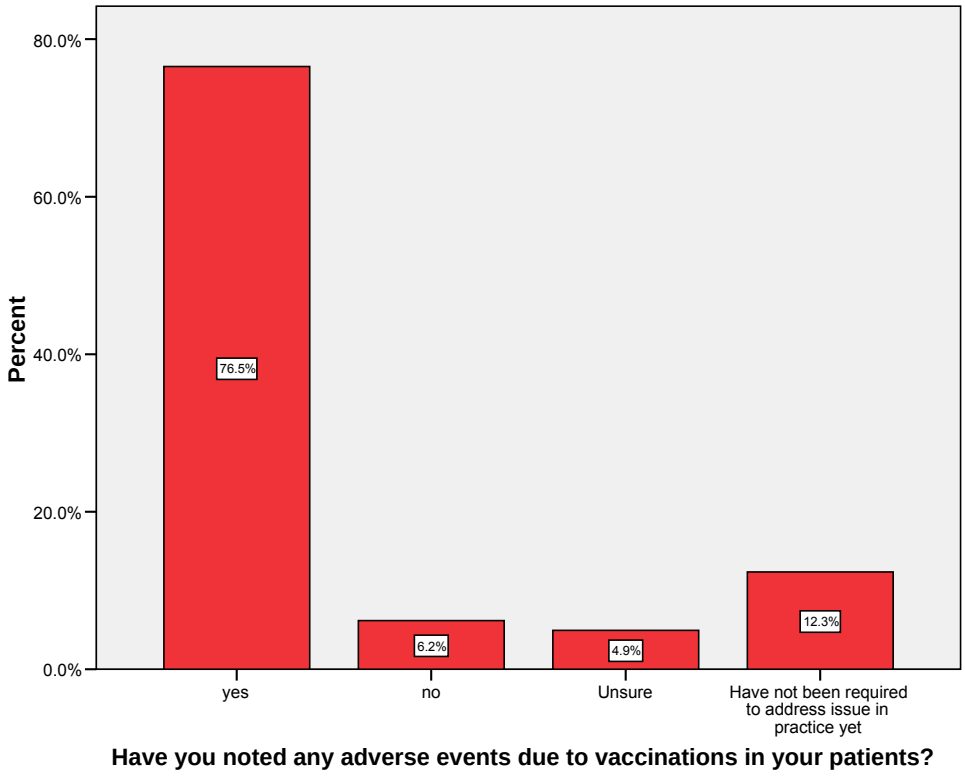

Figure 11: Graph showing noted vaccine adverse effects

4.4.4.1 Percentage

The percentage of the vaccinated population showing reactions ranged from 1 to 100% according to these participants, with a mean of 42.8% and a standard deviation of 33.5%, according to Table 27.

4.4.4.2 Type of adverse effects

Fever was the most commonly reported adverse reaction (61.6%) followed by eczema (54.7%) and irritability (53.5%) as seen in Table 27.

Table 27: Types of adverse effects noted

	Count	%
Fever	53	61.6%
Eczema	47	54.7%
Irritability	46	53.5%
Ear, nose and throat infections	44	51.2%
Local inflammation	43	50.0%
Lymphadenopathy	33	38.4%
Chest infections	31	36.0%
Headaches	28	32.6%
Abscess formation	27	31.4%
ADD/ADHD	25	29.1%
Autism	19	22.1%
Anorexia	14	16.3%
Other	14	16.3%
Joint pains	13	15.1%
SIDS	10	11.6%
Anaphylaxis	7	8.1%
Stiff neck	7	8.1%
Thrombocytopenia	4	4.7%

4.5 Cross tabulation of results

To examine associations between the opinions and treatment regimes used by homoeopaths with regards to childhood vaccinations.

Table 28: Cross–tabulation between general opinion of vaccines and preferred method of vaccinating infants

Preferred method of vaccinating infants		Q2.7: Are you in favour of vaccinations in general?						*p* value
		Yes		No		Insufficiently informed to comment		
		Count	%	Count	%	Count	%	
Using orthodox vaccinations only	No	16	84.2%	61	98.4%	5	100.0%	0.033
	Yes	3	15.8%	1	1.6%	0	.0%	
Using combination homoeopathic and orthodox	No	5	26.3%	28	45.2%	1	20.0%	0.222
	Yes	14	73.7%	34	54.8%	4	80.0%	
Avoiding orthodox vaccinations	No	19	100.0%	42	67.7%	5	100.0%	0.006
	Yes	0	.0%	20	32.3%	0	.0%	
Using homoeopathic remedies only	No	19	100.0%	41	66.1%	5	100.0%	0.005
	Yes	0	.0%	21	33.9%	0	.0%	
Insufficiently informed to comment	No	18	94.7%	61	98.4%	4	80.0%	0.087
	Yes	1	5.3%	1	1.6%	1	20.0%	

The majority of participants did not want to use orthodox vaccines only – of those who were in favour of vaccines in general, 84.2% did not want to use orthodox vaccines on their own compared to a mere 15.8% who did. Of those who were not in favour of vaccines in general, 98.4% did not want to use orthodox vaccines as a stand-alone treatment as opposed to a mere 1.6% who did. Esterhuizen (2010) stated 19 people indicated they are in favour of vaccines in general (yes to Q2.7), and all those 19 people (100%) said NO to avoiding orthodox vaccinations (therefore they support orthodox medicine) and NO to using homoeopathic remedies.

Table 29: Cross-tabulation between age group of homoeopath and general opinion of vaccines

			Q2.7: Are you in favour of vaccinations in general?			
			Yes	No	Insufficiently informed to comment	Total
Age group	<30	Count	3	15	2	20
		% within age group	15.0%	75.0%	10.0%	100.0%
	30-39	Count	7	32	3	42
		% within age group	16.7%	76.2%	7.1%	100.0%
	40-49	Count	3	3	0	6
		% within age group	50.0%	50.0%	.0%	100.0%
	50-59	Count	3	8	0	11
		% within age group	27.3%	72.7%	.0%	100.0%
	>=60	Count	2	2	0	4
		% within age group	50.0%	50.0%	.0%	100.0%
Total		Count	18	60	5	83
		% within age group	21.7%	72.3%	6.0%	100.0%

There was statistically no significance between the age group of the homoeopath and their opinion (Esterhuizen, 2010). However, on closer inspection, homoeopaths within the age groups 40-49 and 60 years and above are split 50-50 between whether to vaccinate or not. This is significantly relevant as the average opinion (72.3%) is that homoeopaths do not want to vaccinate children. Nobody over the age of 39 years of age feels insufficiently informed to comment.

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	7.429(a)	8	0.491
Likelihood Ratio	7.758	8	0.457
Linear-by-Linear Association	4.566	1	0.033
N of Valid Cases	83		

11 cells (73.3%) have expected count less than five. The minimum expected count is 0.24.

ANOVA test to compare mean age between the three categories of response to Question 2.7. *p*=0.224, therefore there was no significant difference overall between the three means.

ANOVA

Age

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	444.435	2	222.218	1.523	0.224
Within Groups	11671.661	80	145.896		
Total	12116.096	82			

Bonferroni post hoc tests to compare the mean age between each combination of categories. There was no significant difference between any of the pairs of categories.

Post Hoc Tests: Multiple Comparisons

Dependent Variable: Age

Bonferroni

(I) q2.7	(J) q2.7	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
Yes	No	4.172	3.246	.607	-3.77	12.11
	Insufficiently informed to comment	9.789	6.106	.339	-5.14	24.72
No	Yes	-4.172	3.246	.607	-12.11	3.77
	Insufficiently informed to comment	5.617	5.622	.962	-8.13	19.37
Insufficiently informed to comment	Yes	-9.789	6.106	.339	-24.72	5.14
	No	-5.617	5.622	.962	-19.37	8.13

Table 30: Cross-tabulation between gender and general opinion of vaccines

			Q2.7: Are you in favour of vaccinations in general?			
			Yes	No	Insufficiently informed to comment	Total
Gender	Male	Count	12	19	0	31
		% within gender	38.70%	61.30%	0.00%	100.00%
	Female	Count	7	41	5	53
		% within gender	13.20%	77.40%	9.40%	100.00%
Total		Count	19	60	5	84
		% within gender	22.60%	71.40%	6.00%	100.00%

The males were more likely to say yes and agree with vaccinations in general, than the females (38.7% of the males and 13.2% of the females). No males and five females felt insufficiently informed to comment on this topic.

