# Large Scale Homœoprophylaxis: Results of Brief and Long-Term Interventions

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**Abstract**
*Introduction*: The term homoeoprophylaxis (HP) was first coined by Burnett in 1884 to refer to medicines selected according to the Law/Principle of Similars to prevent targeted infectious diseases. HP medicines were first used by Hahnemann in 1798 and have been used since to protect significant numbers of people against a range of infectious diseases in many countries. This paper updates a recent analysis of HP use internationally, and examines a large intervention conducted over 11 years.
*Aims*: To present a brief "snapshot" of some major HP interventions in three countries and to illustrate to those who are unfamiliar with HP the extent to which it has been and is being used, often by Government-employed medical officers and scientists, in many countries. To use new data to analyze the value of HP against established diseases.
*Methods*: Using a previous analysis as a starting point, a literature search for new data concerning a massive HP intervention against Japanese Encephalitis in Andhra Pradesh, India was conducted. As well, new data for Acute Encephalitis Syndrome and new data from Telangana state to 2017 was collected. The new data was incorporated into the previous analysis and new summaries prepared.
*Results*: Thirty-four annual HP interventions were noted in India, Cuba and Brazil. When counted by person, by disease, and by year, over 250 million people were covered by the interventions studied. The effectiveness of HP appears to range between 63% and 99% with a weighted average around 90%. These results are consistent across short and long-term use. The HP programs against Japanese Encephalitis and Acute Encephalitis Syndrome in Andhra Pradesh and Telangana, India, and against Dengue Fever in Macaé, Brazil, were found to provide new insights into the use of HP in both short and long-term interventions.
*Discussion*: HP is used to prevent targeted diseases in large and small populations. Its use is often directed by government agencies and conducted by medical doctors and scientists. HP is potentially valuable, especially in situations where vaccination is not possible either due to there being no vaccine for the disease, or when an existing vaccine cannot be obtained in sufficient quantities, or in time to treat an outbreak; however, it also has potential value in all other situations where immunization is required.
*Conclusion*: There are proven benefits from the widespread use of appropriate HP interventions, including saving lives and preventing suffering. HP can provide governments a very economical practical option to combat infectious diseases in both short and long-term disease outbreaks.
**Keywords**: homoeoprophylaxis, infectious diseases, transitory, established, immunization, government sponsorship, genus epidemicus, nosodes.
*Conflict of interest* The author declares that he consults parents regarding immunization options, including homoeoprophylaxis.
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## Introduction

Homoeoprophylaxis (HP) is defined as the systematic use of potentized natural substances selected using the Law/Principle of Similars and administered using the Law/Principle of Minimum Dose to prevent the development of the characteristic symptoms of a targeted infectious disease in previously unprotected persons (i.e., have not had the disease nor used vaccination or HP).

Burnett first used the term Homoeoprophylaxis in 1884 saying, "that likes are prevented by likes, I could adduce very many examples to show," and that HP is "the prevention of disease according to the law of similars."(1) Dr. Samuel Hahnemann first used Belladonna 2C to prevent Scarlet Fever in 1798 (2), and later suggested three remedies to prevent Cholera (3). Since then HP has been used to prevent most infectious diseases in most countries.(4,5,6) However, it has only been in the last 15 years that the evidentiary base of HP has been significantly developed.

Table 1 summarizes a recent analysis which quantified the use of HP in 26 interventions in three countries.(7) Over 90 million people on an annualized basis had been protected, with effectiveness between 75% and 95%. Most of the interventions were directed by government agencies and undertaken by doctors and scientists employed by the agencies.

There was no attempt to list every HP intervention in these three countries, nor list the use of HP in other countries. In fact, it is probable that many HP interventions have not been

| Country | Programs | Interventions by Person, by Year and by Disease |
|---|---|---|
| | | |
| Cuba | 7 | 25,520,000 |
| India | 10 | 65,364,071 |
| Brazil | 9 | 1,072,039 |
| | **26** | **91,956,110** |

*Table 1: Summary of HP Interventions Listed*

documented because they are often undertaken in emergencies which require an immediate practical remedy distribution, and where meticulous pre-planning and highly organized record keeping are secondary to saving lives and suffering.(8)

## Objectives of Report

This report will introduce new information regarding the largest ongoing intervention in Table 1—against Japanese encephalitis (JE) in Andhra Pradesh, as well as against Acute Encephalitis Syndrome (AES) in Andhra Pradesh and Telangana States in India—and show the new figures for total coverage. This will lead into a discussion about the use of HP in endemic as well as epidemic conditions and inform policy on the potential use of HP in medium to long-term prevention in national health systems.

