A STUDY ON THE MANAGEMENT OF MENOPAUSAL SYNDROME BY REGISTERED HOMOEOPATHIC PRACTITIONERS IN ETHEKWINI MUNICIPALITY

by

NONDUMISO CHARITY THUSI

Dissertation submitted in fulfilment of the requirements for the Degree Master of Health Sciences in Homoeopathy in the Faculty of Health Sciences at the Durban University of Technology

Supervisor: Dr Maharaj

Date: May 2021

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is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources).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.

The research described in this dissertation was supervised by Dr M. MAHARAJ, Head of Department and Senior Lecturer: Department of Homoeopathy, Faculty of Health Sciences, Durban University of Technology, Durban, South Africa.

03- May- 2021

Signature of student Date

Approved for final submission

03-May- 2021

Dr M Maharaj Date

M Tech: Homoeopathy

DEDICATION

To the Lord God Almighty, The King, He who carried me!

This work is dedicated to my brother who has been my pillar from the beginning till this day, without your love, patience and support I wouldn't have made it.

To my late grandmother, I am sad that you did not get the chance to see this final accomplishment, but I will always carry you in my spirit.

ACKNOWLEDGEMENTS

I would like to express my heartfelt gratitude, appreciation and acknowledgement to the following people, who made all of this work possible:

The Lord God Almighty

You taught me patience and courage through tribulation. You loved and took care of me even when I didn't deserve it. Thank you God for all you have done for me in the past years, thank you for the days and nights, in which you have spoken to me, blessed me, provided for me, protected me, comforted me, healed me and given me strength to get through. Thank you God for reminding me to TRUST in you with my life!

Muzi-Omuhle Mazibuko

My brother, my pillar, thank you so much for everything, your support, and the way you believed in me supersedes all understanding. I love you so much mntaka mah.

The Entire Radebe Family

I thank God for each and every one of you, and I am truly grateful for your support.

My Friends

Thank you so much guys for your love and support even in the hardest of times

(especially: **Sthembiso Gamede**, **Zanele Hadebe**, **Balungile Tshabalala**, **Minenhle Zuma** and **Thobeka Zuma**)

Hlengiwe Makhaye

You have showed me a mother's love with no limits.

My classmates

Thank you so much guys, with you this journey became a little less painful and fun, you were the best classmates one could ever ask for!

Dr Maharaj

Thank you so much Dr Maharaj, this wasn't an easy journey, thank you so much for your support, courage, patience and taking this work seriously, I am truly grateful.

Dr Ngobese-Ngubane

I always came to you crying and faint hearted but you always knew the right words to keep me going, thank you so much.

Dr Couchman

You always handed me a helping hand whenever I was in need, thank you so much.

All my Lecturers

Thank you so much Doctors for your support and faith in me, even when all seemed vague and vivid in my eyes but you kept pushing me.

To all my participants

Thank you so much Doctors, without you, this work wouldn't have been possible, God bless you all.

ABSTRACT

INTRODUCTION

Menopause is the permanent cessation of the menstrual cycle due to loss of ovarian follicular activity. Changes occur gradually over the years during a transitory phase known as the perimenopause or the climacteric phase which may take place around about the age of 45 to 55 years. This phase is associated with the reduction of oestrogen levels, which then gives rise to menopausal symptoms including hot flushes, moodiness, sleep disturbance and sweating, weight gain, fatigue and low libido. The most commonly used type of treatment is hormone replacement therapy (HRT). HRT has been shown to alleviate menopausal symptoms for many, although with adverse effects and health risks. The severity of symptoms diminishes the quality of life but the risks and side effects of HRT are such that many women look for alternative and gentler medical help.

AIM

The aim of the study was to explore and describe regimens utilised by registered homoeopathic practitioners in eThekwini in the management of menopausal syndrome. The study was guided by the following grand tour question: How would you describe your approach to patients presenting with menopausal syndrome?

METHODOLOGY

A qualitative, explorative, descriptive and contextual study design was utilised. Qualitative research is employed in the healthcare field to investigate how people think of their experiences and knowledge and to further explore their perspectives on the care and treatment they offer for managing menopausal symptoms within the healthcare system (Holloway and Wheeler 2010). Twelve respondents were selected using snowball sampling. Inclusion and exclusion criteria were utilised as guidance to the selection process. Respondents were interviewed individually using an interview guide. Each of the interviews were audio recorded and transcribed prior to data analysis. Data was analysed using Tesch’s eight-step procedure and Creswell’s data analysis.

RESULTS

Results from this study indicate that even though the majority of respondents did not use homoeopathy alone as their first line approach, they were satisfied with the results obtained from their individualistic prescriptions for each of their individual patients.

The thematic analysis further revealed that respondents were critical of other forms of medical approach to managing menopausal syndrome and were very enthusiastic and hopeful regarding homoeopathic treatment.

CONCLUSION

The principal themes arising from the data collected for this study strongly suggested that homoeopathic medicine as well as its practice to manage menopausal symptoms is widely accepted and is beneficial for patients as assessed by the participating homoeopaths. It appeared that participants had trust in their knowledge and skills and were enthusiastic and confident regarding their impact on their patient's lives as homoeopaths. With regards to these findings, the researcher strongly recommends the need for the integration of homoeopathic practice and conventional medicine into the South African primary healthcare system. This is because the integration of homoeopathic medicine as a primary health care provider will help to offer an alternate and safe platform to ease the overwhelming load of health complaints on conventional medical practices.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

Majer-Julian (2013) states that menopause is the definitive end of menstruation which occurs following the loss of follicular activity. The average onset of menopause is between the ages of 45 and 55, although women can develop menopause as early as in their 30s and 40s (Stoppler, 2016). The diagnosis can only be made retrospectively once twelve months have elapsed since the final menstrual period. Determination of this transition can be made by assessing the various hormones normally secreted by the ovaries such as and luteinising hormone (LH) and follicle stimulating hormone (FSH). These hormones are responsible for the normal functioning of the ovaries during the reproductive life of a woman (Naik, Chandel and Abichandani 2013).

1.2 MENOPAUSE SIGNS AND SYMPTOMS

Menopause includes the perimenopausal years which are associated with irregularities in oestrogen and progesterone causing symptoms such as hot flushes, night sweats, irritability, headaches, mood swings and loss of libido (Jane and Davis 2014).

1.3 ALLOPATHIC TREATMENT AVAILABLE

Allopathic treatment for menopausal syndrome is hormone replacement therapy (HRT) which is effective but has potential side effects such as vasoregulatory dysfunction, high blood pressure and venous thrombosis as a result of endothelial dysfunction (Fushtey, Malynovska and Sid' 2015). Furthermore, the risk of cancer in crucial functional organs including the breast, endometrium, ovaries and the cervix increases. During hormonal therapy, the nervous system is stimulated which then prompts the manifestation of premenstrual-like symptoms including mood changes. Other adverse effects include dermatological manifestations like acne and hirsutism which result from progestogens which have a similar effect to testosterone caused by inducing of androgen receptors (Hamoda *et al.* 2016). Therefore, there is a growing demand for natural alternatives, like natural progesterone creams (McTeer 2003).

More studies in this field will give more insight into the management of menopausal syndrome by non-medical practioners such as registered homoeopaths.

1.4 RATIONALE

Allopathic treatment for menopause is HRT which is effective in providing symptomatic relief. There are a variety of HRT treatments available including oral preparations, transdermal applications and implants. HRT can be a combination of both oestrogen and progesterone, or oestrogen on its own. Research has shown significant unfavourable effects in a marginal number of women. Side effects include complications such as a rise in endometrial, breast and ovarian cancers (Hansa 2011). Venous thrombosis and hypertension are other risks encountered while on HRT. This therapy is contraindicated in women with liver, ischaemic heart and gallbladder disease, hypertension, diabetes and history of thrombosis (Symonds and Symonds 2004). For these reasons there is a growing demand or need for a protocol that has less side effects to reduce and minimise the level and extent of HRT side effects and help stabilise bodily homeostatic regulation. This has created a gap in the literature as there is little documented information on the current homoeopathic management of menopausal syndrome, especially in the South African context. Therefore, this study aimed to determine treatment regimens which have been explored to be effective in the management of menopausal syndrome utilised by registered homoeopaths as a holistic approach to menopause.

1.5 ADVERSE EFFECTS OF HRT

Research has shown significant unfavourable effects in a marginal number of women. Hachul, Bezzera and Andersen (2017) state that HRT has proven to have various subordinate health complications such as vaginal bleeding, gallbladder illnesses, breast cancers and many more. Side effects include complications such as a rise in endometrial, breast and ovarian cancers (Hansa 2011). This therapy does not have that much of an effect on the psychological manifestations associated with menopause as allopaths control these through sedatives, anxiolytic drugs, and hypnotics which may cause other side effects such as drowsiness, loss of memory, drug dependence, impaired motor function, non-social behaviours or allergic reactions (Modi, Donga and and Dei 2012). Venous thrombosis and hypertension are other risks encountered while

on HRT. This therapy is contraindicated in women with liver, ischaemic heart and gallbladder disease, hypertension, diabetes and history of thrombosis (Symonds and Symonds 2004). Thus, there is a growing demand or need for the protocol that has less side effects to reduce and minimise the level and extent of HRT side effects, and help stabilise bodily homeostatic regulation.

1.6 RESEARCH PROBLEM

The lack of knowledge about management regimens that homoeopathic practitioners use in treating or managing menopausal syndrome is a gap which this study intends to fill by exploring homoeopathic and additional adjunctive therapies that have been used successfully in the management (treatment) of menopausal syndrome.

1.7 AIM OF THE STUDY

The aim of the study was to explore and describe the regimens employed in the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini.

1.8 RESEARCH QUESTIONS

Grand Tour Question

1. How would you describe your approach to patients presenting with menopausal syndrome?

Sub Questions

1. Describe your understanding of menopausal syndrome.
2. Explain how you diagnose menopausal syndrome.
3. What is your therapeutic approach to managing patients with menopausal syndrome?
4. What type of homoeopathic treatment do you prescribe for patients presenting with menopausal syndrome?
5. What additional modalities do you employ or recommend for patients presenting with menopausal syndrome?

CHAPTER 2: REVIEW OF RELATED LITERATURE

2.1 DEFINITION AND CLASSIFICATION

Menopause is the permanent cessation of menstruation in a non-hysterectomised woman following the permanent cessation of ovarian function. This transition takes place gradually over the years commonly known as climacteric or perimenopause which involve active and inactive follicular function (Modi, Donga and Dei. 2012). This period includes physiological and biological adjustments, characterised by a decline in the female ovarian regulatory hormone (oestrogen and progesterone) levels with an increase in the gonadotrophin levels (McTeer 2003). Diagnosis can only be made retrospectively once 12 months have elapsed since the last menstrual period occurrence (Jane and Davis 2014). Menopause (culmination of periods) can also result from medical or surgical intervention or both. A woman with an intact uterus may have stopped menstruating for a range of reasons, such as having had an endometrial ablation or a hormonal intrauterine device (IUD) inserted (Beers *et al.* 2006).

2.2 PHYSIOLOGY

2.2.1 Mechanism of menstrual cycle

The average onset of menstruation is 12 years of age (Neville *et al*. 2004). The female menstrual cycle lasts between 25 to 28 days, and presents in three stages:

1. The proliferative phase

This is the oestrogen dominant phase that occurs prior to ovulation. At the start of this stage of the cycle the most superficial layer of the endometrium known as the functional layer is desquamated due to the shedding process that takes place during menstruation (Germann and Stanfield 2008). After menstruation the endometrial layer remains only 2mm thick which is very thin compared to endometrial thickness at the start of menstruation. This delicate epithelialised layer seen in immediate menstrual cycle appears very similar to the endometrial cytoarchitecture in postmenopausal women along with hypothalamic amenorrhea suffering women. Oestrogen (Oestradiol) synthesised by the ovaries from about day 4 or 5 of the cycle stimulates

growth and differentiation of the endometrium. Endometrial thickness starts from a thickness of about 4.5mm on day 4 to approximately 10mm on day 9 or 10. Endometrial growth termination occurs prior to oestradiol level spike and before the secretory phase progesterone production commencement, therefore denoting that nonsteroidal factors inhibit endometrial growth (Santoro and Neal-Perry 2010).

2. Secretory phase

This is the progesterone dominant phase consecutive to ovulation in the second half of the menstrual cycle. In this phase, ovulation takes place and releases corpus luteum which then in turn secretes both oestrogen and progesterone in large amounts (Guyton and Hall 2005). Progesterone dominance counteracts the oestrogen epithelial proliferative process by down-regulating oestrogen receptors in the endothelial epithelial cells. This reduction of oestrogen receptors allows progesterone supremacy to take place; progesterone induces further enlargement of the endometrial glands thus inducing thickening of the endometrial wall preparing it for implantation. In the midst of this process, the endometrium also produces large amounts of prolactin and insulin-like growth factor proteins (IGFBP). Progesterone induces extensive modifications in the endometrial wall and secretory products of the endometrium (Santoro and Neal-Perry 2010). The corpus luteum disintegrates causing oestrogen and progesterone plasma levels to deteriorate significantly, which then induces the menstruation process if implantation has not taken place (Germann and Stanfield, 2008).

3. Menstruation

When the corpus luteum shrinks and degenerates, oestrogen and progesterone plasma levels drop rapidly allowing the commencement of bleeding. If no implantation has taken place the endometrial wall is infiltrated by degenerative cells that induce disintegration (a process when the endometrial wall breaks and sheds in pieces) of the thickened endometrial lining causing it to shed. Due to the rapid decline in the proliferative hormones there is decreased stimulation to the endometrial lining which had previously encouraged continuous thickening, therefore the endometrium fragments and collapses to about 65% of its prior proliferated thickness (Germann and

Stanfield 2008). Blood loss ceases in about 4 to 7 days from commencement of menstruation (Guyton and Hall 2005).

2.2.2 Female sex hormones

2.2.2.1 The role of oestrogens

Oestrogens are made up of three reproductive hormones (oestradiol, oestrone and oestriol) which are responsible for monthly egg production during a women's reproductive life. Oestrogens are primarily produced by the ovaries although small amounts of it are also produced by the adrenals and the placenta of a pregnant women (Hamoda *et al* 2016). Oestrogens under the influence of gonadotropins produced by the anterior pituitary gland maintain the primary and secondary female characteristics at puberty and during a woman's fertile phase of life. Oestrogens are produced in minute amounts prior to puberty and as the female child approaches puberty oestrogen levels gradually increase so as to prepare the body for the transitional change. The transitional changes include maturation of the fallopian tubes, uterus, vagina, and external genitalia. The oestrogens are also responsible for the alteration of the vaginal epithelium into stratified from cuboidal epithelium. Furthermore, they are liable for the maturation of endothelium and endometrial gland growth (Guyton and Hall 2005).

2.2.2.2 The role of progesterone

The Corpus luteum is responsible for the secretion of progesterone. Progesterone induces and maintains endometrial functions. Progesterone enhances glandular tissue growth in the breasts and also inhibits milk production and uterine contractions especially during pregnancy (Germann and Stanfield 2008).