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.255(a)	2	0.01
Likelihood Ratio	10.691	2	0.005
Linear-by-Linear Association	9.145	1	0.002
N of Valid Cases	84		

Two cells (33.3%) have expected count less than 5. The minimum expected count is 1.85. Pearson's chi squared test to compare response to question 2.7 between males and female participants. p = 0.010 therefore there was a statistically significant difference in response between the genders.

Table 31: Cross-tabulation between years of practice & general opinion of vaccines

			Q2.7: Are you in favour of vaccinations in general?			
			Yes	No	Insufficiently informed to comment	Total
Years practicing category	<= 3years	Count	6	20	3	29
		% within Years practicing category	20.70%	69.00%	10.30%	100.00%
	4-6 years	Count	1	14	1	16
		% within Years practicing category	6.30%	87.50%	6.30%	100.00%
	6-9 years	Count	2	9	1	12
		% within Years practicing category	16.70%	75.00%	8.30%	100.00%
	>=10 years	Count	9	19	0	28
		% within Years practicing category	32.10%	67.90%	0.00%	100.00%
Total		Count	18	62	5	85
		% within Years practicing category	21.20%	72.90%	5.90%	100.00%

As homoeopaths gained experience in practice, so they felt more competent to comment (from 10.3% who felt insufficiently informed to comment in the first three years, to zero homoeopaths who had ten years or more experience). All homoeopaths were not in support of vaccines in general (mean of 72.9%) although this fluctuated throughout the years of practice from 67.9% for those in practice for ten years or more and as much as 87.5% for those who had been practicing for between four to six years.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.781(a)	6	0.342
Likelihood Ratio	8.648	6	0.194
Linear-by-Linear Association	2.98	1	0.084
N of Valid Cases	85		

Six cells (50.0%) have expected count less than five. The minimum expected count is 0.71.

ANOVA

Years practicing

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	464.058	2	232.029	3.059	.052
Within Groups	6219.166	82	75.843		
Total	6683.224	84			

Bonferroni post hoc comparisons showed that there were no individual differences between any pairs of categories in terms of years practicing.

Post Hoc Tests: Multiple Comparisons

Dependent Variable: Years practicing

Bonferroni

(I) q2.7	(J) q2.7	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
Yes	No	4.826	2.332	0.125	-0.87	10.53
	Insufficiently informed to comment	9.178	4.403	0.121	-1.58	19.94
No	Yes	-4.826	2.332	0.125	-10.53	0.87
	Insufficiently informed to comment	4.352	4.049	0.857	-5.54	14.25
Insufficiently informed to comment	Yes	-9.178	4.403	0.121	-19.94	1.58
	No	-4.352	4.049	0.857	-14.25	5.54

Table 32: Cross tabulation between whether homoeopath has children of their own and their general opinion of vaccines

			Q2.7: Are you in favour of vaccinations in general?			
			Yes	No	Insufficiently informed to comment	Total
Children of your own	Yes	Count	11	35	1	47
		% with children of your own	23.40%	74.50%	2.10%	100.00%
	No	Count	8	25	4	37
		% with children of your own	21.60%	67.60%	10.80%	100.00%
Total		Count	19	60	5	84
		% with children of your own	22.60%	71.40%	6.00%	100.00%

Nearly 3/4 (74.5%) of participants, who had children, felt they would not vaccinate, versus 67.6% who did not have their own children. Only one homoeopath who had their own child felt insufficiently informed to comment whereas four homoeopaths without children felt the same way.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	2.789(a)	2	0.248
Likelihood Ratio	2.884	2	0.236
Linear-by-Linear Association	0.869	1	0.351
N of Valid Cases	84		

Two cells (33.3%) have expected count less than 5. The minimum expected count is 2.20. Pearson's chi square test to compare response to Question 2.7 between those with and without their own children. P=0.248 therefore no significant difference in response between the categories. There were similar percentages of agreement and disagreement in those with and without their own children.

Table 33: Cross tabulation between other qualifications and homoeopaths general opinion of vaccines

			Q2.7: Are you in favour of vaccinations in general?			
			Yes	No	Insufficiently informed to comment	Total
Other qualifications	No	Count	7	33	4	44
		% with other qualifications	15.90%	75.00%	9.10%	100.00%
	Yes	Count	12	29	1	42
		% with other qualifications	28.60%	69.00%	2.40%	100.00%
Total		Count	19	62	5	86
		% with other qualifications	22.10%	72.10%	5.80%	100.00%

Three quarters (75%) of participants who did not have another qualification felt that vaccinations should not be performed whereas 15.9% of them felt vaccinations should be given and 9.1% of them felt insufficiently informed to comment.

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.329(a)	2	0.189
Likelihood Ratio	3.471	2	0.176
Linear-by-Linear Association	3.156	1	0.076
N of Valid Cases	86		

Two cells (33.3%) have expected count less than 5. The minimum expected count is 2.44. Pearson's chi square test to compare response to Question 2.7 between those with and without other qualifications. *p*=0.189 therefore no significant difference in response between the categories. There were similar percentages of agreement and disagreement in those with and without other qualifications.

The adverse effects (77.9%) of vaccinations were the foremost concern of participants whereas homoeopathic training accounted for 67.4% and personal beliefs or experiences accounted for 55.8%. Majority of participants (60%) preferred to use a combination of homoeopathic remedies and orthodox vaccinations. Almost equal proportions of participants avoided orthodox vaccines (23.3%) and used only homoeopathic remedies (24.4%). A mere 4.7% used orthodox vaccinations only. The majority of homoeopaths (80.5%) indicated that their intervention protocols would differ depending on individual circumstances.

In summary, with regards to this research, most participants (72%) felt that children should not be vaccinated at all and polio was the only disease that most participants (40%) agreed with vaccinating against. The majority of participants felt that contracting most diseases, such as chickenpox, measles and mumps was safer than being vaccinated against them. Only 10% of participants rated vaccinations as very important.

CHAPTER FIVE

DISCUSSION

This Chapter includes an evaluation and discussion of the results of the statistical analysis of the questionnaire (Appendix B) from Chapter Four.

5.1 Introduction to the findings of this study

In the cultural context of the vaccination programme it is important to highlight the concerns and misconceptions that are present, as well as to understand parental decisions with regards to childhood vaccinations (Callréus, 2009).

The participants rated improved sanitization, followed by improved nutrition, improved access to healthcare, improved healthcare and improved education as the most important interventions contributing to the decline of infectious diseases. Considering many South Africans do not have access to these, as shown in Chapter 2.6, it was reassuring to see that the vast majority of homoeopaths (80.5%) indicated that their intervention protocols would differ depending on individual circumstances.

5.2 Part A: Demographics

5.2.1 Gender distribution

Of the participants, 63.1% were female and 36.9% were male therefore showing that far more participating homoeopaths within South Africa were female (Figure 1).

5.2.2 Age distribution

The mean age of the sample group was 37.8 years. The course began at the Durban University of Technology (D.U.T.) in 1987 and was introduced to the University of Johannesburg (U.J.) in 1992, so it would be expected to see more younger participants (Table 3 and Figure 2).

5.2.3 Racial distribution

The majority of the sample group were white (89%), with only 8.5% Indian, 1.2% Black and 1.2 % Asian (Table 1). This is not a true reflection of the population of South Africa and it would therefore be relevant to survey black, rural practitioners to establish their opinions and intervention protocols with regards to vaccinations considering the conditions they face are considerably different from those of the white homoeopaths and their patients in generally affluent areas.

5.2.4 Qualification distribution

Most of the participants (47%) obtained their qualification through D.U.T. – possibly due to the fact that it has been running for longer, whilst 39.8% of the participants obtained it through U.J. (started in 1992) and only 13.3% of the participants obtained their qualification elsewhere (Table 2).

5.2.5 Year of qualification and registration with AHPCSA

Table 3 showed that the mean year of qualification and registration was 2002, with the minimum year of qualification being 1971 whilst the minimum year of registration was 1976, with the maximum year for both was 2008.

5.2.6 Age on qualification

Table 3 also showed that the average age on qualification was 29.16 years with the minimum being 22 years and the maximum being 56 years. This statistic, however, had no bearing on the study, as such, according to the cross tabulation between age group of homoeopath and general opinion of vaccines (Table 29).