## Methods

The author visited India for the fourth time in 2018. Additional information about the use of HP to immunize against JE and AES in Andhra Pradesh and Telangana was collected. An extension to the previous JE program was identified and described.

Data concerning JE and AES from 1997 to 2017 was sought, and a variety of relevant sources were identified.(9) Trends were calculated.

Confounding factors were recognized: 1. In July 2014 Andhra Pradesh was separated into two states, with a new state Telangana being formed. Hence the data series had to accommodate this change, 2. Data regarding JE and AES was originally combined but has been shown separately from 2008 onwards. Some AES cases are caused by JE and some are not, making data classification difficult.(10) However, since HP is based on the Principle of Similars, and the symptoms of JE are similar to AES, the HP program against JE would have some benefit against AES because of this similarity.

It was therefore decided to combine the data for JE and AES, as well as to combine the results for Andhra Pradesh and Telangana states to provide as much consistency in the data trends as possible.

## Results

The HP interventions undertaken in three countries, and summarized in Table 1, were described in detail elsewhere.(7) Many more examples of HP interventions both in these and in other countries exist.(11)

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

Methods used to measure the effectiveness of results also is variable. Table 2 shows the classification scheme used in Table 3 to provide readers with a guide to the methodology used in each intervention.

| Code | Description |
|---|---|
| **Statistical** | |
| A | Direct control group |
| B | Indirect control group [12] |
| C | Simple % of cohort studied |
| D | Historical trend of actual reports |
| E | Fall factor analysis [13] |
| F | No control or historical trend |
| | |
| **Descriptive** | |
| G | Clearly positive result |
| H | Somewhat positive result |
| I | Unclear result |
| J | Negative result |
| K | Results not yet published |

*Table 2: Classification of Effectiveness*

The lack of homogeneity of studies as well as the variable quality of analysis makes a reliable meta-analysis of data problematical. However, there is consistency among reports quantifying effectiveness (which ranges between 63.9% to 99.96% with a weighted average after removing the highest and lowest readings of 89.45%). This reinforces the value of the overall findings, as does the fact that these interventions are "real world" responses to urgent needs, rather than academic studies.

Four major changes were made from the original analysis: 1. The removal of 500,000 participants in a 2014 intervention against Dengue Fever in Eastern provinces in Cuba. The intervention occurred, but the results are still not readily available; 2. The inclusion of a column showing whether the remedy used was a Nosode (N) (prepared from diseased material) or a Genus Epidemicus (GE) remedy (the most indicated treatment remedy); 3. The inclusion of a column showing if the intervention was Government directed; and 4. The addition of 160 million persons on an annualized basis due to the JE program in Andhra Pradesh being extended from 2001 to 2009. It was discontinued in 2010 due to the dramatic reduction in cases achieved. The implications of this change will be further examined below. The results are shown in Table 3 and the amended intervention totals are summarized in Table 4.

If further details of each intervention are required, they are available in the original analysis noted above.(7)

The amalgamation of JE and AES data from 1995 to 2017 in Andhra Pradesh and Telangana is reported in Table 5 and Figure 1. The figures in bold italics show where different figures were reported for the same time period in the different sources examined.(9) The figures used were selected by the author as being the most reasonable estimates based on examination of results shown in the different sources. Variations between these different figures were not large and use of possible alternatives would not meaningfully change the results or conclusions.

The spike in notifications and deaths from JE in 2003 needs to be examined more closely. There was disagreement whether the outbreak was encephalitis or Reye's Syndrome. Dr J. John stated that "The clinical features of the encephalopathy syndrome clearly suggest an acute brain disease of children in outbreaks, for which reason the illness is often mistakenly diagnosed as