2.2.2.3 The role of follicle stimulating hormone and luteinising hormone

The hypothalamus produces gonadotropin-releasing hormone (GnRH) which is responsible for and controls the release of and target action of the two gonadotrophins, namely, FSH and LH from the anterior pituitary gland (Smitz *et al.* 2016; Simoni *et al.* 2019). This process is termed the hypothalamic-pituitary-gonadal axis feedback system, which in the younger stage of life stays inactive until around the age of 12 years in a female child (Burger *et al.* 2007). The gonadotropins FSH and LH stimulate

the ovaries to secret oestrogen and progesterone which are then responsible for the primary development of the female reproductive system and regulate the menstrual cycle as they fluctuate during the reproductive phase of life (Orlowski and Sarao 2018).

2.2.3 Changes occurring at menopause

During an ordinary menstrual cycle, the ovaries are responsible for the production of a series of hormones under the influence of gonadotropins. Originally women are said to have about 1.5 million oocytes at the onset of menstruation and they have approximately four hundred thousand progressively active eggs. During the interval from menstrual onset to menopause women ovulate nearly four hundred times and by the time they reach menopause all their eggs are depleted (Kaur and Goel 2019). Once all the eggs are depleted or have deteriorated then the ovaries no longer adequately respond to gonadotropin stimulation, and this affects oestrogen, progesterone and all other gonadotropic hormone production. The reduction or depletion of these hormones result in the unfavourable physical, psychological and sexual changes in women's lives during menopause (Neville *et al.* 2004; Santoro and Neal-Perry 2010).

At the menopausal phase there is ovarian failure meaning that there is no negative feedback from the ovaries, yet the hypothalamic-pituitary-ovarian axis remains functional, hence FSH levels escalate (Berek 2007; Shabaan, Mohasib and Emam 2018).

The alterations in the menstrual cycle are associated with the brief follicular phase and in contrast to a younger woman where FSH levels are always on a surge throughout the cycle, there is a gradual decline in oestradiol secretion by the ovaries. Androgens are constantly produced and their action is not hindered in any way (The North American Menopause Society 2000; Symonds and Symonds 2004).

2.3 CLINICAL PICTURE OF MENOPAUSE

2.3.1 Signs and symptoms

Menopause is a transitional phase associated with irregularities in oestrogen and progesterone causing symptoms such as hot flushes, night sweats, mood swings

including depression, lack of energy and joint pains, irritability, weight gain, headache and loss of libido (Beers *et al.* 2006).

Premature menopausal changes usually begin just before or around the age of 40 (Cutler and Genovese-Stone 2000). Normal climacteric changes occur during the age of 48 to 51 years, and are characterised by irregularities in the menstrual cycle followed by a gradual cessation of menses which eventually becomes evident as a period of 12 months of amenorrhea (Borker, Venugopalan and Bhat 2013).

2.3.1.1 Vasomotor symptoms

The most well-known symptom of menopause is hot flushes which occur as a sudden sensation of heat that cascades from the head, collar and upper chest, accompanied by perspiration. The occurrence of these symptoms vary depending on stimulating factors which may include caffeine, alcohol, drugs, weather changes, or food ingredients (Wang-Cheng 2007). Another aetiology for these symptoms may be the alterations in the thermoregulatory centre in the hypothalamus caused by changes in the levels of oestrogen and progesterone which mainly are a decrease in these hormones (Morris and Rymer 2001).

2.3.1.2 Psychological symptoms

Common symptoms during the climacteric phase are mood swings, decreased or low self-confidence, lack of sleep or insomnia, irritability, poor memory, feeling of losing control, decreased tolerance, anxiety, depression, difficulty concentrating, decreased sexual excitement, and vulnerability (Shabaan, Mohasib and Emam 2018). Additional symptoms are nervousness, lack of motivation and low self-esteem or self-reliance and impaired memory (Ghattas, Ali and Wahed 2019).

2.3.1.3 Urogenital changes

The significant decrease in the secretion and production of ovarian oestrogen amounts to unfavourable effects on the crucial and functional organs of the female reproductive system. This decrease causes atrophy of the uterus and cervix, weakens the cervical lining which reduces mucous production promoting vaginal dryness which contributes to recurrent urinary infections (Robinson, Toozs-Hobson and Cardozo, 2013). The diminished oestrogen levels also cause smoothening of vaginal walls which increases

friction and discomfort leading to micro tears in the vaginal lining (Singh, Herwijnen and Phillips 2013). Reduced oestrogen levels consequently lead to thinning and dryness of skin in areas like the face causing wrinkles, the armpit, pubic area and scalp causing signs of alopecia (Hansa 2011).

2.3.1.4 Cardiovascular risks

Ra, Kim and Jeong (2019) state that the cardiovascular disease risk or effect rate increases with age, and that the general prevalence for mortality and morbidity is higher in men than in women. However, as oestrogen levels diminish and there is a weakening of the protective effects of oestrogen against cardiovascular disease, leading to a rise in systolic blood pressure, triglyceride levels and total cholesterol in post-menopausal women (Naftolin *et al.* 2019).

2.3.1.5 Musculoskeletal symptoms

A significant reduction of bone mineral density increases the risk for bone fracture and osteoporosis. The main factor influencing this gradual decrease in bone mineral density is the diminution of estradiol levels post-menopause (Sagara *et al.* 2010).

2.4 DIAGNOSIS

Diagnosis of menopause can only be clinically done retrospectively after 12 months of amenorrhea (Borker, Venugopalan, and Bhat 2013). Oestrogens (oestrone, oestradiol and oestriol) levels normally oscillate, so confirming the diagnosis by testing oestrogen levels does not help. The most reliable way to diagnose menopause is to assess FSH levels on numerous occasions following three months of amenorrhea and a measurement above 40 iu/l indicates menopause (Oats and Abraham 2005).

Before starting with treatment, a thorough physical examination should be performed and family and past medical history should be documented and analysed. Bone mineral density may also be tested by measuring oestradiol levels as it constitutes the greatest influence on normal functional bone mineral density (Sagara *et al.* 2010). Mammography may also be executed. These assessments aid in determining the risks of postmenopausal problems (Beers *et al.* 2003).

2.5 MANAGEMENT AND TREATMENT

Most treatment involves lifestyle changes. Dressing comfortably and limiting heat triggers may ameliorate hot flush episodes. In order to reduce sleep problems, irritability and other vasomotor symptoms, it is recommended that one must employ relaxation techniques, avoid stress stimuli and adhere to routine exercise. Lubricants and moisturisers may be utilised to ease the discomfort of vaginal dryness during sexual engagement. Hormone replacement therapy is the highest ranked kind of treatment for menopause therefore it is usually prescribed (Beers *et al.* 2006)

2.5.1 Hormone Replacement Therapy

Allopathic treatment for menopause is HRT which is effective in giving symptomatic relief. HRT can be a combination of both oestrogen and progesterone, or oestrogen on its own (Pitkin 2013).

2.5.1.1 Categories of Hormone Replacement Therapy

There is a variety of HRT treatment available including:

- Oral preparations that are absorbed through the digestive system which so far has proven to be the most tolerable route of administration. These preparations contain equine oestrogens and oestradiol.
- Transdermal application that are administered subcutaneously in the form of gels, patches, cream, nasal sprays and vaginal preparations which may aid with genital discomforts such as vaginal dryness, incontinence and urinary tract infections.
- Implants that are inserted through the skin under the influence of a local anaesthetic so they can release hormones subcutaneously for dissemination throughout the blood stream till they reach their target tissue (Sturdee 2003; Marjoribanks *et al.* 2017).

2.5.1.2 Benefits of Hormone Replacement Therapy

The most basic beneficial characteristic of HRT is to provide symptomatic relief and it also has preventative and ameliorative effects on the development of postmenopausal osteoporosis as well as being cardio protective. HRT has proven to be beneficial as follows:

- Amelioration of unbearable night sweats and hot flushes/
- Slowing down of osteoporotic effects in bones of postmenopausal women (Lethaby *et al.* 2008).
- Improvement of endothelial-dependent vasodilatation specifically due to the oestrogenic effect of the therapy (Naftolin 2019).
- The progestin part of the therapy has been noted to minimise the risk rate for endometrial hyperplasia in women with a uterus (Pitkin 2013).
- Under careful observation this therapy has proven to reduce coronary heart disease by at least 30% (Davey 2006; LaCroix *et al.* 2011).
- Slowing down cognitive decline or the development of dementia and minimising overall mortality rate for current users (Marjoribanks *et al.* 2017).
- Amelioration of skin dryness and helps to preserve skin elasticity.
- HRT eases sexual discomforts by reducing vaginal dryness, superficial dyspareunia and vaginal wall thinning so to prevent it from tearing and this has the added benefit of lowering urinary tract infections (Naftolin *et al*. 2019).
- HRT alleviates mood and gives relief to depressive episodes.
- Administration improves and enhances sexual desire and orgasm (Arya *et al.* 2013).

2.5.1.3 HRT adverse effects

Long term use of the therapy may give rise to the risk of development of endometrial, breast, ovarian and cervical cancers. Breast cancer risk increases within the first year of prescription and from the fourth year onwards there is an increased risk of gallstones (Hamoda *et al.* 2016).

Other side effects include symptoms like acne and hirsutism due to testosterone-like progestogens due to activation of androgen receptors. During treatment, the central nervous system is negatively stimulated and this adversely affects mood and causes premenstrual syndrome-like adverse effects (Hamoda *et al.* 2016).

Endothelial dysfunction which develops to vasoregulatory dysfunction, hypertension and venous thrombosis are effects that have been proven to result from the use of HRT (Fushtey, Malynovska and Sid’ 2015).

The Women's Health Initiative (WHI) was a randomised controlled study of integrated oestrogen and progestin hormone replacement therapy for preventing postmenopausal disease risk rate in women. The experimental (of both oestrogen and progestin) group comprised 16 000 participants who had no preceding coronary heart maladies. The results indicated that at least 29% of the experimental group developed primary a coronary heart malady and their rate of risk for breast cancer also amplified, but before the study participants were offered colon cancer and bone fragility or fracture defence (Berek 2007).

The Heart and Oestrogen/Progestin Study (HERS) was also a randomised controlled study of hormone therapy in more than 2 700 women with pre-existing coronary heart condition. This experiment settled that the therapy did not benefit any of the participants with the barring evidence of the coronary heart condition in women who were already suffering from the disease (Berek 2007).

A double-blind, placebo-controlled, randomised clinical trial of conjugated equine oestrogen (CEE) compared with placebo was conducted with 10 739 women aged 50 to 79 years in the United States. Findings were that the risk of hip-fracture was 0.36% on the CEE participants group compared to 0.28% in the placebo group. It was also concluded that the risk rate for cardiovascular disease was higher in the CEE group presenting with 2.26% compared to 2.12% in the placebo group. Deep vein thrombosis, stroke and pulmonary embolism also had an increased risk rate noted in CEE participants group during the trial (LaCroix *et al.* 2011).

Three trials examined the incidence of coronary heart disease, stroke and venous thromboembolism incidents. These were the Women's Health Initiative (WHI) trials involving oestrogen/progestin oestrogen-only and oral conjugated oestrogen (CEE). The WHI trial discovered that hormone therapies did not increased mortality because of coronary heart disease or myocardial infarction. Nevertheless, both therapies were found to be linked with elevated incidences of stroke. Using the WHI data, it was analysed that oestrogen/progestin therapy caused nine strokes per 10,000 women, and oestrogen-only therapy caused 11 additional strokes per 10,000 women. Deep-vein thromboembolism (DVT) incidents intensified with both oestrogen/progestin and oestrogen-only therapies. Therapies of combined oestrogen and progestin resulted in

12 additional DVT cases per 10,000 women and oestrogen-only therapy resulted in seven additional DVT cases per 10,000 women (Grant *et al.* 2015).

2.5.1.4 Contraindications for HRT

The use of oestrogen only or combined oestrogen and progestin therapy is contraindicated in women who present with pre-existing conditions like gall bladder disease, ischaemic heart disease, metabolic syndrome and diabetes. Hormone therapy has unfavourable effects on the circulatory system by causing increased rates of hypertension and venous thromboembolism risks and occurrence. These therapies are also contraindicated in women with pre-existing liver disease, benign breast cancer or breast cancer, history of thrombosis, hypertension, uterine fibroids, migraines and endometriosis (Symonds and Symonds 2004; Hamoda *et al.* 2016).

Medical conditions contraindicated for HRT explained:

Metabolic syndrome

Metabolic syndrome is a combination of risk factors (including body mass index [BMI], lifestyle, use of hormonal birth control, anaemia, insulin resistance, obesity which may be central or abdominal and systemic hypertension) that increases susceptibility to cardiovascular disease and diabetes mellitus type 2 which can occur in menopausal women, which in turn can escalate morbidity and mortality. This condition is a result of the significant decline in oestrogen levels in correlation to genetic susceptibility and central obesity which leads to poor lipid breakdown (Malhotra *et al.* 2018).

Apart from the above mentioned risk factors correlated to metabolic syndrome, there are other metabolic risks such as elevated plasma glucose, hypertension and dyslipidaemia which contribute to the development of atherosclerosis, prothrombotic and proinflammatory conditions which become evident through intensified inflammatory cytokine activity. Another crucial risk factor is “hypertriglyceridemia waist” which significantly increases the risk of cardiovascular disease. Hypertriglyceridemia waist is a measurement of the waist circumference of more than 90cm in men and more than 85cm in women. A woman who presents with metabolic syndrome is likely to be at risk of developing coronary heart disease and five times more likely to acquire diabetes mellitus (Jouyandeh *et al.* 2013; Oh *et al.* 2018).

Therefore, a woman who presents with either cardiovascular disease or metabolic syndrome are prohibited from using hormone replacement therapy because it may exacerbate these conditions (Malhotra *et al.* 2018; Dibaba *et al.* 2018).

Diabetes Mellitus

During menopause women encounter various phenotypical and biochemical alterations apart from hormonal changes. These alterations make them susceptible to developing type 2 diabetes mellitus (T2DM). The transition from active to inactive reproductive phase is associated with central weight gain which actively contributes to an increased waist circumference. Apart from central obesity menopause can further be associated with muscle atrophy and sarcopenia which both contribute to alterations to phenotypic body composition. These phenomena are affected by ovarian ageing and are not only due to normal ageing (Mauvais-Jarvis *et al.* 2017).

Earliest findings of major studies proposed that weakened glucose metabolism during the climacteric phase was not correlated to diminished oestrogen levels but related to normal ageing. Conversely, later evaluation of data from the Study of Women's Health Across the Nation (SWAN) determined that the higher risk of developing T2DM was due to the significant decline in oestradiol levels (Park *et al.* 2017). The European Prospective Investigation into Cancer (EPIC)-InterAct study proved that premature ovarian insufficiency which often takes place before the age of 40 years was linked with a 32% greater risk for T2DM, after 11 years of follow up (Brand *et al.* 2013). A Chinese observational study with 16 299 women found that early or premature menopause occurring before the age 45 years was linked with a 20% greater risk for T2DM (Shen *et al.* 2017). Correspondingly, studies conducted with women who have had an ovariectomy (surgical menopause), together with data from the National Health and Nutrition Examination Survey (NHANES) I Epidemiologic Follow-up Study, affirmed increased risk of up to 57% for developing T2DM (Appiah, Winters and Hornung 2014).