5.2.7 Additional qualifications other than homoeopathy

Twenty participants had one or more other qualification, as shown in Table 4, which may account for the fact that the mean age of qualification is higher than the 6 years required to complete the course directly from school.

5.2.8 Duration of practice

The mean duration of participating homoeopaths practicing is as little as 8.72 years although the range is from 0 to 37 years as shown in both Table 3 and Figure 3.

5.2.9 Children of their own

Majority of the participants (56%) had children of their own and Table 31 shows how this influences their opinions.

5.3 Part B: Opinions of practitioners regarding the vaccination schedule, as suggested by the South African government

To investigate the opinions homoeopaths have regarding childhood vaccinations considering anecdotal evidence shows that practitioners are seen as vital members of the health team and suggests their role is critical for patient health and Zotti et al. (2002) state parents are greatly influenced by what their practitioner recommends.

5.3.1 Administration of specific vaccinations

As indicated in Table 5, polio was the only disease that most participants agreed with immunizing against (40%). No participants strongly agreed with vaccinating against chicken pox, only one felt strongly about vaccinating against Hepatitis A, Measles and MMR whereas three participants strongly agreed with the BCG, DPT, Hib and pneumococcal vaccines. Five participants strongly agreed with vaccinating against Hepatitis B and eight participants (9.4%) strongly agreed with the polio vaccine.

For all other vaccines queried (except Hepatitis B which had 27.1% voting neutrally), the most frequent response was that the participants strongly disagreed with the vaccinations. These percentages varied from 55.3% for chickenpox, 47.0% for MMR, 36.5% for Measles on it's own, 29.4% for Hepatitis A, 27.1% for both DPT and pneumococcal, 26.2% for Hib down to 24.7% for the BCG vaccine. Eight participants felt they were insufficiently informed to comment on the pneumococcal vaccine, six felt similarly about the Hib vaccine, four felt the same about BCG and both hepatitis vaccines and three participants did not comment on the remaining vaccines (Table 5).

5.3.2 Timing of specific vaccinations

With regards to the timing of each vaccination, most participants (21.1% - 35.4%) felt that they were either too close together – especially for DPT, MMR and polio, or recorded that they were insufficiently informed to comment (26.3% - 38.2%). Hirsch et al (1981) and Jaber et al. (1988) state that administering numerous vaccines simultaneously may create a burden on the system and therefore cause a greater likelihood of adverse reactions than giving the vaccinations separately. 100% of participants felt that polio vaccine was repeated too often (Table 6).

5.3.3 Optimal duration prior to administering initial vaccination

Figure 4 and Table 7 show that the majority of participants either thought that children should wait a few months before being vaccinated, or they should not be vaccinated at all (28.2% each). Noble et. al. (1987) showed that there was an 85-90% reduction in severe reactions and deaths when vaccines were administered after age two. Of the participants, 22.4% agreed that a number of years should be allowed to elapse before the first vaccine is administered, while only 5.9% felt it should be a matter of days. Only two participants stipulated a number of days that should elapse, one responding one day and the other seven days. The median number of months reported was six, with a range from one to ten months. The median number of years was two (range one to five years).

5.3.4 Optimal duration between vaccinations

Figure 5 and Table 8 show that most participants (30%) feel children should not be vaccinated at all whilst 27.5% felt that there should be between one-six months (mean three) between vaccinations. However, 23.8% of participants felt insufficiently informed to comment whilst 17.5% felt a number of years (between one and three) should pass between vaccinations, if they were to be done at all.

5.3.5 Factors contributing to the decline of infectious diseases

The participants rated improved sanitization, followed by improved nutrition, improved access to healthcare, improved healthcare and improved education as the most important intervention contributing to the decline of infectious diseases (Table 9). Only 10% of participants rated vaccinations as very important. Considering Puoane (2003) revealed that 80 % of residents in Khayelitsha live in shacks and an average of 105 people share each toilet; the most common meal in South Africa is a plate of maize meal and a cup of tea which contain minimal nutritional value; there's a doctor:patient ratio of 1:30 000 in parts of the Eastern Cape; a mere 52 % of the population within South Africa have completed grade nine or more. Of the remainder, 32 % have not completed grade seven and 16 % have no schooling at all.

5.3.6 Poly-vaccinations

The vast majority of participants (82.4%) were against the use of poly-vaccinations and 5.9% felt insufficiently informed to comment (Table 10). As mentioned in 5.3.2. various research indicates poly-vaccinations may burden the system and result in adverse reactions (Hirsch et al. (1981), Jaber et al. (1988) and Neustaedter (1996)).

5.3.7 General support of vaccinations

Majority of the participants (72.1%) were not in favour of vaccines in general although 22.1 % did support the use of vaccines. 5.8% felt they were insufficiently informed to comment (Table 11). This is in congruence with Bhatia (2006) who states that vaccination – be it conventional or homoeopathic - has always remained controversial for various reasons. There were many cross-tabulations done with regards to this question as it was felt that this formed the crux of the research questionnaire and would assist in gaining a better understanding of the participants' perspectives.

5.3.8 Adequate scientific proof

Table 12 shows that 55.3% of participants thought that there was not enough scientific proof that vaccinations prevent infectious disease but 12.9% felt insufficiently informed to comment.

5.3.9 Common side effects of vaccinations

The vast majority of participants (90.6%) agreed that fever was a common side effect of vaccinations, whilst local inflammation (87.1%), pain and discomfort (85.9%), irritability (84.7%) and rash (78.8%) were also reported commonly (Table 13). However, none of these are seen as serious, nor as chronic diseases hence may not be viewed with such severity. WHO (2005) acknowledges that the safety of existing vaccines have created many concerns as risks accompany every vaccination.

5.3.10 Vaccinations effect on the incidence of infectious diseases

Table 14 shows that most participants (65.5%) believed that vaccinations had changed the incidence of polio. However, for the other diseases mentioned, most participants were unsure or did not believe that vaccinations had changed the incidence of the disease (e.g. 61.9% don't believe vaccines changed the incidence of TB and 63.1% don't believe vaccines changed the incidence of chickenpox). However, the Department of Health (2005) states that since being introduced, vaccinations have decreased the rates of diseases by 90% and WHO (2005) states vaccinations currently saves three million lives per year, worldwide.

5.3.11 Risk of vaccinations versus their usefulness in preventing diseases

There was an almost equal positive (40.7%) and negative (44.4%) response to Question 2.11 which asks whether the homoeopaths felt the risks of vaccinations outweighed their usefulness in preventing diseases although 14.8% were unsure (Figure 6). This is interesting as 72% of homoeopaths stated, in Question 2.7 that they were against vaccinations, in general. It can then be assumed that although most homoeopaths are against general vaccination, 44.4% of them do believe that the usefulness of the vaccines outweighs the risks within South Africa.

5.3.12 Risk of adverse reactions versus "herd immunity"

Table 15 shows that 62% of participants did not believe that the risk of adverse reactions was acceptable if the majority of the population was protected against infectious disease yet 10.1% felt insufficiently informed to comment. The Department of Health (2005) states vaccinations provide herd immunity, thus curbing the spread of disease within the community. However, Cave (2004) states an increasing number of parents question the safety, effectiveness and necessity of vaccines.

5.3.13 Safety of natural contraction of infectious disease versus vaccination

Table 16 shows that the majority of participants felt that contracting chickenpox (84.5%), measles (73.8%) and mumps (75.6%) was safer than being vaccinated against them. To a lesser extent, they felt the same about rubella (61.4%) and pertussis (51.8%). Moskowitz (1983) states vaccinations short-circuit important primary immune responses due to the route of administration and Swift (2004) therefore questions whether a normal immune reaction can occur following a vaccination.

5.3.14 Desire of administration of vaccinations to practitioners own children

Table 17 shows responses to Question 2.14 and are ranked from most to least frequently selected. Polio was the most commonly selected response (52.3%), followed by 42% who responded that they will not use orthodox vaccines. Tetanus was selected in 37.2% and Hepatitis B in 24.4%. Only 5.8% said they would vaccinate against chickenpox.