| Year | Disease | Numbers | Government directed | Type/Dose | Effectiveness (%) |
|---|---|---|---|---|---|
| | **CUBA[14]** | **25,020,000** | | | |
| **2007** | Leptospirosis | 2.2 million | Yes, via Finlay Institute | N | B. |
| **2007** | Hepatitis A | 1 million | Yes, via Finlay Institute | N | D. |
| **2008** | Leptospirosis | 2.2 million | Yes, via Finlay Institute | N | B. |
| **2009** | Dengue Fever | 20,000 | Yes, via Finlay Institute | N, GE | A. 74.1% to 100.0% |
| **2010** | Swine Flu | 9.8 million | Yes, via Finlay Institute | N | D. |
| **2010** | Pneumococcal | 9.8 million | Yes, via Finlay Institute | N | D. |
| | **INDIA** | **224,718,447** | | | |
| **1989 1991 1993** | Japanese Encephalitis[15] | 322,812 persons 39,250 follow up | Yes, via CCRH | GE | 99.96% C |
| **1996** | Dengue[16] | > 39,200. Follow up 23,520 | Yes, via CCRH | GE | 99.97% C |
| **1999 -2009** | Japanese encephalitis[17] | 20,000,000 per annum 14 years and younger | Yes, Government Department of Indian Medicine and Homoeopathy. | GE+N+ constitutional | B, D |
| **2006** | Chikungunya [18] | 1061 HP 563 control | No, post-grad doctors at Government University | GE 200 t.d.s for 5 days | 75.7% A 82.19% C |
| **2007** | Epidemic fever[19] | Distributed to 1,855,374 In 8 wards. | Yes, Kerala government's RAECH program. Average intake 58.86% 6,602 surveyed. | GE | 63.9% A 73.83% C |
| **2012** | Dengue[20] | 2,500,000 | Yes, Medical and Health Department, Chittorr, | GE | K |
| | **BRAZIL** | **870,698** | | | |
| **1974** | Meningococcal[21] | 18,640 HP 6,430 no HP | No, private doctors | N. 1 dose | 95% A |
| **1998** | Meningococcal[22] | 65,826 HP 23,532 not HP | Yes, government-funded study, conducted by two Professors of Medicine from the University Foundation in Blumenau, Brazil, and a Blumenau specialist physician and Health City Secretary. | N | 95% 6 mths to 91% 12 mths A |
| **2001** | Dengue[23] | 1,959 | No, private doctors | GE 30. 1 dose | 81.5% B, E Inferred rate |
| **2007** | Dengue [23] | 7,300 people 20,000 doses | Yes, Health Secretary Program, Sao Jose do Rio Preto | GE complex 1 dose | G |
| **2007** | Dengue[24] | 156,000 people 216,000 doses ** | Yes, Secretary of Health of the municipality of Macaé, Rio de Janeiro, | GE complex 1 – 2 doses | 86.7% B Inferred rate |
| **2007 – 2012** | Dengue[25] | Doses * 2007: 216,000 2008: 203,878; 2009: 211,059; 2010: 178 677; 2011 150,682; 2012 125,621. | Yes, Secretary of Health the municipality of Macaé, Rio de Janeiro, | GE complex | 89.4% B inferred rate |

*Table 3: Major HP Interventions in Three Countries*
** The number of persons who used HP in the 5 years from 2009 to 2012 is estimated to be 628,273 using the ratio of doses to people shown in the 2007 intervention [24]*
*** Not included in analysis as shown in following reference*

encephalitis. Since JE virus is the widely recognized common cause of encephalitis, especially in outbreaks, physicians and public health and administrative officials have a tendency to attribute all outbreaks of brain disease in children to JE virus."(26) This conclusion was challenged by Professor M.N. Rao(27), and another analysis associated part of the cause to Chandipura virus.(28) Thus, it is uncertain whether the spike in 2003 is due to JE, as in one other analysis cited the 2003 rates were negligible.(17)

Table 6 shows the annual averages for notifications and deaths for JE and AES for the last 6 years of the HP intervention and 8 years after the intervention ceased. 2003 figures were

| Country | Programs by Years * | Interventions by Person, by Year and by Disease |
|---|---|---|
| | | |
| Cuba | 6 | 25,020,000 |
| India | 18 | 224,718,447 |
| Brazil | 10 | 870,698 |
| | **34** | **250,609,145** |

*Table 4: Amended Summary of HP Interventions Listed*

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

excluded from the analysis due to the uncertainty noted above.

An example of effectiveness classification "B" (indirect control group) is shown in the Brazilian interventions against Dengue in Macaé, Rio de Janeiro (25), as described in Table 7 and Figure 2. In districts surrounding Macaé the trend was clearly upwards, whereas in Macaé the trend was reversed.

