A qualitative exploration of the homoeopathic remedies indicated for the reaction to a HIV positive diagnosis

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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M Tech: Homoeopathy

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PhD

Abstract

Introduction

HIV is a virus that proliferates via certain body fluids (blood, semen and pre-seminal fluid, rectal fluids, vaginal fluids and breast milk) and attacks the white blood cells in the body's immune system, called CD4 cells (or T-helper cells). There are a number of studies that have been conducted on the use of complementary and alternative medicine (CAM) related to HIV. This study focused on the emotional response of an HIV positive diagnosis on patients. This study sought to determine these responses. The overall wellbeing of a person from a physical, emotional and mental point of view is of utmost importance. A person needs to be emotionally and physically well so that they can live longer. A holistic approach to an HIV diagnosis enables all the spheres of existence to be in coherence, which then impacts on a good life expectancy.

Aim of the study

The aim of the study was to determine the emotional responses of patients to their HIV positive diagnosis and explore the potential homoeopathic remedies indicated for this.

Methodology

The study followed a qualitative explorative design. This type of design is used to define the problem or by developing an approach to the problem. It is also used to go deeper into issues of interest and explore the subtle differences in connection to the problem at hand (Mora 2010).

Purposive sampling is used and 20 participants were recruited for this study. Of the 20 participants, 12 completed the study and eight dropped out. The data was collected and analysed using the thematic analysis procedure.

Results

The findings from the study showed that the majority of participants had a fear of dying as a major concern arising from their status. Furthermore, the qualitative results showed that participants went through denial, emotional shock and pain, amongst other emotions. when they were initially informed about their status. It emerged that

participants were optimistic going forward due to the later acquired knowledge about HIV. However, in spite of the availability of ARV's, participants wanted a wider variety of treatment modalities in addition to the tablet mode of administration.

The results of rubric selection and repertorisation showed that Calcarea carbonica, Ignatia amara, Natrum muriaticum, Phosphoricum acidum, Gelsemium sempervirens, Pulsatilla pratensis, Arnica montana and Nux vomica were the remedies most frequently indicated for the presented emotional responses.

Conclusion

The prominent themes of the study strongly suggest that participants are greatly affected emotionally at the time they first find out about their status. It also emerged that there were lifestyle changes and adjustments that the participants had to make as a result of their positive diagnosis. It was established that participants showed regrets regarding unprotected sex which led to their infection and diagnosis. Based on the results, the researcher recommends that there is a need for integration of homoeopathy into the primary healthcare system because of its holistic approach to treatment. This is more especially towards the emotional aspect that the research sought to investigate. Significantly, the integration of homoeopathy will provide a wider variety options to management of patients and reduce the workload in the government clinics.

Dedications

I dedicate this dissertation to God. The joy of the Lord has always and will always be my strength. I am who I am by Grace. His faithfulness towards me is beyond words and I am full of thanksgiving. My life is hidden with Christ in God.

I dedicate this to my late grandmother, the woman who raised me and taught me so much. I am grateful and I appreciate everything you did for me. Thank you for the principles and values that you instilled in me and I appreciate it all. Your selfless contributions and role in bettering the community were outstanding. I will forever remember your unconditional love, generosity and kind heart.

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List of acronyms

Acronym	Full term
CAM	Complementary and alternative medicine
HIV	Human immunodeficiency virus
AIDS	Acquired immune deficiency syndrome
CD4	Cluster of differentiation 4
T cells	Thymus cells
UNAIDS	Joint United Nations Programme on HIV and AIDS
Stats SA	Statistics South Africa
FDA	Food and Drug Administration
TB	Tuberculosis
CDC	Centers for Disease Control and Prevention
HAA	Health in Africa
DUT	Durban University of Technology
Has	Homoeopathic Association of South Africa

CHAPTER 1: INTRODUCTION

1.1 Introduction and background

This study focused on homoeopathy only in relation to the impact of an emotional response to an HIV positive diagnosis in patients. The overall wellbeing of a patient in terms of the physical, emotional and mental spheres is of utmost importance. Patients need to be emotionally and physically well so that they can live longer. A holistic approach to a HIV positive diagnosis in patients enables all the spheres of existence to be in sync, which then impacts on a good life expectancy.

There are a number of studies that have been conducted on the use of Complementary and Alternative Medicine (CAM) in HIV management. A study that was conducted by Foote-Ardah (2003) revealed that: (1) managing symptoms, (2) self-experimenting to evaluate disease progression; (3) gaining freedom from medical regimes; and (4) managing AIDS stigma are the four main strategies that are dealt with through the use of CAM. Suarez and Reese (2000) suggested that CAM use might have a role in reducing the anguish related with chronic disease – letting persons concentrate on other aspects of their being. Psychological variables may be impacted by some CAM modalities, through improvement of physical health through lifestyle adjustments and lessening stress.

1.2 Overview

HIV is a virus that proliferates via certain body fluids (blood, semen and pre-seminal fluid, rectal fluids, vaginal fluids and breast milk) and attacks white blood cells in the body's immune system, called CD4 cells, (or T-helper cells) (CDC 2018c). The Joint United Nations Programme on HIV and AIDS (UNAIDS) states that the incidence of HIV in South Africa in 2016 was 270 000 (Joint United Nations Programme on HIV and AIDS [UNAIDS] 2016). This number confirms the ongoing decrease in incidence of HIV diagnosis in South Africa. The UNAIDS Global Report (2013) stated that the incidence was 540 000 in 2004 which decreased to 370 000 in 2012. South African statistics mid-year population estimates for the year 2016 showed that people living with HIV had increased to a total number of 7,03 million (Statistics SA 2016). The mid-

year population estimated by Statistics South Africa reported that the overall number of people living with HIV in South Africa had an estimated increase between 2003-2013 from 4 million to 5.3 million therefore an additional 1,3 million cases were reported (Statistics SA 2013). This shows that HIV still remains an epidemic and is incurable, although controllable to some extent.

1.3 Use of homoeopathy

Homoeopathy is a safe, gentle, and a natural system of healing. It works within the body to relieve symptoms. The body restores itself, improving overall health. This system of medicine is safe to use because even small children can be treated. There are no side effects with the treatment compared to many traditional medications. The remedies are very affordable, are made from natural substances and are FDA regulated (National Center for Homeopathy 2017).

Evidence supports the efficacy of homoeopathy for emotional disorders such as depression. Research by Shukla, Rai and Ahmed (2015) showed that the thought patterns of the respondents showed a remarkable change. A study on post-traumatic stress disorder by Honora (2012) showed that homoeopathy improved overall severity and intensity of post-traumatic stress disorder.

1.4 Aim of the study

The aim of the study was to determine the emotional responses of patients to a HIV positive diagnosis and explore the potential homoeopathic remedies indicated for the management of this.

Questions:

1. What are the acute emotional responses to an HIV positive diagnosis?
2. What are the most appropriate or frequently indicated homoeopathic remedies for these responses?

1.5 Rationale of the study

The research may result in the application of homoeopathic interventions for those who receive an HIV positive diagnosis; knowledge of the most indicated remedies may assist those who still have ongoing emotional symptoms who can subsequently

receive such remedies. The purpose of the study was to identify the most frequently indicated homoeopathic remedies used for the emotional reaction patients encounter when receiving a HIV positive diagnosis. By identifying such remedies, recommendations can be made for future clinical research as well as providing insight for practitioners which may positively impact on clinical practice. Participants may also be referred to a professional for assistance or help.

1.6 Delimitation of the study

The study was limited to HIV positive individuals that were between the ages of 18-60 years of age and were engaged only with one interview. This study evaluated the emotional responses to diagnosis through the tool of interviews. Emerging themes were evaluated using the repertory (an index of disease symptoms that lists remedies associated with specific symptoms) and materia medica (a book that lists substances used in homoeopathy along with detailed indications for their indications) to work out which remedies were indicated for possible use as remedies in the management of emotional reaction to HIV diagnosis.

1.7 Limitations

- Only 12 participants were interviewed.
- Only individuals who were previously diagnosed with HIV in the past 5 years were included.
- The participants included those who were available and those who wanted to participate in the study. Those who were not available at the time were not included. Therefore, the results obtained are a representative of the sample size of the study.

CHAPTER 2: LITERATURE REVIEW

This chapter reviews literature related to homoeopathy as an intervention. The review introduces homoeopathy, its history, treatment protocols and its role in epidemics. Furthermore, the pathophysiology, symptomatology and complications (including the emotional and possible physical manifestations of emotional issues into physical symptoms i.e. somatisation)) pertaining to HIV are discussed. The management of patients is discussed and an overview of homoeopathy in HIV is discussed. Possible remedies according to the repertory used on management of emotional responses are discussed further. Lastly, homoeopathy in the community is discussed.

2.1 Introduction

Homoeopathy is a safe, gentle, yet potent method of reinstating health that has been used globally for over 200 years. In the 1800s Dr Samuel Hahnemann (the founder of homoeopathy) healed many people of various acute and chronic complaints. Samuel Hahnemann was a physician, chemist, linguist, historian of medicine and scientific activist (O'Reilly 1996). He treated severe epidemic diseases such as cholera, malaria and typhoid (Cooney 2017). Due to the history of homoeopathy and epidemics this shows that it has the potential to be used as an intervention in HIV. Arand (2015) states that epidemics are diseases that present with very similar symptomatology where the cause is the same and the disease attacks many people. Infections take place when diseases prevail amongst an over populated environment. Fevers arise in such occurrence having a unique nature due to the identical origin of the disease. Over a period, the result is either death or recovery as a mode of cessation of the disease process. Cooney (2017) further explains that epidemic diseases exist today as they have through documented history, including diseases such as malaria, influenza, TB, HIV and Ebola. These diseases have a great influence on our world, both economically and in the number of individuals affected by these diseases. The Centers for Disease Control and Prevention (CDC) (2018a) states that 37 million people are living with HIV/AIDS worldwide. Statistics in South Africa for the mid-year populations estimates in 2016 produced by Statistics SA (2016) indicates that the number of people living with HIV has increased to 7,03 million.

2.2 History of Homoeopathy

Homoeopathy proposes that a cure can only succeed through the counter-action of the life force in response to the correctly taken medicine (O'Reilly 1996). It uses healing substances that do not cause side effects like conventional pharmaceuticals, which can suppress symptoms that can later reoccur (often on a deeper level). Homoeopathy cures from the inside out. It removes the underlying emotional or mental stress of chronic disease first, and then moves the illness out of the body. Homoeopathy does not cause side effects and enhances the quality of life as it heals (De Schepper 2001).

For the purposes of cure, homoeopathy uses medicines with the capacity to (dynamically) alter and differently tune the condition it is similar to (similia similibus). The administration to the patient is as a simple dose, so it is in small doses and not mixed with other medicines. The dose serves to lift the natural malady without causing debilitation or pain. The end result is favourable for the recovery of the patient and restoring the vitality of the individual (De Schepper 2001:5).

2.3 Laws of homoeopathy

Homoeopathy is guided by the following cardinal principles:

1. The Law of Similars, stating that a substance that is able to produce symptoms in a healthy individual, has the same ability to cure those symptoms in a diseased human being (Kayne 2003).
2. Law of Simplex – which says that only one single, simple medicinal substance is to be administered in a given case at a time, this is called a simillimum (Chauhan and Gupta 2007).
3. The Law of Infinitesimal Dose, which says that the greater the dilution of the remedy, prescribed according to the Law of Similars, the greater the effect (Kayne 2003).

2.4 Homoeopathy in 21st century

Homoeopathy is used as a holistic approach in dealing with patients. A thorough investigation in terms of a case taking is used. The information that is looked at first is

the main complaint. Once this information is received from the patient and explored in detail then the other important things to look at is the family history, social history and the mental and emotional state of the patient. Also reviewed in intake are: other physical symptoms (head to foot scan) sensitivity of patient as determined by sensitivity to light, smell, sound, food and emotion, food cravings or aversions, thirsty or not typically so and tendency to being chilly or warm.

The new era that we are living in today is different than that of Samuel Hahnehmann's time which was in the 18th and 19th century. Mostly the diseases that were seen in those days were bacterial and viral for example the typhus epidemic. The presentation of diseases nowadays has changed. There are a number of external causes such as environmental toxicity, exposure to heavy metals etc. There are also a lot of genetically modified plant materials and products, and extensive use of pesticides and herbicides. In some areas there is a lack of proper sanitation resulting in contaminated water and soil leading to a potential diseases and nutritional deficiencies. Stress in the form of academic requirements, competition, workplace and financial instability As if the afore mentioned factors are not enough, there is also Wi-Fi and 5G electromagnetic fields which can cause oxidative damage, melatonin reduction and interfere with cell metabolism. There has not been any research conducted in terms of the long term effects of the 5G electromagnetic fields. Even before a child is born he/she has already been exposed to radiation, environmental toxins and also heavy metals. As soon as a child is born they receive a whole lot of vaccinations which are challenges to their developing immunity. Baby formulas have GMO ingredients, and are mixed with fluorinated and chlorinated water. This formula then gets served in PBC bottles which is just the beginning of occurrence of the mutation process. The diseases in the 21st century can only be cured by restoring the vital force rather than introducing more chemicals into the system. This is what is advocated in homoeopathy (Canadian College of Homeopathic Medicine 2018).

2.5 Homoeopathy in South Africa

Homoeopathy in South Africa is governed and regulated by a statutory body, the Allied Health Professions Council of South Africa (AHPCSA). The Homoeopathic Association of South Africa (HSA) is a voluntary association that is recognised by the AHPCSA as the official representation of the homoeopathic profession. The HSA

serves as a representative body in the sense that they actively engage with government, the Department of Health and the AHPCSA. It plays a role in engaging other organisations and structures that influence the profession and is in constant communication with other health related bodies and institutions. The role of the HSA is to represent and promote the homoeopathic practitioner, the profession and its interests. This includes related education matters, for the better health and wellbeing of all South Africans (Homoeopathic Association of South Africa 2018).

Considering the ever increasing demand for healthcare, and in order to provide competent homoeopathic practitioners, the Durban University of Technology (DUT) saw fit to formalise homoeopathic education and make it a priority. Formalised homoeopathic education standards in South Africa are closely aligned to those of medicine; as a result the education programme there has been recognised internationally as an education of excellence. Homeopathic physicians are legally recognised through registration with the AHPCSA (Durban University of Technology [DUT] 2018).

Homoeopathic treatment respects the wisdom of the body in the sense that its medical approach is individualised to suit each patient's particular health needs. The homoeopathic approach does not treat only physical complaints, but also considers mental and emotional states. These mental and emotional states can be in some cases key components in the process of treatment and healing (DUT 2018).

2.6 Homoeopathic treatment protocols

2.6.1 Management of cases

The homoeopathic consultation is a tender yet detailed examination of the physical and emotional blend or constitution of the individual and attempts to build an insightful picture of a patient (De Schepper 2001). The homoeopathic consultation is governed by particular philosophical viewpoints which commands the essential approach towards the patient and the disease process (De Schepper 2001).

O'Reilly (1996) states that it is expected that a medical practitioner must be an unprejudiced observer and have healthy senses. The observer must pay particular attention during observation and in recording the image of the disease. Overall observation of the patient starts from the time the patient enters. Every complaint that

is narrated by the patient is written down by the homeopathic practitioner. A practitioner takes the case and listens to the patient without making any interruptions unless the patient goes astray to what is related to their case. For each and every symptom, the practitioner then asks for more detailed information using the following guidelines:

- **Concomitants**: are there other symptoms that emanate with the initial symptoms?
- **Location**: where is it sore / where is the discomfort situated?
- **Aetiology**: the hidden cause of the disharmony.
- **Modalities**: symptoms connecting to what makes an individual better or worse.
- **Sensation**: how does it feel?
- **Intensity**: the severity of the pain using a scale of 1-10.
- **Timing**: at what time of the day/night do the symptoms become worse?

A medical practitioner is trained to ask both closed and open-ended questions. Open-ended questions allow the patient to give their own narration without putting words into the patient's mouth. Doing this ensures that a patient gets proper and correct treatment (O'Reilly 1996).

There are three levels of the human being namely mental/spiritual, emotional/psychic and physical (this includes sex, sleep, food and the five senses). These three levels are not separate and well defined, but there is comprehensive interaction between them. The standard of health or disease of an individual can be assessed from a survey of all three levels. This is a pivotal diagnosis for any health practitioner to be able to make, because it is crucial for assessing the advancement of the patient (Vithoulkas 2004).

2.6.2 The mental plain

According to Vithoulkas (2004) the mental plain is the highest and the most important level through which the human being functions. A general definition for this plain is that it is the plain in which changes in understanding or conscience of an individual are being registered. For an individual to think, criticise, compare, calculate, plan, describe, synthesise, conjectures visualise, classify, create, communicate etc, he/she uses the mental plain. Symptoms of mental illness can be found as a result of a

disturbance of these functions. The mental level plays a vital role in the human being. The true essence of an individual is in the mental and spiritual content of a person. If the internal tools of achieving a higher consciousness are disarranged, the possibility of an evolution in consciousness is less likely. An individual can continue to lead a content life and be of service to others and to him/herself despite a handicapped body, loss of sight or hearing or even having lost limbs. However, disturbance on the mental plain can jeopardise the very existence of an individual and can hamper functionality as well.

The three essential qualities that must be present with the different functions of the mind are (i) clarity; (ii) rationality, coherence and logical succession; (iii) creative service for the good of others as well as the good of oneself. Of all three, the most important one is the third, but all the three qualities should be there. Qualities of a diseased mind constitute confusion, disunity and distraction. Therefore, the practice of selfishness and acquisitiveness remain the chief factors that alter the mind. As a result, if people refrain from these, they will have a healthy mind (Vithoulkas 2004).

2.6.3 The emotional plain

Vithoulkas (2004) states that the emotional plain is of next importance in the existence of the human being. The most primitive to the most subline of all grades and shades of emotions are included. This amount of existence precedes as the defence mechanism by means the receptors of emotional spurs from the environment and, also functions as the medium of conveying feelings, actions, and emotional disruptions happening in the individual. The emotional plain of existence can be defined as that level of human existence which expresses changes in emotional condition. There is a wide variety of emotional expressions: joy/sadness, calmness/anxiety, courage/fear, love/hate, trust/anger, etc. This level is central to the everyday existence of every human being. Feelings as to their quality can be explained as positive or negative. Positive feelings draw a person towards a condition of happiness and the negative feelings take the direction of unhappiness; therefore, if more negative feelings are experienced or felt, the unhealthier a person is likely to be.

On this level appears anguish, irritability, fears and phobias, anxiety, and depression, so prevalent in this present day. The educational and political systems have never systemically grown the emotional plain which is mostly frail, undernourished and

consequently endangered. Therefore, a hierarchy of symptoms within this level is useful as a measure of development during treatment (Vithoulkas 2004).

2.6.4 Physical plain

The physical level of existence is the part of the individual with which medicine has conventionally concerned itself. It has been researched comprehensively and thoroughly through anatomy, physiology, pathology, biochemistry, molecular biology, etc. The body also upholds a hierarchy of significance as to its organs and purpose (Vithoulkas 2004).

Human being will always try to keep disruption away from the vital organs. Consequently, a disruption that advances during any therapy from less important to more important organs denotes a decline in general health. The opposite route of development shows progress towards a more desirable state of health (Vithoulkas 2004).

After the case is taken, symptoms are grouped together as either mental, physical and emotional. Peculiar, queer, rare and strange (or called PQRS) symptoms of the case are also highlighted as they are most peculiar and unique to the patient. The case is analysed with the use of a repertory where the symptoms are translated into rubrics and are then found in the repertory. Once all the symptoms are written into a repertory sheet or punched into a repertory software they are then graded. The remedy that appears in more rubrics than the others and also with the highest number is then identified and read. Thereafter, a remedy gets prepared for the patient. Identifying the potency and dosage used for a patient depends on what the patient is suffering from and how long they have been suffering from that condition. A prescription is given to the patient and they are instructed on how to take the medication. A follow up appointment gets scheduled for a patient then the patient leaves.

2.6.5 Homoeopathy and epidemics

Homoeopathy can be considered as one of the best options in epidemics for the following reasons:

1. It is easily administered. This is due to its palatable nature.
2. The remedies are economically viable; the remedies are cost effective.
3. There are no side effects after drug administration.

4. In cases of mutations in the invasive organism as can be observed where there would be a change in the nature of the disease, there is no interference of finding the correct homoeopathy remedy. The homoeopathic remedies work by boosting the life energy of an individual.
5. The aim is to boost the body's immune system.
6. In cases of epidemics where there are unidentified causes homoeopathy can offer preventative measures.
7. Signs and symptoms serve as the basis of treatment and not the identification of the infective micro-organism (Arand 2015).

Cooney (2017) states that homoeopathy has shown efficacy in treating communicable diseases. An example would be what was called the great white plague, the influenza epidemic of the early 20th century. During this 1918 to 1920 event, under orthodox therapy the death rate was 30% and 25 000 deaths happened in America alone. Those under homeopathic treatment presented a mortality rate under 1%. People who lived through it reported that it was unpredictable and people would just die because they would see them well one minute and the next minute they were gone. Dr H. A Roberts was a physician in the army at the time. Another boat pulled alongside to collect spare coffins because all its mortality rate was too high. On his return to port, the commander said to Roberts "used all your coffins?" To which Roberts, who had been treating his ship with homoeopathy said, "Yes and not lost one man" (Winston 1998). Therefore, homoeopathy was shown to be effective.

A clinical study was conducted in Peru by Gaucher *et al.* (1993). This study evaluated the effectiveness of homoeopathy in the treatment of an epidemic of cholera. The first 20 patients who were seen in the health centre became the study sample. The main complaints that were reported were acute diarrhoea and vomiting that was of moderate to severe nature. Intravenous rehydration was performed together with administration of a homoeopathic remedy. The main remedies that were used were Cuprum metallicum, Veratrum album, Camphora, Arsenicum album, China, Phosphoric acid. The results appeared favourable and convincing. A treatment scheme was prepared to be used by the staff of the cholera health centres. Using homoeopathy as part of the treatment regime for cholera was effective. This study has effectively

demonstrated the effectiveness of homoeopathy in terms of epidemics as it has been tested with cholera.

2.7 HIV

2.7.1 Background

The Human Immunodeficiency Virus (HIV) is a retrovirus belonging to the lentivirus family. Retroviruses possess the capacity to use their RNA and a host DNA to produce viral DNA and have long incubation intervals. Just like other retroviruses, the body becomes infected with HIV. HIV has a long incubation period resulting to signs and symptoms and then eventually becomes Acquired Immune deficiency Syndrome (AIDS), this is because it weakens the immune system. The severe damage it causes to the immune system is brought about by the damage and destruction that is caused by HIV to the DNA of CD4 cells in order to replicate itself. As many as 10 million to 10 billion virions gets produced and this occurs on a daily basis (Calles, Evans and Terlonge 2010).