The American Diabetes Association (2019) states that abdominal obesity and muscle atrophy due to sarcopenia during or after menopause results in systemic low-grade inflammation. Visceral adiposity enhances secretion of cytokines, which contribute to developing insulin resistance in peripheral tissues. Moreover, the climacteric phase is

a stage of virtual androgen excess. In post-menopause the ovaries continually secrete androgens, with greater bioavailability, due to the decline in sex hormone-binding globulin (SHBG). These hormonal fluctuations further exacerbate insulin resistance (Paschou *et al.* 2018). The is no clear evidence suggesting that menopause directly affects insulin resistance apart from individual body composition. The rate of insulin resistance was found to be higher in post-menopausal women as measured through intravenous glucose tolerance test (IVGTT) (Toth *et al.* 2000).

2.5.2 Other menopausal treatment options

2.5.2.1 Nutritional supplements

Stengler and Stengler (2003) states that many nutrients may be used to assist in alleviating menopausal symptoms:

Calcium and Vitamin D (*cholecalciferol*)- these are found in food including milk, spinach, kale, collards, soybeans, fish like sardines, tuna and salmon. A combination of Vitamin D and calcium is imperative for bone health as they help protect against osteoporosis by normalising and slowing down bone metabolism thereby maintaining normal mineral bone matrix as this impacts bone density, and reducing bone porosity due to decreased oestrogen levels during the transitional and active menopausal phase (Munir and Birge 2014). Supplementing calcium and Vitamin D helps reduce the rate of osteoporotic effect and stabilises bone structure and mineral density thereby reducing bone fractures particularly hip fractures. Vitamin D plays an essential part in thermoregulatory control which aids in normalising temperature thereby alleviating hot flushes which occur due to diminished oestrogen levels. (Kotsirilos, Vitetta and Sali 2011).

Magnesium- this is found in food sources like nuts, seeds including sunflower, chia, pumpkin and sesame seeds, in leafy greens like kale and spinach and fruits like banana and avocado. Magnesium helps regulate calcium levels towards normal functional levels which in turn aids in normalising calcium and phosphate concentration in the bone thereby stabilising mineral bone density (Durward 2016). It also helps regulate the sleep hormones serotonin and melatonin which then work to alleviate insomnia and mood, which is why it is called the happy mineral. It is also correspondingly vital for bone health and specified in osteoporosis as it helps stabilise

bone metabolism and restructuring, muscle cramps and spasms, fatigue, fibromyalgia and heart disease (Airey and Houdret 2004).

B vitamins- particularly vitamin B6 (Pyridoxine, pyridoxal, pyridoxamine), are found in food substances like tofu, fish, chicken, pork, bananas, avocados and sweet potatoes. These also have a direct input in regulating serotonin levels which is one of the hormone involved in the production of the sleep hormone melatonin (Breus 2018). As melatonin levels are regulated back to normal, this alleviates sleeping patterns back to normal which in turn ameliorates symptoms like irritability and depression which are often experienced in menopause. Vitamin B12 (cobalamin) is said to help with metabolism, thereby increasing glucose availability in the body which impacts on systemic (mental and physical) fatigue (Airey and Houdret 2004).

2.5.3 History of homoeopathy

Homoeopathy was first developed by Dr Samuel Hahnemann in the early seventeenth century (De Schepper 2001). This is a system of medicine with a basis on the principle of “like cures like”. When Hahnemann was dissatisfied with the state of the medical system, he consequently translated medical and other texts. Dr Samuel Hahnemann conducted an experiment on *Cinchona officinalis* (Peruvian bark) after he had noticed the intriguing similarities between malaria symptoms and the Peruvian bark which was used to manage malarial symptomatology (O’Reilly 2010). From this experience he came to the innovation of the “Law of Similars” which is the first law of homoeopathy (Spence, Thompson and Barron 2005).

Homoeopathy is a holistic, gentle, deep acting, health-giving medicinal system. This medicinal system uses healing substances that do not lead or predispose patients to adverse effects like orthodox pharmaceuticals do Orthodox pharmaceuticals can conceal disease symptoms which may later reappear with an intense effect on the human system. Homoeopathy stimulates the body to heal itself from the inside to the outside. It allows healing of preceding mental and emotional effects which give rise to chronic disease distress, and thereafter eliminates the ailment completely from the body. Homoeopathy does not cause or source adverse effects but rather improves the body’s healing process which in turn enriches the quality of life (De Schepper 2001, 2006).

Kent (2007) defines homoeopathy as energy medicine which works hand in hand with the body's healing energy to reinforce it, utilising harmless, safe remedies that are selected with the patient's particular symptoms for both acute and chronic sicknesses. Homoeopathy treats the totality of a patient's symptoms from spiritual, mental, emotional to physical symptoms, therefore the most suitable chosen remedy will carry out an enhanced noticeable imprint of health before it starts acting on the illness symptoms and root causes.

According to Kayne (2003) the healing energy is very much dependent on the individual being treated, therefore homoeopathy aims not to create resistance but rather utilises natural substances to induce the body's own healing response. There are three main essential working principles in homoeopathy:

1. "The Law of Similars", likes cure likes. This means that a substance that can produce a similar symptom picture in a healthy person to the presenting symptoms of an illness is the same substance that can be used to cure that illness (De Schepper 2006).
2. "Minimum Dose". Remedies are made to standardised pharmaceutical methods and guidelines. Remedies are diluted and made into a potency which can make even a toxic substance safe to use (De Schepper 2006).
3. "Single Remedy". Hahnemann believed that a person could not suffer from more than one illness at a time, and his final principle was to use a single remedy instead of multiple prescribing. This is known as the classical approach in homoeopathy (Chauhan and Gupta 2007).

Homoeopathy is a system of natural treatment which comprehends a person as a whole. A human is composed of mind, body and spirit. Any alterations in the arrangement of these sections leads to symptom occurrence (De Schepper 2006). The main purpose of homoeopathy is to maintain balance and calmness inside the body (Chauhan and Gupta 2007).

Homoeopathy is lawfully identified as one of the primary healthcare professions in South Africa. The Allied Health Professions Council of South Africa (AHPCSA) is the regulatory body that governs homoeopathy in South Africa. The AHPCSA lists the scope of a homoeopathic doctor as follows: "diagnose, and treat or prevent physical and mental diseases, illness or deficiencies in humans; prescribe or dispense

medicine; or provide or prescribe treatment for such disease, illness or deficiencies in humans" (Allied Health Professions Council of South Africa 2015)

Types of prescribing techniques used in homoeopathy

Homoeopaths may use various prescribing techniques in practice. These may include prescribing the similimum remedy, prescribing complex remedies, using adjunctive complementary therapies such as Bach Flower Remedies, tautopathy and autosanguinous therapy (Watson, 2004).

1. Similimum

A homoeopath takes a full family and medical case history of the patient considering all the symptoms that distinguish a person as an individual, including mental, general and physical symptoms, then chooses the most important rubrics and looks for them in the repertory (which can either be via computer software or in a book). The repertory lists symptoms that have been drawn from provings or clinical experience-based cases in the form of rubrics (Bloch and Lewis 2003). The repertory provides a variety of different remedies related to each symptom and then, using a book known as a materia medica, the homoeopathic practitioner broadly explores the remedies before deciding on the most specifically suitable remedy for the patient. In order for a homoeopath to choose a remedy in a logical system they must make use of the repertory and the materia medica. Then the carefully chosen remedy which matches the symptom picture presented by the patient in terms of peculiarity and individualisation of the symptoms is then prescribed; this remedy is known as the similimum (De Schepper 2006).

2. Tautopathy

Tautopathy is a form of of homoeopathic prescription where the remedies used do not necessarily go through experimental clinical trials to explore their effects on healthy human beings, therefore this form of homoeopathy is termed indirect homoeopathy (Patel 2005). Tautopathy is a prescription method where remedies are prepared from treatment medications or biochemical toxins. This means that a remedy is made from medicine, drug or biochemical toxins that are affecting the patient. This method of prescription may be used as an adjunct to constitutional healing treatment, when a

well-defined remedy picture cannot be achieved, or if a patient has not been well since taking a certain drug prescription, or exposure to a chemical toxin or if the patient has ill-effects from vaccines. Thus, tautopathy is useful in:

- Drug withdrawal
- Treatment of side effects of prescribed medication
- When well indicated remedies fail to act
- When there is a relapse after a well indicated remedy (Watson 2004)

Very few people seem to understand that a very large part of the illnesses which are dealt with in ordinary practice may be the outcome of involuntary intoxication. Drug induced symptoms are continuously manifesting in clinical records, either due to self-administration or prescriptions by physicians who's only aim is to prescribe drugs to ensure symptom suppression without realising that they are causing drug induced symptoms. The keynote to an accurate and precise diagnosis along with good therapy relies on a well-documented case history, ensuring that there is no omission of important symptoms and drug prescription intake history (West 1958).

3. Autosanguinous

''*It is not the science of similars but that of the identicals*'' says Patel (2005). Autosanguinous is yet another type of homoeopathic prescribing method, where remedies are prepared from the patient's own disease product called a nosode (Watson 2004). The remedy is made out of the patient's own blood. A sample of blood is drawn from the patient and then potentised homoeopathically or modified by adding a homoeopathic remedy, which is then prescribed to be taken orally. In severe or chronic cases the autosanguis remedy can be administered intravenously, subcutaneously or intramuscularly.

Autosanguinous therapy is "not the science of similars but that of the identicals" (Patel 2005). An example of such therapy is drawing blood or sputum from a patient chronically suffering from TB, which is then diluted homoeopathically and then administered orally to the same patient. This method is usually used in chronic, often incurable cases and persistent allergies (Sankaran 2006; Fusion Homoeopathics 2012).

4. Complex prescribing

Homoeopathic practitioners known as classical homoeopaths follow Hahnemann's principles of prescribing, by giving only a single remedy at a time to a patient. However, a limited number of remedies may be combined and utilised successfully as a complex. Complexes are used predominantly when the practitioner is unsure of the complete disease picture matching one specific remedy, so they rather make a combination of the few remedies that fit or overlap in covering the disease pattern (Vithoulkas 1990). Another reason for using a complex is to treat more than one complaint simultaneously (Hansa 2011). The drawback of this type of prescription is that the homoeopath may not be sure as to which single remedy in the complex healed the patient. At its worst the remedy combination may cause effects at different times, so one remedy may yield a healing crisis, while another is healing the patient and the other is antidoting. Therefore, this kind of prescribing technique is not the best as it makes it difficult for the physician to look for the next remedy on a follow up, even if the healing remedy is within the combination it will not be obvious for the physician to determine its follow up potency (Vithoulkas 1990).

Complex prescribing for menopausal syndrome may be advantageous for women who do not have enough time for a consultation (Kayne 2003).

Bach flower remedies

Dr Edward Bach (1886-1936) was a physician and a bacteriologist who uncovered the utility of flower remedies to treat and manage the most commonly experienced temperamental dispositions (Kayne 1997). Bach flower remedies do not possess any harmful of habitual effects therefore may be utilised by anyone of any age, and they can be used safely simultaneously with other medication. These remedies are highly dilute and prepared from wild flowers. Their utility is aimed at restoring the body's natural vitality by repairing the emotional and mental dispositions (Chancellor 1995).

The Bach flower remedies are envisioned to heal a person as an individualised being in regard to a particular personality characteristic. They are not necessarily treatment for physical ailments, but since our bodies respond either positively or negatively to our individual way of thinking and how we feel about ourselves, they assist us to feel more optimistic, therefore our bodies are more likely to respond correspondingly

positive, and thereby re-establishg a general amelioration in our whole being. In menopause they are used and prescribed according to the presenting mental-emotional symptoms of the individual patient as they are experiencing them during the menopausal phase. The prescribed Bach flower remedy is matched to the distinct mental-emotional symptom patterns arising due to menopausal transition or active experience of menopause (Howard 2005).

Bach flower remedies relevant to menopause comprise the following:

Rock rose is prescribed for individuals who are in a terrified state, panic and ultimate fright, whether a person is in a satisfactory or competent health state or not. Individuals suffering this disposition are normally in a serious condition, therefore it is very useful when the individual's temperament condition is progressively starting to affect those around them (Chancellor 1995). A number of women experiencing menopausal symptoms go through a phase of feeling unable to cope and fear of losing control.

Impatiens is indicated for people who experience the feelings of impatience, irritability, extreme mental conflict and for individuals who are quick in mind and deed. Pain and muscular tension are signs of manifestation of mental tension. Impatiens is an effectual remedy for all reflections of pain caused by tension such as cramps, or other convulsive conditions (Chancellor 1995). It is common that women experiencing menopause suffer intense temperament fluctuations and irritability which this flower remedy may be able to soothe.

Clematis is utilised in individuals who suffer a sense of indifference, dreaminess, absentmindedness and oblivion. The people in need of Clematis have poor memory, they avoid hindrances or disharmony by allowing their thoughts to roam and by withdrawing (Chancellor 1995). Reduced levels of concentration are a common symptom in women experiencing menopause.

Star of Bethlehem is often specified for after-effects of mental or physical shock. This remedy is included with the other five indicated remedies in the Rescue Remedy and its function is to counteract shock in any form. Dr Bach termed this remedy "The comforter and soother of pains and sorrows" (Chancellor 1995). Women undergoing menopause often have a sense or feeling of vulnerability, insecurity and depressive mood that can be counteracted by the Bach flower remedies.

Cherry Plum is a remedy indicated for feelings of desperation and profound depression for those on the border of a nervous breakdown. The anguish becomes so intense that they fear their minds may give way under strain. They fear losing control over their feelings or actions and are compelled to do something frightful or commit an act which in a happier time and normal state they would not even ponder for a moment (Chancellor 1995). Menopausal women generally experience the feeling of losing control and anxiety which is the reason for inclusion of this flower remedy.

Biopuncture

This type of therapy was established by Jan Kersschot a German medical doctor who used this technique for more than 20 years in his private practice. This therapy entails the injection of biological substances including herbs and homoeopathic remedies into the specific areas that are affected. The word 'biopuncture' was formed by combining the word biotherapeutics (the [bio-] part) with acupuncture (the [-puncture] part) (Nye 2020; Vogel and Leisegang 2017).

Most of the injections are given subcutaneously and intramuscularly. Products or remedies commonly used in this therapy include *Arnica*, *Calendula*, *Echinacea*, *Chamomilla* and *Nux vomica* (Nye 2020).