5.3.15 Basis for opinions on vaccinations

Table 18 shows that the concern of adverse effects (77.9%) was the foremost concern of homoeopaths with regards to forming their opinions with regards to orthodox vaccinations whereas homoeopathic training accounted for 67.4%, while personal beliefs or experiences accounted for 55.8%.

5.3.16 Indication of whether the intervention protocol would differ according to the appropriateness of individual patients

The vast majority of homoeopaths (80.5%) indicated that their intervention protocols would differ depending on individual circumstances (Table 18). Considering the varying circumstances facing the South African population, I find this essential, especially as Morrell (2000) states that the decline in infectious diseases was due to better methods of sanitation, sewage disposal and distribution of food and water as well as access to safe drinking water and basic healthcare. Therefore these all need to be taken into account when treating a patient or working out the most appropriate intervention protocol for each individual.

5.4 Part C: Homoeopaths experience with regards to childhood vaccinations

To investigate the treatment regimes followed by homoeopaths prior to, post, or as an alternative to recommended allopathic childhood vaccination treatment within South Africa.

5.4.1 Preferred "vaccination" method

Of the participants, 60.5% preferred to use a combination of both homoeopathic remedies and orthodox vaccinations. Almost equal proportions of participants avoided orthodox vaccines (23.3%) and used only homoeopathic remedies (24.4%). A mere 4.7% used orthodox vaccinations only, as seen in Figure 8.

5.4.1.1 Elaboration of the use of orthodox vaccines

Table 19 shows that 22.1% of homoeopaths would use orthodox vaccinations if the disease was life threatening. Only 3.5% would use them if there was a family history of the disease.

5.4.1.2 Elaboration of combining homoeopathic and orthodox vaccines

Those who preferred using a combination of orthodox and homoeopathic remedies opted mainly to treat adverse reactions homoeopathically (47.7%) while 36% administered the standard remedy prior to or post orthodox vaccinations (Table 20).

5.4.1.2.1 Standard concurrent single remedy, stipulation of remedy and potency scale

Table 21 shows that just under half (46.5%) of the practitioners used Thuja as a concurrent standard remedy which is not surprising as Smits (2006) states that “for many years Thuja was acknowledged by homoeopaths as the proven remedy for these complaints” when speaking about the “post-vaccination syndrome.” A mere 19.8% used Silica and this correlates with an anti-miasmatic approach used in homoeopathy towards vaccinations and may protect against potential damage caused by vaccinations (Neustaedter, 1996). Table 21 also shows the median potency used was 30CH which conforms to aphorism 128 and was the dilution advocated by Hahnemann for most purposes (O’Reilly, 1997).

5.4.1.2.2 Standard concurrent remedy complex

For those who administered a vaccination complex, it can be noted that no two complexes administered were the same as these complexes are practitioner specific, as seen in Table 22.

5.4.1.3 Treatment protocol if orthodox vaccinations are avoided

Of those who preferred avoiding orthodox vaccines, their preferred alternative method of intervention was treating symptoms according to the law of similars (30.2%). Treating symptoms according to the clinical picture was preferred in 18.6% of participants

(Question 3.2.1) as was using a constitutional remedy preferred by 18.6% of participants (Table 23).

5.4.2 Standard treatment protocol pre and post-vaccinations

Table 24 indicates 61.8% of participants had a standard protocol for treating children prior to or following their allopathic vaccinations. Figure 9 shows that of those who had a standard protocol for treating children prior to their orthodox vaccinations, administering a standard homoeopathic remedy was the most common practise, followed by a constitutional remedy and then the practitioners own combination. Figure 10 shows that for those who administered a treatment protocol post orthodox vaccination, a standard remedy remained the most popular, followed by their own combination and thirdly nosodes.

5.4.3 Preferred treatment alternatives

Many of the participants (60.8%) recommended alternative preventative strategies to treat children as opposed to using orthodox vaccinations (Table 25).

5.4.3.1 Method

Table 26 shows that the most common types of alternative homoeopathic strategies used were constitutional prescribing (27.9%), followed by administration of remedy according to presenting disease (19.8%) and the administration of nosodes (18.6%).

5.4.4 Noted adverse effects in patients

5.4.4.1 Percentage

Majority of participants (76.5%) had seen adverse reactions that they believed to be caused from vaccinations in their patients, as noted in Table 27.

5.4.4.2 Types of adverse effects

Fever was the most commonly reported adverse reaction (61.6%) followed by eczema (54.7%) and irritability (53.5%) as seen in Table 27.

5.5 Cross tabulation of results

To examine associations between the opinions and treatment regimes used by homoeopaths with regards to childhood vaccinations.

Table 28: Cross–tabulation between general opinion of vaccines and preferred method of vaccinating infants

Most participants seemed to be comfortable using a combination of homoeopathic and orthodox method of vaccinating infants as 73.7% of participants who indicated they were happy with vaccinations in general would employ this treatment method whereas 54.8% of those who weren't happy with vaccinations in general would use this method. However, 19 participants stated they would avoid orthodox vaccines and 19 participants stated they would use homoeopathic remedies only.

Table 29: Cross tabulation between age of practitioner and general opinion of vaccines

Statistically, no differences in between the age of the practitioners and their general opinion of vaccines were found. However, on looking at the table, it is of interest to note that there is a 50-50 split of opinion between whether to vaccinate or not in the age groups of 40-49 as well as those over 60 whereas all other age groups show a preference against vaccinating by a minimum of at least 72.7%. It was also interesting to note that nobody above the age group 30-39 felt insufficiently informed to comment – they had all formed their own opinions by this age group.

Table 30: Cross tabulation between gender & general opinion of vaccines

Table 30 shows a statistically significant relationship between gender and general opinion of vaccines and we can therefore conclude that gender does, in fact, seem to affect a practitioners general opinion of vaccines as female practitioners were less likely to agree with administering orthodox vaccinations, in general.

Table 31: Cross tabulation between years of practice & general opinion of vaccines

The sample data was not strong enough to conclude that there is a statistically significant relationship between years of practice and general opinion of vaccines. However, on glancing at the results within the tables, one can see that there are significant variations throughout the different age categories.

Of the homoeopaths practicing for three years or less, 10.3% felt insufficiently informed to comment. This number decreased to only one respondent who had been practicing for 4-6 years as well as 6-9 years and disappeared altogether after that. Although the percentage of homoeopaths against vaccines in general (72.9%) always outweighs those in support of vaccines in general (21.2%), it is interesting to note the variation. Majority (69%) of homoeopaths who have been practicing for three years or less were against vaccines. This figure increased to 87.5% for the homoeopaths who had been practicing for 4-6 years but then dropped to 75% for those with 6-9 years in practice and 67.9% for those with ten years or more experience as in Table 31.

Table 32: Cross tabulation between whether practitioner has children of their own and their general opinion of vaccines

Most homoeopaths felt they would not vaccinate their children – whether they had children of their own or not – 74.5% of those with children felt they would not vaccinate versus 67.6% who did not have children and 23.4% with children stated they would still vaccinate whereas 21.6% without children said they would vaccinate. However, again the results when using the sample data was not strong enough to conclude that there was a statistically significant relationship between whether the practitioner had children and whether this influenced their general opinion of vaccines.

Although there is statistically no significance between those with children of their own and those without versus their opinions of whether vaccinations should be given or not, I found it interesting to see that only one respondent who had children felt insufficiently informed to comment whereas four who did not have children felt insufficiently informed to comment, indicating that those with children have given more thought to this topic.

Table 33: Cross tabulation between other qualifications and general opinion of vaccines

Of the participants who did have other qualifications over and above a homoeopathic degree, the percentage of participants who felt insufficiently informed to comment dropped down to 2.4% and although there weren't statistically significant changes, more participants with multiple qualifications felt that vaccinations should be given – increased to 28.6% as opposed to 69% who felt vaccinations should not be given.

According to Ernst (2001) there is a shift from allopathic treatment towards more complementary options, making more homoeopaths primary contact practitioners. Thus homoeopaths are dealing with more questions regarding vaccinations and they could therefore either enable or disable the policies of the government. This research therefore aimed to investigate the generalized opinions and treatment regimes of homoeopaths with regards to childhood vaccinations and to therefore determine whether a consensus on this topic exists, within the homoeopathic profession in South Africa. Furthermore, this study aimed to establish a basis from which a cohesive opinion amongst registered homoeopaths could exist within the unique South African context with regards to their opinions and intervention protocols regarding childhood vaccinations and the possible alternatives. From the above results, one can see there is no cohesion besides that the majority do not support orthodox vaccinations.