2.7.2 Pathophysiology

HIV consists of a structure that is seen under a microscope as having a cylindrical centre. This cylindrical centre is surrounded by sphere shaped lipid bilayer envelope. Gp 120 and Gp 41 are the major viral glycoproteins that are found in the lipid bilayer. The major function of the two proteins is mediating the recognition of the CD4 and chemokine receptors. For this reason, the virus attaches to these proteins and is able to invade CD4 cells. There are enzymes, multiple proteins, genomic materials, RNA that are necessary for the replication of HIV and also its maturation. Two single stranded copies are found in the inner sphere. Other functions of the inner sphere are for maturation, reverse transcription integrase and protease. What makes HIV different is the fact that it uses 9 genes for its coding process and the process is necessary for proteins and enzymes to be produced. The three key fundamental genes are called env, pol and gag. The function of the env is to encode the glycoproteins also known as the HIV structural components. The function of the pol is enzyme encoding namely integrase, reverse transcriptase and protease. Lastly, the function of the gag is encoding core proteins (Calles, Evans and Terlonge 2010).

The life span of infected cells is short. This is because the virus is using them as factories for the multiple production of new copies of themselves. HIV manages to replicate by continuously using new host cells. HIV uses dendritic cells in the mucous membrane and also the skin as its mode of entry, usually taking place in the first 24 hours after exposure. After a period of 5 days the infected cells travel to the lymph nodes and then reach the peripheral blood which is where viral replication becomes rapid. The recruited CD4+ cells make their way to the lymph nodes as they are recruited to respond to the viral antigen. Activation and proliferation takes place through the complex interaction of cytokines that are released into the microenvironment of the lymph nodes. Susceptibility to HIV infection is due to the occurrence of events rendering the CD4+ cells weak. This explains the general lymphadenopathy that is characterised by the acute retroviral syndrome that is seen in adults and teenagers. Contrary to this, HIV infected monocytes permit viral replication but do not allow killing. Therefore, monocytes work as reservoirs of HIV and as effectors of damage to tissues in organs like the brain (Calles, Evans and Terlonge 2010).

2.7.3 Diagnosis/signs/symptoms

HIV has four clinical stages.

Clinical stage one

During this phase the immune system produces antibodies attempting to protect itself from HIV. This is the period where “viral set point” is established. A prediction of how quickly a disease progression will takes place is achieved through the viral load of the set point (Calles, Evans and Terlonge 2010).

Clinical stage two

The minor symptoms of HIV are candidiasis, lymphadenopathy, herpes zoster, papular pruritic eruptions, persistent hepatosplenomegaly and molluscom contagiosum. At this point the viral load will increase and the CD4+ count is likely to fall to between 350-499/uL, which is seen in children older than 5 years. Stage 2 is observed once a person is at this stage.

Clinical stage three

Due to the weakened immune system, HIV infected individuals can develop life threatening infections including recurrent bacterial pneumonia, cryptosporidiosis, pulmonary and lymph node tuberculosis, persistent fever (longer than 1 month), and persistent candidiasis. At this point, the patients may be wasting, or losing weight. The viral load will continue to increase and the CD4+ count goes down to 200-349 cells/uL observed in children older than 5 years of age.

Clinical stage four

New opportunistic infections continue to develop in individuals that are in this advanced stage. Some opportunistic infections that are most likely to develop due to a severely depressed immune system include toxoplasmosis, cytomegalovirus infection, mycobacterium avium complex, cryptococcal meningitis, progressive multifocal leukoncephalopathy, karposi sarcoma and pneumocystis jirovecii pneumonia. The viral load at this stage gets very high and the CD4+ count drops to less than 200 cells/uL in children older than 5 years (Calles, Evans and Terlonge 2010).

2.7.4 Complications

HIV gets into the body and attacks the white blood cells of the body. When this happens, infections find a habitat and replicate themselves. This happens due to an already compromised immune system. This has the potential to lead to illnesses, cancers, or even neurological problems. Travelling also increases the risk of getting opportunistic infections. AIDS wasting syndrome occurs when a person develops AIDS, they lose at least 10% of their body weight, particularly losing muscle tissue. Lipodystrophy, which is also known as fat redistribution, is one of the common complications seen in people with HIV and AIDS. Pneumocystis pneumonia is a serious infection that can develop as a complication causing swelling and fluid build-up that is seen in the lungs. Cytomegalovirus is one of the complications as well; it is related to the herpes virus and gives a person cold sores Which, for HIV positive individuals, can cause blindness and other more serious problems. TB is often not a problem for most of those infected by HIV. Despite this, TB is an opportunistic infection and is the leading cause of death for people with HIV. Mycobacterium avium complex is a group of bacteria that are related to TB and have the potential to severely affect those infected by HIV. AIDS Dementia Complex, also known as ADC is a type of

dementia that is observed in advanced stages of AIDS. Non-Hodgkins lymphoma, also called AIDS related lymphoma, is a cancer of specific white blood cells. Lastly, Kaposi's sarcoma is known to be a type of cancer that people with AIDS often get (WebMD 2018).

Niessl, Baxter and Kaufman (2018) state that to effectively reach a point where there is an HIV cure would be through the use of two options. It is either by eradicating HIV from the body completely through eliminating HIV reservoirs from the body which is also known as a sterilising cure, or a process known as functional cure which includes long term control of HIV replication in the absence of antiretroviral treatment. Latency-reversing agents based strategies which focus on a shock/kick and kill strategy where HIV is reactivated from its latent state, have yielded limited success in clinical trials. This means that additional information is required to assist in rationally designing further effective cure strategies. With the detailed insight now being provided pertaining to the phenotype and anatomic location of singular infected cells, these types of techniques support the evaluation, advancement and monitoring of vitro and vivo HIV cure strategies. This provides hope and shows progress towards HIV cure research although there is still much more to be done.

2.7.5 Emotional response to diagnosis

The emotional plain of existence can be explained as that level of human existence which expresses changes in emotional condition. There is a broad diversity of emotional expressions: joy/sadness, calmness/anxiety, courage/fear, love/hate, trust/anger, etc. (Vithoulkas 2004).

Kartikeyan *et al.* (2007) state that on receiving the news of an HIV positive status, patients undergo emotional shock and this results in a state of feeling guilty, blaming oneself or denial of the positive status. As a result of denial, patients undergo multiple testing hoping for a negative test result. The realisation of the truth results in frustration, anger, distress and blaming oneself for engaging in high risk behaviour. Interventions for persons diagnosed, as HIV positive is vital because a diagnosis results in a number of psychological reactions. Major changes in life get triggered as a result of a positive diagnosis which can be gauged as most similar to a prison sentence or a death of a life partner. However, an individual's response may be dependent on components such as the level of resilience. This can be observed from

their previous mechanisms of coping with stressors in the past. The available support system of an individual also plays a very major role. Both psychological and physical illness takes place as a result of these factors. Significant bravery is essential to come to terms with a disease that up to now remains incurable.

According to Fabianova (2011) people living with HIV/AIDS have a feeling of uncertainty but still have to cope with the situation. They often have feelings of insecurity originating from the fear of their upcoming future. There is also a tendency to focus more on their families and on their jobs. The feeling of being more inexact, becoming more concerned because of the quality of life, life expectancy, as well as the treatment outcomes and the response of the society is also of great concern to them. This section of the chapter reports on the psycho-social aspects of people living with HIV/AIDS and their responses. Besides identifying particular issues like fear, loss, grief, hopelessness and helplessness syndrome, guilt and self-esteem, anxiety and depression, denial, anger, aggression and suicide attempts are also identified. The objective was also to analyse the spiritual needs of, discrimination against and stigmatisation of HIV positive people. The analysis is that discriminatory attitudes of the population is significant and has a direct link to fundamental ignorance as far as HIV transmission routes are concerned. Children are the most vulnerable group, especially in the situation when they are orphaned and need to cope with the dead and dying. Discussion on HIV/AIDS in many third-world countries is still accompanied by taboo, misunderstandings, shame, guilt and rejection. Culture has conditioned silence about sexuality and sexual behaviour which then leads to risky sexual behaviour, sexual abuse and especially sexual abuse of children. Due to cultural, religious and legal aspects of the topic of HIV/AIDS, death and sexuality, the discussion is led only by a small group of experts. Rejection or lack of awareness about HIV/AIDS significantly limits the ability of effective and decent care for HIV-positive people and their families. It is very important to speak about HIV/AIDS loudly, to speak about the feelings and reactions of people living with HIV/AIDS. The literature has been able to identify areas where those that get diagnosed might be helped. This is in terms of dealing with accepting their status and being in situations whereby they are moving towards a better and more effective management of their health.

Hussain (2013) conducted a study that observed 10 clients that came in for HIV testing several times in a period of 3 months. Data was sourced from the record files of the Integrated Counselling and Testing Centre at Agra over a period of three years from 2009 to 2011. Analysis of the repeat testing and counselling sessions among the HIV-negative clients was also undertaken. Levels of distress were assessed using GHQ-12 and K-10 questionnaires. Even though they were well educated and knew about the risks of acquiring HIV they were still committing adultery and some having casual sex. After the pre- and post-test counselling session, this led to guilt and fear on becoming infected and psychosis could be observed as a result. Multiple testing resulted and their result would not satisfy them due to the window period time frame which was explained to them but they requested more expensive tests and they continued to come back at regular intervals for repeat testing. This shows that even though people are well aware of the modes of acquiring HIV they still become ignorant and act carelessly. Reality kicks in moments after the sexual encounter and its only then that they think of the consequences of their actions. This study has fully demonstrated the impact a positive diagnosis can have on a patient. Ignorance and carelessness are the key factors in this study that the researcher is communicating through his findings.

In a study that was conducted amongst patients living with HIV in Malaysia it was suggested that in such circumstances the physical sphere was the least affected and the psychological and social well-being showed more impairment (Hasanah, Zaliha and Mahiran 2011). A cross sectional study on 271 patients diagnosed with HIV attending a clinic in Kota Bharu was conducted. Informants completed the Malaysian version of the Functional Assessment of HIV Infection (FAHI) and Malaysian Hospital Anxiety Depression Scale (HADS). The participants achieved well in the somatic sphere. They were mostly compromised in the social domain. Those who obtained the HIV infection via a heterosexual course appeared to have remarkably less social well-being, while those who obtained HIV through drug inoculation were not linked with losses in the overall QOL or any of its realms. Non-disclosure ironically had a larger consequence on social well-being. About 38% were most likely to have anxiety, depression or both, and these emotional disruptions were notably associated with total FAHI and its five domains. Therefore, it was said that it was important that patients that were diagnosed with HIV get more psychological intervention and psycho

education. This study showed that the areas that need more attention still need to be addressed. The study shows that even though HIV has been known for some time and researched in terms of better management in terms of treatment and emotional support, there is still a lot that still needs to be done. This includes homoeopathic management and other CAM managements so as to increase life expectancy. The study further demonstrates that focusing more on the emotional wellbeing of a patient can help decrease the level of stigma as well as improving a patient's perspective of their health and overall life expectancy.

Grov *et al.* (2010) state that depression was significantly related to increased HIV-associated stigma, increased loneliness, decreased mental functioning, decreased levels of energy, and being younger. Data was collected from 1000 patients. Participants were at least 50 years of age, previously diagnosed with HIV, not institutionalised, residing in or receive healthcare in New York City, and adequately fluent in English. A self-administered pen-and-paper survey which took approximately one hour to complete was utilised. The data demonstrated the need for service providers and researchers to emphasise more forceful and innovative efforts to resolve both psychosocial and physical health issues that are linked with the AIDS epidemic in the USA. Data suggested that focusing efforts to lessen HIV-related stigma and loneliness may have lasting effects on decreasing major depressive symptoms and improving perceived health. Therefore, the emotional wellbeing of the patient is of utmost importance. This is because the news to some individuals especially to those individuals that like to keep to themselves, can tend to have negative effects over time if they do not get the emotional support they need or require.

Horter *et al.* (2017) conducted a study on acceptance, denial and linkage to HIV care in Swaziland. Twenty-eight participants were purposefully sampled for interviews to explore linkage experiences in different age groups and between both genders. The results showed that the accounts of patients' linkage to care and health seeking was influenced by the process of HIV acceptance or denial. Some participants experienced denial for longer periods of time while some temporally and nonlinear. Denial had a link to insights of HIV risk; as a result a positive result for those that are less likely to identify as at risk would not be expected and therefore they are unprepared for such news. Acceptance of HIV status can bring about disclosure, which in turn is seen to

support linkage to HIV care. A positive value placed on health care, perceived need for and motivated need for healthcare were seen to be attributed by the acceptance of an HIV status. Consequently, the engagement with HIV treatment and care can be influenced more by the manner in which people living with HIV (PLWHIV) process the news of a HIV diagnosis. Therefore, HIV testing services should include multiple counselling sessions if required in support with HIV acceptance and disclosure.

Lingen-Stallard, Furber and Lavender (2016) carried out a survey to explore women's experiences of receiving a positive HIV test result following antenatal screening in England. A survey was conducted with in-depth interviews. Thirteen black African women were recruited for participation in the study. The results showed that women had extreme reactions to diagnosis and this was driven by their cultural belief that they would die. Sadness at the loss of their old self developed as a result of initial shock and disbelief of the unexpected result. Consideration of terminating pregnancy, suicide and self-harm was evidence of anger and turmoil. The women felt isolated and relationship breakdowns often took place. Non-disclosure and focusing on the wellbeing of their children was their coping mechanism. Midwives need to take note of the psychological and social impact of HIV and interventions should focus on more support or referral for appropriate support. Appropriate training is required amongst midwives as they are the ones that provide health care to pregnant women.

Earnshaw *et al.* (2018) conducted a study to explore the barriers to antiretroviral treatment (ART) initiation and acceptability of theory-based strategies to optimise ART initiation. Semi-structured interviews were conducted amongst 30 participants in Gugulethu township in Cape town. Results showed that the barriers of ART initiation identified at the individual level as emotions, motivation and coping. Participants highlighted that when people first find out about their status they often have a wide variety of powerful emotions with most of them being negative. PLWHIV described feelings of disbelief and shock on testing positive for HIV. Fear was also reported on initial diagnosis. This fear included fear for their lives, reactions of their communities and the way in which ART would affect them. Respondents described having challenges coping with an HIV positive diagnosis and also that they lacked motivation as a reason for not initiating ART. Participants were in general supportive of the proposed intervention because they felt that the peer support would motivate PLWHIV

to access treatment and help them cope with their diagnosis. Therefore, for those who have not initiated treatment, theory driven socio-behavioural interventions are necessary to address the multi-level barriers to initiation of ART by meeting the unique needs at hand.

A cross sectional study was conducted on the relationship of trauma, dissociation and adherence to antiretroviral treatment (Keuroghliana *et al.* 2011). The study was conducted amongst 43 participants who were diagnosed with HIV. The association of trauma, detachment, and their interaction with the likelihood of antiretroviral adherence was evaluated using a ranked binary logistic deterioration test. Amongst 38 eligible patients, a larger Post Traumatic Stress Disorder (PTSD) was related with lesser odds of obedience. The study revealed a link between dissociation and medication adherence. The presence of PTSD showed a likelihood of a decreased probability of HIV medication adherence. The findings were discussed in the context of clinical management of people that are living with HIV. The people were reported to have a history of trauma and the necessity for interventions mainly focusing in dissociative symptomatology to enhance adherence. Detachment watered-down the effect of PTSD on obedience, resulting in lower odds of obedience. PTSD symptoms were significantly related to lesser likelihood of obedience in persons reporting great levels of detachment but not in those reporting low levels of dissociation (Keuroghliana *et al.* 2011). This study shows that there is more work that needs to be done in terms of emotional support for patients. This plays a vital role because patients can possibly live longer by accepting their positive statuses. This can be achieved effectively through emotional support so that they are able to take their medication on a regular basis.

A qualitative study that was conducted in San Francisco revealed a vast number of emotional responses (Hult, Maurer and Moskowitz 2009). This study was conducted amongst 50 participants. Face to face interviews were undertaken with patients who had recently been diagnosed with HIV. Participants were requested to tell their story of testing positive for HIV. Interviews were transcribed for team-based narrative qualitative analysis. The majority of patients were tested at either a hospital or an HIV test site. The most common emotion was that of a feeling of being surprised followed by shock, where a person would fail to comprehend the news that they tested positive.

Another percentage of the participants were reported to have felt sad and depressed, crying when they received their results. Other participants had a desire to commit suicide and lastly there was also a numb reaction upon receiving a positive result or a feeling of the results being an illusion. Therefore, HIV service providers need to tread carefully in the way they play their role in the testing process, including delivery of the news and post-test counselling. All these factors directly impacted the individual's experience of testing positive (Hult, Maurer and Moskowitz 2009). This study demonstrates the physical manifestation of emotional symptoms into physical symptoms which is why somatisation is a vital element to look into because emotional reaction to diagnosis can be easily camouflaged by physical symptoms.

Somatisation in emotional response to diagnosis

This section explores somatisation, an acute response to diagnosis, manifesting as a physical response to an emotionally charged diagnosis. Somatisation can be defined as a tendency to experience psychological distress in the form of somatic symptoms and to seek medical help for these symptoms, which may be initiated and/or perpetuated by emotional responses such as anxiety and depression (Al Busaidi 2010).

According to an article by Kallivayalil and Punnoose (2010), somatisation is a public health and a clinical obstacle due to it having the potential to lead to social impairment, occupational difficulties and increased healthcare use. Somatisation can be conceptualised as a way of responding to stress. It can also be a camouflaged psychiatric disorder (e.g. depression or anxiety) or intensified personal perceptual style as a result of a personality trait (abnormal neuropsychological information processing) or as looking for care for emotional distress or as a response to healthcare motivation (iatrogenic somatisation). Patients may present with fear or uncertainty of the news they are about to discover at the point when they finally decide to go and do a test. This may be directly or indirectly linked to their actions or behaviour. Therefore, they seek medical attention (Kallivayalil and Punnoose 2010).

Bauer *et al.* (2014) state that patients with somatisation are inclined to undergo higher than average levels of anxiety and social dysfunction. In primary healthcare, clinicians often refer to somatisation as medically unexplained symptoms. In the new DMS-V criteria there it is no longer a requirement that symptoms be medically unexplained for

a diagnosis of somatisation to be made. Patients' symptoms may or may not be linked with another medical condition, but they would still need to be notably distressing or troublesome to everyday life and be accompanied by immoderate thoughts, feelings or behaviours. In homoeopathy we apply a holistic approach so as to get the root cause of what the patient presents with (the "main complaint'). Such an approach makes the management of the patient more effective and addresses underlying issues as well.

Somatisation is expensive to the healthcare system and to the patient, as these individuals have higher rates of medical use including hospital visits, testing, procedures and hospitalisations. This is where CAM can be beneficial in helping ease the workload in the public hospitals. Most of these people are referred to specialists within public hospitals which means high medical bills even though they are not getting proper help. Furthermore, there are long queues to fetch medicine yet they are not being assessed (whether the medication is working or not). On the other hand, the public-private integration partnerships have shown the potential to improve health care access, quality and efficiency (Sekhri, Feachem and Ni 2011). Sekhri, Feachem and Ni (2011) further state that poor infrastructure, shortages of medications, and low quality of care are among the shortcomings that are affecting developing countries in terms of providing proper medical care to patients. Therefore, integration between existing public health services and CAM may be a better option to try and bridge the gap and harness service delivery.

Murry *et al.* (2013) describe somatoform disorders and functionally unexplained symptoms as extremely common in primary care settings. These disorders however are consistently underdiagnosed which precludes effective treatment. Because somatoform disorders are linked to high impairment, proper management of patients is required. This results in high healthcare costs which then leads to both physician and patient frustration. It is therefore important to improve early detection. Symptoms, which do not have a medical explanation, are extremely common in primary care and are central to the diagnosis of somatoform type disorders when they are associated with psychological distress and high healthcare use. Not only are these disorders common, they are costly. Successful detection is not only important to lessen healthcare costs but also to improve patient care. In the response to the news of an

HIV positive diagnosis some patients undergo somatisation (Murry *et al.* 2013). Therefore, it is of importance not to ignore these symptoms that develop as a result of diagnosis so as to manage these patients accordingly and make sure that they receive proper medical attention.

2.7.6 Allopathic treatment

The CDC (2018b) states that individuals who are diagnosed with HIV must take treatment as soon as they are diagnosed. The medication given is called anti-retroviral therapy or also known as ART. If this medication is taken as directed, the medication lessens the amount of HIV in the body (viral load). These levels when lessened help keep the immune system working and prevent further illness. This is referred to as viral suppression which is further defined as having copies of less than 200 HIV viral cells per millilitre of blood. The viral load can also be reduced to an extent that it becomes undetectable by a test. This is called undetectable viral load, at which point it can be said that the HIV is under control.

2.7.7 Allopathic management of HIV

The Pre and Post HIV Test Counselling Guide (Canadian Aboriginal AIDS Network 2012) states that post-test counselling is the counselling process offered when patients/clients return to receive their HIV test results after testing. The post-test counselling that is offered to patients varies depending on whether they have a positive result or a negative result.

The Department of Health South Africa (2015) states in their guidelines that in pre-counselling, (the counselling provided before deciding on whether a person wants to test or not) information should be available to all clients who are considering taking the HIV test and in their preferred language. Post-test counselling should be given to all clients, regardless of the outcome of the HIV test. They should receive post-test counselling on an ongoing basis as appropriate.

However, in-depth and long pre-test counselling is no longer required and individual risk valuation and counselling through the pre-test information session is no longer advocated. The post-test counselling session must concentrate on keeping the person negative (Department of Health South Africa 2016).

HIV-negative clients should be offered a comprehensive post-test counselling prevention package that includes information and advantages of MMC (medical male circumcision), TB screening, risk reduction, correct and regular use of condoms. Clients who test HIV positive should be informed and counselled about possible emotional responses (e.g. denial and anger) and they should be guided as to when and how these emotions can manifest and what impact they can have on adherence to healthy lifestyle choices. (Department of Heath South Africa 2015).

Post-test counselling includes: giving a person their test result and letting them express their feelings about being HIV antibody positive, negative or indeterminate.

Ongoing counselling is the type of counselling that is offered after receiving test results. The aims include helping to manage the impact that HIV has on a person's own life and the lives of the people around them. Such counselling should also provide emotional and psychological support (Department of Health KwaZulu-Natal 2001).

Therefore, the emotional wellbeing of a patient is taken under consideration although the patient receives some degree of support, which may require a referral for further management.