Some of the important utilities of these products include *Arnica* being used for haematomas as well as myalgia, *Nux vomica* used for digestive ailments including constipation, *Ignatia* used for issues related or caused by stress and *Echinacea* used to boost the body's natural defence system. Safety of this method is ensured by using sterile equipment so to minimise transmission of communicable diseases like HIV and hepatitis. Another factor that helps promote safety of this technique of healing, is ensuring that the injecting physician is adequately trained so that they employ the appropriate technique of injection. In terms of safety of medication administered, due to the carefully prepared infinitesimal dosage medication, this enables side effects to be negligible (Nye 2020).

The mechanism of this therapy is due to administration or injection of the indicated substance at the primary site, which is then dispersed to the various parts of the body through the bloodstream, which then helps and stimulates the body to initiate its own healing mechanism in order to restore strength (Vogel and Leisegang 2017).

The following are commonly used Biopuncture products to alleviate menopausal symptoms:

Traumeel- due to the significant decline in oestrogen levels there is reduced bone protection from the normal regulatory bone metabolism, therefore there is an increased rate of wear and tear especially during or after menopause. The weight bearing joints like the knee and hip are the most affected. The excess wear and tear causes inflammation which leads an increase in pro inflammatory cytokines and decreases anti-inflammatory cytokines, which then yield prolonged inflammation and pain. Injecting Traumeel around the affected joint helps restore and regulate the cytokine imbalance which then allows for decreased inflammation thereby relieving joint pain (Heel 2008).

Coenzyme compositum- helps in restoring balance in citric acid and the Kreb's cycle, enhances mitochondrial metabolism and strengthens cellular energy supply, all of which helps alleviate systemic fatigue and moodiness in menopausal women and restores their energy to engage in their regular daily activities (Heel 2008).

Testis compositum- this contains vitamin C, enzymes and low dose testosterone. This is very beneficial when injected in the region of the ovaries which then works in the ovaries to enhance oestrogen secretion which brings about regulation of sexual functions like restoring normal vaginal fluid secretion, vaginal wall connective tissue elasticity and libido. It also aids metabolic support which in turn alleviates constant exhaustion (Heel 2008).

2.5.4 Phytotherapy

Phytotherapy is an empiric system of medicine that makes use of plant remedies which are usually intended to support the healing life-force, in disease treatment, hence is complementary to homoeopathy (Gaier 1991).

Herbs have traditionally been used to stimulate an effect on the organic physiological responses throughout the body consequently reinforcing the body's own curative powers. Herbal therapeutic reaction is strengthened by the relationship of the different constituents sourced in multiple herb formulation, unlike many other singular biochemical agents. These complementary actions or their combined action may have

diverse effects depending on the illness and constitution of the individual. Phytotherapists can achieve deep lasting effects from herbal therapy by treating both the manifestations of disease and its underlying cause. The association between clinical inspection and the understanding of plant properties must be coherently integrated to attain reliable clinical outcomes with botanical medicine (Govender 2003).

The following are herbs commonly used to stimulate and support the body during the climacteric phase:

Angelica sinensis (*Dong Quai*) has been used for many years as a tonic and spice in Chinese medicine and is a common herb that is used through the menopausal period (Bloch and Lewis 2003). The treatment of menopausal signs and symptoms which include hot flushes using *Angelica sinensis* as it seems to be very useful in toning blood vessels which in turn yield better results by relieving hot flushes (Bone and Mills 2007).

Vitex agnus-castus (Chaste tree) is used as a standard in the treatment of menopausal symptoms as well as for HRT withdrawal. Vitex agnus-castus has the same effects as a prolactin inhibitor, dopamine antagonist, galactogogue and is indirectly progesterogenic (Bone and Mills 2007).

Dioscorea Villosa (Wild yam) is known to relieve hot flushes, mild joint and muscle aches and vaginal dryness (Bloch and Lewis 2003). Its main actions are anti-inflammatory, oestrogenic and antispasmodic. Extreme dosages can cause unsettling and irritating effects in the digestive tract (Chevallier 2007).

Cimicifuga racemosa (Black cohosh) has an oestrogenic influence that contributes to a lot of the menopausal symptoms as well as symptoms resulting from ovarian insufficiency or dysfunction (Bone and Mills 2007). Recent research has presented incidents of autoimmune hepatitis in some women as a minor adverse effect from taking the herb (Nazario 2003).

2.5.5 Traditional Chinese Medicine

Traditional Chinese Medicine (TCM) is a universal term used to describe a group of medical practices which are originally from China but have spread all around the globe.

TCM includes acupuncture, moxibustion and Chinese Herbal Medicine (CHM) as the main ones and many other disciplines namely dietary therapy, t'ai chi and meditation. Haungdi, the Yellow Emperor, is thought to have written the first text titled The Yellow Emperor's Classic of Internal Medicine (the Nei Ching) as he ascended to the throne of China around 2698 BC. In this text he mainly focused on discussing medicine, health, lifestyle, nutrition and existing religious beliefs (Kayne 2002; Micozzi 2001).

The TCM approach is to eliminate early disease development by re-establishing co-ordination and balance within each patient according to the holistic principle. In TCM, menopause is understood as a combined category of oestrogen along with other essential hormone deficiencies and substance essence (*Jing*). *Jing* is said to be stored in the kidneys as a physiologic function and substance. Since *Jing* is the foundation of yin and yang, in menopausal syndrome it is then correct to say that menopause symptoms manifest as a result of derangement of *Jing* which leads to a functional imbalance between yin and yang. Disproportion between these two allows appearance of symptoms such as hot flushes seemingly the most prominent and troublesome which are a result of yin's failure to counteract yang properties (Kwee *et al.* 2007).

Yin and yang

Emperor Fu His formulated the duality symbol known as yin and yang which is used to depict that life comprises two opposites that bestow meaning on one another. This symbol was then taken to represent the foundation of Chinese medicine where yin represents a negative state which is associated with cold, dark, stillness and passiveness; and yang representing a positive state with heat, light and vigour (Kayne 2002; Novey 2000).

The five elements (wu xing)

Kayne (2002) explains that Chinese philosophy relates five elements to body organs in representation of the cycle of life. The five elements are wood, fire, earth, metal and water, they comprise both tangible and intangible essential elements within the body, however the first three elements possess energy and spirit qualities recognised as the three treasures/vital components.

Commonly used herbs in TCM for the treatment of menopausal symptoms

In a double-blind and double-dummy randomised placebo-controlled study, 31 Dutch women were observed over a period of 12 weeks plus 4 weeks of non-treatment follow-up observation to evaluate the effectiveness of CHM on menopausal symptoms in contrast to HRT and placebo. It was concluded that *Zhi Bai Di Huang Wan* (a Chinese herbal combination of *Anemarrhena, Phellodendron,* and *Rehmannia*) is effective in the reduction of the extent and frequency of menopausal symptoms including hot flushes and night sweats. The herb reduces heat by stimulating the production of fluids which counteracts the effect of heat, thus reducing the extent occurrence of hot flushes and night sweats (Kwee *et al.* 2007).

Astragalus (*Astragalus spp*) is another famous tonic herb from China. In traditional Chinese medicine it is known to tonify the blood and spleen and support the defensive chi. It is used in combination with other herbs to enhance and stimulate recovery after prolonged stress and for healing of distressed organs (Liao *et al*. 2018).

Licorice root (*Glycyrrhiza glabra* and *G. uralensis*) is another popular herb in China. Licorice is said to be the only herb to elicit beneficial effects on all 12 meridians (channels that carry blood and energy throughout the body by linking organs and basic qualities) in Chinese medicine. This herb strengthens and induces immune system functioning and also has a stimulatory effect on the adrenal cortex, thus allowing it to express its cortisol like properties that contribute in the reduction of weight gain rate by controlling glucose metabolism and reducing inflammation (Frank and Painter 2009).

Schisandra (*Schisandra chinensis*) is ordinarily used as a common tonic that promotes liver health. Its use can be expanded to being a tonic that counteracts stress and exhaustion. It has regulatory effects for insomnia and neurasthenia, and recovers mental synchronisation and physical endurance. It helps normalise blood glucose levels, tone down blood pressure and regulates temperature thereby reducing the frequency of hot flushes and unsought frequent sweats (Frank and Painter 2009).

Jiaogulan (*Gynostemma pentaphyllum*) is known to have blood pressure regulatory effects, immune system booster, improving fat metabolism and maintains normal cholesterol levels (Liao *et al.* 2018).

2.5.6 Ayurvedic medicine

Ayurveda is described as "*the science of life*''. It is the oldest in the world's health care history and is well known as the traditional medical system in India. This type of medicine has been around for about 10 000 years. All information regarding the origin of Ayurveda is documented in *The Vedas,* the sacred texts of India (Novey 2000).

In Ayurveda diseases are considered to be an imbalance in the body system and their healing process involves various techniques in order to restore optimal function and equilibrium. A considerable number of Ayurvedic practitioners also employ treatment methods including nutrition, yoga, exercise, compound herbal medicines and surgical techniques comparatively as therapies and dynamically for conservation of health (Airey and Houdret 2004).

Determining the individual constitution and the root of illness

It is believed that each person has a unique constitution they are born with which is an inherited balance of the three doshas (*Vata, Pitta and Kapha*). This inheritance is what determines the person's body type and personality, and determines the constitutional disease predispositions. In order for an Ayurvedic practitioner to begin treatment they need to first understand the individual's constitutional nature. From that they try to understand the disease nature and pattern according to the presenting disturbance in the dosha balance and the *ojas* which is the body's ability to withstand pressure or stress. The causative nature of illness is understood in relation to lifestyle and surrounding environment effects which initiate dosha imbalance (Novey 2000).

Doshas are the most essential part of the healing technique in Ayurveda. It is believed that the body is constituted by three major divisions:

- The three doshas which are formulated from the five basic life elements (namely air, ether, fire, water and earth) (Novey 2000).
- Seven tissues (*dhatus*) (Micozzi 2001).
- Three (*malas*) waste products (Micozzi 2001).

Health is believed to be a product of the balance of the three doshas, the seven tissues, the three waste products, gastric fire altogether with mental clarity and harmony, senses and spirit. The five basic life elements and senses combine together

to make up the three doshas. These elements are the ether, air, fire, water and earth. Each of them signify different senses including hearing and speech, touch, sight, taste and smell respectively (Kayne 2002; Novey 2000).

The three doshas

- Vata is made up of ether and air, which is responsible for all body kinetics as it represents the nervous system and is in control of emotions like fear, as well as providing principal protection to health. Vata is representative of the large intestines, pelvic cavity, skin and ears (Airey and Houdret 2004).
- Pitta comprises fire and water. This dosha principally governs digestion, nutritional absorption, skin pigmentation, cognition and comprehension which in turn gives rise to feelings of jealousy and hate. Organs included in pitta are the small intestines, stomach, blood, eyes and skin (Airey and Houdret 2004).
- Kapha results from the combination of earth and water, which becomes the biological water principal. Kapha governs the body's resistance and biological power, encourages wound healing and cognition support which ultimately gives rise to greed, envy and love (Kayne 2002).

In Ayurvedic medicine menopause is regarded as the vata stage with some changeable pitta signs since it is a transition from young to old. Apanavata is a key dosha that governs the pelvic region with its organs and the organ functions which includes elimination of waste products and menstruation. In order to successfully manage menopause with Ayurveda, one must give more attention to this dosha. It is also said that women living a modern life aggravate the vata dosha because they neglect the natural way of living by eating more processed foods (Kamini and Dhiman 2013).

Commonly used herbs in Ayurveda for the treatment of menopausal symptoms

Asparagus racemosus (*Shatavari*) has always been used as an aphrodisiac, it stimulates rejuvenation, psychological and physical health. In menopause, it ameliorates hot flushes, grumpiness, vaginal discomfort and excessive night sweating. It decreases the rate of developing candida by proliferating the number of circulating leukocytes and enhances macrophage activity. It calms down the Pitta dosha

abnormalities in the body. *Shatavari* is usually used for normal female issues including amenorrhoea, delayed menarche, females with medical history of stillbirths or with frail children, and with general issues comprising of diarrhoea, polyuria and skin depigmentation. *Shatavari* acts as a diuretic, antispasmodic, hypotensive and as a general female tonic. It helps slow down bone loss/ resorption by stimulating bone formation thus accumulating bone mass. This proves that this herb is very useful in minimising the rate of developing menopausal osteoporosis (Gujarathi and Gujarathi 2010).

Triphala (means "three fruits" and those are *Haritaki*, *Amalaki* and *Bibhitaki*) is an organic digestive tonic which works best by improving digestion, assimilation and elimination; when one of these digestive properties is out of balance then this allows for build-up of toxins in the gut system leading to impurities like skin breakouts, bloating, fatigue, constipation, dysmenorrhoea and melancholy. This herb balances the Vata dosha (Maharishi Ayurveda 2013).

Bacopa monneiri (*Brahmi*) is used to alleviate conditions including stress, post-natal depression, anxiety, attention deficit disorder (ADD) and epilepsy. It is a major product of some memory tonics. Stress, anxiety, menstrual disturbances, hair loss and fatigue are a few conditions of which the herb may be prescribed for. It nourishes blood cells and helps eliminate toxins. This herb is a tranquilliser which improves coordination of the nervous system thereby improving overall brain functioning and mental capacity. It enhances calmness and relaxation, relief from tension headaches and emotional fluctuations (Chauhan 2020).

Angelica sinesis (*Dong qui*) is normally used to help with gynaecological issues, like regulation of menstruation, toning blood and constipation amelioration. Prescription is based on individual constitution (Kayne 2002).

Gold is prescribed due to its exceptional effect of strengthening the nervous system. This element is best used in Ayurveda for its properties to relieve arthritis as it has the ability to reduce rheumatic factor which alleviates immunological responses. It also supresses the release of histamine as a response to anaphylactic stimulation. The maximum prescription dose for gold is 15 mg per day (this is usually in powder or tablet form) (Airey and Houdret 2004).

Silver possess cooling properties therefore is beneficial in counteracting pitta. This element contains traces of free sulphur, sodium, potassium and aluminium which are all nutritive and beneficial elements to the body especially the bones. The normal dosages for this prescription ranges from 30 to 120 mg (Galib *et al.* 2011).

Iron assists with anaemia thus is valuable for bone marrow. These substances are converted into powder form before they can be potentised to minute doses suitably safe for human consumption. Iron is effectively used in debilitating conditions when the blood is depleted of iron. It restores the life and function of organs. Iron contains traces of phosphorus, magnesium, potassium and calcium which strengthens its effects on bones. Its purified form is useful in conditions that cause inflammation, oedema and jaundice. Its recommended prescription dose is between 30 to 240 mg (Galib *et al.* 2011).

Ashwaganda (*Withania somnifera*) is commonly called Indian ginseng, being grouped with the ginsengs because of its similar actions. It is considered a tonic, a nervine and a sedative. Ashwaganda has been used in Ayurvedic medicine for more than 2,500 years and has been found to work wonders in menopausal psychological complaints which include anxiety and stress control as well as being an immunomodulatory adaptogenic herb (Frank and Painter 2009).