It was clear that there is no strict consensus although most homoeopaths (72.1%) do not agree with orthodox vaccinations, in general. However, their intervention protocol varied tremendously as well as their opinions regarding the optimal duration that should elapse prior to as well as between vaccinations.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

It was presumed that most homoeopaths would disagree with vaccinations and 72% of them are not in favour of vaccinations, in general. However, 44.4% of them felt that the risks of vaccinations did not outweigh the benefits. This is a slightly ambiguous result and more accurate or further questioning may have clarified this. On reviewing data, it was noted that Question 2.11 on the questionnaire may have been mis-interpreted.

Given South Africa's unique socio-economic environment, it can be postulated, homoeopaths would not like vaccinations. However, childhood diseases which should be able to be controlled in other first world countries – if conditions were ideal, lead to death in South Africa and therefore we need to take extra precautions within South Africa. Whether vaccinations are further detrimental or not, under these circumstances, is not yet determined.

Aspects which seemed to affect the participant's opinions were the age of the practitioner – and the way in which they had been educated – "old school" practitioners were commonly under the impression that orthodox vaccinations were compulsory. Other important factors include the practitioners' confidence within themselves as well as the profession including what they have been exposed to so they can offer alternatives to their patients and their parents with confidence.

Although literature demonstrates homoeopaths take a strong anti-vaccination stance, results have not been as strong as was expected, therefore this could be further studied on other vaccines, especially HIV / AIDS, HPV, herpes or other diseases – not only childhood vaccines.

Results indicate that majority of participants did not support the use of vaccinations although their treatment protocol and general opinions regarding vaccinations, in general, varied tremendously.

In conclusion, although literature demonstrates homoeopaths take a strong anti-vaccination stance, results have not been as strong as was expected. Some form of standardization regarding this issue within the profession would create uniformity and a sense of togetherness where the practitioners could stand united and the combined knowledge and experience could be used to gain results quickly and efficiently.

6.2 Recommendations

This survey can be adapted to be conducted amongst traditional healers in the rural areas of South Africa to ascertain whether their perceptions are congruent with government recommendations.

- Recommend a further study on adverse effects caused by vaccinations noted in homoeopathic and other medical practices.

- Controversy still looms and continues to do so as more and more vaccines are introduced and more advertising campaigns are launched. This further confuses the "vaccination debate" and destroys the impression of a unified profession which this research is trying to establish, or build on. Considering homoeopathy is not well established within South Africa and doesn't have a good reputation with the general public as yet, contradictions such as this further tarnish its reputation therefore establishing a unified stance could help its image. Therefore establish basic guidelines for practitioners to follow.

- Recommend rural homoeopaths within South Africa are surveyed to determine if their interventions differ from the homoeopaths surveyed here, depending on the conditions facing their patients.

- In conclusion, since Burnett's era in 1884, the theory and practice of homoeopathy has taught us that the approach to prevention, involving the injection of material doses of live or attenuated viral material, along with various chemicals, has consequences not

only for short-term health, but more significantly, for long-term health. It is thus understood that the issue of vaccination has been consistently addressed by homoeopaths and needs to be more consistently taught in homoeopathic schools, and discussed in organizations and journals.

- Additionally, homoeopaths need to be better acquainted with homoeoprophylaxis, a treatment unknown to many homoeopaths and derided by some.

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APPENDICES

Appendix A: *Practitioner Information Letter*

Faculty of Health Sciences
D.U.T. Department of Basic Medical Sciences
P.O. Box 1334
Durban
4000

DATE:

Dr Practitioner's Name
Practitioner's Address

Dear Dr Practitioner's Name

I am currently a homoeopathic student at the Durban University of Technology involved in a research project to fulfill the requirements of my course.

Title of research: A survey of the opinions and interventions of homoeopaths living throughout South Africa, who are registered with the Allied Health Professions Council of South Africa (AHPCSA), regarding childhood vaccinations.

Name of researcher: Kate Couchman (083 454 4504 or 031 268 7262)
Name of research supervisor: Dr Charmaine Korporaal, M. Tech (Chiro), CCFC, CCSP, ICSSD (031 373 2094)

Rationale for the study: Sinclair (2002) acknowledges there is a debate with regards to vaccinations as the public realize orthodox vaccinations are not the only option available to them. Ernst (2001) states there is a shift from allopathic treatment towards more complementary options. Considering homoeopaths are primary contact practitioners, this research aims to investigate where they stand regarding this topic and if there is a consensus between the practitioners, as a whole.

Neustaedter (1991), The World Health Organization (WHO) (2006) and Coulter (1990) state that childhood vaccinations are a controversial topic within society as a whole, as well as homoeopathy. Scheibner (2006) states the World Health Organization (WHO) acknowledges there are many side effects and contra-indications of vaccinations but Offit et al. (2002) state there are also many concerns regarding not vaccinating children.

Curtis (2003) states there are homoeopathic alternatives to immunization. This study aims to investigate the opinions and interventions utilized by homoeopaths, as primary health care physicians. At present, there is no literature regarding the opinions of homoeopaths in South Africa on the use of childhood vaccinations. Considering homoeopaths are primary contact physicians, they could either enable or disable the policies of the government.

This research therefore aims to investigate the generalized opinions and interventions of homoeopaths with regards to childhood vaccinations and to therefore determine whether a consensus on this topic exists, within the homoeopathic profession in South Africa.

Objectives that the study wishes to achieve: Investigate the interventions followed by homoeopaths prior to, post, or as an alternative to recommended allopathic childhood vaccinations. I also wish to analyze the trends within the opinions and interventions used by homoeopaths in South Africa, with regards to childhood vaccinations.

I have chosen this topic because no survey assessing homoeopaths' opinions of vaccinations has previously been conducted. The results may prove to be valuable as a greater awareness of homoeopathic interventions with respect to vaccinations may be highlighted.

The process of receiving and returning the questionnaire: I have included a copy of the questionnaire. Please complete the questionnaire as accurately as possible and return your completed questionnaire at your earliest convenience. To ensure complete confidentiality, the questionnaire will not be returned directly back to the researcher, instead it will be received by Mr Julian Pillay who will then dispose of any personal information once he's noted the return of your completed questionnaire to ensure confidentiality. He will then hand the completed document over to me. Mr Pillay is a third

party participant and has no direct association with the Homoeopathic department. Please note consent to participate in this survey will be assumed by your completion and return of this questionnaire.

Risks, costs and benefits to the respondent: I don't foresee any potential risks to you, the participant, as we will ensure complete confidentiality is maintained. There will also be no costs involved on your behalf, besides the time you spend on completing the questionnaire. However, the benefits of your co-operation are to assist the researcher determine homoeopaths opinions regarding vaccinations which will potentially alleviate and expose some of the controversies associated with this controversial topic. Please be assured that this is not a "marketing ploy" but a sincere, potentially informative research topic that will assure confidentiality will be maintained.

Your participation in this research study would be invaluable and necessary for us to obtain a realistic view of demographics and the current status of practice of homoeopaths in this regard. Therefore, I would be very grateful if you would assist me by completing the attached questionnaire, which should take no longer than 20 minutes of your time. Please do not hesitate to contact me should you require any further information regarding this research study.

If you do decide to complete this questionnaire, I would like to take this opportunity to thank you in advance for your participation and valuable input.

Yours sincerely

Kate Couchman	Dr C.Korporaal M.Tech:(Chiro)
RESEARCH STUDENT	SUPERVISOR
(031) 268 7265 or 083 4544 504	031 373 2094 or 083 246 3562

Appendix B: Final Questionnaire for Registered Homoeopathic Practitioners

REGISTERED HOMOEOPATHS OPINIONS AND INTERVENTIONS WITH REGARDS TO CHILDHOOD VACCINATIONS.

This survey takes about 20 minutes to complete. The data will only be identified by code numbers and no names and contact details will be connected to them ensuring confidentiality. By completing the questionnaire, it will be assumed that you have given your informed consent in order for the information to be utilized for research purposes.