2.7.8 HIV as an epidemic concern

An epidemic is when a disease is spread rapidly amongst a large number of people in a given population. During an epidemic a disease normally spreads in a period of 2 weeks or less (Lake 2018). HIV today is still incurable. The only form of intervention that has been used and that has shown an improvement on life expectancy is ARVs. Commencement of treatment straight after diagnosis has been proven to be an even effective approach over the last few years. However, recent statistics show that the number of people living with HIV in South Africa has increased to 7,03 million (Statistics SA 2016), which is a major public health concern. This means that further management and intervention is still required to further manage the infected individuals.

2.7.9 Homoeopathy and HIV

This section examines homoeopathy and how effective it has been in prior studies that were conducted amongst HIV positive individuals.

Quirk and Sherr (2015) conducted research in the context of Homoeopathy for Health in Africa (HAA) which is a volunteer organisation and a registered Tanzanian non-profit that has founded village and rural clinics in Africa to provide HIV/AIDS patients with homoeopathy therapy supplementary to standard medical therapy. The Kilimanjaro region in Tanzania is said to have 70 000 HIV patients and an HIV prevalence of 5.4% (this is where the HAA headquarters is situated). They have established 15 clinics. These clinics are not labelled as HIV/AIDS clinics but rather general health clinics due to stigma. Patients discover the HAA clinic through HIV/AIDS support groups, hospital AIDS clinic staff, or from friends and family in their locations and make appointments. Homoeopathy treatment is described as additional to ARVs and not a substitution and can be taken simultaneously with ARVs and other medication. Patients receive encouragement from the homoeopathic practitioners to attend their monthly medical centre appointments to receive their follow up management and refill of medicines. This study shows how integration helps with patient care and support through the systems that are already put in place with that of homoeopathy so as to help the patients in terms of health management. According to the HAA clinic records, patients present to the homoeopathic clinics with symptoms of itching and burning eruptions, weight loss, weakness, leg and foot ulcers, headaches, nausea and digestive problems, Kaposi sarcoma, anxiety, chest pains, cough, and peripheral neuropathy. A well-known side effect of an ARV drug, which is a interruption of sleep by bad dreams, affects many patients. Serious deterioration in patients' capability to work and manage their day to day livelihood can be observed as a result of many symptoms that emerge from the side effects of ARV medication. In follow up interviews clinicians announce that after homoeopathic treatment patients describe recovery in weight loss, weakness, healing of ulcers, headaches, nausea and vomiting, anxiety, chest pains, cough, and decreased peripheral neuropathy, eradication of skin symptoms and cessation of nightmares. A lessening or disappearance of opportunistic infections such as Kaposi sarcoma and fungal infections takes place. Increased energy is narrated by patients, they gain weight and reacquire appetite. Previously immobilised patients are able to gather firewood, carry water, work in the fields, hike mountains, earn money and care for and feed their offspring. As the symptoms and side effects of ARVs decrease, this reduces the need for switching ARV lines and enables patients to tolerate their ARVs and maintain compliance for longer (Quirk and Sherr 2015).

The holistic approach therefore has yielded favourable results in the management of symptomatology and general wellbeing.

2.7.10 Homoeopathic treatment to HIV

In this section, we explore how homoeopathy has been used in the treatment of HIV in terms of the changes it has demonstrated mainly in relation to CD4 counts.

CD4 counts

Muraleedharan *et al.* (2010) report that in an open label observational prospective multi-centre study over a period of one and a half years a sample was chosen from previously diagnosed patients attending the Outpatient Department of the Regional Research Institute of Homoeopathy, Mumbai and Clinical Research Unit of Homoeopathy, Chennai for homoeopathic therapy. The ages ranged from 18 to 50 years and a total of 90 patients as per the CDC classification met the inclusion criteria for the trial from various classifications of HIV infection. In-depth case histories of each patient were captured in a predefined documenting format, comprising various individualised symptoms in order to ascertain the similimum. Of the 90 patients 72 patients completed the 6 months follow and were assessed. The homoeopathic remedies that were prescribed during the study were Calcarea carbonica, Lycopodium clavatum, Natrum muriaticum, Phosphorus, Pulsatilla, Rhus Toxicodendron, Sepia and Sulphur. The frequently used remedies were Lycopodium clavatum, Natrum muriaticum, Phosphorus and Pulsatilla. Out of all the remedies only Lycopodium clavatum had shown statistically significant results in the trial as an indicated remedy prescription. The post intervention CD4 data with a p value equal to 0,154 was assessed and compared to the controls but was not remarkable. However, the viral load change was significant after the intervention with a p value equal to 0.012. This study shows how homoeopathy as an intervention affected and changed the viral load in the patients that participated in the study.

Shah (2015) conducted a study which found that out of 27 participants, 7 exhibited a constant decline in the viral load from 12 to 24 weeks. This study was achieved by enrolling seropositive participants in an explanatory clinical trial. An HIV nosode prescription of 30C for the first 3 months and 50C for the following 3 months was given three times daily sublingually. Follow-up appointments were scheduled for participants

in which they would be observed. A sublingual dose of six pills was given sublingually to each participant. All credentials, for example patient informed consent forms, laboratory studies at the central laboratory, security, and ethical procedures were taken care of. The participants were followed for a period of 6 months, and collected data were investigated. The participants were observed for CD profile and viral count at arranged appointments. Participants were examined by an HIV AIDS specialist, and essential investigations were conducted at a central laboratory. Participants were referred to a counsellor at a non-governmental organization (NGO) for counselling as per the protocol (Shah 2015). Nine participants demonstrated an increment in the CD4+ count by 20% altogether in 12th and 24th week. Remarkable weight gain was noted at week 12, and 63% and 55% presented an increment in either weight or appetite. The viral load escalated from baseline to 24th week; 14 out of 27 participants demonstrated either enhancement or constancy in CD4 % at the end of week 24. There were no unfavourable events and no dropouts. Thus, the study showed that there was some degree of overall wellbeing that was seen on those that participated in the study in different areas (both emotionally and physically).

A controlled clinical trial was conducted by Ullman (2003) on 50 patients which found that patients in stage 3 (persistent generalised lymphadenopathy) of HIV who were administered a homoeopathic remedy experienced a notable change in CD4 T-lymphocytes counts and a statistically significant rise in CD8 T-lymphocytes. A total of 25 dissimilar homoeopathic remedies were prescribed founded on the totality of patients' symptoms. The potencies of these homoeopathic medicines that were 6X, 30C, 200C, LM3 and LM5. The "X" and "C" potencies fluctuated between three times per day to once per day. LM potencies were prescribed in water three or four times a day. The control group received a placebo that was considered exactly like the active treatments and followed an identical procedure. Patients in the active group that were given homoeopathic growth factors, namely, insulin-like growth factor-1, platelet-derived growth factor BB, transforming growth factor *b*-1, and granulocyte-macrophage colony stimulating factors. These therapeutic agents were produced homoeopathically to 30C, 200C, and/or 1M potencies. Patients were given 10 drops three times per day from each of four bottles of either the homoeopathic remedies or placebo. Those on the treatment found precise immunologic, neurologic, metabolic, physical and quality-of-life together with improvements in lymphocyte amounts and

reductions in HIV viral loads. Individually, these therapeutic agents were produced homoeopathically to 30C, 200C, and/or 1M potencies. Patients were given 10 drops three times per day from each of four bottles of either the homoeopathic remedies or placebo. Those that were in the placebo group revealed no change in results (Ullman 2003). Therefore, the study demonstrated that homoeopathy as an intervention yielded favourable results.

Rastogi *et al.* (1999) found in their study on persistent generalised lymphedema there was a statistically remarkable difference. This study was conducted with 100 participants who were in a double blinded randomised clinical trial with 50 patients in each group. The study lasted for 6 months in which CD4 counts were evaluated then later compared to the baseline immune status. There was a statistical difference in terms of the CD4 T-lymphocytes count between before and after the trial levels in the verum group. In the placebo group, the results produced a non-significant outcome. The study shows the effectiveness of homoeopathy in terms of symptomatology related to generalised lymphedema and the favourable results it yielded thereof.

2.7.11 Homoeopathic remedies used in the management of emotional responses

We will now examine the major remedies helpful for specific emotional responses. . In homoeopathy symptoms are translated into rubrics (a symptom as it is written in a homoeopathic repertory). A book called a synthesis is used to find these rubrics as per the specific area they were said to be located by a patient (as per Schroyens 2012 (the repertory used in homoeopathy)).

2.7.11.1 Ailments from bad news

Here we find the following big remedies: Calcarea carbonica and Gelsemium.

<u>Calcaria carbonica (Calc carb)</u>

This is one of the salts that make up the three constitutional salts. It is found inside the bone and lymphatic system. Calcaria is one of the polycrests because it is one of the most ubiquitous materials in life processes. The need for Calcaria may start form birth in most of the population and this may account for a high percentage. In older persons this may show a sign of a very strong immune system. Calcaria is often indicated over a wide variety of conditions and disease. Examples are neurological diseases, mental

illness, heart failure and cancer. Even in advanced stages of a disease, if Calcaria is truly the indicated remedy the prognosis is very good. A typical Calcaria typology is a patient that is responsible, hardworking and solid. He/she is focused strongly on practical matters and security. In any project being undertaken, being methodical and determined is of note. Because of this, a main pathology in adults of being over-worked can occur. A state of being overwhelmed eventually sets in, because the patient takes on more and more responsibilities. There is a great sensitivity to cold. A person requiring this remedy has a tendency to be averse to work or exertion. The mental picture of the remedy is that there are apprehensions that are worse towards the evening; fears loss for no reason, contagious diseases, misfortune. Tends to be forgetful and low spirited. Has anxiety with palpitations. There is obstinacy. Slight mental activity will produce hot head. There is a sense of impossibility of ever getting better and fear of death, disturbing all around him/her day and night. Headache is from mental exertion. Sexual intercourse is followed by weakness and irritability (Vermeulen 1994).

Gelsemium sempervirens (Gels)

Gelsemium is a flowering plant (also known as yellow jasmine) that belongs to the gelsemiaceae family. It is used for asthma, pain due to migraine headache and pain due to trigeminal neuralgia amongst other uses. A Gelsemium person has a fear losing control. The person is most likely to experience mental and physical complaints due to agitation. In the muscles it produces soreness, weakness, tiredness, heaviness and aching. This is especially felt in the muscles of the limbs. All types of functional paralysis take place as a result of affections of the motor nerves. This can be seen in the bladder, larynx, throat and eyes. Passive arterial or venous congestion takes place due to circulation becoming sluggish. This then causes heaviness with sense of fullness in the liver, heart etc. There is bodily and mental manifestation of a general state of paresis. A person wants to lie down flat or wants to lie down quietly half-flat. Incomplete relaxation and prostration. Disobedience of will is seen where lake of ordination takes place instead. This remedy is for ailments from anger, unpleasant surprises, depressing emotions and traumatic shock. The pelvic pains alternate with the symptomatology of the head. The person is weak, excitable, timid, easily angered, delicate, an adolescent and children. Here the mental picture is that the person has a

desire to be quiet, to be left alone. There is apathy concerning his/her illness. Tends to have absolute lack of fear. Delirious on falling asleep. Emotional excitement is often seen, and fear, etc and this leads to bodily ailments. There are bad effects from fright, fear, exciting news. Fear of falling, tribulations, death and pain. Have stage fright. There is weight around the head, a feeling of a band around the head. Sexual power fatigued, slightest touch causes emission (Phatak 1999).

2.7.11.2 Ailments from disappointment

The major remedies here are Aurum metallicum, Ignatia, Mercurius solubilis, Natrum muriaticum, Phosphoricum acidum, Pulsatilla pratensis and Staphisagria.

Aurum metallicum (Aur gold)

Aurum is gold. This mineral is used for anxiety and depression. Gold's site of action is focussed more on the mind. Here there is hopelessness, loss of love of life and acute mental depression. All the blood seems to go to the lower limbs rushing away from the head. There is venous congestion, more to the head and chest. The feeling is as though the blood in boiling in the veins when one orgasms. The sensation felt in the bones is as though there is cutting and boring. The wandering pains end up attacking the heart impelling one to motion. There is glandular swelling and induration. The symptoms are extremely violent. On walking, the heart feels loose. It is as though there is wind blowing to the part of the body. The clinical indications for this remedy are a weak memory, nervous, hysteric women, and lifelessness. The remedy is for ailments from prolonged anxiety, anger, fright, grief, disappointed love loss of property and unusual responsibility. The mental picture of this remedy is that there are fluctuation of moods of joyfulness and grumpiness. Irritable argumentative humour. Weakness of the memory. There is an irresistible impulse to weep. Anger and passion. The slightest contradiction stimulates his/her anger. Suicidal tendencies, desperate, desire to jump off high places. Sees hindrances everywhere. Hopeless. Misery of self and with others (Clarke 1991).

Ignatia amara (Ign)

Ignatia is a tree, common in some parts of Asia and belonging to the Loganeceae family. This is one of the most famous grief remedies and it has its own characteristics. Ignatia is the remedy of choice in cases whereby grief is accompanied by hysteria and

spasticity. Most of the time and in cases where Ignatia is indicated it is where this state is secondary to another remedy as a result of a specific grief or set of griefs. This has led to Ignatia being said to be a short acting remedy. Since Ignatia is indicated following an acute grief, the depth of grief and sorrow that is found locked in the heart it is often huge and unendurable. Ignatia is used when the grief is stuck or is long lasting or symptoms are produced as a result of it. Ignatia is a clinical remedy for depression, headache, chronic fatigue, migraine, environmental illness and so on. The Ignatia patient tends to be trembling, alert, apprehensive, rigid, nervous patient who suffers acutely in the body and mind and drinking coffee makes them worse. This is the first remedy to think about in cases of emotional shock. It is best suited for cases of emotional upsets, especially depression, grief, anxiety and stress. Ignatia is needed when the emotional shock period becomes extended, or when other ailments occur as a result of grief, relationship meltdown or some other significant loss. In cases where there is hysteria evolving into physical symptoms, Ignatia tends to work well. Laughing or crying at serious matters, fainting. Headache as if nail were driven through the side of the head (Boericke 2007).

Mercurius solubilis (Merc sol)

Mercurius solubilis is mercury precipitated into powder. Boericke (2007) states that the first potency prepared was made by Samuel Hahnemann. He prepared Merc sol from soluble black oxide or pure metallic mercury. Merc has an affinity to affect more or less every tissue and organ of the body. Profound anaemia is produced due to decomposition taking place in the blood. Lymphadenopathy an increased glandular activity especially of the mucous and salivary glands. Mucous membranes of the throat and the mouth have ulcerations. There is a variety of symptomatology to the extent that a patient's physical and mental behaviour is questionable. Patient is sweaty, tremulous and weak. The characteristic of the pain is that is stays in one place. There is a great sensitivity to cold and heat. Everything is as though it is short. This remedy is clinically for foot-sweat, suppressed gonorrhoea, and fright. The sensation of pain is stinging and burning. The mental picture of this remedy is that there is great anguish. Restless, repetitively pacing and agitation. Moral misery with great lethargy, discouragement, dread of labour and disgust of life. Great meaninglessness of everything. Does not even care to eat. Wishes to escape with nocturnal nervousness

and apprehensions. Responds to questions gradually. Continuous complaining and grumbling. Bad effects of shock that leaves one in a state of great anxiety and worse at night.

Natrum muriaticum (Nat-mur)

Phatak (1999) states that Natrum is a salt, which profoundly affects water distribution in the body. This remedy is for ailments from loss of fluids, grief, fright, fit of passion, disappointment, masturbation, and injury to the head. Salt retention such as oedema and dropsy are some of the symptoms that takes place as a result of its excessive intake but with that being said, it also affects the blood which causes leukocytosis and anaemia. Coming under its influence is the spleen, liver, heart and the mind. The typology of the Natrum is a thirsty, thin, malnourished (due to digestive problems) individual. His/her mental behaviour and physical symptoms are awkward and hopeless in nature. There is emaciation and a descending abdomen or neck. There is dryness that is seen in the vagina, rectum, throat, mouth and so forth. The pains are neuralgic accompanied by tears. The tendons and muscles contract. Emaciation despite living well. There is great weariness and weakness. There is a tendency to take cold. Oversensitivity to all sorts of influences. The young girls who need this remedy are those who become lovelorn and fall in love with men who are married. Sexual excess and emotion results in paralysis. Smoking tobacco causes the body to tremble. The mental symptoms of Natrum are that there are tears with laughter. Wants to be alone and cry. The person is irritable, gets into an urge about trifles. Aggravated by consolation. There is awkwardness, hastiness. Psychic effects of diseases; ill effects of grief, fright, anger etc. There is depression predominantly in chronic diseases. Blinding headache. Sexual desire and physical weakness.

Phosphoricum acidum (Phos ac)

Phosphoricum acidum is an acid. This remedy is useful for the women who are overtaxed mentally and physically and young people on a growth spurt. The most common symptoms that is found across all the acids is the debility and weakness. Accompanied by free secretions such as in profuse urination, sweating and loss of fluids with the exception of diarrhoea. The manifestation of debility in the physical sphere first appears in the mental sphere. There is slowness of the special senses and the mind. Breath gets taken away by the sensitivity to odour, light and sound.

There is a sensation of weight and pressure on the forehead, navel, sternum, breasts and so on. If the symptoms include grief, venereal excesses, loss of vital fluids and if the system is ravaged from acute disease, all these call for the use of this remedy. The pains are described as bruised soreness as though growing. This remedy is also for ailments from bad news, shock, chagrin and pining. The mental picture includes a disposition to weep, as from nostalgia. Bad effects from grief, sorrow, unfortunate love, with great emaciation, sleepiness, and morning sweat. Sadness and uneasiness regarding the future. Anxious inquiries regarding the disease under treatment. Great indifference. Dullness and indolence of mind, with want of imagination. Weakness of memory. Cannot connect with thoughts. Crushing headache. Sexual power deficient. Headache after sexual intercourse. Weak, relaxed genitals, suddenly during coitus that prevents ejaculation (Clarke 1990).

Pulsatilla pratensis (Puls)

Pulsatilla is a species of genus Pulsatilla belonging to the Ranunculaceae family. Vermeulen (1994) states that Pulsatilla is known as a “weather cock” remedy with distinct shifting and changing symptoms. This remedy tends to affect one side, the mind, veins, mucous membranes and the respiratory system. Symptoms suddenly cease after having risen to a certain pitch. The typology of the remedy is pre-eminently a female remedy who is gentle, mild, of plethoric disposition, weeping when talking and who cries readily. There is shortness of breath, no thirst, chilly and these symptoms are accompanied by digestive or menstrual disorders. The chilliness comes with pain. The pains have a sensation of burning and stitching pains with numbness. There are contradictory symptoms that change. The pains are described as wandering, jerking, tearing and ulcerative pains. There is a banded sensation. There are pulsations that are felt all over the body. Dyspnoea (laboured or difficult breathing) is caused by symptoms in the distant parts of the body. Wool or flannel clothing brings on eruptions and itching. The mental picture of Pulsatilla is of a person who tends to weep a lot. They are timid and resolute. The person likes sympathy. Have fears especially in the evening, they do not want to be alone, fear ghosts and the dark. Can be easily discouraged. Morose distress of the opposite gender. Given to extremes of pain and pleasure. Headache on one side, as if the brain would burst and the eyes pop out.

Staphisagria (Staph)

Boericke (2007) states that Staph is one of the polycrest remedies. The prescription of this remedy is based on the basis of the causation or essence (aetiology-the manner of causation a disease condition of a patient). A Staph patient is gentle and sweet. She/he draws sympathy from the prescriber, giving the impression of making the necessary effort in order to be a good patient. The story that the patient often tells is of sorrow, which then makes this true. Suppression is the underlying cause of the illness in Staph. The patient is unable to stand up for him/herself because they are sweet. This is especially for wives whose husbands are abusive, children of aggressive or abusive parents and so on. After taking this remedy it is important to note that the patient finds the courage to end a bad relationship or marriage. Confrontation is very hard for the patient. In cases where anger can no longer be supressed, there is a tendency of throwing things more especially in the direction of the offending person. The mental picture of Staph is impulsiveness, violent outburst of passion, hypochondriacal, sadness. The patient is very sensitive to comments from others about her/him. She/he dwells on sexual matters; prefers to be alone. Grumpy. There is sadness with fear of the future. There is lamentation and grief regarding the state of well-being. The anxiety and nervousness permits no relaxation.

2.7.11.3 Ailments from anger

The remedies recommended for anger are Aconitum nappelus, Aurum metallicum, Chamomilla, Colocynthis, Ignatia amara, Ipecacuanha, Nux-vomica, Opium, Platina and Staphisagria.

Aconitum nappelus (Acon)

Aconite is a flowering plant belonging to the Ranunculaceae family. Aconite has been used for acute conditions from shock and exposure, this remedy has also been used in more chronic conditions such as anxiety neurosis, panic disorder and phobic states. The complaints, particularly the anxiety states or the acute conditions, come suddenly and with great intensity. There is great anxiety and overwhelming terror of death in all the acute and chronic conditions. The prediction of the exact date and age of death may be made by the patient. Rapid development of inflammation is evident in almost any organ in acute conditions. After only minutes or hours after exposure to wind,

shock or fright, inflammation follows quickly. In cases where a violent or frightening event takes place for example an earthquake or car accident, Aconite must be prescribed first even if a more specific remedy will be required later. Aconite has the ability to release fright or shock that has been in a person's system even for a lifetime. There is great worry, fear and anxiety that follows every ailment, however insignificant. Delirium is characterised by raging, unhappiness worry, hardly conscious Apprehensions and fears. Believes he/she will soon die but fears death; predicts the day. Fears crossing the street, a crowd, the future. There is restlessness and tossing about (Morrison 1993).

Aurum metallicum (Aur)

Although this remedy was previously discussed for disappointment, it is also an excellent choice for anger. Arum is metallic gold. Boericke (2007) states that the deepest imaginable depression and states of suicide have been able to be cured by Aurum as one of its uses. Feeling of no connection, being and existing in a dark and isolated void. People who set high goals, idealist and very intense people are suitable for this remedy. Tremendous irritability and even violent ideas or thoughts may follow in cases where goals of an Aurum patient are frustrated. Grief and disappointed love may often devastate the patient. Deep religious convictions are present in the patient. Regardless of the spiritual work, the person still falls into deep clinical depression and suicide. Despite the inclination of prescribing this remedy for suicidal feelings however, in some cases there are suicidal feelings but rather may present as an overly serious person with an abnormal focus on achievement and career. Alcohol and drug abuse are some of the addictive behaviours that the individuals are vulnerable to. Aurum is one of the main anti-syphilitic remedies (remedies used to strengthen the body against genetic weaknesses that makes the body prone to specific conditions or disease process). Any physical pathology is accompanied by sinusitis, headache and heart disease. The mental picture of Aurum is that there is an irresistible impulse to weep. Anger and passion. The slightest contradiction stimulates his/her anger. There are suicidal tendencies, desperation, and desire to jump off high places. Sees hindrances everywhere. Fluctuation of moods of joyfulness and grumpiness. Irritable argumentative humour. Weakness of the memory.