2.6 THE EFFICACY OF HOMOEOPATHIC TREATMENT OF MENOPAUSAL SYNDROME

Domleo (2002) conducted a study to determine the effectiveness of *Folliculinum* 30CH in the treatment of menopausal symptoms in terms of the participants' perception, using questionnaires. There was no overall improvement in the participants who received treatment compared to those that received placebo. The only symptoms that improved within the treatment group were the psychological symptoms in the Greene Climacteric scale and the number of hot flushes. These two variables are the most common reason for treatment requests during menopause and have the most negative impact on quality of life as they cause insomnia and psychological symptoms.

Macquet-Maurel (2003) conducted a study to determine the efficacy of *Dioscorea villosa* cream in the treatment of menopausal symptoms in terms of subjective data. Thirty female subjects were selected to participate in the study, of which 15 were

placed in the treatment group and 15 in the placebo group. Inter group comparison procedures revealed no difference between treatment and placebo groups after treatment, however intra group comparison displayed significant improvement in the depression, anxiety, somatic and sexual symptom scores within the treatment group. Similar improvements were observed in the placebo group that could be due to the common base ingredients that were present in both treatment and placebo creams or due to the placebo effect. It was also concluded that this trial showed no difference between the efficacy of this cream in terms of subjective data given by the participants.

McTeer (2003) conducted a study to determine the efficacy of *Dioscorea villosa* cream in the treatment of menopausal symptoms in terms of subjective and objective data. The study included 30 participants, 15 of which were placed in the treatment group and the remaining 15 in the placebo group. The ProgestoNat Cream® was shown to be effective in treating vasomotor symptoms of menopausal syndrome. This is valuable in that these symptoms have the most negative impact on quality of life.

Hagen (1995) conducted a study to determine the effectiveness of the homoeopathic similimum on the menopausal syndrome in terms of the patient's perception of treatment using the Psychological General Well-Being Index (PGWBI), the patient's perception of treatment and a hot flush questionnaire. The study included 30 participants, 15 of which were placed in the placebo group and the remaining 15 in the treatment group. The treatment showed a 33% greater improvement in anxiety, depression, well-being and vitality than the placebo group according to the scores of the PGWBI questionnaire and the hot flush questionnaire before and after treatment. The treatment group showed a 40% greater improvement over the placebo group, this included significant improvement in vasomotor, emotional and other symptoms.

Hansa (2011) conducted a study to determine the efficacy of a complementary formulation of *Folliculinum* D6 and Five-Flower Formula™ in the treatment of menopausal symptoms in terms of participant's perception of the treatment. The study included 60 participants, of which 29 were placed in the treatment and the remaining 31 were put on the placebo group. Inter-group comparison procedures revealed improvement yet this improvement was not statistically significant. The only symptoms that improved in the treatment group were the hot flushes and psychological symptoms

however, there were no significant differences between the treatment and placebo group.

It was concluded that the complementary formulation of *Folliculinum* D6 and Five-Flower Formula™ was not statistically effective in the treatment of menopausal symptoms in terms of the participants' perception of the treatment.

2.7 SUMMARY

Menopause is an androgen-dependent induced disease of the endocrine neurological, and dermatological and musculoskeletal systems, affecting women from middle age to menopause. This disorder includes psychosocial implications due to homoeostatic derangement of the essential hormones, therefore counselling should be incorporated into requirements for each woman (Govender 2003). Morley and Perry (2003) state that menopause is a source of distress with substantial psychological and social impact. There has been a considerable decline in the syndrome's morbidity due to an enormous increase of knowledge available and understanding of the syndrome as well as effective treatment options and referrals from other physicians. If there is prompt and effective treatment with consistent review and referral, the conventional medicine pharmaceutical and psychological effect of this collective and damaging menopausal syndrome may be reduced hence ensuring long-term benefits for the patient.

According to Tan, Vasey and Fung (2001), the delay in seeking medical attention for menopause is usually an obstacle to cure and it is necessary that there is timely intervention to prevent the risk of bone fragility which may lead to bone fracture, hypertension as well as cardiovascular disorders and other consequences. Accessible, truthful, community based education on the natural history of menopause, pathogenesis, risk of remnant, the effectiveness and anticipated period of treatment, and the importance of prompt medical attention, is essential for a thorough understanding and elimination of the disease symptoms. Due to the limited amount of information at present, there are accumulative misapprehensions on the of patient's sufferings causatives as well as their understanding of their illness. Therefore integrating data on treatment according to preferences (in terms of extent and gender), patient contribution on treatment choice can be assisted by the physician's input,

comprehension of treatment alternatives enhanced and patient compliance. This then would yield better results during and after treatment.

CHAPTER 3: MATERIALS, DESIGN AND METHODOLOGY

3.1 INTRODUCTION

Qualitative research allows for gathering of non-numerical data in its own right by crosscutting discipline, fields and subject matters (Denzin and Lincoln 2011). This type of research aims to interpret the data collected in order to understand a particular focus population or a community. There is a variety of methodological categories that fall under qualitative research which include interviewing, participant experimental observation and visual methods to mention a few. Qualitative research is used to respond or find solutions to research questions, since it enables the researcher to gather patient perceptions and experiences on treatment and care provided within the healthcare system, as suggested by Holloway and Wheeler (2010). Qualitative research methods allows information to be presented and interpreted as it arises from its original setting (Denzin and Lincoln 2011).

3.2 STUDY DESIGN

This study paradigm was of a qualitative nature using a descriptive and exploratory design. An exploratory study was best suited for this topic as the researcher aimed to ascertain the treatment regimens of practising homoeopathic practitioners through semi-structured interviews. The researcher thought that a semi-structured interview with the research participant would provide an open space for conversation (Kidd 2011), in which the thoughts and perceptions on how the participant usually manages menopausal syndrome could be attained. The semi-structured interview conducted with individual research participants was audio recorded, and later on transcribed and analysed using Tesch's eight steps analysis. A minimum of 12 participants was selected using purposive (snowball) sampling (Terre Blanche, Durrheim and Painter, 2006) in the area of eThekwini. In utilising this method, it was expected for the unorthodox to be done: to begin with the area of the study and allow for what is relevant to emerge (Tesch 1990). This did, in turn, improve the rigour of the analysis process by validating (or not) some of the researcher's own impressions of the data.

3.3 DRAWING UP THE SEMI-STRUCTURED INTERVIEW GUIDE

A semi-structured interview was conducted with every individual participant of the study. An interview guide was drawn up (Appendix C). The interview guide consisted of two sections and each participant was required to answer all of the questions reflected in each section. The first section was titled: **Grand Tour Question**, and the question was: How would you describe your approach to patients presenting with menopausal syndrome?

The second section was titled: **Sub-Questions** which consisted of five questions as follows:

1. Describe your understanding of menopausal syndrome.
2. Explain how you diagnose menopausal syndrome?
3. What is your therapeutic approach to managing patients with menopausal syndrome?
4. What type of homoeopathic treatment do you prescribe for patients presenting with menopausal syndrome?
5. What additional modalities do you employ or recommend for patients presenting with menopausal syndrome?

3.4 STUDY LOCATION

This study was conducted throughout various areas in eThekwini; the researcher visited the participating practitioners in their own private practice areas. The researcher noted that the study was particularly dominated by English speaking participants and of the Indian and White ethnic groups. Furthermore, their practices are in the major areas of eThekwini including Berea, Glenwood, Windermere, Bluff and Hillcrest.

3.5 STUDY POPULATION

The study participants were derived from the practitioner register of the Homoeopathic Association of South Africa (HSA) website from where their email addresses were extracted This website is in the public domain, so the researcher was not in breach of the Protection of Personal Information Act. The population for this study were all registered homeopaths practicing in the eThekwini in KwaZulu-Natal region.

Inclusion Criteria

- Homoeopaths registered with the Allied Health Professions Council of South Africa with a valid practice number.
- Be practicing in eThekwini.
- Must have been practicing for a minimum of five years in a private practice and had experience with menopause (have treated or managed menopause before in practice).
- Full-time and part-time (even those with additional jobs) practitioners.

Exclusion Criteria

- Refusal to sign the letter of informed consent.
- Not registered with the Allied Health Professions Council of South Africa.
- Practicing out of eThekwini.
- Less than five years in a private practice.
- No experience of treating or managing menopause in practice.

3.6 RECRUITMENT OF PARTICIPANTS AND SAMPLING PROCESS

Participants who responded to the researcher's email notice on the study were contacted to confirm that they met the inclusion criteria then an appointment was scheduled with these potential participants.

The researcher provided all participants with a full explanation about the study by means of an information letter and verbal explanation at the appointment, after which a consent form was signed by the participant. Participants were made aware that they could discontinue participation at any point without having to explain why.

Purposive (snowball) sampling (Terre Blanche, Durrheim and Painter 2006) was employed to select participants. This type of sampling is described by Ulin, Robinson and Tolley (2005) as "a technique for locating information by asking others to identify individuals or groups with special understanding of a phenomenon". The investigator asked each participant to suggest others with similar ability to address the issue (Ulin, Robinson and Tolley 2005). Although this approach introduces bias, it allows people with knowledge and experience within the field to propose candidates who would have

similar experience. This method of sample selection was chosen so as to obtain rich data from experts in the topic being investigated. However, it was noted that the data collected become repetitive, indicating saturation, and the researcher felt satisfied that the situation had been thoroughly explored, hence no additional interviews were conducted (Terre Blanche, Durrheim and Painter 2006).

3.7 SAMPLE SIZE

The researcher conducted interviews until saturation of data was reached (Guest, Bunce and Johnson 2006) which was at the 12 participants. Data saturation is reached when data collected becomes repetitive, indicating that the situation had been thoroughly explored, hence no additional interviews are necessary (Terre Blanche, Durrheim and Painter 2006). Mason (2010) states that samples for a qualitative study are generally much smaller than those of quantitative studies.

3.8 DATA COLLECTION INSTRUMENTS

Data collection instruments are the tools used for gathering data. It is the researcher's responsibility to ensure that the tool chosen is valid and reliable (Holloway and Wheeler 2010).

- **Trustworthiness and confirmability** was ensured by allowing the participants to answer questions using different methods and ensuring member-check whereby the researcher gave the participant the chance to review data collected and interpretation of the data by the interviewer, as this allowed the participant to verify and fill in gaps in their answers (Graneheim and Lundman 2004).

- **Credibility** of the study was ensured by the researcher discussing the research process and the findings with the supervisor who is qualified and competent in the field. This provided insight into aspects which the researcher may have missed. The researcher used field notes and an audio recorder to collect data. The researcher transcribed the data, and also ensured that the transcribed notes were a true and original reflection of the participants' experiences and knowledge.

- **Reliability and validity** in the study were insured by using an interview guide (Appendix C) to gatherer all participant's responses which were then analysed and were found to have similar themes and subthemes which verified the guide's validity and reliability (Muhammad, Muhammad and Muhammad 2008).

- **Dependability** was ensured by maintaining an audit trail through safe keeping of original data of each interview for reference purposes.

- **Transferability** was facilitated by the researcher offering a clear description of the context, selection of participants, data collection and the progression of data analysis

3.9 ETHICAL CONSIDERATIONS

An approval letter (Appendix E) was obtained from the Institutional Research Ethics Committee (IREC) at the Durban University of Technology (DUT). Permission to conduct the study/interview was granted by each participant visited by signing the informed consent (Appendix B). The study was explained in the information letter (Appendix A).

During data collection, participants were assigned numbers which only the researcher had access to. These numbers denoted their personal details and no names were mentioned at any point. Confidentiality was maintained even on the final dissertation.

- All participants were given a letter of informed voluntary consent (Appendix B) and a letter of information (Appendix A) prior to the commencement of data collection and were free to withdraw from the study at any time.

- **Confidentiality** of all participants was maintained at all times. No personal details of participants were required to be recorded as each participating practitioner was assigned a unique code. Only the researcher and her supervisor have access to the information collected which was electronically saved and is password protected. Physical files are stored in a locked cupboard in the homoeopathy department (Polit and Beck 2012).

- **Autonomy** was accomplished by requesting potential participants to sign an informed consent form as an indication of voluntary participation. Before signing

they were allowed time to think and understand what they were being asked to do and then decide whether or not to participate after making a reasonable judgement on the effect which participation may have had on them (Khumalo 2015).

- **Beneficence** was ensured by the researcher emphasising the benefits (included in Appendix A) to the participating practitioners and that the results of the study would be to their benefit through expanding and enhancing their management techniques and strategies for menopausal syndrome (Khumalo 2015).

- This study did not include any kind of drug or medicinal administration therefore maleficence was significantly minimised as no harm was caused to participants.

3.10 DATA STORAGE AND MANAGEMENT

Data collected was kept in a safe, protected area for the duration of the research and is now stored in a locked office at the Homoeopathy Department at the Durban University of Technology. Permission to access the stored data will only be granted to the researcher and her supervisor. After five years this data will be shredded or destroyed.

collection is one essential aspect of any research study. It has been noted that gathering data from various sources and procedures, resourcefully and efficient to the issue being discussed, results in very much enriched and all-inclusive data that produces a clear bigger picture of the issue being studied (Ngobese, 2018). In this respect, Johnson and Christensen (2004) recapitulated that the selection of data collection technique method used in the study must be based on the level which will allow the researcher to acquire information essentially enough to answer the research question and generate a full clear picture of the issue being explored.

Data collection in this study was accomplished when saturation point was achieved. Data saturation is a key tool to show and ensure that satisfactory data was collected to support the study (Johnson and Christensen 2004). This was noted and supported by the researcher and the supervisor in trust (Holloway and Wheeler 2010).

Once the population sample had been selected, each practitioner was approached to participate in the study, via email. Upon agreeing to participate, a letter of information (Appendix A) was then given to the participant prior to the interview, informing each participant of the nature of the study. Thereafter a consent letter (Appendix B) was also given and required to be signed allowing the researcher to gain informed consent from each participant. Herein it will also be stated the anonymity of the study. Khumalo (2015) states that the semi structured interview ought to be conducted in a hushed and confidential space to allow practitioners comfortability and diplomacy so to allow them to feel unrestricted to discuss relevant topics without any interruptions. Participation was strictly voluntary; no participant was obligated to take part in the study or given encouragement for their participation. Furthermore, participants were free to withdraw from continuing the interview at any stage without giving any reason to the researcher.

Thereafter the researcher set up a time to meet with the participating practitioner who met the inclusion criteria – at the convenience of the practitioner. A voice recorder was utilised for the recording of the interview to assist in the collection of data from the practitioner. At the commencement of the interview which approximately lasted five to ten minutes, the grand tour question was asked with subsequent sub questions to assist the researcher in attaining information required. Once data saturation had been reached, all information was transcribed from the interviews recorded and chronicled in separate word files – as per each participant.

Observational data was also gathered by the researcher on an uninterrupted and proceeding basis, whereby the interview setting and non-verbal conduct of participants were included. The understanding and comprehension of the participant's experience beyond verbal clarification was recorded in field-notes by the researcher immediately after the interview as possible (Padgett 2012).