INSTRUCTIONS:

- All practitioners are requested to fill in Part A (Demographic data).
- Part B applies to the opinions of homoeopathic practitioners with regards to the vaccination schedule, as suggested by the South African government.
- Part C applies to your typical treatment regime with regards to vaccinations.
- Please **CIRCLE or HIGHLIGHT** answers where appropriate.
- There may be specific instructions for particular questions, please follow these as indicated for the particular question.
- When an option is given for “other” please specify in the space provided.
- Please return the completed questionnaire in the self-addressed envelope.

Part A: Demographic data

1.1 Please state your Gender.

Male	1	Female	2

1.2 Please state your age at your last birthday.

1.3 Please state your ethnicity.

Asian	1	Black	2	Coloured	3	Indian	4	White	5	Other	6

Other: _____

1.4 Where did you obtain your homoeopathic qualification?

Durban University of Technology – previously Technikon Natal	1
University of Johannesburg – previously Witswatersrand Technikon	2
Other – please specify_____	3

1.4 Please indicate in the respective block the year of qualification for your homoeopathic qualification and registration with the Allied Health Professions Council of South Africa (AHPCSA).

Qualification	
Registration	

1.5 Please state your age on qualification.

1.7 Please state the field and descriptions of any additional qualifications obtained other than your Homoeopathy Degree.

	Field e.g. Science, Health etc.	Description e.g. Psychiatry, Accountancy
1		
2		
3		

1.7 Please state the number of years you've been in practice as a homoeopath.

1.8 Do you have children of your own?

Yes	1
No	2

Part B: Opinions of the recommended childhood vaccination schedule used within South Africa.

2.1 Please rate your agreement with the administration of each of the following vaccinations.

Vaccination	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Insufficiently informed to comment
BCG	1	2	3	4	5	6
Chickenpox	1	2	3	4	5	6
DPT	1	2	3	4	5	6
Hepatitis A	1	2	3	4	5	6
Hepatitis B	1	2	3	4	5	6
Hib	1	2	3	4	5	6
Measles	1	2	3	4	5	6
MMR	1	2	3	4	5	6
Polio	1	2	3	4	5	6
Pneumococcal	1	2	3	4	5	6

Comment:_____
_____

2.2 Please rate your opinion with regards to the timing of each of the following vaccinations.

Vaccination	Too close together	Timing is appropriate	Too far apart	Uncertain	Repeated too often	Insufficiently informed to comment
BCG	1	2	3	4	5	6
Chickenpox	1	2	3	4	5	6
DPT	1	2	3	4	5	6
Hepatitis A	1	2	3	4	5	6
Hepatitis B	1	2	3	4	5	6
Hib	1	2	3	4	5	6
Measles	1	2	3	4	5	6
MMR	1	2	3	4	5	6
Polio	1	2	3	4	5	6
Pneumococcal	1	2	3	4	5	6

Comment:_____
_____

2.3 What duration do you feel is optimal to elapse before a child is given their first vaccination? Please circle, then stipulate the number of days / months / years in the column alongside.

Days	1	
Months	2	
Years	3	
Children should not be vaccinated	4	
Insufficiently informed to comment	5	

Comment: _____
_____

2.4 What duration do you feel is optimal to elapse between vaccinations before administering the consecutive vaccination? Please circle, then stipulate the number of days / months / years in the column alongside.

Days	1	
Months	2	
Years	3	
Children should not be vaccinated	4	
Insufficiently informed to comment	5	

Comment:_____

2.5 In your opinion, please rate the importance of the following in contributing to the decline of infectious diseases.

Vaccination	Very important	Important	Hardly important	Uncertain	No influence	Insufficiently informed to comment
Decreased virulence of micro-organism	1	2	3	4	5	6
Improved education	1	2	3	4	5	6
Improved nutrition	1	2	3	4	5	6
Improved sanitation	1	2	3	4	5	6
Improved healthcare	1	2	3	4	5	6
improved access to healthcare	1	2	3	4	5	6
Vaccinations	1	2	3	4	5	6

Comment:_____
_____

2.6 Do you support the use of poly-vaccinations (more than one vaccination administered in a single visit)?

Yes	1
No	2
I am insufficiently informed to comment	3

Please elaborate:_____
_____

2.7 Are you in favour of vaccinations in general?

Yes	1
No	2
I don't know or am insufficiently informed to comment	3

Comment:_____
_____

2.8 Do you believe there is enough scientific proof that vaccinations prevent infectious diseases?

Yes	1
No	2
I don't know or am insufficiently informed to comment	3

Comment:_____
_____

2.9 Do you believe any of the following are common side effects of vaccinations?

Signs & symptoms	Yes	No	Unsure	I am insufficiently informed to comment
ADD/ADHD	1	2	3	4
Anaphylaxis	1	2	3	4
Anorexia	1	2	3	4
Autism	1	2	3	4
Encephalitis	1	2	3	4
Fever	1	2	3	4
Headaches	1	2	3	4
Irritability	1	2	3	4
Joint pains	1	2	3	4
Local inflammation	1	2	3	4
Lymphadenopathy	1	2	3	4
Neurological disorders	1	2	3	4
Non-infectious rash	1	2	3	4
Pain & discomfort	1	2	3	4
Stiff neck	1	2	3	4
Thrombocytopenia	1	2	3	4

Other - Please elaborate:_____
_____

2.10 Do you believe vaccinations have substantially changed the incidence of any of the following infectious diseases?

Infectious disease	Yes	No	Unsure	I am insufficiently informed to comment
Chickenpox	1	2	3	4
Diphtheria	1	2	3	4
Haemophilus influenza B	1	2	3	4
Hepatitis A	1	2	3	4
Hepatitis B	1	2	3	4
Measles	1	2	3	4
Mumps	1	2	3	4
Pertussis	1	2	3	4
Pneumococcal	1	2	3	4
Polio	1	2	3	4
Rubella	1	2	3	4
Tetanus	1	2	3	4
Tuberculosis	1	2	3	4

Comment:_____
_____

2.11 Do you believe the risk of vaccinations outweigh their usefulness in preventing diseases?

Yes	1
No	2
I don't know or am insufficiently informed to comment	3

Comment:_____
_____

2.12 Do you believe the risk of a few adverse reactions to vaccines is acceptable if the majority of the population are protected against infectious diseases?

Yes	1
No	2
I don't know or am insufficiently informed to comment	3

Comment:_____
_____

2.13 Do you believe that contracting any of the following infectious diseases naturally, is generally safer than being vaccinated against them?

Infectious disease	Yes	No	Unsure	I am insufficiently informed to comment
Chickenpox	1	2	3	4
Diphtheria	1	2	3	4
Haemophilus influenza B	1	2	3	4
Hepatitis A	1	2	3	4
Hepatitis B	1	2	3	4
Measles	1	2	3	4
Mumps	1	2	3	4
Pertussis	1	2	3	4
Pneumococcal	1	2	3	4
Polio	1	2	3	4
Rubella	1	2	3	4
Tetanus	1	2	3	4
Tuberculosis	1	2	3	4

Comment:_____
_____

2.14 Please circle the number corresponding to all of the infectious diseases you would want your children to be vaccinated against with the recommended orthodox vaccinations.

Chickenpox	1
Diphtheria	2
Haemophilus influenza B	3
Hepatitis A	4
Hepatitis B	5
Measles	6
Mumps	7
Pertussis	8
Pneumococcus	9
Polio	10
Rubella	11
Tetanus	12
Tuberculosis	13
I wouldn't use orthodox vaccinations	14

Comment: _____
_____

2.15 Please circle the number of all of the appropriate options that indicate the basis for the formation of your opinion with regards to orthodox vaccinations?

Antenatal classes	1
Concern of adverse effects	2
Concern of infectious diseases	3
Concern of suppression	4
Government campaigns	5
Government stipulations	6
Homoeopathic training or literature	7
Personal beliefs or experience	8
Religion	9
Scientific literature	10
Other _____	11

2.16 Please indicate if your intervention protocol would differ according to the appropriateness of individual patients with regards to the patient's socio-economic, educational and nutritional status as well as their accessibility to sanitation, sewage disposal, basic healthcare and distribution of food and water as well as available hygiene.