Chamomilla (Cham)

Chamomilla (also known as chamomile) is an annual plant of the Asteraceae family. According to Morrison (1993) Chamomilla is a remedy that is overly sensitive, emotional and temperamental. The abuse of narcotics and coffee results in the over sensitiveness. This remedy is best suitable for nurses, little children and pregnant women in their diseased states. There is bad temper and the individual becomes snappish with frantic irritability. The patient is very cross to the extent that they cannot be appeased. The patient demands instant relief for his/her suffering, saying she/he would rather die than suffer. Numbness is experienced on waking up and following pain. There is jaundice, diarrhoea, twitching, convulsions and colic after anger. This remedy is for bad effects of ill temper. When a person experiences a convulsion, they become stiff accompanied by opisthotonos. The face becomes wry, thumbs turn inward and the eyes roll up. The mental symptoms of the remedy are snappish mental states, impatient, restless and irritable states. People who sigh and complain when they do not get their way. Extreme sensitivity to pain, wanting relief NOW. Asking for things then refusing them. Impatient. Angry, especially at being looked at or spoken to.

Colocynthis (Coloc)

Colocynthis is a desert viny plant. This remedy is not only used for acute cases of the digestive tract but rather it also has long lasting effects on the nerves (specifically the large nerves of the body), more especially the sciatica, spinal and trifacial nerves. The pains it produces in the abdomen are described as tearing, griping, cramping, atrocious which come all of a sudden. This makes the patient cry out, twist and turn, bend double or wriggle for relief or press something hard against the abdomen. The intensity of the pain causes the patient to vomit due to nausea and diuresis. The neuralgic pains are described as boring, clamping, cutting or gnawing which is then followed by numbness that is made better by pressure. This remedy is recommended for persons who are easily angered, copious menstruation in women with sedentary lifestyles and persons who are irritable and with tendency to corpulence. This remedy is for ailments from catching cold, grief, indignation, chagrin, and anger. There is a distinct feeling of being encircled with an iron band that is screwed tightly. There is impatience, irritability and effortless anger. The mental picture of the remedy states that this person is easily offended and is humiliated by small things. Anger is

accompanied by intense pain, or intense pain being as a result of the anger itself. Disposed to be cross and vexed. Aversion to speaking and is unwilling to respond to questions (Phatak 1999).

Ignatia amara (Ign)

Although this remedy was previously discussed for disappointment, it is also an excellent choice for anger. Ignatia is a tree, native to the Philippines and belonging to the Loganeceae family. It is used for anxiety related symptoms. Ignatia produces hyperaesthesia in all the senses and has a tendency to clonic spasms. Mentally, co-ordination of function is interfered with and the emotional element is uppermost. Because of this, Ignatia is one of the chief remedies for hysteria. There is a rapid change of physical and mental conditions that are opposite each other. The patient is a nervous, alert, rigid, trembling, apprehensive patient who has acute conditions of the mind and body made worse by drinking coffee. What is most characteristic is how superficial and erratic the symptoms are. It is for the ill effects of grief and worry. The pain is in circumscribed spots and is small. The mental symptoms are sorrow and attention to sorrow, with moaning. Temperament to be terrified. The patient is miserable, has dissatisfied humour, and spontaneous reflections on pain and displeasing things. Intolerance of sound. There is a predisposition to sorrow without saying anything about it. Irritation, followed by a silent anguish and grief. Fear of thieves at night. Cries, and is discouraged at the least incitement. Hopelessness of being cured (Morrison 1993).

Ipecacuanha (Ipecac)

Ipecacacuanha is a flowering plant in the Rubiaceae family. This remedy is indicated for adults and fat children that are feeble and prone to catching a cold in weather that is moist and warm. The remedy is for ailments from injury, supressed eruption, loss of blood, morphia, and reserved displeasure. Ipecacacuanha produces gastrointestinal disturbances because it acts mainly on the pnuemo-gastric nerve. It has an affinity for the respiratory system that is accompanied by continuous nausea. The discharges that are produced tend to be foamy and profuse. The haemorrhage tends to be gushing and has a bright red colour accompanied by nausea. Most complaints are accompanied by vomiting and shortness of breath. An Ipecac patient is awkward and stumbles against everything. The whooping cough in ipecacuanha is accompanied by

convulsions due to indigestible food causing suffocation or from suppressed exanthema (skin rash accompanied by disease of fever). There is oversensitivity to warmth or cold. The metal picture of Ipecac is irritability; holding everything in disapproval. A person is full of longings, but is uncertain. Mental depression. Ailments from vexation, with indignation. Impatience. Slowness of conception. Cannot endure the least noise. Anxiety and fear of death. Irritability and disposition to be angry. Morose with contempt of everything (Clarke 1991).

Nux vomica (Nuv-v)

Nux vomica is medium sized tree from the Loganaceae family. Nux vomica is described as an everyday remedy. This is because it corresponds to many disease conditions affecting modern humans. Nux vomica is best suited for people who are under high amounts of stress and the strain of working long hours, a person who has business cares and worries. This remedy is best suited for people leading a sedentary life although doing a lot of work that requires high levels of mental alertness and activity. As part of a lifestyle that demands so much energy and strenuous work, such persons tend to opt for indulging in wine, woman, rich stimulant food and sedative drugs and therefore suffer in consequence. The typology of a Nux vomica patient is rather quick, spare, thin, irritable, nervous and active. This remedy affects the nerves which then causes impressionability both mentally and physically and causes hypersensitivity. There are digestive disturbances that are produced, partial congestion and hypochondriacal states. This remedy is suitable for dyspeptic persons where food is then not properly digested. A Nux patient is prone to spasm, fainting and convulsions. There are sensations of alternating heaviness and lightness. The mental symptoms of Nux include being very irritable. Sensitive to all impressions. Unpleasant, hateful. Cannot tolerate light, odours, noises etc. Does not want to be touched. Time passes too slowly. Even the least ailment affects her greatly. Fault finding, brooding. Disposed to criticise others. Headache generally, better for walking in open air. Penis becomes relaxed during sexual intercourse (Vermeulen 1994).

Opium (Op)

Opium is a dried latex that is found from the seed capsules of opium poppy. It is used for insomnia and narcolepsy amongst other uses. Morrison (1993) Morrison states that opium is the only remedy during its proving that did not produce a single painful

reaction. A popular phrase describing an opium state is that it is a feeling of being blissed out. This phase describes a peaceful, euphoric and a dreamlike state mimicking the effect of all the opiates. In the secondary action though, provers experienced quite the opposite of painlessness. These symptoms were characteristic of hyperesthesia and pain both mentally and physically. This went to show that the proved reactions are exhibited in clinical practice. The blissed-out feeling is not always present. A hurried and intense state (as in Nux vomica) can be seen. A great desire for work is seen in a patient, carrying out tasks rapidly and the person is very sharp. When a state of exhaustion of the resources occurs, the opposite may be evident. This state is characterised by confusion, dullness and somnolence. There are cases whereby these two states can alternate in the same patient. The opposing state that is found in Opium is fear to which Opium patients are subject even though the typical states of euphoria and dreaminess are present. Opium is the remedy of choice in ailments that are brought on by fright. Opium is highly recommended in cases of amorality and children develop morality later on in life. The mental symptoms of Opium are that a person requiring this remedy appears inconsiderate, or has pronounced fretfulness and restlessness. There is fickleness and changeability. The patient is quick to take alarm and has a timid character. Hasty and inconsiderate confidence. Shock with distress, followed by warmth in the head and seizures. Sorrow over insults followed by convulsions.

Platina (Plat)

Platinum is a proud metal and is known to be a woman's remedy. It is used for menstrual disorders and extreme sensitivity of female genitalia. This remedy has its action mainly on the reproductive system where it can be seen affecting the ovaries, uterus and the sexual organs. The nerves are affected in this remedy, especially the trifacial and the sensory. This then causes numbing or thrusting pains, violent cramping and squeezing pains, which then results in spams. The spasms alternate with dyspnoea. The nerves and the mind are overly sensitive. The haemorrhage in this remedy tends to have black clots and fluid blood. The mental and physical or sexual symptoms alternate. The tremors are painful. The pains either increase or decrease gradually. There is a bandaged feeling. The discharges tend to be very sticky namely the stool, menses, tears, etc. There are tonic and clonic spasms accompanied by

laughter. The remedy is also for ailments from fright, vexation, bereavement, prolonged haemorrhage, masturbation, (before puberty), fit of passion and sexual excess. The sensations in Platina are described as prickling. There are violent shocks as from pain. The mental symptoms include a proud feeling, with over-estimating oneself. Indecisive mood. Delirium. Mental imbalance after fright and humiliation. Fear with quivering hands and feet, a delusion of the fancy. Loud cries for help. Hysteric mood, with great lowness of the spirits, nervous weakness, vascular excitement. A wavering mood (Phatak 1999).

Staphysagria (Staph)

Although this remedy was previously discussed for disappointment, it is also an excellent choice for anger. Staphisagria is a species of delphinium from the Ranunculaceae family. This remedy is for ailments after anger and insults, reserved anger, injury, fall, clean cut wounds, operation wounds, sexual abuse, dentition, tobacco and mercury. Staphysagria has affections of the nervous system, accompanied by trembling and this becomes the key feature about this remedy. Sexual disturbances, moral and physical are produced in this remedy. The libido in this remedy gets provoked in an irregular and excessive manner. This also comes with a tendency to masturbation as well which corresponds to the physical state due to the effect of that habit. Staphysagria acts on the teeth, the urinary system, fibrous tissue of eyelids and tarsi, skin glands and right deltoid. The person is overly sensitive, can be easily offended by the least word that seems wrong and this hurts the person a lot. The special senses become overly sensitive; a person cannot tolerate any taste, noise, odour, and touch. The sensations of pain are described as squeezing, stinging or smarting pains as if cut. The pains have a tendency to move to the teeth. In Staphysagria stitching pains remain after the operation. There is generalised stiffness of all joints and fatigue. The whole tends to feel weak and painful. The mental symptoms of Staphysagria include a desire for death. Sadness with fear of the future. Weeping and grief respecting the state of health. Susceptibility. Anxiety and agitation which allow no rest. Justifiable ill humour over what has happened or has been done by oneself: weeping and dejection. Instability of ideas. Excessive dull intellect, with inability to attend to any occupation (Clarke 1990).

2.7.11.4 Ailments from shock

The big remedies are Ammonium carbonicum, Arnica montana, Ignatia amara, Opium, and Acidum picricum.

Ammonium carbonicum (Am-c)

Ammonium carbonicum is a carbonate of ammonia. According to Phatak (1999) it is used for hysteria, bronchitis and measles. Ammonium has an affinity to affect the circulatory system, where the heart becomes weak and collapses. There are sluggish tendencies of the circulation; as a result, the under-oxygenated blood produces drowsiness, weakness and lividity. Lack of reaction and the immune system becomes compromised. The remedy is for people who have a disposition towards being fat, having a weak heat which then results in wheezing and suffocative feeling. There is a huge sensitivity to cold air. The soreness of the body causes one to lie down. A person tends to be active but gets tired easily. The discharges are adherent, acrid and feel hot. The mental symptoms seen in Ammonium include a hostile humour during wet stormy weather. An aversion to the opposite gender (like Sepia), weeps, panic-stricken, fainting, nervous, anxious, and being tired from motion. Aggravated by listening to conversations. Anxiety, fearful in the evening and feels like crying. A bad mood in the morning with a tendency to weep, which is better in the evening. There is a likelihood of making mistakes when writing, calculating and speaking

Arnica montana (Arn)

Arnica is European flowering plant from the sunflower family. Arnica is known to be a traumatic remedy par excellence. Trauma can be of any kind, both mentally and physically. The effects whether they are recent or remote are treated using Arnica. This remedy has an affinity for the blood with an ability to cause putrid and septic conditions. Since the blood vessels are relaxed in this state, ecchymosis occurs and this leads to haemorrhagic and epistaxis tendencies. The remedy also acts on the nervous system, which causes neuralgia. The muscles have a sore sensation, bruised all over and painful. The body part is followed by soreness after the pain or following bleeding. In cases of pus formation, it becomes a prophylaxis. The emaciation here tends to be progressive. The pains are described as paralytic, to have sudden shifting tendency from one joint going to another. This is a remedy to think of in ailments of

financial loss, fright, repentance, anger, excessive use of any bodily organ, impotence in males as a result of over indulgence and following exertion of any kind. The mental symptoms of Arnica include fear of being touched, of anyone who is approaching. Unconscious; answers correctly when spoken to, but relapses. Nervous; pain is unbearable; oversensitivity of the entire body. Wants to be alone. After mental strain or shock. Says he/she is fine. Agoraphobia. Indifference; morose; inability to active work continuously. Headache as from a nail in the temple. Impotence from excess or abuse (Phatak 1999).

Ignatia amara (Ign)

Although this remedy was previously discussed for disappointment and anger, it is also an excellent choice for shock. Ignatia comes from the seeds of St. Ignatius bean tree. Clarke (1991) states that the seeds of Ignatia contain a larger proportion of strychnine compared to Nux vomica. This then accounts for the great differences that exist between the two remedies. It is used following ailments from grief, fright, disappointed love, jealousy and old spinal injury. Ignatia tends to affect the mind. The co-ordination of functions is interfered with and the emotional element is hugely influenced. This then causes contradictory, erratic, paradoxical effects both mentally and physically and has the ability to change rapidly, opposing each other. The nervous system tends to be affected. This then causes spasmodic effects. These spasmodic effects are often described as being violent with rigidity, tremors and with twitching. There is often a sensation as that of a lump, sharp pressure or a foreign body. Paralysis follows in Ignatia after night watching in a sick chamber or after a great mental emotion. Symptoms seem to pass following profuse urination. The mental symptoms include a person becoming reserved, with unceasing sad thoughts; serious depression with complaining. Sadness and concentration, sorrow with sighing. Wants to be alone. Despair of being healed. Anger followed by quiet heartache and grief. Cries with complete discouragement at the least provocation. Changeable disposition. Predisposition to grief without uttering any word about it. Anxiety, nervousness. The headache symptoms of Ignatia is that the headache is made worse by loud talking. The concomitant of the headache is a backache and it alternates with the headache, which ends up in vomiting and yawning. The sensation that is felt in Ignatia is as though a nail is driven out through the sides.

Opium (Op)

Although this remedy was previously discussed for anger, it is also an excellent choice for shock. According to Phatak (1999), opium is made up of 18 alkaloids. The three best known of these alkaloids are codeine, morphine and apomorphine. It is used for trauma, sleeplessness and fear. Opium has an affinity to affect the central nervous system where it affects the mind and senses desensitising the nerves, causing painlessness and depression. There is loss of concentration, of power, judgement and self-control in opium. The paralysis of opium is noted by painlessness of brain, tongue, bowels and so on. During sleep, there is jerking, tremors and twitching. Epilepsy in sleep; from approach by strangers, from fright, it is worse for anger and insults. Faints every 15 minutes. The complaints are accompanied by sweat. There are ailments from fear, shame, sudden joy, sun and fright. The mental symptoms include an enraged state. Not wanting anything, says there is nothing wrong with her/him. Sluggish. Dull. Wants to go home, thinks he/she is away from home. Indifference from pain and pleasure. Delusion body parts are larger. Inclined to lie. Short-temperedness, anxiety, tendency to start. Fears that remain after fright; delirium tremens, with terror. The head symptoms are vertigo after fright, particularly in old people who suffer from light-headedness and injuries involving the head. The paralysis gets experienced in the head as well.

Acidum picricum (Pic-ac)

Picric acid is an acid and generally has an affinity to act on the reproductive organs, kidneys, brain, spinal cord, lumbar region and the occiput. It is used to relive the symptoms of weakness. The body and mind tends to have a heavy feeling and a sense of tiredness. There is a degeneration of the spine specifically accompanied by paralysis. The sensations found here are notably described as prickling as of needles. There is also a burning sensation in many parts especially along the legs and spine. This remedy is specifically for a worn-out person, both in the mental and physical spheres. This remedy is also indicated for type-writers' palsy. The mental symptoms that are found in picric acid are daytime sleepiness and sleeplessness at night particularly after mental labour and passionate notions. There is a worked out exhausted feeling, want of will power, must give in but there is no anxiety, the patients mind is greatly tranquil, indifferent to everything, he/she cannot tolerate the least

mental exertion, worse for every metal effort. The male symptoms include hard erections accompanied with pain that is felt in the testes moving up the spermatid cord. The impotence notably has a susceptibility to developing boils and carbuncles (Phatak 1999).

2.8 Homoeopathy and the community

This last chapter focuses on homoeopathy and its community service through the wellness centres in and around Durban. The focus of the study is more on the wellness centre that is known as Ukuba Nesibindi Community clinic as some of the interviews will be held there.

The Ukuba Nesibindi Community Wellness Centre

Dube (2015) states that Lifeline in collaboration with Durban University of Technology opened its first homoeopathic community clinic in 2004. This was said to facilitate high standards of health care, teaching and learning. Ukuba Nesibindi Community Clinic (UNHCC) is in Warwick junction, Durban. UNHCC is in the third floor of the lifeline building in Acorn Road which is just less than one kilometer from the main campus of DUT. UNHCC offers a free homoeopathic consultation and treatment service. The area is well known for high crime rates, prostitution, violence, small informal businesses and low cost housing. This is an area that is classified as being disadvantaged. Community outreach programmes offered by Lifeline include free courses in computer skills, beadwork, and hair dressing. These provide empowerment to help individuals to be equipped with skills that will make them be eligible to find employment. Free HIV counselling, school day care and rape counselling are amongst the services offered on the premises of Lifeline (Dube 2015).

The UNHCC is operated by senior (Btech-4th year and Mtech- 5th year) homoeopathic students. A qualified homoeopath clinician supervises students during the consulting hours. The facility operates on private funding and acts as a pilot project where homoeopathy is applied as a form of community based primary healthcare within the public sector (Watson 2015). The study by Watson (2015) found that recruited patients responded well to the treatment. This was regards to the main and secondary complaints and overall variables to the treatment they received. Patients showed a good level of satisfaction with the clinic's location and amenities. Twenty five of the

participants raised issues with privacy which is due to filing cabinets, clinician rooms and dispensary which are not separated from the consultation room. There have since been major renovations though since the study by Watson which addressed these issues. This ensures that patients care and confidentiality is maintained and not compromised in any way. Therefore, patients can speak freely and can express themselves without any fear. This promotes better management of their physical, mental and emotional complaints.

CHAPTER 3: METHODOLOGY

3.1 Qualitative methodology

Qualitative research design is exploratory. Qualitative research is defined as a process of enquiry that is naturalistic. The purpose of it was to sought in-depth understanding of the emotional response to a HIV positive diagnosis in the eThekwini district of KZN. This type of design is used to define the problem or emerge an approach to the problem. It is also used to go deeper into issues of interest and explore subtle differences in connection to the problem at hand (Mora 2010).

Fouché and Schurink (2011) stated that qualitative research designs lays out all the decisions a researcher makes in planning the study. This is sometimes referred to as a phase in the process of the research. In qualitative designs a researcher almost always, develop individualised designs as they proceed.

The qualitative researcher is concerned with understanding rather than explanation, with naturalistic observation rather than controlled measurement, with the subjective investigation of reality from the worldview of an insider as opposed to that of an outsider. Every research project starts with an idea or a thought, develops into a topic and is eventually fine-tuned into a research question or into a problem formula. In qualitative designs particularly what is important is that personal interest and curiosity are sources for the topic (Fouché and Schurink 2011).

Thus, qualitative research was appropriate to be the research method used in the research, given that the study sought to explore subjective reactions to a positive HIV diagnosis.

3.2 Data collection tool

An interview schedule (or guide as it is sometimes referred to) is written so as to guide interviews. Its core purpose is to provide a set of predetermined questions that might be used to engage the participant and to point out the narrative ground. This challenges the researcher to think critically about what they hope the interview might cover, thus when the schedule is produced beforehand it provides the appropriate

guidelines to discipline the interview and accomplish the purpose desired by the researcher (Greeff 2011). In this study an interview schedule was constructed to guide the researcher on relevant questions to ask during the conduction of the research (Appendix A)

3.3 Setting

The interviews were conducted at Ukuba Nesibindi Wellness Centre and the DUT Wellness Centre in the eThekwini district of KZN.

Dube (2015) states that Lifeline in collaboration with Durban University of Technology opened its first homoeopathic community clinic in 2004. This was said to facilitate high standards of health care, teaching and learning. Ukuba Nesibindi Community Clinic (UNHCC) is in Warwick junction, Durban. UNHCC is in the third floor of the lifeline building in Acorn Road that is just less than 1 kilometer from the main campus of DUT. UNHCC offers a free homoeopathic consultation and treatment service. The area is well known for high crime rates, prostitution, violence, small informal businesses and low cost housing. This is an area that is classified as being disadvantaged. Community outreach programmes offered by Lifeline include free courses in computer skills, beadwork, and hair dressing. These provide empowerment to help individuals to be equipped with skills that will make them be eligible to find employment. Free HIV counselling, school day care and rape counselling are amongst the services offered on the premises of Lifeline (Dube 2015).

The UNHCC is operated by senior (Btech- forth year and Mtech- fifth year) homoeopathic students. A qualified homoeopath clinician supervises students during the consulting hours. The facility operates on private funding and acts as a pilot project where homoeopathy is applied as a form of community based primary healthcare within the public sector (Watson 2015). The study by Watson (2015) found that recruited patients responded well to the treatment. This is with regards to the main and secondary complaints and overall variables to the treatment they received. Patients showed a good level of satisfaction with the clinic's location and amenities. Twenty five of the participants raised issues with privacy which is due to filing cabinets, clinician rooms and dispensary which are not separated from the consultation room. There have since been major renovations though since the study by Watson which have fixed these issues. This ensures that patients care and confidentiality is

maintained and not compromised in any way. Therefore, patients can speak freely and can express themselves without any fear. This promotes better management of their physical, mental and emotional complaints.

3.4 Sampling

Tongco (2007) explained that the purposive sampling method involves the following steps:

1. Decide on the research problem.
2. Decide on the type of information that is required.
3. Define the exclusions and inclusions criteria of participants.
4. Find the participants based on the exclusion and inclusion criteria.
5. Keep in mind credibility and competency in assessing the prospective participants.
6. Make use of appropriate data gathering techniques.