## Discussion

Most HP interventions occur in rapid-onset emergency situations. They are not academic exercises, but real-world inter-

| Andhra Pradesh | | | | | Telangana | | | | | Combined Andhra Pradesh, Telangana JE and AES | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Japanese Encephalitis | | AES | | | Japanese Encephalitis | | AES | | | | |
| Year | Notif. | Dths | Notif. | Dths | Year | Notif. | Dths | Notif. | Dths | Year | Notif. | Dths |
| **1995** | 986 | 269 | | | | | | | | **1995** | 986 | 269 |
| **1996** | 332 | 108 | | | | | | | | **1996** | 332 | 108 |
| **1997** | ***984*** | 247 | | | | | | | | **1997** | 984 | 247 |
| **1998** | 524 | 192 | | | | | | | | **1998** | 524 | 192 |
| **1999** | *965* | 203 | | | | | | | | **1999** | 965 | 203 |
| **2000** | 343 | 72 | | | | | | | | **2000** | 343 | 72 |
| **2001** | 33 | ***4*** | | | | | | | | **2001** | 33 | 4 |
| **2002** | ***22*** | ***3*** | | | | | | | | **2002** | 22 | 3 |
| **2003** | ***397*** | ***183*** | | | | | | | | **2003** | 397 | 183 |
| **2004** | 7 | 3 | | | | | | | | **2004** | 7 | 3 |
| **2005** | 34 | 0 | | | | | | | | **2005** | 34 | 0 |
| **2006** | 11 | 0 | | | | | | | | **2006** | 11 | 0 |
| **2007** | 22 | 0 | | | | | | | | **2007** | 22 | 0 |
| **2008** | ***16*** | 0 | 22 | - | | | | | | **2008** | 38 | 0 |
| **2009** | ***35*** | 0 | 49 | - | | | | | | **2009** | 84 | 0 |
| **2010** | ***7*** | ***5*** | 139 | - | | | | | | **2010** | 146 | 5 |
| **2011** | 4 | 1 | 73 | - | | | | | | **2011** | 77 | 1 |
| **2012** | 3 | 0 | 64 | - | | | | | | **2012** | 67 | 0 |
| **2013** | 7 | 3 | 345 | 3 | | | | | | **2013** | 352 | 6 |
| **2014** | 0 | 0 | 31 | 0 | **2014** | 0 | 0 | 155 | 5 | **2014** | 186 | 5 |
| **2015** | 0 | 0 | 50 | 0 | **2015** | 8 | 1 | 157 | 1 | **2015** | 215 | 2 |
| **2016** | 0 | 0 | 4 | 0 | **2016** | 4 | 0 | 72 | 0 | **2016** | 80 | 0 |
| **2017** | 1 | 0 | 37 | 0 | **2017** | 11 | 0 | 136 | 0 | **2017** | 185 | 0 |

*Table 5: JE and AES Notifications and Deaths in Andhra Pradesh and Telangana states*

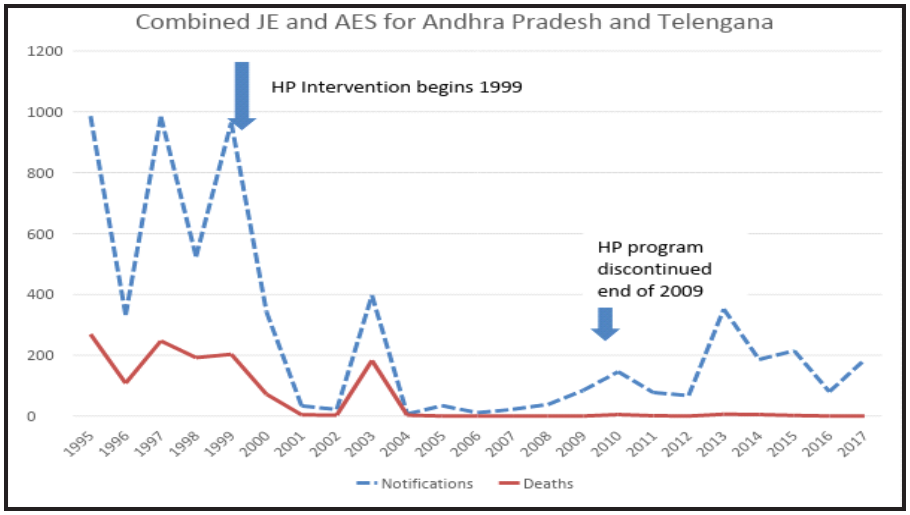


*Figure 1: Combined JE and AES Notifications and Deaths for Andhra Pradesh and Telangana*

| | | | Annual Averages | |
|---|---|---|---|---|
| | Years | # | Notifications | Deaths |
| During intervention | 2004 - 2009 | 6 | 32.7 | 0.5 |
| After Intervention ceased | 2010 - 2017 | 8 | 163.5 | 2.4 |