Yes	1
No	2
Unsure	3

Comments: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Part C: Your experience with regards to vaccinations

3.1 In general, what is your preferred method of "vaccinating" infants?

Using orthodox vaccinations only	1
Using a combination of homoeopathic remedies and orthodox vaccinations	2
Avoiding orthodox vaccinations	3
Using homoeopathic remedies on their own	4
I don't know or am insufficiently informed to comment	

Comment:_____
_____
_____

3.1.1 If you prefer the use of orthodox vaccinations, please circle as many options as you feel are appropriate. If you respond to this question please continue with question: 3.2

As stipulated by the South African government	1
Using certain life-threatening vaccines only	2
Using all the vaccinations, but delaying the administration	3
Using the vaccinations to which the individual shows signs of susceptibility	4
If there is a family history of the indicated disease, I prefer using orthodox vaccinations	5
Other _____ _____	6

3.1.2 If you prefer combining homoeopathy with orthodox vaccinations, please circle as many options as you feel are appropriate. If you respond to this question please continue with question: 3.2

Administering a standard remedy prior to or post orthodox vaccinations	1
Administering a "vaccination complex" prior to or post orthodox vaccinations	2
Administering a "constitutional remedy" prior to or post orthodox vaccinations	3
Using homoeopathically prepared vaccines as well as orthodox vaccines	4
Using homoeopathically prepared nosodes as well as orthodox vaccines	5
Treat any adverse reactions homoeopathically	6
Other:_____ _____	7

3.1.2.1 If you administer a standard remedy concurrently, please stipulate which remedy and which potency scale

		Potency
Belladonna	1	
Nux Vomica	2	
Silica	3	
Sulphur	4	
Thuja	5	
Other: _____	6	

3.1.2.2 If you administer a "vaccination complex" concurrently, please stipulate which remedies and potencies constitute your complex.

_____
_____
_____

3.2.1 If you prefer to avoid orthodox vaccinations completely, please elaborate on your alternate method of treatment. If you respond to this question please continue with question: 3.2

Using homoeoprophylaxis – according to a specific regime	1
Using homoeopathically prepared vaccines as opposed to orthodox vaccines	2
Using homoeopathically prepared nosodes as opposed to orthodox vaccines	3
Using a constitutional remedy to strengthen the vital force at specific milestones	4
Giving the patient a constitutional remedy when symptoms arise	5
Treating the symptoms as they arise according to the Law of Similars	6
Treating the symptoms as they arise according to the clinical picture (Genus epidemicus)	7
Treating the symptoms as they arise according to the Aetiology	8
Other. Please elaborate _____	9

3.2.2 Do you have a standard protocol for treating children prior to or following their orthodox vaccinations?

Yes	1
No	2
Have not been required to address this issue in practice yet	3

Comment:_____
_____

3.2.2.1 If yes, please specify what form of remedy you administer.

	Prior to	Post
Tautopathic preparation of the vaccination	1	1
Isopathy – the use of the "same" medicine for curing a disease	2	2
Nosodes	3	3
Constitutional	4	4
Homoeopathic prophylaxis	5	5
Administration of a standard remedy	6	6
Administration of your own combination	7	7
No remedy given	8	8
Other – please elaborate_____ _____	9	9

3.3 Do you recommend any other preventative strategies to treat children as opposed to utilizing orthodox vaccinations?

Yes	1
No	2
I don't know or am insufficiently informed to comment	3

Comment: _____
_____

3.3.1 If yes, please indicate your strategy.

Tautopathic preparation of the vaccination	1
Isopathy	2
Potentized nosodes	3
Constitutional	4
Homoeopathic prophylaxis	5
Administration of a standard remedy	6
Administration of your own combination	7
Administration of a remedy, according to the acute presenting disease	8
No remedy given	9
Other – please elaborate _____	10

3.4 Have you noted any adverse effects due to vaccinations in your patients?

Yes	1
No	2
Unsure	3
Have not been required to address this issue in practice yet	4

3.4.1 If yes, please indicate approximately what percentage of your vaccinated patients have been affected.

3.4.2 Please indicate what type of adverse effects you have noted.

Abscess formation	1
ADD/ADHD	2
Anaphylaxis	3
Anorexia	4
Autism	5
Chest affections	6
Ear, nose or throat affections	7
Eczema or other skin affections	8
Fever	9
Headaches	10
Irritability	11
Joint pains	12
Local inflammation	13
Lymphadenopathy	14
SIDS	15
Stiff neck	16
Thrombocytopenia	17
Other: _____	18

Thank you very much for completing this questionnaire.

I appreciate the time you've taken to complete it as well as for your input, to make my research possible. If you would like a copy of the final abstract, please note it will be available at Steve Biko campus, Durban University of Technology.

Appendix C: "Invitation" to Potential Focus Group Participants

26 April 2007

Dear Potential Participant

I am currently drafting my questionnaire for my mini-dissertation, entitled "**A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations."** The study will take the form of a descriptive survey. In this case, the population being surveyed will be homoeopaths who are registered with the Allied Health Professions Council of South Africa and live in South Africa.

The survey will be conducted by means of a self-administered questionnaire which will be sent to the relevant sample group.

As a survey of this nature has not previously been conducted, the questionnaire was compiled from many different sources. The questions utilized in this questionnaire have been either adopted or adapted from various previously utilized questionnaires due to their similarity to this survey and the assumption they have previously undergone pilot studies in order to maximize clarity and validity.

I am therefore writing this letter to request your participation in my focus group on 7 May at 8:00. A light breakfast will be provided and I would appreciate any input you may have to offer so as to improve my questionnaire.

Please could you confirm whether you would be available at this time at your earliest convenience. My telephone numbers are as follows: Home (031) 2687262 and cell 082 6363 548.

Thank you in advance.

Yours sincerely

_____

Kate Couchman

Appendix D: Letter Of Information for Focus Group Participant

Dear Participant.

I would like to welcome you into the focus group of my study.

The title of my research project is:

A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations.

Background to the study:

The South African Government Gazette (2003) states vaccinations are the administration of a vaccine to stimulate a protective immune response that will prevent disease in the vaccinated person if contact with the corresponding infectious agent occurs subsequently.

"Vaccination - be it conventional or homoeopathic - has always remained controversial" (Bhatia, 2006). Tenrreiro (2005) suggests that improved vaccine risk/benefit communication needs to be implemented. Vaccinations carry certain risks, however there are also many concerns regarding not vaccinating infants.

Currently, no literature regarding the opinions of homoeopaths residing in South Africa on the use of childhood vaccinations can be found. This study therefore aims to investigate the general opinions and interventions of homoeopaths with regards to childhood vaccinations and to therefore determine whether a consensus on this topic exists, within the homoeopathic profession in South Africa.

There are many side effects and contra-indications of vaccinations but there are also many concerns regarding not vaccinating infants.

This research therefore aims to investigate the generalized opinions and treatment regimes are utilized by homoeopathic practitioners, as primary health care physicians, with regards to vaccinations and to therefore determine whether a consensus on this topic exists, within the homoeopathic profession in South Africa.

Despite the importance of this issue, there has been no extensive research into this field within the homoeopathic community. Thus the reason for holding the focus group is to stimulate individuals thinking and encourage them to develop ideas about the topic (Salant and Dillman, 1994). Focus groups also encourage individuals other than those doing the research to support the research process by increasing research relevance. (Salant and Dillman, 1994).

In order to understand the outcomes required for the focus group it is important to understand the objectives set out for this study: The purpose of this study is to determine the opinions of homoeopaths with regards to childhood vaccinations and their approach to patient management regarding the use of vaccinations.

This study will document the interventions offered by homoeopaths concurrently or as an alternative to allopathic vaccinations.

Finally, this research will analyze the trends within the opinions and interventions used by homoeopaths with regards to vaccination treatment.

Therefore the research would require you, as members of the focus group, to assist in identifying as many pertinent factors as possible as a result of your participation or association with the programme.

Your participation in this study is much appreciated and you are assured that your comments and contributions to the discussion will be kept confidential. The results of the discussion will only be used for research purposes.

If you have any further questions please feel free to contact me.

_____

Kate Couchman
(082 6363 548 / 031 268 7262)

Appendix E: Confidentiality Statement – Declaration for Focus Group

IMPORTANT NOTICE:

THIS FORM IS TO BE READ AND FILLED IN BY EVERY MEMBER PARTICIPATING IN THE FOCUS GROUP, BEFORE THE FOCUS GROUP MEETING CONVENES.