Purposive sampling is built exclusively on the discernment of the researcher. This means that a sample is composed of elements that contain the most characteristic, representative or classical attributes of the population that serve the motive of the study best. The researcher must think critically about the variables of the population and then choose the sample cases accordingly. Comprehensive identification and formulation of pre-selected criteria for the selection or participants is therefore, of fundamental importance (Strydom and Delport 2011).

Qualitative research methods generally use small samples that are purposively selected to meet the objectives of the study. The small sample that the researcher used was as a result of data saturation. There were no newer emotional responses reported by the participants.

Sampling in qualitative research is less structured, less quantitative and less firmly applied than in quantitative research. The reason for this is mainly due to the techniques of qualitative data collection, namely, observation and interviews. There are no rules for sample size in qualitative investigation. Sample size depends on what the researcher wants to know (the motive of the enquiry), what is at stake, what will

be competent, what will be credible, and what can be done with the available time and resources (Strydom and Delport 2011).

In qualitative research sampling is relatively limited, based on saturation, not representative. The size is not statistically determined, is low cost and less time. It can thus be inferred that in qualitative investigations non-probability sampling is used almost without exception.

3.5 Recruitment process

A minimum of 10 participants (informants) were recruited purposively, including, but limited to, HIV/AIDS activists, members of support groups, community leaders and organisers of HIV/AIDS activist groups (who were open about their HIV status and/or had publicly disclosed their HIV positive status) were approached by the researcher and notified of the impending research. Those who were interested in participation contacted the researcher directly.

3.6 Sampling method and procedure & informed consent

A purposive sampling method was used to select participants. They were given a consent form to read and sign if they agree to participate in the study (Appendix B).

According to Dudovskiy (2016) purposive sampling, also known as judgement, selective or subjective sampling, is a non-probability sampling technique. It is distinguished by an intentional effort to acquire representative samples by including representatives from typical groups or typical areas in a sample. The researcher relies on his/her own judgement to choose sample group members. Purposive sampling is common in qualitative research studies.

In purposive sampling the researcher has enough knowledge of the topic to pick a sample of experts and individuals. Therefore, skills and capabilities of the researcher to find suitable candidates to contribute to the attainment of research aims plays an important role on the outcome of studies using this sampling technique.

Purposive sampling was best suited for this study because it saved time since the target was only the suitable subjects. The researcher had prior knowledge of the study enabling her to choose and approach suitable participants. This sampling method enabled the researcher to identify and select participants who had knowledge and

experienced the emotional response to a HIV positive diagnosis. In addition to this, these individuals had to be willing and available to participate in the study. They had to be able to communicate experiences and opinions in an articulate, reflective and expressive manner. The results were more representative of the targeted population. It could also be the only way to recruit candidates for a more rare representation of a group, this is because the targeted population was a vulnerable group. (Dudovskiy 2016).

3.7 Theoretical saturation and sample size

Theoretical saturation plays a role in determining sample size in purposive sampling. Theoretical saturation can be described as a point where no more new data can add additional insight into the research questions.

The recommended principles for deciding saturation in theory-based interview studies (where theoretical groups are pre-established by present theory). Primarily, a researcher must stipulate a minimum sample size for initial examination (initial analysis sample). Additionally, a researcher must stipulate how many more interviews will be conducted until a point where they are lacking new ideas and evolving around the same data already collected (stopping criterion) (Francis *et al.* 2010).

The research design planned for a minimum of 10 participants with additional participants being added if necessary until data saturation was achieved. The final sample size was 12.

Qualitative research is essentially an investigative research process. It is used to obtain an understanding of unrevealed reasons, opinions, and motivations. It provides insight into the problem or helps to develop ideas or hypotheses for possible quantitative research. Qualitative research is also used to reveal trends in thought and opinions, and to discern deeper perspectives on the problem. Qualitative data collection methods differ in terms of using unstructured or semi-structured methods. Some common techniques include focus groups (group discussions), individual interviews, and participation/observations. The sample size is typically small, and participants are selected to achieve the given research design (Wyse 2011).

<u>Inclusion criteria</u>

- Participants who were between 18 and 60 years of age
- Participants of either gender
- Participants should have been diagnosed as HIV positive within the last 5 years

Exclusion criteria

- If you have not been diagnosed with HIV
- If you are under the age of 18 or over 60 years

3.8 The consultation process

After a telephonic screening procedure (to confirm suitability for inclusion), an appointment was made for the participant to see the researcher. When the participant arrived for the interview he or she was given a letter of information and informed consent to read. The researcher answered all the questions related to the study to ensure informed consent was obtained. If the participant agreed to participate in the study, he or she was asked to sign the informed consent form. The participant then underwent an in-depth interview using a set of probing questions (Appendix B) for approximately an hour. The researcher conducted the interviews herself and all proceedings were digitally recorded and transcribed by the researcher.

3.9 Data processing and analysis – analysis and output

A qualitative research design was used for this study. In-depth personal interviews were conducted to collect data, with the intent to determine the emotional responses experienced with regards to the diagnosis of HIV. An interview guide was used to collect data and a purposive sampling method was used to select a minimum of 10 suitable participants, previously diagnosed as being HIV positive.

Analysis of data was guided by 6 phases of thematic analysis as per Braun and Clarke (2006):

- Phase 1- Familiarising oneself with the data
- Phase 2 -Generate initial themes
- Phase 3 -Search for themes
- Phase 4 -Review themes
- Phase 5- define and name themes
- Phase 6- Produce the report

Emergent themes were translated into homoeopathic symptoms which were then converted into homoeopathic reportorial format and repertorised using Radar Opus. The materia medica of emerging remedies were subsequently explored and related to the emergent themes and suitable homoeopathic remedies were proposed for treatment and further research.

3.10 Research rigour and trustworthiness

Gunawan (2015) advises four principles for developing the trustworthiness of a qualitative analysis, which were followed in this study.

3.11 Credibility

In order to safeguard credibility of the study, the researcher discussed the research process and the outcomes with the co-supervisor who is qualified and experienced in the field and gave insight into factors about which the researcher may be concerned. The researcher used a tape recorder to collect data, the data were transcribed and the researcher made sure that the transcribed notes were a true reflection of the participants' experiences.

3.12 Dependability

An audit log was established through safe care of raw data of each interview for upcoming reference.

3.13 Transferability

To enable transferability, the researcher provided a distinct and discrete description of the context, selection of participants, data collection and the procedure of data analysis.

3.14 Confirmability

Subsequent to the transcription of the voice-recorded interviews, each participant was given the opportunity to review the notes to affirm if they were an accurate reflection of his/her views concerning their experiences.

3.15 Ethical issues

The research was conducted amongst a vulnerable group and therefore confidentiality of the information was of utmost importance. Participation in this study was on a voluntary basis and there was no coercion or pressure to participate. Prospective participants were limited to HIV/AIDS activists, members of support groups, community leaders and organisers of HIV/AIDS activist groups who were open about their HIV status and/or had publicly disclosed their HIV positive status; this limited risk of participation and the potential for stigma based on their HIV status. Anonymity and confidentiality were maintained in both the recruitment and interview process. HIV/AIDS activists, members of support groups, community leaders and organisers of HIV/AIDS activist groups were approached by the researcher directly and notified of the impending research. Those who were interested in participating were contacted by the researcher directly. Thereafter the participants identifying details were not used and each participant was assigned a code. There was no substance given to the participants, and included only verbal communication that explored their emotional state when they first found out about their statuses. In the unlikely event that interviews evoked untoward and/or distressing emotional responses participants were referred to one of the DUT homoeopathy wellness centres for treatment and/or referred to a counsellor, psychologist or Lifeline with whom DUT collaborates at Ukuba Nesibindi wellness centre.

Three elementary ethical doctrines were pursued at all times, namely, the principles of respect for persons, beneficence and justice. Respect for persons means respecting their autonomy and that if they have lessened autonomy, respect that they entitled to defence of their autonomy. Beneficence refers to doing no harm and to giving consideration to the possible advantages and/or risks that the individual may experience as a result of this research. The researcher sought for ways to maximise any possible benefits that the research may represent for research participants while still confirming the principle of legitimacy. Of greatest importance was the maintenance of the safety and confidentiality of all the participants, both in the data analysis and discussion and distribution of findings (Polit and Beck 2012).

3.16 Conclusion

The purpose of this chapter was to narrate the research methodology of this study, explain the sample selection, describe the mechanism used in collecting the data and to issue an explanation of the data analysis procedures used for data analysis. The results that were acquired from the data collection process will be presented in Chapter 4 and the discussion of results in Chapter 5.

CHAPTER 4: RESULTS

This chapter presents the outcome of the data gathering process, reports the results and discusses the findings obtained from the semi-structured interviews.

4.1 Demographic data

Gender

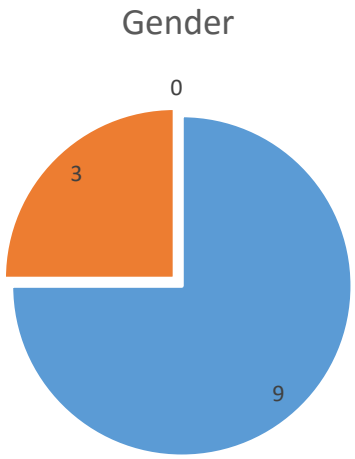

Figure 4.1: Gender

Figure 4.1 shows that the majority of participants were females.

Age

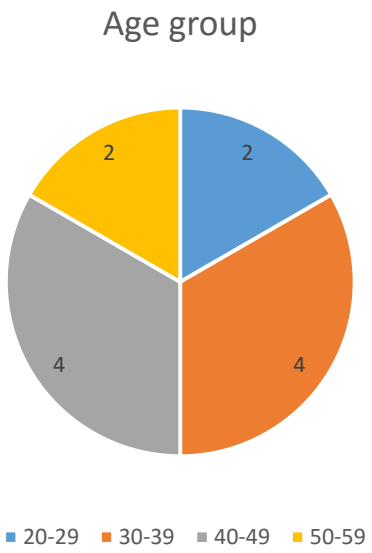

Figure 4.2: Age

Figure 4.2 shows that participants were between the ages of 21-54 years, with the majority being 40 years and older.

Race

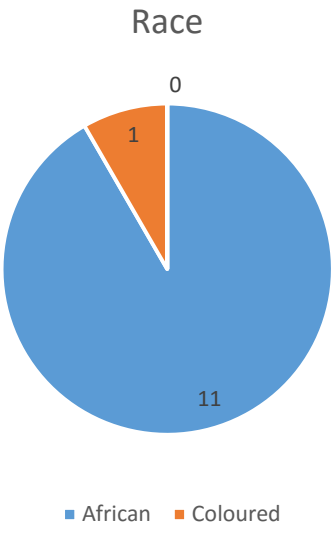

Figure 4.3: Race

Figure 4.3 shows that all the participants were African (black) except one who was coloured (a mixture of different races in their family background). Nine interviews were

conducted in IsiZulu and three were conducted in English and all 12 interviews were included for the data analysis.

4.2 Emerging themes and subthemes from the semi-structured interviews with participants

The analysis of the data gathered from the semi-structured interviews resulted in the identification of the themes and subthemes highlighted in Table 4.1.

Table 4.1: Identification of themes and subthemes

Themes	Subtheme
1. Concerns about HIV status	• Discrimination • Fear of dying • Duration of treatment and medium of ARV administration • Incurability of HIV • Psychological and other health problems
2. Acute emotional response to HIV status	• Denial • Shock and emotional pain • Broken and hurt • Emotional discomfort
3. Chronic emotional response to HIV status	
4. Change in lifestyles	• Becoming more responsible • Relationships • Drinking habits and partying • Changes in sexual habits
5. Chance to change status	• Dating • Lifestyle behaviour • Condomising

Themes were identified in line with achieving the research question which was:

- What are the acute emotional responses to an HIV positive diagnosis?

Data from semi-structured interviews was transcribed verbatim and excerpts are used to illustrate the presentation of the themes and subthemes below. The names of interviewees have been changed to protect their identity.

4.3 Theme 1: Concerns about HIV status

Question- What is your deepest concern about your status?

Although the discovery of ARVs have been widely reported to boost the immune system of patients and prolong their lifespan, it is however noted that isolation, stigmatisation and concerns of being HIV positive are the biggest silent killers of most

patients. Bearing this in mind, it was sensible to know from the perspective of HIV patients what their deepest concern about their status was. It was found that discrimination, the fear of dying, the long duration of treatment, psychological disorders, and other medical complications were among concerns mentioned by the participants.

4.3.1 Subtheme 1: Discrimination

Among the numerous challenges confronting HIV positive patients was the alienation and discrimination they constantly face in the wider society. While a lot of public enlightenment has been engendered by various government departments and the media, HIV patients continue to be discriminated against in the workplace due to their status. This is reflected in the following quotes by participant P1.

> *The concern that I have about my status is the possibility that I may not get some of the job opportunities due to my status. Also… [*Starts weeping] *the fact that some people have not yet been able to accept that my situation is like this. Yes, that is it. (P1)*

From the above comment, it is safe to say that HIV positive patients are denied certain opportunities because of their health status. This is also reflected in the quote below.

> *It is painful because there are certain things that I cannot do although it is said that we live in a democratic country. (P1)*

Despite the above negativity, P1 felt positive when asked to express how he feels about his status.

> *Yes, well I have become used to it now since it has been a while. In fact, it's no longer the same. (P1)*

4.3.2 Subtheme 2: Fear of dying

Many HIV patients are constantly uneasy about dying and leaving their loved ones and family behind. Unsurprisingly, many of the participants interviewed noted that their deepest concerns about being HIV positive was dying. This is supported by the following statement by the interviewees.

> *My deepest concern would be dying and leaving my 2 babies but otherwise I am fine.* (P5)

Similar fear was also expressed by participant 9.

My concern is my children because there are no parents anymore and I am the only one who is taking care of them. That is the only thing because I had already accepted. My concern about my kids is if I could die who will be left behind to take care of them. I always think about it almost all the time. (P9)

Participant P7 also hinted at the desire to live for the sake of her family.

My deepest concern right now is that actually I don't know what I can say to you because I have been living with the disease for long now. It's just that my grandchildren, my daughter, I would like to live longer for them. I wouldn't like to just close my eyes and leave this world because I never went out and look for this thing. (P7)

From the above statements, one can deduce that fear of dying can be heightened by some of participants having young children. This is supported by the following responses to the question "How does your HIV status make you feel?"

Well, most of the time I am okay but you do get those moments where you think about what will happen to the children more especially because I have a very young one, should anything happen. (P5)

It was found that the above concern of dying also arose as an emotional discomfort for another interviewee.

I'm very sensitive (cries). It makes me feel terrible, I have never been sick I just tested positive. My concern is getting sick, leaving my children behind makes me feel powerless because it gets to a point where I do not know what I could do. In the end I have that in me that in the end I will die and I will be killed by it. (P4)

4.3.3 Subtheme 3: Duration of treatment and medium of ARV administration

Patients are required to constantly be on ARVs to effectively suppress the viral load. Some of the participants however noted a concern with the treatment duration and medium by which the drug is administered, as expressed below.

My concern is how long will I take the medication for, I am counting because most people get to live for about 15 years after that it is almost like you don't live very well. (P4)

With reference to the concern of the medium of the ARV administration:

Right now my concern would be I wish there was an easier way of taking the medication instead of daily like an injectable or something that maybe one could take in 3 months. Sometimes we forget, sometimes we are at work, that is my wish. Knowing that what I wish for is not happening now or won't happen any

time soon makes me feel like our government is failing us somehow, if they were able to make pills then there could have been an alternative. Something that is easier to administer for me that would make a huge difference. (P12)

4.3.4 Subtheme 4: Incurability of HIV

Despite the advancement in science and technology in the last decade, and the intensive research and enormous resources invested in finding a cure for HIV, sadly, there is not yet a cure for the virus. P12 lamented as follows:

It is that it is incurable and that I have to be on treatment for the rest on my life. (P12)

Despite the mentioned concern, P12 was more upbeat on her HIV status.

I'm okay (laughs). I have accepted it, it was not easy for me at first because I used to ask myself why me? But at least I'm lucky because I'm one of the people who have medical aid. I then was able to go for therapy and counselling. One of the things that one of the ladies who was counselling me asked me because I used to ask myself why I, so she said if not you then who do you think should it happen to? So until today that is something that I have taken with myself. (P12)

From the above statement, it is clear that receiving both treatment and counselling have contributed to the positive mood of P12.

4.3.5 Subtheme 5: Psychological and other health problems

Although ARV medication has been clinically proven to suppress HIV viral loads and thus reduce the ability of the virus to multiply in the host immune system, it is also noted to induce some side effects.

I felt sick not that I was sick but rather I was stressed. I would experience a headache and I used to think that is it real that I have the disease. I used to feel like it would be better to just die especially when I used to think a lot. I used to think that as young as I am but already I am infected. (P11)

Nonetheless, it emerged that P11 was positive regarding the status of HIV. It was found that having supportive family and better knowledge about HIV has contributed to participants accepting the condition as it is. This is reflected in the quote below.

I feel alright now because I know that I won't be just sick all the time and I won't just die. Even when I used to get tested, I would get tested every 3 months up until I got diagnosed. Right now I am fine because even in my family there are

people who are living with HIV so they also gave me advice and I am still going to live for some years too. (P11)

Equally concerning, and in terms of the health problem associated with HIV, one of the participants narrated a concern about erectile dysfunction. According to the interviewee:

The only concern that I have right now is that I do not become happy when I am with a woman. I am not going to talk much about other things that require me to have money. I will speak about the sexual intercourse. When I am rushing for the sexual intercourse to do, it ends up not happening the way I want it to happen. Even when I put on a condom I find that my manhood is soft. I become tired and not be able to continue. Even with the erection, it doesn't become as strong as it is supposed to be. Thereafter the intercourse finishes quickly and I am unable to continue. This has been happening for some time. I have even tried the doctors but there has not been anything that they were able to find wrong in me. I have even tried the pills that I was told that they are being sold but nothing has changed. (P2)

Furthermore, when P2 was asked to express how it feels to be HIV positive, the following statement emerged:

I am unable to satisfy my wife and therefore there is no happiness. Not that there is anything of any kind, that is all. (P2)

4.4 Theme 2: Acute emotional response to HIV status

Question- How did you feel when you first found out about your status?

Noting the great societal stigma and fear linked to have been HIV positive, it was sensible to know how the patients felt when they first found out about their status. It emerged that the interviewees experienced emotional pain, some felt hurt and broken, while others were in disbelief and denial.

4.4.1 Subtheme 1: Denial

Amongst the participants who had expressed denial the first time they discovered their HIV positive status, one of interviewees noted the following:

I did have denial, yes I was in denial to an extent that I was supposed to start treatment and I started it then stopped. After some time, I was infected with TB and then that resulted to me having to start the treatment again because still it was not helping after hearing that to not take it because I found out when I was pregnant. (P8)

While expressing similar denial, P12 narrated the following:

> *The first time I didn't believe it because it came as a shock. I kept asking myself as I said why me what had I done? If felt like my whole world was coming down on me. Everything that I envisioned for my future faded just in front of me, at that very moment that is how I felt. (P12)*

For P8, the emotional response was noted to be unbearable as the interviewee had requested for the test to be repeated again.

> *I cried, I cried a lot and I couldn't believe it. I even requested to be tested again. I cried, I just couldn't believe that it was really true. (P8)*

4.4.2 Subtheme 2: Shock and emotional pain

With reference to the emotional pain and shock expressed by some of the interviewees, P2 said the following:

> *When I was told that I was positive I was very shocked. It was also very painful because I knew that is it me who infected her. I never expected it because this thing comes unexpected. I even kept it as a secret from my wife up until she got into a situation. I didn't know where I would begin to tell her. It got to a point where I was forced to tell her and I did. So now both of us are travelling this same journey together. (P2)*

Similarly, P5 narrated how surprised and shocked it was the first time the HIV status was revealed. The emotional response to the news for been tested positive was apparently heavy on the interviewee. This is reflected in the statement below.

> *Whoa, that day it felt like there was noise of buses, trains, airplane but together all at the same time in my head. I wasn't even expecting it because I was only preparing myself to go overseas then they asked me for a Tb test so I went for a Tb screen. While I was there, a person came and spoke to us about HIV and testing and all of that. I thought to myself I am not a person who sleeps around so I might as well just for the sake of doing it. So when I got there I was counselled and tested then I was positive! I was shocked, I was thinking really then I kept quiet for days and I wasn't feeling okay for the first few years. I then did some research, I thought I was going to die the following day. It was shocking because the first thing that came into my mind was death. (P5)*

4.4.3 Subtheme 3: Broken and hurt

Another notable emotional acute response observed during the course of the interview was that some of the participants felt broken and hurt.

When I first found out I was broken I was hurt but I knew somewhere along the line that I was going to get this. From all the STI's that I had all the years from my husband I knew that this thing was coming and I was afraid. I was very afraid of it and I ended up getting it. Never mind, I used to go and treat myself from the STI's but he wasn't because they say I don't have it you know, there's nothing wrong with me. (P7)

From the narrative, it emerged that the broken heart suffered by P7 may also be attributed to the abusive relationship the interviewee experience. This can be further deduced by the following statement.

He always blamed me that I am the one whereas I use to be indoors, he was the one who was always out there coming home with all his sperm on him and still penetrating me knowing very well that he slept outside and now forcing me to have sex with him. I lived a hard life my sister very hard. I told my family first time about it when I got tested because I tested two lines same time, I didn't even by chance get one line. I cried a while, I cried then I had my family support and it was very good. They said listen don't worry you are a strong woman you will make it, maybe this was your way out because he was very abusive.

Also expressing similar hurt from finding out to be positive, P10 narrated the following:

I was very hurt because I used to blame people and say it's them. I think I got infected from the person I was with. Back then I was still at home and it wasn't that bad but my partner then moved to the city to come study. When she got back home I didn't use protection, I think that is where things went bad. My partner was the one who tested and got back with the results and told me about her condition, she also encouraged me to go and get tested. I went and got tested and I found out that I was HIV positive. She said she was scared to tell me because may be I would have refused to get tested. (P10)

4.4.4 Subtheme 4: Emotional discomfort

Added to the above mentioned acute emotional response to HIV status, one of the interviewees expressed discomfort and strong emotional concerns about dying.

Thirty minutes wouldn't pass without me thinking about it, thinking that I am going to die. I even had a headache then I decided to tell my one sister and the headaches were a little bit better and she was able to comfort me. (P9)

Similarly, emotional discomfort was also alluded to by P4.