Polit and Beck (2012) state that data collection progression can carry on until data saturation has been reached or a paramount sample size has been met. Saturation is achieved when each category is abstractly dense, when differences in data are distinguishable and explainable, and when no new data pertinent to the existing categories arises during collection (Khumalo 2015).

3.11 DATA ANALYSIS

In order to identify the emerging themes, the researcher followed Tesch's eight steps to qualitative data analysis as well as Creswell's data analysis (Creswell 2009).

Tesch's eight steps for data analysis are:

1. Get a sense of the data as a whole by reading through all the data carefully. By doing this, the researcher is able to get the necessary background information. When something comes to mind about the data, the researcher writes these ideas down.

2. The researcher starts with one document and while going through it, asks themselves 'What is this about?' The question does not refer to the content of the document, but to the topic. These topics are written in the margin of the document.

3. In due course the researcher makes a list of all the topics, one column per data document, placing all the columns on the same sheet. All the topics are reviews and similar topics are grouped together.

4. Abbreviate these topics as codes. With this list of codes, the researcher goes back to the data and writes the codes next to the appropriate segments of the text. Be open for new categories and codes that may emerge. When any ideas about the data come to mind, the researcher writes this down in their notes (analytic memos).

5. Find the most descriptive words for the topics, which then become categories. Reduce the categories by grouping together those that relate to each other. Look for subcategories. A 'normal' number of categories is between 20 and 50.

6. Make a final decision on the abbreviation of each category and alphabetise the codes to ensure that no duplication occurs. The researcher must remember that categories have fuzzy boundaries and a segment of data can fit in two or three categories.

7. Put the data belonging to each category together and perform a preliminary analysis, looking at all the material in one category at a time. Focus on the

content of each category. During this process, the researcher keeps the research question in mind in order to discard irrelevant data.

8. When it is necessary, the researcher recodes the existing data. The organising system helps the researcher to give structure to their research reports.

Creswell's (2014) approach to data analysis is presented as a linear, hierarchical process. The six steps are interrelated and do not necessarily follow in the order they are given.

1. **Organise and prepare the data for analysis-** This refers to the transcribing of the interviews and the sorting and arranging of the data when different sources of information were used.

2. **Read through all the data-** By doing this, the researcher gets a general sense of the information and possibly its overall meaning so that the researchers can write down general ideas about the data.

3. **Coding of the data-** This is the process of organising the data into chunks of information and writing a word that represents a category in the margin.

4. **Description of the setting or people and categories or themes for analysis-** During the coding process, the researcher gives detailed descriptions of the setting or the participants involved as well as descriptions of the categories or themes for analysis.

5. **Present the results of the analysis-** This was is done in a narrative passage to convey the findings of the analysis. It may include a chronology of events, a detailed discussion of several themes or a discussion of interconnecting themes.

6. **Interpretation of the results of the analysis-** The aim is mainly to answer the following question: 'What were the lessons learned?'

3.12 Summary

This chapter presented the qualitative method chosen. It defined the snowball sampling of respondents, data collection methods and data analysis tools. The sample consisted of 12 interviews.

CHAPTER 4: RESULTS AND DISCUSSION

This chapter presents the outcome of the data gathering process, reports the results and then discusses the findings obtained from the semi-structured interviews. Data that emerged from the interviews were deductively coded and thematically analysed. All analysis was performed using NVivo version 11.

4.1 SOCIAL-DEMOGRAPHIC INFORMATION OF THE PARTICIPANTS

The biographical information of the participants are detailed in this section.

4.1.1 Participants age

Table 4.1 describes the minimum, maximum, and mean age of the participants. The minimum age indicated was 34 years while the maximum age was 64 years. Overall, the mean age indicated was 43.6 ± 8.

Table 4.1: Mean age of the participants

	N	Minimum	Maximum	Mean	Std. Deviation
Age	12	34.00	64.00	43.6	8.0

4.1.2 Gender

The gender of the participants is shown in Table 4.2. The majority (n = 9, 75%) were females, with males in the minority (n = 3, 25.0%).

Table 4.2: Gender of participants

		Frequency	Percent
Gender	Male	3	25.0
	Female	9	75.0
	Total	12	100.0

4.1.3 Occupation

Table 4.3 shows that the majority (n = 11, 91.7%) were homoeopaths and n = 1 practiced as both a homoeopath and an acupuncturist.

Table 4.3: Participant's occupation

		Frequency	Percent
Practice	Homoeopaths	11	91.7
	Homoeopaths/Acupuncturist	1	8.3
	Total	12	100.0

4.1.4 Practice location

The locations where participants practiced is detailed in Table 4.4. Half (n = 6, 50%) of the participant's practices are located in central Durban.

Table 4.4: Participant's practice location

		Frequency	Percent
Area	Berea	2	16.7
	Morningside	1	8.3
	Hillcrest	1	8.3
	Durban	6	50.0
	Bluff	1	8.3
	Kloof/Glenwood	1	8.3
	Total	12	100.0

4.1.5 Years of practice

The number of years which the participants had been practicing homoeopathy are shown in Table 4.5. The minimum years of practice was 10 years while the maximum years was 21. Overall, the mean years of practice was 13.9 ± 3.2.

Table 4.5: Participant's years of practice

	N	Minimum	Maximum	Mean	Std. Deviation
Number of years in practice	12	10.00	21.00	13.9	3.2

4.2 EMERGING THEMES AND SUBTHEMES FROM THE SEMI-STRUCTURED INTERVIEWS WITH PARTICIPANTS

Analysis of data gathered from the semi-structured interviews identified the themes and subthemes highlighted in Table 4.6.

Table 4.6: Identification of themes and subthemes

Themes and subthemes
Theme 1: Understanding of menopausal syndrome from a homoeopathic perspective
Subtheme1: Menopausal symptoms and diagnoses
Theme 2: Homoeopathic approach in the management of menopausal syndrome
Subtheme 1: Constitutional and phytotherapy remedies
Subtheme 2: Blood and medical screening
Subtheme 3: Recording of symptoms
Theme 3: Homoeopathic treatment regimes in the management of menopausal syndrome
Subtheme 1: Treatment regimes
Subtheme 2: Dosage and administration
Theme 4: Supplementary modalities for the management of menopausal syndrome
Subtheme 1: Diet and lifestyle changes
Subtheme 2: Herbal remedies
Subtheme 3: Chinese medicine
Theme 5: Advantages of homoeopathic treatment approach over hormone replacement therapy

Themes were identified in line with answering the research questions which were:

1. Describe your understanding of menopausal syndrome.
2. Explain how you diagnose menopausal syndrome?
3. What is your therapeutic approach to managing patients with menopausal syndrome?
4. What type of homoeopathic treatment do you prescribe for patients presenting with menopausal syndrome?
5. What additional modalities do you employ or recommend for patients presenting with menopausal syndrome?

In addition, and in supporting the discussion on themes, relevant quotes from the data generated from the interviews are used in this chapter. The semi-structured interviews were transcribed verbatim. The names of participants have, however, been changed to ensure anonymity.

4.2.1 Theme 1: Understanding of menopausal syndrome from a homoeopathic perspective

In order to inform the homoeopathic approach in the management of menopausal syndrome, it necessary to understand the interpretation of menopausal syndrome from the perspective of practicing homoeopaths. Makara-Studzińska, Kryś-Noszczyk and Jakiel (2014) define menopausal syndrome as a time of many changes in the psychological-social functioning of women, with reduced ovarian hormonal activity and oestrogen levels. Consistent with this view, one of the participants noted that menopausal syndrome is a transitory period in the body that is associated with hormonal changes. According to the participant, these changes could be a shift from motherhood into an intellectual in-depth emotional being.

> It shifts you from a state of not being a mother, leaving from a sexual being to an intellectual in-depth emotional being, it's also a time when females they've got that emptiness because by now kids are leaving home or they would go back to just being the wife rather than having the title of being a mother which takes so much of their time, so there's a lot of shifts and a lot of changes. (P2)

The above participant observed that the transitory changes are not only on the physical, but also on the mental and emotional levels. Echoing similar sentiments, another of the participants sees menopausal syndrome as a transition to power where women are trying to break away from physical reproduction.

> The menopause is supposed to be transiting to power so it's breaking free from the physical reproduction, to a new age. (P7)

Furthermore, another of the participants described menopausal syndrome as the body reacting to physiological changes going on in the body allied to physical, emotional or environmental changes.

> With any change in our body, our body is going to react whenever it's a physical or emotional or environmental change, so with menopause there is a physiological change that's going on in our body (P3).

Overall, and drawing from the participants' interpretation and or understanding of menopausal syndrome, it can be surmised that menopausal syndrome is a transitory period as a result of hormonal changes in the body which consequently lead to

physiological and emotional changes. Accordingly, menopausal syndrome is viewed as a necessary rite of passage for every woman, although the symptoms may vary from individual to individual.

> It's a necessary rite of passage that everyone has to go through and some women will have less symptoms and won't need much treatment. (P7)

(a) Subtheme 1: Menopausal symptoms and diagnoses

From the previous section, it is noted that menopausal syndrome causes both physiological and psychological changes in the body. This is in agreement with Andrade *et al.* (2019) who state that the menopausal condition may prove a serious psychological challenge for women, and thus lead them to seek relief in medical appointments and the use of supplements. Given this concern, effective diagnosis of menopausal syndrome is vital in the management of menopausal syndrome. Thus, the symptoms presented by patients during consultation becomes very important in diagnosing women showing the signs of menopause. As stated by one of the participants:

> I think the primary reason why people come in and ask your assistance is regarding the hot flushes it tends to annoy them, tends to affect their daily life functioning a lot of times in some way it becomes a legitimate problem where we find sometimes there's sweating, drenched their clothes its variable from person to person. (P4)

The importance of effective diagnoses was echoed by another of the participants who emphasised on differentiating menopause and perimenopause. The participant noted that perimenopause is an early sign of menopause where the patients can still be menstruating but will find that their menses are irregular. The participant pointed out the following:

> They won't get their period for 3 or 4 months and they bleed again, they'll have all the symptoms of perimenopause and menopause like weight gain, moodiness, irritability, aggression, depression, hot flushes. (P6)

This is consistent with Macías-Cortés *et al.* (2015) who refer to the perimenopause period as the interval when women's menstrual cycles become irregular and they are at increased risk of depression.

If patients are getting hot flushes and sweating profusely while sitting in an air conditioned room, this is indicative of menopause. Another distinguishing symptom of perimenopause and menopause is painful intercourse and recurrent urinary tract infections. This is reflected below.

> The other thing is that physically we notice that there's painful intercourse because during menopause they have decreased lubrication in the vaginal area, they have recurrent urinary tract infection because of that, they have micro-tears in the vagina during intercourse and that's one of the reasons why they don't want to have intercourse. (P6)

Expanding further, another of the participants noted the following menopausal symptoms:

> Menopausal syndrome that's the start where menses start to go a bit haywire and expecting the night sweats particularly and a lot of people have trouble with that and they wake up to actually have to change their bedding and the grumpiness that can come with it and often weight gain, sort of tiredness so what I'd often do is also check their thyroid because there's quite a lot of overlap because a lot of underactive thyroid crop up around about menopause. (P10)

Further to this, it was noted that when a patient has not had periods for a period of 12 months and are not on any injection or contraceptives, it may be presumed as being menopausal. In order to verify this, one of the participants noted to send the patients for hormonal screening.

> Send for hormonal screening to check for reproductive hormones, to check if the eggs are still there, and are still producing hormones. (P8)

Drawing from the above narrative, one can gather that menopausal syndrome may present clinical (hot flushes, irregular periods) and emotional symptoms (angry, irrational mood). This is in agreement with Gupta *et al.* (2019) and supported by one of the participants who noted the following:

> I would diagnose it mainly by the clinical symptoms and signs, the common and hot flushes, irregular periods or the cessation of menses and I can add all the mental and emotional symptoms like getting angry, irrational mood. (P7)

4.2.2 Theme 2: Homoeopathic approach in the management of menopausal syndrome

Although the traditional approach to the management of menopause in women such as HRT have been reported to effectively provide relief to menopausal symptoms, there are, however, concerns that HRT may increase the risk of breast and ovarian cancers (Hansa 2011).

Given the above concerns, the use of complementary and alternative medicine (CAM) is gaining considerable recognition and popularity in management of menopausal syndrome. Several observational and randomised clinical studies (Clover and Ratsey 2002; Bordet *et al.* 2008; Gupta *et al.* 2019) have reported the positive role of homoeopathy in alleviating menopausal complaints and improving patients' quality of life. Although homoeopathy may offer a safe and clinically effective intervention, nonetheless, it remains under-researched particularly in the management of menopausal symptoms (Thompson and Relton 2009). Bearing this in mind, the participants were asked to explain the homoeopathic approach in the management of menopausal syndrome in their practice. It was found that each practitioner has developed their own unique way of managing the condition. This perhaps might be attributed to the fact that homoeopathy practice is premised on individualised treatment.

According Thompson and Relton (2009), individualised treatment in homoeopathic practice is regarded as the gold standard of homoeopathic care. The authors perceive it as a complex intervention where the homoeopathic medicine is matched to the individual using holistic principles. As explained by one of the participants (P2): "I first start homoeopathically with the homoeopathic remedies and at times I will if necessary I will look for a couple of adjuncts and at the same time I go for nutritional advice*".*

More importantly, it was stated that a homoeopathic approach in the management of menopausal syndrome is multidisciplinary due to the fact that homoeopaths individualise their patients.

> It's multidisciplinary for me because I don't just give hormone remedies, the big one obviously being *Sepia officinalis*, *Natrum muriuticum*, *Pulsatilla pratensis* but because we're individualising patients. (P8)

Equally relevant, it emerged that the homoeopathic remedies in the management of menopausal syndrome in women involve the use of constitutional and phytotherapy remedies as well as medical screening and blood tests. These are detailed in the subthemes below.

a) Subtheme 1: Constitutional remedy and phytotherapy remedies

With reference to constitutional and phytotherapy remedies, one of the participants noted the remedy given will largely depend on the symptoms. For example, while high potency remedies may be preferred, lower potencies might be useful in the treatment of specific symptom like hot flushes.

> My first line is a full case, repertorise and then remedy. I might do a constitutional remedy, a high potency. Depending on the symptoms I might include lower potencies for a specific symptom, like hot flushes. (P3)

In terms of the exact constitutional remedy, it was revealed that homoeopathic remedies such as such as *Kalium sulphuricum, Kalium phosphoricum, Natrum muriuticum, Delphinium staphysagria, Pulsatilla pratensis, Lycopodium clavatum, Sepia officinalis, Agnus castus* and *Cimicifuga racemosa* were the commonly used constitutional remedies. This is reflected in the excerpts below.

> I am always trying to find the constitutional remedy, which may be something like *Kalium sulphuricum* which has nothing to do with menopausal syndrome, but it may be *Sepia officinalis* which has something to do with it, but I'm not worried that if I don't get *Sepia officinalis* or *Agnus castus* or *Cimicifuga racemosa* or one of those classical remedies (P7).