*Table 6: Averages for Notifications and Deaths During and After the HP Intervention*

| Incidence by 100,000 inhabitants | Macaé | Rio de Janeiro | Campos dos Goytacaze | Sao Francisco do Itabapoan | Regiao Norte Flumiens | Estado do Rio de Janeiro |
|---|---|---|---|---|---|---|
| 2007 | 961.79 | 411.26 | 538.45 | 14.65 | 558.23 | 361.93 |
| 2008 | 280.21 | 2,059.24 | 3423.5 | 520.67 | 2,081.19 | 1,503.19 |

*Table 7: Dengue incidence coefficient by municipality, state and region, 2007-2008*

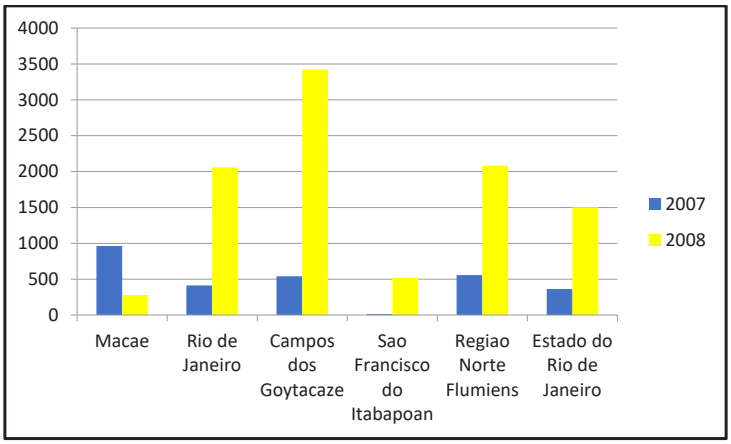


*Figure 2: Dengue incidence coefficient by municipality, state and region, 2007-2008 (by 100,000 inhabitants)*

ventions to save lives and suffering. Doses are administered as required. However, both the largest Indian and the largest Brazilian interventions studied involved giving annual doses, and in the case of the Indian intervention, irrespective of whether there was a seasonal outbreak or not.

The interventions in India against JE and AES in Andhra Pradesh and Telangana from 1999 to 2009 show that an annual program of HP against a long-term disease can be successful. Each year in August children aged to 15 years were given the following protocol: Days 1,2,3 – Belladonna 200; Day 10 – Calcarea Carbonicum 200; Day 25 – Tuberculinum Kent M.(17)

Data in Tables 4 and 5 and Figure 1 show that when the program was stopped in 2010 due to its success, it was followed, over time, by a general increase in the incidence of the disease. This is unsurprising given that around 1.3 million infants are born in the two States each year who had not been protected by HP.

The annual interventions in Brazil in the municipality of Macaé, Rio de Janeiro from 2007 to 2012 were similarly successful.

These annual prescriptions are somewhat similar to the author's experience from 1985 to the present day using annual doses of indicated remedies against a range of established diseases in Australia, including Pertussis, Pneumococcal disease, Hib, Meningococcal Meningitis and Tetanus.(29)

There is a degree of consistency across the HP interventions shown in Table 2, with a range of effectiveness between 63% and 99%. A weighted average of 89.45% is indicative of overall findings. These findings are consistent with the author's long-term study from 1986 to 2002 where the effectiveness of HP was 90.4% (95% CI; 87.6% – 93.2%).(30)

Practical HP interventions show that appropriate HP programs (31) provide governments with infectious disease options for both transitory and established diseases which are very flexible (potentially against any strains of infectious diseases), can be made rapidly available, have zero toxic side effects, and are relatively inexpensive.

Appropriate HP programs offer travellers infectious disease options for similar reasons and may offer protection against diseases for which no vaccine is available (such as AES and Chikungunya).

The practical differences in prescribing for transitory and established diseases—remedy selection, potency and frequency of doses—are discussed in detail elsewhere and are beyond the scope of this article.(32) However, evidence above and in other studies suggests that HP effectiveness is similar for both short-term and long-term diseases.(33) Reactions to the remedies have not been collected in most interventions, which as stated above, are immediate responses to save lives rather than carefully prepared studies. The author's study did collect data on reactions which occurred in less than 2% of doses and were typically brief and mild.(34) The safety of appropriate HP interventions allows treatment of every person in a cohort without the need for pre-screening.

## Conclusion

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

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

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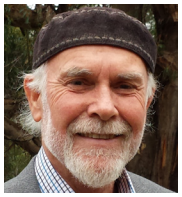
Figure 2: Dengue incidence coefficient by municipality, state and region, 2007-2008 (by 100,000 inhabitants)



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