…wow, I wasn't alright, I felt bad. Before, this disease was known to be for those who were sleeping around as for me I wasn't. I understood though after some time that it wasn't just about that even if you are not sleeping around you can still get infected. I had a serious relationship with someone who was paying lobola for me and after I found out it was the exact same person who started to

neglect me. It was my little secrete because I never told anyone even my family. After some time, I told my sister, she is the only person that I spoke to. (P4)

From the foregoing theme, it is apparent that getting the knowledge of being HIV positive for the first time provoked acute emotional responses amongst the participants. While the majority of the participants had unsurprisingly denied the results, others expresses sadness, pain and hurt to the extent that they manifested headaches thinking about their HIV status.

Contrary to the above, one of the participants felt no emotions after finding out about his HIV status.

I wasn't surprised. It was the kind of lifestyle I used to live. The kind of life I'm talking about I call it the "fit in if you don't fit in you fuck off". It is a nasty lifestyle with too much alcohol and girls. (P3)

4.5 Theme 3: Chronic emotional response to HIV status

Question- Comparing then and now, how do you feel now?

While it is understandable that an HIV patient shows initial shock, denial, and fear for being diagnosed with the virus, it becomes very important to know the long term emotional response of patients living with the virus. It was found that the majority of the participants interviewed had come to terms with their status, and hence feel differently now compared to the first time they found about it.

I feel normal. When I first found out though I was horrified, scared and felt I was in a dark place because I didn't have much information about the condition. However, now I'm okay because I know that I am just like a normal human being and I just need to eat healthy, exercise, condomise or abstain and make sure that I don't have multiple partners. So yes, I feel okay because I don't think I am different from another person. (P5)

Equally, one of the participants also mentioned that she is now open with her status. Consequently, this has enabled her to support and educate other women to come to terms with their status as well.

I'm open with my status since I found out. I have been trying to help other women. I speak on the wards about my status, trying to educate other women. Some women do not believe that it can happen to them, I never believed that it could happen to me and it happened to me. (P7).

Equally significant, it was noted that having knowledge about HIV lifted the spirit of some of the participants. This is reflected in the following statement:

> *I feel alright now because I know that I won't be just sick all the time and I won't just die. Even when I used to get tested, I would get tested every 3 months up until I got diagnosed. Right now I am fine because even in my family there are people who are living with HIV so they also gave me advice and I am still going to live for some years too. (P11)*

The importance of knowledge about HIV regarding the emotional changes when compared to the first time the participant found out about their status and how they feel now was echoed by participant P12.

> *Back then I did not want to live anymore and I didn't even want to eat but now I can go out like I am back to my normal self. When I look at myself now I think I'm back to the person I was before I was diagnosed. This is because back then I didn't have much knowledge of the condition. Like I do not see anything different about myself or my condition. Sometimes it is hard because I have to constantly take my medication so maybe I am out with friends I need to remember to take my pills and then go home. (P12)*

From the above theme, it is reasonable to assume that knowledge of HIV has positively improved the quality of life of the participants. More importantly, their confidence and desire to inspire others have been shaped by the knowledge of the HIV they have now.

4.6 Theme 4: Change in lifestyle

Given the perceived concerns noted by the participants (Theme 1) regarding living with the virus, it was reasonable to find out whether the participant's lifestyles have been altered by virtue of being tested positive. The following question was used to initiate the discussion "Has your life changed in any way?"

4.6.1 Subtheme 1: Becoming more responsible

Participants P 3 and P4 noted that they have become more responsible since knowing their HIV status. The change was attributed to the fact that they have children to look after. This is reflected in the following quote by P3.

> *A lot, yes. The way I carry myself now. Then as well I realised with my responsibilities too because I have a child. The network is coming back to me so I am fine. I have cut down on so many things, others I have stopped completely. Even at work I no longer work hard labour, I do promotions, setups so I run around a lot now. So now it's more about focusing at work, the child*

needs to grow and it's my responsibility. Even my son's mother, she understood and accepted, although it wasn't that easy for her but she knew the kind of lifestyle I was living. This was after a very long time trying to get me to live right but I never wanted to listen to her. Everything though has its own reward. (P3)

4.6.2 Subtheme 2: Relationships

For participant P10, the change in lifestyle manifest in not having any relationship.

Yes, a lot. I no longer have a person that I am in a relationship with. Maybe that is why I feel my life has changed a lot. It is understandable though because even the one who infected me has passed on. Her passing really hurt me a lot because we already had 2 kids with her. I have had some relationships after but the fact that I had a stroke my relationships never lasted after that. I would just have a desire. I would like that one day I would have a relationship. (P10)

4.6.3 Subtheme 3: Drinking habits and partying

Equally, participant P7 observed that his drinking habits have reduced:

My life has changed yes, parting wise. I used to go out and drink but now I need to moderate myself. I still do go out but I drink within the limits yes. So my life has changed because there are so many people that open up to me and say they are sick, I tell them that look you need to go to the clinic. (P7)

4.6.4 Subtheme 4: Changes in sexual habits

Participant P12 noted that being HIV positive has not change anything, but nevertheless acknowledged the following:

The only thing that has changed is I am more cautious when it comes to sexual activities, I am more cautious when it comes to whom I let into my life and also that I have to live on medication for the rest of my life that has changed my life drastically too. (P12)

Equally important P3 noted the changes in terms of his sexual activities.

In my health though there is a change in the stamina I used to have in my sexual activities. I would have several people just maybe say one after the other up to 10 people before. That has changed today, there was that kind of change. (P2)

4.7 Theme 5: Chance to change status

Participants were asked the following question "is there anything you could have changed if you were given a chance to go back the day before getting infected?" The majority of the participants answered that they would have made a firm decision to use

condoms and ensure that their partners got tested. Equally, some expressed regrets for dating while others regretted ever dating a man.

4.7.1 Subtheme 1: Dating

One of the interviewees expressed regret for having dated the person alleged to have infected her with the virus.

> *Yes, if only I stayed with my baby daddy none of this would have happened or if I didn't date the guy after my baby daddy. But the only thing with my baby daddy is that he started to become abusive and then I decided to leave him. We used to check regularly with baby daddy and all along the time I knew that I was negative. With the other guy I wasn't careful enough until the time he told me to go and check. Then I started to lose weight for no particular reason. I wasn't sick or anything at the time but I was just losing weight. (P1)*

Furthermore, some of the interviewees hinted at having to refrain from dating men. One interviewee said:

> *To tell you the truth I am not the kind of person who loves men. I would have even stopped dating and I wouldn't even be having kids. (P6)*

In support of the above interviewee, P4 also noted the following:

> *Yes, the things I would have done was to protect myself from getting the disease or even by not having had a man in my life I would have done that. I believe that the first prevention is by not having a man in your life. Yes, so what I would have chosen was just not to have a partner at all so that I would not get infected. There is nothing else because the medication helps. (P4)*

4.7.2 Subtheme 2: Lifestyle behaviour

One of the interviewees express regret for his lifestyle choice. He was remorseful and had some advice for his friends still living a carefree lifestyle.

> *Yes, I would and I would even advise my friends as well because they are still in that kind of lifestyle that I used to live. What helped was to changed jobs and this allowed me to explore so that I wouldn't live in a box. It has helped me a lot and even with the subjects I did at school helped me a lot. (P3)*

4.7.3 Subtheme 3: Condomising

The majority of the participants noted that they would have used a condom during their sexual encounter. This is reflected in some of the quotes captured below.

Yeah, eish I don't know because you know when you are in a bit of moment and you love someone, sometimes you don't use protection. So I don't really think there is something I could have done. (P5)

Adding to the discussion, P7 narrated the following:

Yes, there is something that I would change. Hey, if I could go back I would do things properly. I think I would force my husband to have used condoms, force him you know. I wouldn't have gotten weak because I got weak because of the hiding. I would say you know let him penetrate me and get this done and over with but I think I would have fought and told him that you know what it's either you use a condom or nothing. Back in the day if you are using a condom with your husband you were told that you were sleeping around and that you were having an affair or something why use condoms. It's not like today where you just use condoms that is how it is. I would have gone back and I would have fought. It's just that I was weak, because of the hiding, and the abuse so I would say just do it anytime. (P 7)

Corroborating further, P8 expressed the desire to have either used a condom or abstained because they had prior knowledge of the importance of it.

The change was that at the time it was already out there that this thing exists and its part on life because there were already activists at the time. We were already being educated about how to take care of yourself by either condomising or abstaining. So I think I was supposed to do more on those areas. (P8)

The above view was supported by P9 and P10 who noted the following:

Yes, I would make sure that a person I meet gets tested and we condomising. (P9 & P10)

4.8 Establishing common trends and patterns in the interview comments among the participants

The preceding sections have attempted to analyse the themes that emerged from the interviews. By drawing on the comments and responses from participants, it can be gathered that similar perceptions were shared by the majority of the participants interviewed. This section aimed to compare the pattern of words that emerged from the interviews. Nvivo 11 was used to organise and analyse data by searching for factors and clustering these into specific themes to search for trends and patterns. Of interest, "treatment" is most prominent as the subtheme for concerns of HIV. This is due to patients having to be on treatment consistently to effectively suppress the viral load as they mentioned this quite often.

As shown in Figure 4.4, the word cloud in Figure 4.4 shows the trends and patterns of responses from the 12 participants. The following words are most prominent: even, treatment, like, live, now, status, people, still, just, time.

Figure 4.4: Word cloud showing patterns and trends

4.9 Symptoms and rubrics

Table 4.2: Symptoms and rubrics

Symptoms	Rubrics
Fear of death	Mind, fear, death of
Headaches from stress	Head, pain, excitement of emotions, bad news after
Erectile dysfunction	Erections, incomplete
Shock and pain	Mind, ailments from shock
Broken and hurt	Mind, ailments from bad news
Emotional discomfort	Mind, excitement, bad news after
Regret	Mind, remorse

The symptoms and rubrics selected from the data gathered during the interviews is shown in Table 4.2. The results of the repertorisation are shown in Figure 4.5.

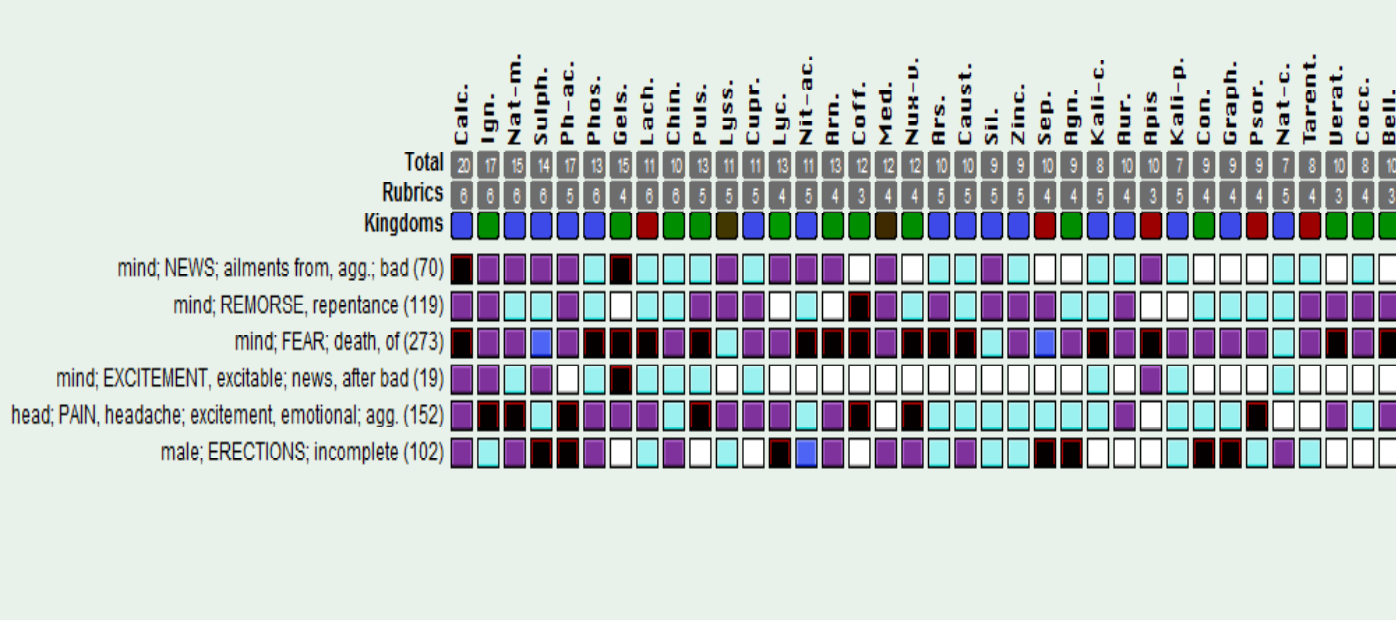

Figure 4.5: Repertorisation

Keynote remedies that appeared from the rubrics that were repertorised are:

- Calcarea carbonica
- Ignatia amara
- Natrum muriaticum
- Phosphoricum acidum
- Gelsemium sempervirens
- Pulsatilla pratensis
- Arnica montana
- Nux vomica

4.10 Conclusion

From the qualitative findings, it emerged that fear of dying was the major concern affecting the participants about their HIV status. Equally important, the thematic findings revealed that the participants were in denial, expressed shock and pain etc. when they first found out about their HIV status. Despite these initial emotional responses, it became apparent that the participants were relatively optimistic going forward which was attributed to their now knowledge about HIV. The analysis of interviews revealed that participants had a change in lifestyle as a result of being diagnosed with the virus. Many of the participants expressed regrets about not using protection during sexual encounters. Repertorisation revealed that Calcarea

carbonica, Ignatia amara, Natrum muriaticum, Phosphoricum acidum, Gelsemium sempervirens, Pulsatilla pratensis, Arnica montana and Nux vomica were the remedies of choice for the emotional response to news of an HIV diagnosis. These results will be discussed in the next chapter.

CHAPTER 5: DISCUSSION, CONCLUSION AND RECOMENDATIONS

5.1 Introduction

The idea of an emotional response to HIV diagnosis might at first look straight forward namely that a person receives pre-testing counselling, is tested and receives their positive results, receives post-test counselling and starts their treatment and thereafter they are fine. However, dealing with that emotional response and coming out of that state is far deeper and is a long process as it requires follow up and support. This is further corroborated by study results that showed that participants experienced denial, shock, anger and pain, emotional discomfort and felt broken and hurt. In addition, a number of emotional responses to diagnosis were identified based on the findings from the literature review.

The previous chapter presented the research results and this chapter presents the discussion of the results. What guides the discussion of the results is the research questions as described in Chapter 1 as well as the emergent themes from the analysis of the interviews.

This chapter will be presented in two sections, where each corresponds to the research objectives respectively.

1. Emotional response to diagnosis
2. Exploration of homoeopathic remedies indicated for emotional response

5.2 Acute response to diagnosis

The main objective of the study was to describe the acute response to an HIV positive diagnosis. In this study, five major themes were described. These themes are discussed below, preceded by a discussion of demographics:

- Demographics
- Theme 1: Concerns about HIV
- Theme 2: Acute emotional response to an HIV status
- Theme 3: Chronic emotional response to HIV status

- Theme 4: Change in lifestyles
- Theme 5: Chance to change status

5.2.1 Demographics

5.2.1.1 Gender

The study revealed that there were fewer male participants compared to female participants. This is because females were more willing to participate in the study. The reason for this is because females tend to be more open about their feelings and wanting to share them than males are. Furthermore, females tend to care more about their well-being because they need to be well so that they can take care of their families and children. Their health becomes a priority and they are the ones who seek medical care more than males.

5.2.1.2 Age

Young adults and middle-aged adults appeared to be more affected compared to the elderly. This is because HIV tends to affect the youth and middle-aged adults more than the elderly. This may be attributed to the carefree lifestyle engaged in by younger adults that is full of drugs and alcohol that makes them more vulnerable to engaging in unsafe sex and casual sex.

5.2.1.3 Race

Eleven of the participants were African and one was coloured. This is because the location of the study has a majority of African people either residing or working in the area.

5.2.2 Concerns about HIV

The in-depth interviews from this study revealed that participants were faced with discrimination both in society and as well as the places that they work in. Although HIV is an epidemic and there has been a wide variety of programmes that educate the public about HIV, HIV infected individuals still get discriminated because of their status. Limited knowledge about HIV which may be due to ignorance or individuals thinking that they can never become infected or affected by HIV has a negative effect on the effectiveness of the campaigns. Their impact is often hindered by the

perceptions that people have about HIV. This is consistent with Fabianova's (2011:176-204) reports on psychosocial aspects of people living with HIV that notes that a fundamental ignorance with regards to HIV transmission routes contributes to discriminatory attitudes in the population. Similarly, ignorance and acts of carelessness were the keys factors identified despite the knowledge of modes of acquiring HIV (Hussain, 2013).

The fear of death is of great concern amongst those living with HIV. The study revealed that fear of death was a concern to some participants. People living with HIV become anxious about their future especially if they have children. The thought of them not being present in their children's upbringing and whether caregivers will ever be able to take care of their children like they would have done, is a major fear. Some of these participants have deceased parents and would have to rely on their relatives for the wellbeing of their children. Fabianova (2011: 176-204) highlighted that feelings of insecurity originate from the fear of impending future due to the incurable disease that they are living with. The number of years they have to live quality of life as well as the response from society is of concern.

Patients consistently have to be on medication to effectively manage HIV. There is only one mode of taking the medication which is orally, so patients feel a restricted by the lack of treatment options. Concerns over length of treatment and mode of administration was reported as a concern by participants. Patients do not like to be taking medication all the time and some even default on treatment and end up getting sick. The adverse effects of medication also trigger concerns over medication.

HIV remains incurable and participants voiced their concerns about this. Calles, Evans and Terlonge (2010) confirm that HIV is a retrovirus having the ability to use a host's DNA and its RNA to replicate itself. ARVs have been seen to improve life expectancy provided that they are taken as directed. They also decrease the viral load to a point of non-detection during testing and in turn help the immune system to function maximally (CDC, 2018b). Ongoing counselling also has a positive impact in the sense that it helps combat the anxieties after testing HIV positive for the first time. This helps patients to cope with living with the virus in terms of psychological as well as emotional support (Department of Health KwaZulu-Natal 2001). Niessl, Baxter and Kaufman (2018) revealed that there has been limited success yielded by the clinical trials

conducted using latency-reversing agents which attempts to reactivate HIV from its latent state so that ARVs and immune system can kill the viruses. Niessl, Baxter and Kaufman (2018) continued to state that recent developments in using visualisation methods in management of HIV have yielded promising results. This information then adds value to the development of cure strategies and contributes to the monitoring, designing and assessments of HIV cure strategies both in vivo and in vitro.

The study revealed that patients experienced psychological problems and other health related complaints. An emotional response to a diagnosis has an ability to manifest itself as a physical complaint (somatisation). This is often the case where a person suppresses their emotions or dwells a lot in their thoughts. Sekhri, Feachem and Ni (2011) suggest the use of CAM so as to ease the workload in the public sector because somatisation results in an increased number of visits to the clinics and hospitals as some may be referred for further medical care and a high medical bill as well. Murry *et al.* (2013) acknowledge that somatisation can occur in cases of hearing the news of a positive HIV diagnosis which then elicits an emotional response. The findings give credence to the importance of knowing that psychological distress can manifest in somatic complaints and subsequent need for medical care and thus becomes a public health and a clinical hindrance (Al Busaidi 2010; Kallivayalil and Punnoose 2010).

5.2.3 Acute emotional response to a HIV status

The study revealed that participants expressed denial when they first found out about testing positive to HIV. The news of an HIV positive diagnosis comes as a surprise to a lot of people. As a result of this patients may delay starting their treatment. The reason for this is because they are faithful to their partners and they do not expect that they would not be faithful to them in return. Some pregnant mothers find out during antenatal visits and at this time are not prepared for such news. Some, due to denial, request for multiple testing just to confirm if the initial result is correct. Similarly, Horter *et al.* (2017) found that whether patients commence treatment and seek medical care was determined by whether they have accepted their positive diagnosis or are in denial of it. Denial was linked to the lack of insight that people have about HIV and the fact that they did not perceive that they were susceptible to getting the disease and therefore are less prepared for the news. Kartikeyan *et al.* (2007) state that denial puts

people in a position where they request repeated testing in the hope that they can get a negative result because they do not believe that they could be HIV positive.

Participants revealed that they were shocked and had emotional pain when they were initially informed of the result. Even though some of the participants knew that they had to disclose to their partners they still could not because they said that they knew that it was them that infected their partners, perhaps they were scared of their partner's reaction to the news. This is consistent with Kartikeyan *et al.* (2007) who found that the emotional shock of a positive result leads directly to a state of guilt and self-blame. These findings are in line with studies by Earnshaw *et al.* (2018) and Hult, Maurer and Moskowitz (2009) that showed that in response to an HIV positive diagnosis participants undergo feelings of disbelief and shock. Also, Lingen-Stallard, Furber and Lavender (2016) found that disbelief and shock of the unexpected result initiated feelings of sadness due to the loss of their old selves.

The study revealed that participants felt broken and hurt on receiving news of a HIV positive diagnosis. It emerged that the brokenness and hurt was attributed to being infected by a spouse and also a partner that the participants had been with for some time. Betrayal by their spouses has a role to play in how the participants feel as it became unbearable for them to comprehend the news.

5.2.4 Chronic emotional response to HIV status

It was imperative to find out about the long term (symptoms lasting for longer than 6 months) effects of an emotional response to a HIV positive diagnosis. Notably, participants reported that they were much better at the time of the interview compared to when they first found out. This was attributed to participants gathering more information on HIV and therefore having the knowledge that one can live longer and not just die – this helped them a lot. Support from family and friends also plays a big role in the life expectancy of those living with HIV. Adherence to treatment keeps patients from looking sickly and therefore avoiding the stigma of that. Disclosure seems to be very helpful as when a person joins a support group where common problems are being discussed and one then finds relief knowing that someone else has gone through what they may be currently going through. Some also become activists so as to help those that have not yet been infected and also those who have

become affected regarding how to survive. Lifestyle adjustments and health adjustment are beneficial and seem to help patients.

In reviewing the literature related to chronic emotional response to diagnosis, the findings from this study had similarities to those that were reported. Kartikeyan *et al*. (2007) alleged that a major role was seen to be played by the support system that is available at their disposal. Equally, Fabianova (2011) points to the importance of speaking about HIV openly, to be open about the feelings and reactions of living with HIV. Horter *et al.* (2017) found that individuals accepting their status, as this encouraged disclosure, supported linkage to medical care.

5.2.5 Change in lifestyle

This section provides insight into the quality of life of those living with HIV, post diagnosis.

Findings showed that participants had become more responsible. The contribution to this change was the realisation that they now live with a chronic condition. Having to raise young children was also a factor and wake-up call for them to make necessary adjustments to ensure that they lived a healthier life. According to Fabianova (2011), people living with HIV have a tendency to pay more attention to their families and at work. The fear of upcoming future due to living with HIV results in insecurities but individuals have to rise above these.