> So constitution is the first part, we look at the state and look at where they are right now and then we put them into constitutional treatment, so whatever remedy, most of the time it's things like *Lycopodium clavatum, Sepia officinalis, Natrum-muriuticum, Delphinium staphysagria, Pulsatilla pratensis*. We have seen a few *Lachesis muta*, so it depends on the patient and patient profile. The other thing is we find tissue salts work very well, so Kalium phosphoricum works. (P6)

> I prescribe constitutional remedies but the usual remedy often come up like *Sepia officinalis, Lachesis muta* and those remedies often come up as a

> constitutional, but I don't limit myself to that, it is sometimes *Pulsatilla pratensis* or *Silicea* or *Calcarea carbonica* and then I'll bring *Glononium* for hot flushes or *Helonias* for candida or anything like that, but I'll bring them in, in lower potencies just to do clinical (P3).

Another of the participants noted the following:

> My approach is for the first consult try to get a similimum if they can give you a good case and then always your phytotherapy the combinations of your *Agnus castus, Cimicifuga racemosa, Dong quai* whatever I feel the patient needs. (P1)

(b) <u>Subtheme 2: Blood test and medical screening</u>

However, before the administration of the above-mentioned remedies, it was noted that patients are sent for medical screening and blood tests.

> My general approach is quite classical, so I'll take a full case, I often have people coming here who already have been sent for blood tests so if that's been done. (P3)

> Basically as a starting point, some of them do come prediagnosed from their gynaecologists and some of them not, so they are seeing me for the first consult, so I would send them for a blood test so that's my landmark and then from there we would dispense. (P9)

Added to the above, another of the participants noted that patients are sent for a menopausal screen.

> And the approach would be, what I usually do with patients I send them for a menopausal screen, and for patients that are not on a medical aid I usually just test for FSH to at least give you an indication of what's going on. (P1)

According to the views of one of the participants, medical screening and blood tests are very useful to prevent misdiagnoses of the menopausal condition.

> We find woman that are 35 years onwards can have symptoms of lupus that get misdiagnosed as menopausal syndrome in the form of night sweats, weight gain, irritability, moodiness, brain fog and depression. So basically you have to make a diagnosis, is this menopause or not and we do that via blood tests where we do hormonal testing to see where they are, do they have low

> oestrogen levels, you find that their LH, FSH all those things are not concurrently in menopause and then that's the diagnosis and obviously case, you do the case history, you look at other mediating factors that could worsen the menopause that's the first step. (P6)

(c) Recording of symptoms

According to Gupta *et al.* (2019), recording a symptom score helps to make the diagnosis of menopausal syndrome. Consistent with these authors, it was found that some of the participants highly valued recording common symptoms indicated by patients.

> I take each patient individually so I would do an individual case regardless but if time constrains are there, obviously there are ways that you cut corners. You look at the most characteristic symptoms of menopause like hot flushes, the dry vagina, mood swings, the main sort of symptoms of menopause and see what's unique about that, so I would say take the key notes of the common symptoms of menopause (P11).

4.2.3 Theme 3: Homoeopathy treatment regimes in the management of menopausal syndrome

Thompson and Relton (2009) write that homoeopathic practice matches medicines to the individual; very low doses of natural substances to stimulate self-healing or the self-repair response with the goal of improving troublesome symptoms, wellbeing and quality of life, and menopausal syndrome is no exception. Theme 2 highlighted the various homoeopathic approaches used by practitioners in the management of menopausal symptoms in their patients. It was revealed that homoeopaths mainly treat homoeopathically using constitutional and phytotherapy remedies. This theme hopes to document the use of these remedies and their mode of administration.

(a) Subtheme 1: Treatment regimes

Specifically, and from a homoeopathic point of view, *Sepia officinalis* is used to manage emotional conditions linked to menopause.

> It's really an emotional time, so there's a lot of time where we use *Sepia officinalis* as one of the main remedies because mothers they feel overwhelmed and they're depressed, moody, irritable. (P6)

Added to the above, another of the participants noted that *Sepia officinalis* is a hormone regulator. In addition, remedies like *Agnus Castus* are said to be effective for night sweats and hot flushes.

> *Sepia officinalis* is a hormone regulator balance. Things like *Agnus castus* herb and also menopause formula by A. Vogel is the big one I use for night sweats and hot flushes and works wonderfully for women that are menopausal and at a point of worrying about bone density. (P8)

Apart from the use of *Sepia officinalis* in the management of emotions in menopausal syndrome, *Pulsatilla pratensis* was also indicated to be effective in helping address emotional changes in lifestyle.

> The female that is at that age with hormonal changes and crying when they're watching an ad, and wanting extra affection from their husband we prescribe *Pulsatilla pratensis.* (P2)

Glononium was indicated for treating hot flushes while *Helonias* for the management of candida (P3). Further to this, *Magnesium phosphoricum* was indicated for the treatment of hot flushes "I also like tissue salts like *Magnesium phosphoricum* that I use for hot flushes*"* (P5).

Equally important, *Kalium phosphoricum* was noted to aid water retention while Molkosan helps women to manage thrush and irritation.

> If somebody complains of water retention, we can give *Kalium phosphoricum* tissue salt. Also advise on the use of lubricants, gels for dry vagina, things like Molkosan which can be used internally and externally as it can help women with thrush, irritation due to friction and get cuts in the vagina, so educate them. (P8)

Considering that menopausal syndrome is a hormonal change particularly a drop in the oestrogen level, it was noted that *Thyroidinum* is used for the management of oestrogen levels.

> *Thyroidinum* all which have an effect on oestrogen levels, *Ovarian* the remedy and *Testosterone.* (P9)

(b) Subtheme 2: Dosage and administration

In terms of the administration of the remedies, one of the participants noted the following:

> I tell them to take it 3 times a day and then we give hormonal support where we use herbal medication, we can use *Sage* which is very good for hot flushes and clinical remedies seem to work, we use a little bit of Traumeel which is a Heel product that tends to balance off. (P6)

The dosage of *Sepia officinalis*, 9CH and or 30CH daily was indicated to be the prescribed dosage.

> That would be the clinical type of things, definitely *Sepia officinalis*, your snake remedies and normally will go fairly low potency like I would treat with either a 9CH or 30CH and it would be daily (P10).

Another of the participants indicated that the dosage must be in lower potencies (P3).

However, if the treatment overlaps with ant-miasmatic condition, a different treatment and dosage duration was suggested.

> Constitutional remedy, if the constitutional remedy overlaps with anti-miasmatic then I'll start with anti-miasmatic and move onto the constitutional remedy. When I start anti-miasmatic I will go maybe 6-8 powders of anti-miasmatic and then wait 2-3 weeks and then start the constitutional remedy because I find it's important to get the anti-miasmatic in there as early as possible. (P3)

4.2.4 Theme 4: Supplementary modalities for the management of menopausal syndrome

As previously stated, homoeopathic management approach in the treatment of ailments is holistic and individualistic. As such, and depending on the patients, different approaches in the treatment may be required. While homoeopaths often utilised constitutional remedies as the first line of approach in the treatment of menopausal syndrome, other supplementary modalities in combination with

homoeopathic remedies were also indicated by the participants in this study. These are reflected in the discussion below.

a) Subtheme 1: Diet and lifestyle change

Arguably, menopause causes great changes in the physiology and psychological wellbeing of females. Hence, it was understandable that lifestyle changes and dietary requirements were noted by the participants as part of their supplementary modalities for managing the condition. As one of the participants noted:

> You can recommend for a patient to be active if they're not, to just walk for 30 minutes by the beach or garden whenever it's safe for the patient to just get the blood flowing, as circulation enables them to detox, get rid of metabolites in the body. (P8)

The above participant emphasised that exercise helps to remedy some of the symptoms which are common for women undergoing the transitory changes of menopause.

> With exercise they feel good because some serotonin goes down and they get emotional, moody and all. So they like to diet and reduce sugar because it comes with loading of weight. (P8)

Making a similar suggestion, another of the participants recommended yoga practice as an anti-stress therapy.

> I recommend anti-stress therapy where they can actually express themselves so like some yoga would be good. (P11)

Furthermore, nutritional advice and recommendation were also indicated.

> Nutritional advice obviously but I actually think just like something new for them because it's a new episode in their lives, so taking on hobbies because that's when they have emptiness and a distraction is good. (P11)

The importance of dieting was noted to help manage the gaining of weight commonly linked with menopausal changes. This is reflected in the narrative below:

> Diet and lifestyle modification, just to help them with losing weight because if they gained weight the hot flushes are a lot worse, but most cases we have to

> advocate to change diet because they have to increase the phyto-oestrogens that assist in improving the oestrogen. Homoeopathy has a very big effect in giving homoeopathic organo-therapy remedies like *Ovarian, Folliculinum* depending on what we would use. *Folliculinum* is one of the main ones that we use, so we can use organo-drainage. (P6)

Specifically, it was recommended that menopausal patients cut the intake of carbohydrates in their diets and increase the intake of proteins and vegetables in order to prevent weight gain.

> I do recommend dietary modifications that work towards, and depends on the patient, if the patient is quite overweight and has insulin resistance we can pick up say metabolic syndrome, then I would want to work with banting or low carb diet. (P7)

> I ask and also make sure that they eat meals that is only protein and above the ground vegetables so to reduce carbohydrates (P2).

Ultimately, exercise and dieting were noted as being important to improve the overall health of the menopausal patients.

> There's going to be diet, looking at diet making sure that we improve the overall health and exercise, so diet and exercise, lifestyle that's always going to be there. (P12)

(b) <u>Subtheme 2: Herbal remedy</u>

In homoeopathy, herbal remedies form part of the cardinal treatment modalities. Thus, homoeopaths often prescribe herbal remedies to manage certain conditions. For the treatment of menopausal syndrome, one of the participants revealed the following:

> I might use certain Ayurvedic herbs like Ashwaganda as a tonic remedy, some kind of kitchen Ayurveda, so spices like ginger, turmeric in diet using good quality like virgin coconut oil to cook as opposed to cooking oils or margarine. (P7)

Added to the above, another of the participants revealed a particular herbal combination known as MenoScript. According to the participant the product is an

absolute phenomenal one that works when the patients is already menopausal. For the premenopausal phase, the following was indicated:

> The premenopausal phase I look at things like pregnenolone which is really helpful or I might with patients with severe symptoms like hot flushes I use Testicomb biopuncture and inject over the ovaries, abdominal area or suprapubic abdominal area. (P2)

Equally significant, herbs are indicated to impact directly on the blood. In particular, *Withania somnifera* was indicated to help address adrenal fatigue due to its nigh nutrition content.

> …. especially with the herbs, because the herbs impact on the bloods directly, you start them on a MediHerb formulation then what happens about 8-10 weeks, you repeat the bloods. The MediHerb we give for adrenal fatigue is *Withania somnifera* and it works nicely because it's high in nutrition ((P4).

Despite the above presumed effectiveness of *Withania somnifera*, a concern of cost was noted by the participants who indicated that the medication is very expensive. "The things I like to prescribe is MediHerb, I feel like it works very well for the patient and that's also not for every single patient because it is very expensive like the cost of R400 a bottle for a month" (P4).

Regardless of the price, it was noted that some patients are happy to take the medication since it was found to help alleviate menopausal symptoms.

> It really does help to eliminate and alleviate a lot of the symptoms but it is pricey some people are happy to take it because they find that their symptoms are unbearable or not manageable and obviously they can afford it. If not, a lot of people just have the homoeopathic and results are obtained most often if they are treated constitutionally. (P4).

On the other hand, and despite prescribing herbal medicine from time to time, another of the participant reiterated that homoeopathic remedy was the first line of treatment.

> I've got Chaste Tree (*Agnus castus*), wild yam (*Dioscorea villosa*), PhytoPlus the Natura one I've prescribed that before, but it's not my first line, I might add it but probably won't give it on the first consultation. I'll try my constitution first and see how the patient reacts. Depending on the reaction I might add herbs

> just for support, but it's not my first line of defence, my first line of defence is always homoeopathic remedy. I get amazing results with them, so I'm quite confident to do that. I think sometimes you grab at the extra things because you are worried you won't get the best results with just trying the homoeopathic things, but you can get nice results just with a *Sepia officinalis.* (P3)

(c) Subtheme 3: Chinese medicine

Chinese medicine such as acupuncture and aromatherapy have gained much popularity as complementary modalities for the management of menopausal syndrome. According to one of the participants:

> Chinese medicine approach, cover the skin, pulses, tongue to get a pattern diagnosis and management would depend on what was presented, so if I need to see them on a regular basis for acupuncture, by weekly depending on the intensity of their symptoms and what's presenting very clearly and obviously my remedy choice based on my initial consult. So if I'm using acupuncture it would be much more regular, treatment from using homoeopathy would be monthly assessment and progress change remedy as required. (P12)

Another of the participants described the benefit of Chinese medicine in the management of menopausal syndrome by explaining the following:

> From the Chinese side it's the Yin – it's the lack of yin, the female energy and when you don't have enough of it so the male heating, movement, Yang, whereas the Yin is the cool and calm so in menopause you're dropping your female essence. (P10)

4.2.5 Theme 5: Advantage of homoeopathic treatment approach over HRT

As earlier stated, there is a controversy surrounding the safety of HRT in the treatment of menopausal syndrome. Both randomised controlled trials and observation studies indicate that HRT use increases the risk of breast cancer, strokes and heart attacks (Newton *et al.* 2014). Consistent with this, it emerged that patients are increasingly becoming aware of the health concerns of HRT causing them to seek homoeopathic care.

> They will come in and ask for homoeopathic care, people are now a little more aware of hormone replacement therapy and also the insinuation that it can

> stimulate cancerous growth in patients that are predisposed, or patients in general. So I find a lot of people who have a strong family history of cancer will come in and say is there anything I can do or is HRT my only option? (P4)

> They are not willing to take HRT or they want to try something else they've tried HRT and had side effects or they have cancer in their family or they nervous of HRT, so I don't often have to diagnose it, if I do then I'll send for blood tests. (P3)

Furthermore, one of the participants vehemently discouraged the use of HRT. In the participant's own words:

> I do not like HRT because you're replacing it, you're putting back into the body and as soon as you stop you go straight to menopause unless your patient is going to stay on HRT forever which is unhealthy. (P2).

While acknowledging that menopause is an inevitable condition for every woman, another of the participants argues that the beauty of homoeopathy is that it works with the symptoms compared to HRT that tends to suppress the condition.

> I think the beauty of homoeopathy is to work with the symptoms as opposed to trying to suppress them in other ways like with HRT. So I think from a homoeopathic perspective we're not trying to cancel the menopause as the HRT does, we're trying to say let's work with it. (P7)

In summary, this chapter explicitly outlined the various homoeopathic approaches in the management of menopausal syndrome. Overall, five themes emerged and have been presented. It was found that each participant adopted a different treatment regime based on the concept of individualistic homoeopathic care. Amongst these concepts include the use of constitutional remedies like *Sepia officinalis* and phytotherapy in the management of menopausal symptoms. The homoeopathic approach also includes blood testing and medical screening, and the careful recording of symptoms. Equally, the participants were noted to engage in other supplementary modalities like dieting and exercise advise, Chinese medicine and herbal remedies that are used in combination with homoeopathic treatment approach. Overall, the chapter strongly suggests that the homoeopathic treatment approach has an advantage over the HRT approach as it is safer and entails less health risks.