1. All information contained in the research documents and any information discussed during the focus group meeting will be kept private and confidential. This is especially binding to any information that may identify any of the participants in the research process.
2. The returned questionnaires will be coded and kept anonymous in the research process.
3. None of the information shall be communicated to any other individual or organization outside of this specific focus group as to the decisions of this focus group.
4. The information from this focus group will be made public in terms of a journal publication, which will in no way identify any participants of this research.
5. Once this form has been read and agreed to, please fill in the appropriate information below and sign to acknowledge agreement.

Member represents	**Member's Name**	**Signature**	**Contact Details**

Appendix F: Code of Conduct for Focus Group

This form needs to be completed by every member of the Focus Group prior to the commencement of the focus group meeting.

As a member of this committee I agree to abide by the following conditions:

1. All information contained in the research documents and any information discussed during the focus group meeting will be kept private and confidential. This is especially binding to any information that may identify any of the participants in the research process.

2. Due respect to be given to every suggestion and comment by any member of the focus group and be debated with reference to the outcomes of the research.

3. The information gathered from this focus group by the researcher will be made public in terms of a mini dissertation and journal publication. The researcher will ensure that any participants in the focus group and research remain anonymous and confidential.

Member represents	Member's Name	Signature	Contact Details

Appendix G: Informed Consent Form for Focus Group Member

DATE:

TITLE OF RESEARCH PROJECT:
A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations.

NAME OF SUPERVISOR: Dr C. Korporaal (031 373 2094 or 083 246 3562)

NAME OF RESEARCH STUDENT: Kate Couchman (031 268 7262 or 082 6363 548)

Please circle the appropriate answer	**YES /NO**	
1. Have you read the research information sheet?	Yes	No
2. Have you had an opportunity to ask questions regarding this study?	Yes	No
3. Have you received satisfactory answers to your questions?	Yes	No
4. Have you had an opportunity to discuss this study?	Yes	No
5. Have you received enough information about this study?	Yes	No
6. Do you understand the implications of your involvement in this study?	Yes	No
7. Do you understand that you are free to		
a) Withdraw from this study at any time?	Yes	No
b) Withdraw from the study at any time, without reasons given	Yes	No
c) Withdraw from the study at any time without affecting your future health care or relationship with the Homoeopathic day clinic at the Durban University of Technology.	Yes	No
8. Do you agree to voluntarily participate in this study	Yes	No
9. Who have you spoken to regarding this study?		

If you have answered NO to any of the above, please obtain the necessary information from the researcher and / or supervisor before signing. Thank You.

Please print in block letters:

Focus Group Member: _____ Signature: _____

Witness Name: _____ Signature:_____

Researcher's Name: _____ Signature:_____

Supervisor's Name: _____ Signature:_____

Appendix H: "Invitation" to Potential Pilot Study Participant

11 September 2007

Dear Potential Participant

I am currently drafting my questionnaire for my mini-dissertation, entitled "**A survey of the opinions and interventions of registered South African homoeopaths, regarding childhood vaccinations."** The study will take the form of a descriptive survey. In this case, the population being surveyed will be homoeopaths who are registered with the Allied Health Professions Council of South Africa and live in South Africa.

The survey will be conducted by means of a self-administered questionnaire which will be sent to the relevant sample group.

As a survey of this nature has not previously been conducted, the questionnaire was compiled from many different sources. The questions utilized in this questionnaire have been either adopted or adapted from various previously utilized questionnaires due to their similarity to this survey and the assumption they have previously undergone pilot studies in order to maximize clarity and validity.

I am therefore writing this letter to request your participation in my pilot study on 18 September during the Departmental Meeting. A light breakfast will be provided and I would appreciate any input you may have to offer so as to improve my questionnaire.

Please could you confirm whether you would be available at this time at your earliest convenience. My telephone numbers are as follows: Home (031) 2687262 and cell 082 6363 548.

Thank you in advance.

Yours sincerely

_____

Kate Couchman

Appendix I: Assessment Form for Pilot Study

A survey of the opinions and interventions of registered South African homoeopaths regarding childhood vaccinations.

Date:

Dear participant.

Thank you for agreeing to assist in the piloting of the questionnaire to be used in the above mentioned research. You are requested to read the attached questionnaire in your own time. Once you have reviewed the questionnaire you are required to fill out the following assessment form. Additional comments can also be written on the questionnaire itself. All gathered information will be useful to ensure that the intended results of the survey are achieved.

Please answer and elaborate on the following:

1. Time taken to complete the questionnaire, please state approximate time for each section: Sec A_____ Sec B_____ Sec C_____

2. Do you feel the time taken to complete the questionnaire was too long in the context of other practitioners who would have to take time from work to complete it?

   _____

   _____

   _____

3. Is the presentation and layout of the questionnaire appropriate?

   _____

   _____

   _____

4. Were the instructions easy to follow?

   _____

   _____

   _____

5. Did you understand what was meant by the term ‘vaccination’?

_____

_____

_____

6. Were the questions clear?

_____

_____

_____

7. Did they follow a logical sequence?

_____

_____

_____

8. Were any questions irrelevant / inappropriate in your opinion?

_____

_____

_____

9. Additional comments.

_____

_____

_____

_____

_____

Thank you for your co-operation.

Yours Sincerely

Kate Couchman
Research Student

Dr C. Korporaal
Supervisor

Appendix J: Revised EPI (South Africa) schedule

EXPANDED PROGRAMME ON IMMUNISATION - EPI (SA)

Revised Childhood Immunisation Schedule from April 2009

Age of Child	Vaccines needed	How and where is it given?
At Birth	Polio Vaccine (0)	Drops by mouth
	BCG (Bacille Calmette Guerin) Anti-tuberculosis vaccine	Injection in Right arm
6 Weeks	Polio Vaccine (1)	Drops by mouth
	Rotavirus vaccine (1)	Liquid by mouth
	DTaP-IPV//Hib (1) Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined	Injection in Left thigh
	Hepatitis B Vaccine (1)	Injection in Right thigh
	Pneumococcal Conjugate Vaccine (1)	Injection in Right thigh
10 Weeks	DTaP-IPV//Hib (2) Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined	Injection in Left thigh
	Hepatitis B Vaccine (2)	Injection in Right thigh
14 Weeks	Rotavirus vaccine (2)	Liquid by mouth
	DTaP-IPV//Hib (3) Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined	Injection in Left thigh
	Hepatitis B Vaccine (3)	Injection in Right thigh
	Pneumococcal Conjugate Vaccine (2)	Injection in Right thigh
9 Months	Measles Vaccine (1)	Injection in Left thigh
	Pneumococcal Conjugate Vaccine (3)	Injection in Right thigh
18 Months	DTaP-IPV//Hib (4) Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and *Haemophilus influenzae* type b Combined	Injection in Left arm
	Measles Vaccine (2)	Injection in Right arm
6 Years	Td (1) Tetanus and reduced strength of diphtheria	Injection in Left arm
12 Years	Td (2)Tetanus and reduced strength of diphtheria	Injection in Left arm

NB. Rotavirus Vaccine should NOT be administered after 24 weeks of age (6 months)

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EXPANDED PROGRAMME ON IMMUNISATION

Appendix K: A list of thimerosal-free vaccines available in South Africa

Vaccine	Tradename	Manufacturer	Thiomersal free
BCG	BCG vaccine SSI	Vaccina (Biovac)	Yes
Cholera	Dukoral	Aventis	Yes
DTaP-Hib	Actacel	Aventis	Yes
DTaP-Hib + IPV	Pentaxim	Aventis	Yes
DTaP	Infanrix	GSK	Yes
DTaP + HepB + Hib + IPV	Infanrix Hexa	GSK	Yes
Hib	ACT-Hib Hiberix	Aventis GSK	Yes Yes
Hib-Hep B			
Hepatitis A	Avaxim Havrix	Aventis GSK	Yes Yes
Hepatitis B	Energix-B H-B-Vax II Heberbiovac	GSK MSD Biovac	Yes – may contain traces from manufacture (<0,005%) No- contains at least 0,005%
Hep A + Hep B	Twinrix	GSK	Yes
HPV	Cervarix Gardasil	GSK MSD	Yes Yes
IPV	Imovax polio	Aventis	Yes
OPV	OPV-Merieux Polioral	Aventis Biovac	Yes
MMR	Priorix	GSK	Yes - live