The study also revealed that a positive HIV diagnosis has led some of the participants to have no relationships. This is because some people living with HIV fear rejection upon disclosure and therefore prefer not to be in a relationship. Another reason for this is because they fear legal actions and, lastly, they fear transmitting HIV. Lingen-Stallard, Furber and Lavender (2016: 31-38) reported that women felt isolated and relationships can break down. The women would then compensate by paying more attention to their children's wellbeing to cope with the situation.

Participants expressed that their social lifestyle which included over indulging in alcohol and social gatherings, have changed. This is due to the participants paying more attention to their health so that they can live longer for them to be able to see their children grow up. They are well aware that changes and adjustments in their

lifestyle from prior to the diagnosis were necessary. Kartikeyan *et al.* (2007) highlighted that major changes in life are triggered in response to a positive diagnosis.

The results revealed that the sexual habits of the participants had changed. This is because participants are now fully aware of the routes of infection and transmission of HIV through the knowledge that they have received about HIV. This shows that the health and lifestyle advice given to them has borne fruit. The Department of Heath South Africa (2015) has urged that clients whose results are positive should be counselled and informed about possible emotional responses. This is because the manifestation and the timing of the manifestations of the feelings (e.g. anger and denial) thereof can have an impact on adherence to healthy lifestyle choices.

5.2.6 Chance to change status

Findings from the study revealed that some of the participants showed regret at having dated the person whom they thought might have infected them. This is because most women were infected with HIV by their partners and spouses whom they trusted and did not use protection with them during intercourse. As a result, they presented with much resentment and anger due to betrayal by their husbands and partners for infecting them and ending up being diagnosed with HIV. Compared to this, most of the males knew that they are the ones who infected their wives or partners due to having multiple relationships so they knew that they would end up acquiring the disease. This caused them to regret the kind of life they lived. Lingen-Stallard, Furber and Lavender (2016: 31-38) reported that anger and turmoil were shown by the manifestation of suicidal thoughts and self-harm behaviour.

The study revealed that participants expressed regret regarding the kind of lifestyle that they lived. As a result, participants had become open about their statuses and advised friends who were still living the life that they also used to live to change because they do not want to see them make the wrong decisions as well. Hussain (2013) pointed out that ignorance and carelessness are the driving forces that lead to regret because participants in their study admitted that they knew about the routes of entry of becoming infected with HIV.

In addition, the findings show that the participants in hindsight would have used a condom during their sexual encounters. Some revealed that they would have rather

abstained altogether. This is because now they know that they should have protected themselves so that their lives would have remained the same. Now that they have a chronic disease that requires medication and lifestyle changes and adjustments, they realise that they should have made the right choice earlier. The findings further lend weight to Fabianova (2011) who states that discussions on HIV/AIDS in many third world countries are still taboo, misunderstood, and associated with shame, guilt and rejection. Culture has indoctrinated people to be silent about their sexuality and sexual behaviour. This leads to risky sexual behaviour.

In summary, it can be deduced that the fear of dying was of great concern for the participants with regards to their HIV status. Similarly, participants were in denial, expressed shock and pain etc. when they first found out about their HIV status. In spite of these initial emotional responses, many participants became more hopeful going forward which was accredited to their increased knowledge about HIV. All the participants had a change in lifestyle as a result of being diagnosed with the virus. Many of the participants expressed regrets about not using protection during sexual encounters. The researcher recommends that more interventions must be put in place so as to combat anxieties about HIV so that adherence and improved life expectancy can be achieved.

5.3 Comparative table showing frequency of usage

5.3.1 Calcarea carbonica

Results showed that Calc carb was the most indicated remedy. This is because it was present in all the rubrics that were used and it had the highest grading. One of the symptoms reported by participants was the fear of death. When looking at the literature with regards to Calcarea carbonica, Vermeulen (1994) states that a person requiring this remedy presents with a fear of death that disturbs him day and night. This means that the symptom presented by the patient is aligned with what a Calc patient suffers from. Another symptom is headaches from stress. When enquiring in the literature headache symptoms are present in literature. The symptoms recorded by Vermeulen (1994) highlight that the headaches are from mental exertion. After hearing the news of a positive status for the first time, one can have mental exertion due to the stress. Being gripped by a sudden fear of uncertainty and becoming overwhelmed by the news takes place. Another symptom that followed was erectile dysfunction. The

materia medica of Calc carb makes mention that the coition is followed by irritation and weakness. The symptoms from the patient were that the stamina to have many sexual encounters as before he was diagnosed was no longer present. A person requiring this remedy has a tendency to be averse to work or exertion. The emotional discomfort is made evident in literature with the symptoms that include that there are anxieties that are worse towards evening; fears loss for no reason, transmissible diseases, bad luck. One of the symptoms was shock and emotional pain. In the literature the symptoms state that the patient tends to be forgetful, low spirited, forgetful, has anxiety with palpitations. There is stubbornness, and slight mental symptoms will produce a hot head. Lastly, participants manifested regret. In the literature, the mental picture of the Calc carb patient shows that there is hopelessness of ever getting better. This is in line with the symptoms of the patient because when a person initially finds out about their status for the first time usually they do not have much information and they deem their prognosis to be a very bad one.

5.3.2 Ignatia amara

This remedy can be used as a differential based on the presentation of a case. One of the symptoms is shock and emotional pain. The literature according to Vermeulen (1994) is that in cases of emotional shock, this is one of the first remedies to think of. In cases where emotional shock becomes extended, Ignatia becomes the remedy of choice. Another symptom is headache due to stress. The literature states that the nature of the headache in Ignatia is that loud talking makes the headache even worse. The headache tends to be made better or worse by stooping (Vermeulen 1994). Boericke (2007) states that Ignatia is a clinical remedy indicated for emotional upsets such as in headaches and stress. The presentation of Ignatia is that the headaches are as if a nail is driven through the sides. It ends with yawning and vomiting. A concomitant symptom is a backache that alternates with the headache. Another symptom was emotional discomfort. Ignatia is a remedy for ailments from worry. When a person has been diagnosed with HIV they are susceptible to worry. Most people living with HIV have children whom they worry about more especially about their wellbeing and who will take care of them should they die.

5.3.3 Natrum muriaticum

One of the symptoms in this study was being broken and hurt. Phatak (1999) states that a person needing this remedy wants to be in isolation. Being hurt and broken can cause a person to want to be alone. The main cause of this is a feeling of betrayal by their partner and also being disappointed by the person who they trust the most. Nat mur is a major remedy for ailments from disappointment. During this time, they may be angry or crying. Consolation aggravates the person in a Nat mur case and that is why they want to be alone. Another symptom is a headache from stress. Nat mur is one of the main remedies for headaches. The nature of the Nat mur headache is that it is a blinding headache. The other symptom is erectile dysfunction. The literature states that there is sexual desire but physical weakness (Phatak 1999). This means that Nat mur can be a remedy to consider taking into account the symptoms and how they match with the remedy presentation.

5.3.4 Phosphoricum acidum

The remedy Phos ac has an affinity for the mind and more specifically its emotional aspect. The symptoms include a fear of death. One of the symptoms of a person who requires this remedy is anxious inquiries regarding the disease for which the person is undergoing treatment. Anxieties exist concerning HIV/AIDS. The main reason for this is being uncertain of the future ahead. Some people get side effects from the medication, which then tend to affect adherence and many worry whether or not there will be permanent damage to the organs and bodies. The literature states that an individual needing Phos ac has sorrow and uneasiness regarding the future (Clarke 1990). Another symptom is a headache from stress. A Phos ac headache is described as a crushing headache. Another symptom in this study was erectile dysfunction. Phos ac states that sexual power is lacking. This was one of the concerns from a participant because this was not a factor before he was diagnosed with HIV. As a result of a positive diagnosis his life changed, and this bothered him greatly because he could not receive any help for this. Literature states that there is a headache after sexual intercourse. Genitals suddenly weaken and relax during coitus which prevents ejaculation (Clarke 1990). This is in line with the symptoms of the patient.

5.3.5 Gelsemium sempervirens

One of the symptoms in this study was emotional discomfort. A person who receives the news of a positive HIV status for the very first time and who had no predisposing factors they were aware of can undergo emotional discomfort. Gelsemium is a remedy for ailments from unpleasant surprises. Here there is indifference concerning their illness (Phatak 1999). Another symptom was being broken and hurt. This feeling can be brought on by betrayal, which is often the case where an individual's only partner cheated on them but never used any protection and became infected. The literature reveals that Gels is for bad effects from fright, fear and exciting news. One of the symptoms in this study was the fear of death. Gels is found to be a remedy for fear of falling, tribulations, death and pain. Another symptom is headaches from stress. This symptom is a result of thinking a lot and not having anyone to talk to at the time. Most people are afraid to come out and disclose just after they are diagnosed which then causes the headaches due to stress. The biggest cause of this is the stigma associated with HIV that still exists even to date. The literature states that due to the headache, there is weight around the head, a feeling of a band around the head. The last symptom was erectile dysfunction. In Gels sexual power is exhausted and the least touch causes emission (Phatak 1999).

5.3.6 Pulsatilla pratensis

One of the sites of action for Pulsatilla is the mind and it is a one-sided remedy, which means that it affects one side of the body. One of the symptoms in this study was feeling broken and hurt. Some participants could not hold in their emotions during the interviews because of being broken and hurt. They had not come to a point of healing fully yet and still needed some time to talk about their emotions because they still felt the pain. Literature shows that the people who need this remedy tend to weep a lot. They have fears especially in the evening; they do not want to be unaccompanied, and fear ghosts and the dark. Another symptom in this study was headache from stress. The Pulsatilla headache is on one side, it is as if the brain would burst and the eyes fall out (Vermeulen 1994).

5.3.7 Arnica montana

Arnica is one of the remedies to considered for the effects of mental strain or shock. One of the symptoms in this study was shock and emotional pain. Many people go to the clinics after feeling unwell and the sister or doctor then recommend performing an HIV test to rule out HIV. During this time, most people are unaware as to what could be the cause of them becoming unwell. Upon receiving the news for the first time, shock and emotional pain may occur. The patients requiring Arnica would say they are fine. There is also agoraphobia. Another symptom in this study was regret. Most of the participants regretted trusting their partners and some regretted not using protection. This left them longing for their old lives and wishing that they could turn back the hands of time. This is because now they know that they could have done things differently to avoid becoming infected. The main reason is that they have seen how their lives have changed ever since they were diagnosed. In Arnica, there is indifference, morose behaviour and inability to work continuously. One of the symptoms in this study was headaches from stress. The Arnica headache has a sensation as from a nail in the temple. Another symptom was erectile dysfunction. In Arnica, impotence is from excess or abuse (Phatak 1999).

5.3.8 Nux vomica

The last remedy of note is Nux vomica. One of the symptoms in this study was emotional discomfort. Most men do not like to talk about their emotions but instead they tend to resort to drinking and drugs. Some even resort to saying that they are going to spread the disease because they do not want to die alone. This is often a selfish decision and decrease one's life expectancy. One of the participants realised that this kind of lifestyle was not good for him anymore and therefore had to cut down on alcohol and partying. He even took it as far as warning his other friends as well. Having children makes one to adjust the lifestyles because of fears of leaving one's children while they are still very young, so one becomes responsible and considerate of others. In Nux vom a person becomes very irritable. He/She is sensitive to all impressions, unpleasant, hateful, cannot tolerate light, odours, noises etc. Does not want to be touched. Time passes too slowly. Even the least ailment affects her/him greatly. Fault finding, brooding, disposed to criticise others. Another symptom in this study was headaches from stress. In Nux vom there is a headache generally, better

for walking in open air. Another symptom was erectile dysfunction. A person who needs Nux vom has an erection that becomes relaxed during sexual intercourse (Vermeulen 1994).

The aim of the study was to determine the emotional responses of patients to a HIV positive diagnosis and explore the potential homoeopathic remedies indicated for this. The study focused on emotional responses of patients who had been diagnosed with HIV within the last five years.

The objective of the study was to explore these emotional responses with the use of an interview schedule. The next objective was to explore the homoeopathic remedies indicated for emotional response. A qualitative, exploratory research approach was used. In depth interviews were conducted and detailed emotional experiences were shared. The previous chapter presented the findings from the study by drawing on literature to support the results. This chapter concludes by drawing on the discussion to provide recommendations by proposing guidelines for future research.

The areas that were explored revealed a wealth of information which may be used to enhancing approaches to HIV testing and care. The areas that were probed were related to emotional responses to diagnosis, moving on from that state and to finally the current and present state that they are in now and what has changed. The data obtained will assist in improving HIV testing approaches and eventually the application of homoeopathic remedies to those patients who test HIV positive.

5.4 Conclusion

The results of this qualitative study yielded data on the emotional response to a HIV positive diagnosis and the exploration of the homoeopathic remedies indicated in such cases. In assessing these emotional responses, several questions were formulated to allow a variety of responses from one person to the other. The study found that the majority of patients had a fear of dying which was a major concern. The researcher observed that this fear was mainly due to the thoughts of leaving their children who they love and care about the most at a tender age since they know that the disease is incurable. This answered the research question: what is the acute emotional response to an HIV positive diagnosis?

The qualitative results further showed that although the initial response of the participants was to go through denial, emotional shock and pain etc., they felt optimistic going forward. The researcher observed that the optimism going forward was due to the knowledge acquired later about HIV. Support groups and disclosure of the status contributed to the increased knowledge base as well as making them feel empowered about their futures and to continue pursuing their destinies. This answered the research question: what is the acute emotional response to an HIV positive diagnosis?

The study showed that there were lifestyle changes and adjustments that the participants had to make as a result of the positive diagnosis. It was established that participants showed regrets of engaging in unprotected sex which led them in their current state.

Repertorisation revealed that Calcarea carbonica, Ignatia amara, Natrum muriaticum, Phosphoricum acidum, Gelsemium sempervirens, Pulsatilla pratensis, Arnica montana and Nux vomica were the remedies of choice for the presented emotional symptoms. Calcarea carbonica was the main remedy and this was accounted for by being in all rubrics and having the highest grading. The symptomatology had the highest coverage in Calc carb, this was also shown by the literature of the Calc carb presentation.

A point worth mentioning is that in spite of the availability of ARVs to patients, the participants highlighted the non-varying modes of treatment administration. This was due to their concerns of the incurability of HIV and having to be on treatment for long periods of time. Participants were looking forward to inventions of other modes of treatment for their convenience going forward. Another point as well is that most potential participants who met the criteria made remarks that they do not wish to open old wounds and therefore did not want to be part of the study. This goes to show that there is still a long way to go for people to heal and accept their statuses.

5.5 Recommendations

Within the limitations of the study, the following recommendations are made:

- That a similar study be conducted to target white and Indian individuals as a comparison with this study. This is because the results of the study were drawn from participants who were African and coloured.
- This study was conducted using the qualitative paradigm. A quantitative study regarding application of the homoeopathic remedies is necessary. This is because it will include a bigger sample size as compared to this qualitative study being directed by data saturation. Future studies should be conducted with regards to the application of homoeopathic remedies indicated for the emotional response to diagnosis.
- More education about HIV needs to be made available to people living with HIV much earlier so that they can experience a shorter duration of emotional response. This will promote adherence and life expectancy.
- This study was limited to the eThekwini District Municipality. It is suggested that surveys be also conducted in other parts of South Africa. A larger study would be most suitable to give a broader and wider perspective concerning the emotional response to HIV diagnosis and the indicated homoeopathic remedies for treatment of this.

REFERENCES

Al Busaidi, Z. Q 2010. The concept of somatization. *Sultan Qaboos University Medical Journal*, 10(2): 180-186.

Arand, P. R. 2015. Guidelines for epidemic management in homoeopathy (online). Available: https://www.homeobook.com/guidelines-for-epidemic-management-in-homoeopathy/ (Accessed 10 March 2018).

Bauer, M., Hersey, D., Kasuba, D., Lauridsen, J., Steward, A. and Barsky, A. 2014. Somatic symptom disorder: effective techniques for diagnosing and managing this complex condition in primary care practices. *Consultant 360*, 54(9):700-704. Available: https://www.consultant360.com/articles/somatic-symptom-disorder-effective-techniques-diagnosing-and-managing-complex-condition (Accessed 20 September 2016).

Boericke, W. 2007. *Pocket manual of homoeopathic materia medica & repertory*. India: J. J Offset Printers.

Braun, V. and Clarke, V. 2006. *Using thematic analysis in psychology*. Available; *Qualitative Research in Psychology*, 3(2): 77-101.

Canadian Aboriginal AIDS Network. 2012. *Pre and post HIV test counselling guide*. 2012. Available: http://caan.ca/wp-content/uploads/2012/05/get-tested-guide.pdf (Accessed 15 August 2016).

Canadian College of Homeopathic Medicine. 2018. *Homeopathic medicine for the 21st century: what does homeopathy offer our modern ailing world?'*. Available: https://homeopathycanada.com/blog/homeopathic-medicine-21st-century-what-does-homeopathy-offer-our-modern-ailing-world%E2%80%99 (Accessed 12 December 2018).

Centers for Disease Control and Prevention (CDC). 2018a. *Global HIV and Tuberculosis*. Available: https://www.cdc.gov/globalhivtb/index.html (accessed 15 March 2018).

Centers for Disease Control and Prevention (CDC). 2018b. *HIV Treatment as Prevention*. Available: https://www.cdc.gov/hiv/risk/art/index.html (Accessed 13 December 2018).

Centers for Disease Control and Prevention (CDC). 2018c. *About HIV/AIDS*. Available: https://www.cdc.gov/hiv/basics/whatishiv.html (accessed 25 July 2018).

Chauhan, V. K. and Gupta, M. 2007. Homoeopathic principles and practice of medicine: homoeopathic fundaments. Mumbai: B. Jain Publishers

Clarke, J. H. 1991. *Dictionary of practical material medica*. Sittingbourne: Homoeopathic Book Service.

Cooney, T. 2017. Homeopathic treatment for epidemic diseases. *IVC Journal*, February: 1-2. Available: https://ivcjournal.com/homeopathic-treatment-epidemic-diseases/ (Accessed 4 March 2018).

Department of Health KwaZulu-Natal. 2001. *Voluntary HIV counselling and testing*. Available: http://www.kznhealth.gov.za/testing.htm (Accessed 3 February 2016).

Department of Health South Africa. 2015. *National HIV counselling and testing policy guidelines*. Available:http://www.health-e.org.za/wp-content/uploads/2015/07/HCT-Guidelines-2015.pdf (Accessed 2 February 2016).

Department of Health South Africa. 2016. *National HIV testing services: policy.* Available: file:///C:/Users/Student/Downloads/hts%20policy%20doc%2019%20jan%203.pdf (Accessed 6 April 2018).

De Schepper, L. 2001. *Hahnemann revisited.* Santa Fe, NM: Full of Life Publications.

Dube, N. S. 2015. Patients' perceptions of their first Homoeopathic consultation at Ukuba Nesibindi Homoeopathic Community Clinic. M.Tech: Homoeopathy, Durban University of Technology.

Dudovskiy, J. 2016. *Purposive sampling*. Available: http://research-methodology.net/sampling/purposive-sampling/ (Accessed 20 January 2016).

Durban University of Technology (DUT). 2018. *Homoeopathy*. Available: https://www.dut.ac.za/faculty/health_sciences/homoeopathy/ (Accessed 5 December 2018).

Earnshaw, V. A., Bogart, L. M., Courtney, I., Zanoni, H., Bangsberg, D. R., Orrell, C., Goggin, K. and Katz, I. T. 2018. Exploring treatment needs and expectations for people living with HIV in South Africa: a qualitative study. *AIDS and Behavior,* 22(8): 2543-2552.

Fabianova, L. 2011. Psychosocial aspects of people living with HIV/AIDS. In: Letamo G. ed. *Social and psychological aspects of HIV/AIDS and their ramifications*. Trnava: InTech, 176-204. Available: http://cdn.intechopen.com/pdfs-wm/22550.pdf (Accessed 16 July 2016).

Foote-Ardah, C. E. 2003. The meaning of complementary and alternative medicine practices among people with HIV in the United States: strategies for managing everyday life. *Sociology of Health and Illness*, 25(5): 481-500.

Fouché, C. B. and Schurink, W. 2011. Qualitative data analysis and interpretation. In de Vos, A. S., Strydom, H., Fouché, C. B. and Delport, C. S. L. *Research at grass roots: for the social science and human services professions*. 3rd ed. Pretoria: Van Schaik Publishers, 307-308.

Francis, J, J., Johnston, M., Robertson, C., Glidewell, L., Entwistle, V., Eccles M, P. and Grimshaw, J. M. 2010. What is an adequate sample size? Operationalising data saturation for theory-based interview studies. *Psychology and Health,* 25(10): 1229-1245.

Gaucher, C., Jeulin, D., Peycru, P., Pla, A. and Amengula C. 1993. Cholera and homoeopathic medicine: The Peruvian experience. *British homoeopathic journal*, 82(3): 155-163.

Greeff, M. 2011. Qualitative data analysis and interpretation. In de Vos, A.S., Strydom, H., Fouché, C. B. and Delport, C. S. L. *Research at grass roots: for the social science and human services professions*. 3rd ed. Pretoria: Van Schaik Publishers, 352.

Gunawan, J. 2015. Ensuring trustworthiness in qualitative research. *Belitung Nursing Journal,* 1(1): 10-11.

Grov, C., Golub, S. A., Parsons, J. T., Brennan, M. and Karpiak, S. E. 2010. Loneliness and HIV-related stigma explain depression among older HIV-positive adults. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 22(5): 630-639.

Hasanah, C. I., Zaliha, A. R. and Mahiran, M. 2011. Factors influencing the quality of life in patients with HIV in Malaysia. *Quality of Life Research*, 20(1): 91-100.

Homoeopathic Association of South Africa. 2018. *The HSA*. Available: https://www.homeopathy.org.za/ (Accessed 5 December 2018).

Honnorat, M. R. 2012. The efficacy of a homoeopathic complex (T.R.S. 200c®) on the symptoms of post-traumatic stress disorder in women. M.Tech dissertation, University of Johannesburg.

Horter, S., Thabede, Z., Dlamini V., Bernays, S., Stringer, B., Mazibuko, S., Lenhle Dube, L., Barbara Rusch, B. and Jobanputra, K. 2017. "Life is so easy on ART, once you accept it": Acceptance, denial and linkage to HIV care in Shiselweni, Swaziland. *Social Science & Medicine*, 176: 52-59.

Hult, J. R., Maurer, S. A. and Moskowitz, J. T. 2009. Aids care: ''I'm sorry, you're positive'': a qualitative study of individual experiences of testing positive for HIV. 21(2): 185-188.

Hussain, T. 2013. Psychological distress leading to repeat HIV testing in an Integrated Counseling & testing Centre (ICTC) at Agra, India—Case report of 10 HIV-negative clients. *HIV & AIDS review*, 12(2013): 43-46.

The Joint United Nations Programme on HIV and AIDS (UNAIDS). 2013. *Global report*. Available: http://www.unaids.org/en/resources/presscentre/featurestories/2014/january/20140117southafrica/ (Accessed 02 June 2016).

Kallivayalil, R. A. and Punnoose, V. P. 2010. Understanding and managing somatoform disorders: making sense of non-sense. *Indian Journal of Psychiatry,* 52(1): 1-65.

Kartikeyan, S., Barmal, R. N., Tiwari, R. P. and Bisen, P. S. 2007. *HIV and AIDS: Basic elements and priorities*. Dordrecht: Springer.

Kayne, S. 2003. Global Perspectives. In: Carlston, M. Classical Homoeopathy. Pennsylvania. Churchill Livingstone. 48.

Keuroghliana, A. S., Kamen, C. S., Neri, E., Lee, S., Liu, R. and Gore-Felton, C. 2011.Trauma, dissociation, and antiretroviral adherence among persons living with HIV/AIDS. *Journal of Psychiatric Research*, 45(7): 942-948.

Lingen-Stallard, A., Furber, C. and Lavender, T. 2016. Testing HIV positive in pregnancy: A phenomenological study of women's experiences. *Midwifery*, 35: 31-38.

Lake, E. 2018. *Disease outbreak. What's the difference between an endemic, an epidemic and a pandemic? Outbreak terms revealed*. Available: https://www.thesun.co.uk/news/4120912/endemic-epidemic-pandemic-difference-disease-outbreak/ (Accessed 28 November 2018).

Mid-year population estimates. 2013. Available: http//beta2.statssa.gov.za./publications/p0302/p03022013.pdf (Accessed 13 August 2015).

Mid-year population estimates. 2016. Available: https://www.statssa.gov.za/publications/P0302/P03022016.pdf (Accessed 5 February 2018)

Mora, M. 2010. *Quantitative vs qualitative research: when to use which*. Available: https://www.surveygizmo.com/survey-blog/quantitative-qualitative-research/ (Accessed 25 May2016).

Morrison, R. 1993. *Desktop guide to keynotes and confirmatory symptoms*. California: Hahnemann clinic publishing.

Muraleedharan, K. C., Dey, S. K., Prasad, P., Siddiqui, V. A., Dixit R., Singh, V. and Nayak, C. 2010. Clinical research: effectiveness of homoeopathic medicines in HIV patients - a clinical trial. *Indian Journal of Research in Homoeopathy,* 4(4): 29-35.

Murry, A. M., Toussaint, A., Althaus, A. and Lowe, B. 2013. Barriers to the diagnosis of somatoform disorders in primary healthcare: protocol for a systemic review of the current status. *Biomed Central*, 2(1):1. Available:

https://systemicreviewsjournal.biomedcentral.com/articles/10.1186/2046-4053-2-99 (Accessed 25 September 2016).

National Center of Homeopathy. 2017. *What is homeopathy?* Available: https://www.homeopathycenter.org/what-is-homeopathy (Accessed 28 July 2018).

Niessl, J., Baxter A. E. and Kaufman, D. E. 2018. Tools for visualizing HIV in cure research. *Current HIV/AIDS Reports*, 15: 39-48.

O'Reilly, W. B 1996. *Organon of the medicinal art*. 6th ed. Redmond: Birdcage Books.

Phatak, S.R. 1999. *Materia medica of homoeopathic medicines*. 2nd ed. Kandem: B. Jain.

Polit, D. F. and Beck, C. T. 2012. *Nursing research: generating and assessing evidence for nursing practice.* 9th ed. Philadelphia: Wolters Kluwer Health / Lippincott Williams and Wilkins.

Rastogi, D. P., Singh, V. P., Singh, V., Dey S. K., and Rao K. 1999. Homeopathy in HIV infection: a trial report of double-blind placebo controlled study. *British Homeopathic Journal,* 88: 49-57.

Schroyens, F. ed. 2012. *The essential synthesis*. London: Homoeopathic book publishers.

Sekhri, N., Feachem, R. and Ni A. 2011. Public-private integrated partnerships demonstrate the potential to improve health care access, quality, and efficiency. *Health Affairs*, 30(8): 1498-507.

Shah, R. 2015. Clinical trial for evaluation of a Human Immunodeficiency Virus nosode in the treatment for Human Immunodeficiency Virus-Infected individuals. *Indian Journal of Research in Homoeopathy,* 9(1): 25-33.

Shukla, G. S., Rai, P. K. and Ahmed, D. 2015. Comparative efficacy of homoeopathy, cognitive behavior therapy and placebo on depression. *International Journal of Pharmaceutical Sciences and Research,* 6 (3): 1302-1313.

Strydom, H. and Delport, C. S. L. 2011. Sampling and pilot study in qualitative research. In de Vos, A.S., Strydom, H., Fouché, C. B. and Delport, C. S. L. *Research*

at grass roots: for the social science and human services professions. 3rd ed. Pretoria: Van Schaik Publishers, 392.

Suarez, T. and Reese F.L. 2000. Coping, psychological adjustment, and complementary and alternative medicine use in persons living with HIV and AIDS. *Psychology and Health*, 15(5): 635-649.

Tongco, M. D. C 2007. Purposive sampling as a tool for informant selection. *Ethnobotany Research & Applications*, 5:147-158. Available: http://scholarspace.manoa.hawaii.edu/handle/10125/227 (Accessed 15 August 2016).

Ullman, D. 2003. Controlled clinical trials evaluating the homeopathic treatment of people with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome. *The Journal of Alternative and Complementary Medicine,* 9(1): 133-141.

Vermeulen, F. 1994. *Concordant materia medica*. Haarlem: Merlijn Publishers.

Vithoulkas, G. 2004. *Science of homeopathy*. New Delhi: B. Jain Publishers (P) LTD.

Watson, T. 2015. A patient benefit and perception survey of the Durban University of Technology homoeopathic satellite clinic established at Ukuba Nesibindi. M. Tech: Homoeopathic, Durban University of Technology.

WebMD. 2018. *HIV and AIDS complications*. Available: https://www.webmd.com/hiv-aids/guide/hiv-aids-complications (Accessed 25 March 2018).

Winston, J. 1998. http://www.nesh.com/the-new-england-journal-of-homeopathy/vol-7-no-1-springsummer-1998/influenza-1918-homeopathy-to-the-rescue/ (Accessed 20 July 2018).

Wyse, S.E. 2011. *What is the Difference between Qualitative Research and Quantitative Research?* Available: http://www.snapsurveys.com/blog/what-is-the-difference-between-qualitative-research-and-quantitative-research/ (Accessed 21 January 2016).

APPENDICES

Appendix A- Interview schedule questions

Interview schedule questions

1. What is your deepest concern about your status now?
2. Can you share with me how you feel about your status?
3. How did you feel when you first found out about your status?
4. Comparing then and now, how do you feel now?
5. Has your life changed in any way?
6. Is there anything you could have changed if you were given a chance to go back the day before getting infected?
7. Is there anything else that you would like to share with me?

Appendix B- Imibuzo

Imibuzo

1. Ikuphi ukukhathazeka okusekujuleni onakho kuwena njengamanje ngesimo sakho sengculaza?
2. Ngicela ungazise ukuthi uzizwa kanjani ngestatus zakho?
3. Wazizwa kanjani uma uthola nge simo sakho sesandulela ngculaza?
4. Ingabe kukhona osekushtshile ngempilo yakho?
5. Ingabe lukhona yini ushinsho owawungalwenza, uma ubunganikezwa ithuba lokubuyisela isikhathis emuva ungakatheleleki ngegciwane?
6. Ingabe kukhona ofuna ukukuxoxa nami mhlawumbe ukwengeza kulenkulumo yethu esesibenayo?

Appendix C- Letter of information

LETTER OF INFORMATION

Dear Participant: Welcome to my research project. Thank you for taking the time to consider participating in my study.
Title of the Research Study: A qualitative exploration of the homoeopathic remedies indicated for the reaction to an HIV positive diagnosis.

Principal Investigator/s/researcher: Nontuthuzelo Qaqamba Mvunelo (BTech: Hom)

Co-Investigator/s/supervisor/s: Dr Madhu Maharaj (MTech: Hom) and co-supervisor Prof R Bhagwan (PhD).

Brief Introduction and Purpose of the Study: Finding out that you are HIV positive can be the most terrifying thing to most individuals. Most often the post-test counselling session usually concentrates more on advising the patient on how to stay healthy and practice a healthy sex life neglecting the emotions that the patient may be undergoing at the time. This study aims to determine the emotional responses of patients to an HIV positive diagnosis and explore the potential homoeopathic remedies indicated therefor.

The study is designed as purposive sampling, qualitative study, in which a minimum of 10 participants will be interviewed. This means that the first thing to do is deciding on the research problem. Secondly the type of information that is required has to be determined. Defining the exclusions and inclusions qualities of participants. Finding the participants based on the exclusion and inclusion criteria. Keeping in mind the credibility and competency in assessing the prospective participants. Making use of appropriate data gathering techniques. Lastly in the process of data analysis and interpretation of results one should bear in mind that purposive sampling is an inherently biased method, therefore the bias must be documented, and interpretation must not be applied beyond the sampled population.

Outline of the Procedures: After the telephonic conversation, an appointment will be made for you. When you arrive for this appointment you will be given this letter of information and informed consent to read. Should you agree to participate in the study, you will be asked to sign this letter of information and informed consent. You will then undergo an interview with a set of questions for approximately an hour. The interview will be conducted at a convenient location which is the Ukuba Nesibindi Homoeopathy Community Wellness Centre or the DUT Homoeopathy Community Wellness Centre. The interviews may also be conducted in the areas where the participants will be located by means of advertisements in those locations.

Risks or Discomforts to the Participant: You may feel the emotional response that was experienced during the time coming back in the process of the interview. Should the symptoms persist please report this to me. At any time, you can stop the process and withdraw I can refer you to a counsellor.

Benefits: the research may result in the application of homoeopathic interventions for those who receive a HIV positive diagnosis in the future; knowledge of the most indicated remedies in the later part of research may assist those who still have ongoing emotional symptoms who can subsequently receive such remedies in the future. If the patient has emotional issues, they will be referred to a professional.

Reason/s why the Participant May Be Withdrawn from the Study: There will be no adverse consequences should they choose to withdraw.

Remuneration: There will be no remuneration.

Costs of the Study: There will be no cost to participants to take part in the study.

Confidentiality: All personal information will remain confidential as the information will be kept in a store room at DUT that will be locked and for a period of five years and thereafter will be shredded.

Research-related Injury: The DUT Clinic Protocol will be followed and the injury would also need to be reported to the Institutional Research Ethics committee, so please ensure that you advise me of any such problems.

Persons to Contact in the Event of Any Problems or Queries:

Please contact the researcher: Nontuthuzelo Qaqamba Mvunelo (tel no. 0764039053), my supervisor: (tel no. 0313732514) or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the Director: Research and Postgraduate Support, Prof S Moyo on 031 373 2577 or moyos@dut.ac.za

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, _____ (name of researcher), about the nature, conduct, benefits and risks of this study - Research Ethics Clearance Number: _____,
- I have also received, read and understood the above written information (Participant Letter of Information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may relate to my participation will be made available to me.

_____	_____	_____	_____
Full Name of Participant	**Date**	**Time**	**Signature / Right Thumbprint**

I, _____ (name of researcher) herewith confirm that the above participant has been fully

informed about the nature, conduct and risks of the above study.

_____	_____	_____
Full Name of Researcher	**Date**	**Signature**
_____	_____	_____
Full Name of Witness (If applicable)	**Date**	**Signature**
_____	_____	_____
Full Name of Legal Guardian (If applicable)	**Date**	**Signature**

Appendix D- Incwadi yolwazi

Incwadi yolwazi

Mhlanganyeli othandekayo: Ngiyakwamukela kwiphrojethi yami yocwaningo. Ngiyabonga ngokuthatha isikhathi sakho ukuzinikela ukuhlanganyela kulolu cwaningo.
Isihloko socwaningo: "A qualitative exploration of the homoeopathic remedies indicated for the reaction to a HIV positive diagnosis'.

Umphenyi oyinhloko /umcwaningi: Nontuthuzelo Qaqamba Mvunelo (BTech: Hom)

Ababuyekezibalolu cwaningo: Dkt Madhu Maharaj (MTech: Hom) Kanye no solwazi R Bhagwan (PhD).

Isingeniso esifushane kanye nenhloso yeSifundo: Ukuthola ukuthi unesandulela ngculaza kungaba yinto esabekayo kakhulu kubantu abaningi. Ngokuvamile isikhathi sokwelulekwa ngesandulela ngculazi nayo uqobo (phecelezi i-post-test) kugxilwa kakhulu ekucebiseni isiguli ukuthi singahlala kanjani siphilile futhi silandele sisebenzise izindlela eziphephile ngokocansi, kunganakwa imizwa okukanye umuzwa isiguli esisuke sibhekene nayo ngaleso sikhathi. Lolu cwaningo luhloswe ukuveza izimpendulo zeziguli emva kokuhlolwa ukuthi zinesandulela ngculazi nokuthikuhlolwe izindlela zokwelashwangokwe-homoeopathy ezibaluliwe lapha.

Lolucwaningo lwakhiwe njengesampuli esicacile okuyi-qualitative study , lapho okungenani abahlanganyeli abanyishumi bezoveza uvo lwabo. Lokhu kusho ukuthi into yokuqala ebalulekile ukwazi inkinga/inhloso yocwaningo. Okwesibili okubalukekile ukubalula uhlobo lwolwazi oludingekayo . Ukuchaza izimfanelo ezingabanjwanga nezifakiwe zabathintekayo. Ukuthola abahlanganyeli ngokususelwa ekunqunyweni nasekufakeni izinqubo. Ukukhumbula engqondweni nokwethembeka ekuhloleni abathintekayo. Ukusebenzisa amasu okuqoqa idatha efanelekile. Ekugcineni ekuhlaziyweni kwedatha nokuchazwa kwemiphumela oyedwa kufanele akhumbule ukuthi isampuli esicacile yindlela ehambelanayo, ngakho-ke ukuhlaziywa kufanele kubhalwe phansi, futhi ukuchazwa akufanele kwenziwe ngaphandle kwababantu abathintekayo.

Uhlaka Lwezinqubo: Emva kwengxoxo yocingo, i-aphoyintimenti izokwenzelwa wena. Uma ufika kule nqunjelwa uzonikezwa le ncwadi yolwazi kanye nemvume enolwazi ozoyifunda.

Uma kufanele uhlanganyele esifundweni, uzocelwa ukuba usayine le ncwadi yolwazi kanye nemvume enolwazi. Uzobe uxoxisana neqoqo lemibuzo cishe ihora. Le ngxoxo izoqhutshwa endaweni elula ukuthi i-Ukuba Nesibindi Homoeopathy Community Wellness Centre noma isikhungo se-DUT Homoeopathy Community Wellness Centre. Lezi zingxoxo zingase zenzeke ezindaweni lapho abahlanganyeli bazobe khona khona ngezikhangiso kulezo zindawo.

Izingozi noma ukuphazamiseka kumuntu ohlanganyele: Ungase uzizwe impendulo engokomzwelo eyayihlangene ngesikhathi sokubuya enkulumweni yocwaningo. Uma izimpawu eziqhubekayo sicela ubike lokhu kimi. Noma kunini, ungayeka inqubo futhi uhoxise ngingakunikeza kumeluleki.

Izinzuzo: Ucwaningo lungabangela ukusetshenziselwa ukungenelela kwe-homoeopathy kulabo abathola ukuxilongwa nge-HIV; ulwazi lwezokwelapha eziboniswe kakhulu lungasiza labo abasenayo izimpawu ezingokomzwelo abangakwazi ukuthola izixazululo ezinjalo. Uma umhlanganyeli enezinkinga emoyeni, uzothunyelwa kungoti kulowo msebenzi.

Isizathu / ukuthi kungani umhlanganyeli angase ahlehliswe eSifundweni: Ngeke kube nemiphumela emibi uma bekhetha ukuhoxisa.

Imali: Ngeke kube khona umholo.

Izindleko zoFundo: Ngeke kube khona izindleko kubahlanganyeli ukuba bahlanganyele ocwaningweni.

Imfihlo: Lonke ulwazi lomuntu siqu luzohlala luyimfihlo njengoba ulwazi luzogcinwa egumbini lesitolo ku-DUT oluzovalwa futhi esikhathini esiyiminyaka emihlanu nangemva kwalokho luzobe lugcwele.

Ukulimala okuhlobene nophando: I-DUT Clinic Protocol izolandelwa futhi ukulimala kuyodingeka futhi kubikwe ekomitini le-Institutional Research Ethics, ngakho-ke sicela uqinisekise ukuthi ungeluleka nganoma yiziphi izinkinga ezinjalo.

Abantu abazoxhumana nabo emcimbini wezinkinga noma imibuzo:

Sicela uxhumane nomcwaningi : Nontuthuzelo Qaqamba Mvunelo (inombolo yocingo 0764039053), umphathi wami: Dkt M Maharaj (inombolo yocingo 0313732514) noma i-Institutional Research Ethics Administrator ngo 031 373 2375. Izikhalazo zingabikwa kuMqondisi: Ukucwaninga nokusekelwa ngePostgraduate, Prof S Moyo on 031 373 2577 ormoyos@dut.ac.za

IMVUME

Isitatimende Sesivumelwano Sokubamba iqhaza Esifundweni Sokucwaninga:

- Ngifakazela ukuthi ngitshelwe umcwaningi, _____ uNontuthuzelo Mvunelo,
  mayelana nemvelo, ukuziphatha, izinzuzo kanye nezingozi zalolu cwaningo - Research Ethics Clearance Number: __,
- Ngithole futhi, ngiyifunda futhi ngiyiqonda imininingwane ebhaliwe ngenhla (Incwadi yomhlanganyeli yolwazi) mayelana nokucwaninga.
- Ngiyazi ukuthi imiphumela yocwaningo, kufaka phakathi imininingwane yomuntu mayelana nobulili bami, ubudala, usuku lokuzalwa, ukuqala kanye nokuxilongwa kuyobekwa ngokungaziwa ngombiko wokutadisha.
- Ngenxa yezidingo zocwaningo, ngiyavuma ukuthi idatha eqoqwe phakathi nalolu cwaningo ingacubungulwa ohlelweni lwekhompyutha ngumcwaningi
- Ngingakwazi, nganoma yisiphi isigaba, ngaphandle kokubandlulula, ngihoxise imvume yami futhi ngihlanganyele esifundweni.
- Nginethuba elanele lokubuza imibuzo futhi (ngokuzithandela kwami) ngizibikezele ukuthi ngilungele ukuhlanganyela kulolu cwaningo.
- Ngiyaqonda ukuthi ukutholakala okusha okuphawulekayo kuthuthukiswe phakathi nalolu cwaningo okungenzeka okuphathelene nokuhlanganyela kwami kuzokwenziwa kimi.

Igama eligcwele lomhlanganyeli lwesivumelwano/ Kwesokudla I-Thumbprint	**Usuku**	**Isikhathi**	**Uphawu**

Mina, _____(Nontuthuzelo Mvunelo) ngalokhu kuqinisekisa ukuthi lo mhlanganyeli ongenhla ugcwele ukwaziswa ngesimo, ukuziphatha kanye nezingozi zesifundo esingenhla.

Igama eliphelele lomcwaningi lwesivumelwano	**Usuku**	**Uphawu**
Igama eliphelele loFakazi (uma likhona) lwesivumelwano	**Usuku**	**Uphawu**
Igama eligcwele lomgcini wezomthetho (Uma likhona) lwesivumelwano	**Usuku**	**Uphawu**

Appendix E- Gatekeeper permission

Ukuba Nesibindi Homoeopathic Community Wellness Centre

Life Line Building

Warwick Junction

Durban

To Dr Ngobese - Ngubane

RE: Request for the use of consultation rooms

I am a Registered Master's homoeopathic student, Ms N.Q Mvunelo (21029569) at the Durban University of Technology. I am kindly requesting your permission to use the Ukuba Nesibindi Homoeopathic Community Wellness Centre and DUT Homoeopathic Community Wellness Centre for conducting research interviews.

Title of the Research Study:

A qualitative exploration of the homoeopathic remedies indicated for the reaction to a HIV positive diagnosis.

Brief Introduction and Purpose of the Study: Finding out that you are HIV positive can be the most terrifying thing to most individuals. Most often the post-test counselling session usually concentrates more on advising the patient on how to stay healthy and practice a healthy sex life neglecting the emotions that the patient may be undergoing at the time. This study aims to determine the emotional responses of patients to an HIV positive diagnosis and explore the potential homoeopathic remedies indicated therefor.

Outline of Procedures: After a telephonic screening procedure (to confirm suitability for inclusion), an appointment will be made for the participant to see the researcher. When the participant arrives for the interview he or she will be given a letter of information and informed consent to read. The researcher will answer all the questions

related to the study to ensure informed consent is obtained. Should the participant agree to participate in the study, he or she will be asked to sign the informed consent. The participant will then undergo an in-depth interview using a set of probing questions (see appendix B) with a set of questions for approximately an hour all proceedings will be digitally recorded.

Contact details are below should you have any queries or require additional information, please feel free to contact any of the following:

Thank you

Kind regards

Nontuthuzelo Qaqamba Mvunelo (researcher): 0764039053

Dr Maharaj (supervisor): 0833882688

Appendix F: Ethics clearance

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
1st Floor, Berwyn Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban South Africa, 4001

Tel: 031 373 2375
Email: [illegible]@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

13 December 2018

Ms N Q Mvunelo
P O Box 540
Kokstad
4700

Dear Ms Mvunelo

A qualitative exploration of the homoeopathic remedies indicated for the reaction to an HIV positive diagnosis

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letter.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely,

Professor J K Adam
Chairperson: IREC

Appendix G- Editing certificate

DR RICHARD STEELE
BA, HDE, MTech(Hom)
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EDITING CERTIFICATE

Re: **Nontuthuzelo Qaqamba Mvunelo**
Master's dissertation: **A qualitative exploration of the homoeopathic remedies indicated for the reaction to a HIV positive diagnosis**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I returned the document to the author with track changes and comments, so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homeopathy at Technikon Natal in 1999 (now the Durban University of Technology). I was a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology for 13 years.

Dr Richard Steele
10 October 2019
per email