CHAPTER 5: DISCUSSION

5.1 Introduction

The main purpose of this study was to explore the experiences and treatment regimens utilised by registered homoeopathic practitioners in the eThekwini municipality. In the previous chapter, the thematic content analysis was presented as representative of the experience and expertise of registered homoeopaths in the treatment of menopausal syndrome in the major areas of eThekwini municipality. This chapter presents the discussion of findings with regards to practitioner experiences. Discussion was governed by the main research question indicated in Chapter 1, Section 1.8: how would you describe your approach to patients presenting with menopausal syndrome? This was then discussed in relation to themes categorised and presented in Chapter 4. Categories are discussed as follows:

- Social-demographic information of the participants
- Understanding of menopausal syndrome from a homoeopathic perspective
- Homoeopathic approach in the management of menopausal syndrome
- Homoeopathic treatment regimes in the management of menopausal syndrome
- Supplementary modalities for the management of menopausal syndrome
- Advantages of homoeopathic treatment approach over hormone replacement therapy

5.2 Social-demographic information of participants

5.2.1 Participant age

As shown in Table 4.1 the minimum age indicated was 34 years while the maximum age was 64 years. This indicated an enormous gap between the old and young generations, as the mean age displayed was 43.6 years. Due to extensive evolution and development, the researcher suggests that the timing of the research corresponded and harmonised with the fact that there are more younger homoeopaths in private practice recently compared to older homoeopaths, and younger homoeopaths are the ones who were more flexible with their time to allow conduct of interviews and the younger homoeopath’s experience over the years they have spent

in private practice allowed them to share enriching knowledge with the study (Majola 2015).

The low older practitioner percentage among participants may be due to older practitioners having more work to do which may also include being authors and publishers due to extensive knowledge gained over the years in practice apart from their established busy private practices (De Villiers and De Villiers 2006). Participants within the age group of 43 years and below are more active in and focused in private practice. Such enthusiasm may also be fuelled by passion to know more and wanting to better impact and improve people's lives as well as self-maturation in terms of clinical competency (Majola 2015).

De Villiers and De Villiers (2006) observed that most older practitioners usually work part-time. They are more experienced than the younger participant group and reported themselves as being more competent than young practitioners, the older medical practitioners were competent enough to work independently to the point of being able to teach or supervise others.

5.2.2 Gender

As shown on Table 4.2 the majority of the participants in this study were females (9, 75%) with only 3 male participants (25%). This gender balance was quite different from Majola (2015) who obtained an equal number of participants from both genders. This may be indicative that more females are engaging into private practice than before (Majola 2015). The gender distribution difference of participants seen in the study may be correlated to the fact that female practitioners were more open and available than male participants. The recruitment process did not specify gender preference. This study did not aim to balance gender respondents or their selection thereof, although this is one potential recommendation for future studies that gender selection shall be balanced and compare results thereof.

De Villiers and De Villiers (2006) noted that older male practitioners often felt confident about themselves being competent and being more experienced than the women, which is the opposite of this study. The female participants interviewed felt confident about their competency, knowledge and management of this female syndrome.

5.2.3 Occupation

As demonstrated in Table 4.3, the majority of the participants practice as homoeopaths only (11, 91.7%) and one of the participants practiced as both a homoeopath and an acupuncturist (8.3%). Dual practice may be an advantage as the practices work correlatively and overlap each other, whereby the practitioner can choose one or both of the practices when managing a menopausal case:

> Chinese medicine approach, cover the skin, pulses, tongue to get a pattern diagnosis and management would depend on what was presented, so if I need to see them on a regular basis for acupuncture, by weekly depending on the intensity of their symptoms and what's presenting very clearly and obviously my remedy choice based on my initial consult. So if I'm using acupuncture it would be much more regular, treatment from using homoeopathy would be monthly assessment and progress change remedy as required (P12)

This is evident enough that the practitioner utilises both practices at times to manage menopausal syndrome. As explained in Chapter 2, section 2.5.5 how menopause is understood in Chinese medicine, this then proves that the two conventional medicines can be incorporated together to achieve a stable state known as *Jing* (Kwee *et al.* 2007).

As for practitioners only practicing as registered homoeopaths, this is also an advantage to them, for they will know exactly what will bring the patient's disharmonised state back to equilibrium. In homoeopathy this is known as the classical method or a single remedy method (Hansa 2011). Kayne (2003) argues that mixed or complex prescribing for menopausal syndrome may be advantageous particularly when one is unsure about which single remedy to prescribe. Additionally, this type of method is very beneficial to menopausal patients when there is not enough time for a full consultation (Kayne 2003).

5.2.4 Practice location

As indicated in Table 4.4, 50% of participants' practices are located in central Durban, while the remaining 50% practice in the greater eThekwini area.

5.2.5 Years in practice

Table 4.5 shows the number of years which the participants have been practicing homoeopathy in private practice. The average number of years in practice was found to be 13.9 years, with the minimum number of years being 10 years and the maximum being 21 years. This was far better that the stipulated amount of years in the inclusion criteria explained in Chapter 3, section 3.7 which was employed during the recruitment process.

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

Themes emerging from the data collected and analysed are discussed individually as follows:

5.3.1 Theme 1: Understanding of menopausal syndrome from a homoeopathic perspective

From the participants' responses it was gathered that about 50% of the participants understood menopause as a major transitory phase caused by a gradual decline in essential functional hormones responsible for normal regulatory functions. As such one participant emphasised that menopause is a result of what you do just prior to the phase commencement:

> If there is things like many years of using contraceptive pill, I find those ladies might struggle a bit more because all of a sudden the body wakes up if they stop the contraceptive pill they go through into menopause. (P1)

Another of the participants emphasised that patients need to closely watch their lifestyle as this impacts a lot on bone density, so they must ensure weight bearing exercise as well as a nutritional diet. Furthermore, it was emphasised that since menopause is a transitory phase, then it is just a phase that needs adjustment and as much suitable treatment to assist with adjustment as this is one crucial female life passage and it is understood to occur as a result to a disturbance to the regular hormone rhythm which may also be a manifestation of some emotional loss.

One participant said that patients are now aware of HRT and its adverse effects which give rise to cancerous growths, and due to a patient's family history of cancer they

want to make sure that that's not the case for them too, hence the reason for seeking homoeopathic assistance. Another reason for consulting homoeopathic practitioners is due to the troubling effects of intense and frequent disturbing menopausal syndrome symptoms like hot flushes, lingering skin issues, decreased tolerance to their usual environment and unwanted weight changes. The participants further explained that it is not that they want to replace what is lost or cancel the phase, they simply aim to work with the body to help adjust to the new phase.

Makara-Studzińska, Kryś-Noszczyk and Jakiel (2014) explained menopausal syndrome as being a psychological-social functioning alteration phase in women. This phase presents with reduced ovarian functional activity leading to diminished levels of oestrogen which then gives rise to the presenting symptoms in menopausal women. As described by Shabaan, Mohasib and Emam (2018), menopause is a transitory phase which presents with many physical and psychological changes. These changes impact on normal behaviour and general life activities which then diminishes the quality of life.

The National Health Services UK (2014) defines quality of life as a term used in healthcare to denote issues influencing an individual's emotional, social and physical welfare or health. This term mainly refers to the ability of an individual to cope with daily life activities. It is a term used to define an individual's perceptions of the effects caused by an illness or disease they are suffering. Quality of life then becomes evidence of how much damage has occurred due to alterations and or fluctuations in the hormonal levels during menopausal symptom experience which in this case is termed the menopausal transition (Greenblum *et al.* 2012).

Quality of life can be affected by the alterations that take place during the menopausal transition (Yazdkhasti *et al.* 2012). As with the description of menopause above by Makara-Studzińska, Kryś-Noszczyk and Jakiel (2014), this significant decline in the essential hormone levels may be due to or rather influenced by less ovarian functional activity, this then yields symptoms including hot flushes, moodiness, sleep disturbance which may lead to sleep deprivation, night sweats and fatigue (Shabaan, Mohasib and Emam 2018). A combination of these symptoms is termed 'menopausal transition' which usually takes place around about the age of 48 to 51 years (Gehad, Samia, A. and Galila 2010).

In order for a physician to accomplish their prerogative in managing the menopausal syndrome and improve the women's quality of life, the physician must first understand the hormonal and symptomatological changes that take place. They need to educate and counsel women about menopausal symptoms and the management thereof. Physicians may better deal with patients' worries about menopause if physicians also ensure that they improve their knowledge base about menopausal syndrome (Manson and Bassuk 2014). As depicted in the data gathered from the study that menopause is a transitional phase, it is crucial that patients experiencing the menopausal transition be always cared for as this is a psychologically and physically demanding phase (Greenblum *et al.* 2012).

Symptoms experienced during perimenopause are usually the same as those experienced in menopausal symptom manifestation, except that in menopause there are no hormonal fluctuations and in perimenopause the women might still be irregularly menstruating which they usually notice around the ages of 45 to the age of 55 years which can last between a few months to a decade (Harvard Medical School, 2019; Mayo Clinic, 2020).

This syndrome is usually diagnosed by gathering all the clinical symptoms (presenting symptoms explained by the patient as well as those gathered on examination). However, when a practitioner is uncertain or needs confirmation or validation of the findings, they can send for blood tests also named the menopausal screen to check hormonal levels including follicle stimulating hormone (FSH), oestrogen, liver, thyroid (thyroid stimulating hormone due to hypothyroidism) and kidney function tests and even triglyceride profile (Mayo Clinic 2020; Ernst 2019). During this time, it is advisable for a physician to send for bone density measurements so to help detect early menopause osteoporosis. Another recommended test to send for is an endometrial biopsy when a patient frequently experiences irregular menses (Harvard Medical School 2019).

5.3.2 Theme 2: Homoeopathic approach in the management of menopausal syndrome

Although the general prescription for menopausal syndrome is HRT, it has been observed that a number of women in menopause are seeking alternative treatment with minimal adverse effects concerning their use of HRT (Hansa 2011).

It is evident from the interviews that practitioners in this study each have their unique way of managing each case as presented. As such more than half of the participants revealed that they usually on the first consult prescribe homoeopathic remedies and some adjunctive herbs so as to see how their patients respond to the medication. In some patients they then prescribe supporting and supplementing medication to further manage the condition. One participant emphasised that they do not just prescribe the same or rather similar remedies to all patients just because they are all suffering the same condition, but they rather treat each patient as a unique case, hence they individualise treatment:

> It's multidisciplinary for me because I don't just give hormone remedies, the big ones obviously being *Sepia officinalis, Natrum muriuticum, Pulsatilla pratensis* but because we're individualising patients. (P8)

This proved that they are mostly focused on understanding individual patient constitutions which will then allow them to prescribe constitutional treatment which is most likely given at high potency:

> My first line is a full case, repertorise and then remedy, I might do a constitutional remedy, a high potency depending on the symptoms I might include lower potencies for a specific symptom, like hot flushes. (P3)

A number of commonly used or prescribed constitutional remedies was noted, and the common remedies were *Kalium sulphuricum, Kalium phosphoricum, Natrum muriuticum, Delphinium staphysagria, Pulsatilla pratensis, Lycopodium clavatum, Sepia officinalis, Agnus castus* and *Cimicifuga racemosa*. These are reflected in the excerpts below.

> I am always trying to find the constitutional remedy, which may be something like *Kalium sulphuricum* which has nothing to do with menopausal syndrome, but it may be which has something to do with it, but I'm not worried that if I don't

> get *Sepia officinalis* or *Agnus castus* or *Cimicifuga racemosa* or one of those classical remedies. (P7)

> So constitution is the first part, we look at the state and look at where they are right now and then we put them into constitutional treatment, so whatever remedy, most of the time it's things like *Lycopodium clavatum, Sepia officinalis, Natrum-muriuticum, Delphinium staphysagria, Pulsatilla pratensis*. We have seen a few *Lachesis muta*, so it depends on the patient and patient profile. The other thing is we find tissue salts work very well, so *Kalium phosphoricum* works. (P6)

> I prescribe constitutional remedies but the usual remedy often come up like *Sepia officinalis, Lachesis muta* and those remedies often come up as a constitutional, but I don't limit myself to that, it is sometimes *Pulsatilla pratensis* or *Silicea* or *Calcarea carbonica* and then I'll bring *Glononium* for hot flushes or *Helonias* for candida or anything like that, but I'll bring them in, in lower potencies just to do clinical. (P3)

A number of studies have been conducted to evaluate and validate the effectiveness of homoeopathic medicine in alleviating menopausal symptoms, and have found a positive result in the use of (Clover and Ratsey 2002; Bordet *et al.* 2008; Gupta *et al.* 2019). Homoeopathy is believed to provide a safe and clinically effective intervention, however it lacks research especially on the management of menopausal syndrome (Thompson and Relton 2009). From data collected it was noted that participants have developed individualised ways of managing this syndrome. This is typical homoeopathic management through case taking, as the physician always tries to individualise each presenting symptom. When all the symptoms have been gathered and characterised, the physician then searches for a remedy that matches the presenting symptom picture in accordance to the peculiarity of each symptom. The matching remedy is then prescribed and is known as the similimum or constitutional remedy (De Schepper 2006).

As previously stated by De Schepper (2006) the prescribed constitutional remedy depends on the presenting symptom picture individualised to each patient. The usual constitutional remedies that come up in relation to menopausal syndrome are *Natrum muriuticum, Delphinium staphysagria, Pulsatilla pratensis, Lycopodium clavatum,*

Sepia officinalis, Agnus castus, Lachesis muta, Calcarea carbonica, Silicea and *Cimicifuga racemosa* (Peace Health, 2012). Very often when a practitioner consults with a patient who is actively in menopause, they usually do complex prescribing where they give combination remedies which include *Kalium sulphuricum, Kalium phosphoricum* and *Natrum muriuticum.* These are given along with a herb to help support the healing life-force and restore normal or harmonious function of the body according to each patient's needs. Herbal remedies usually prescribed include *Vitex Agnus castus, Angelica sinensis, Cimicifuga racemosa and Dioscorea villosa* (Bone and Mills 2007).

As previously mentioned in Theme 1, before proceeding to the point of prescription one has to ensure full gathering and correct recording of the patient's symptoms and then from there classify and characterise them (Gupta *et al.* 2019). If the physician wants validation and clarification of the diagnosis about where in the syndrome progression the patient currently is, they can send for a menopausal screen or specific blood tests to check for functional hormonal levels especially FSH, oestrogen and TSH which serve as basic diagnostic criteria (Ernst 2019).

5.3.3 Theme 3: Homoeopathy treatment regimes in the management of menopausal syndrome

Thompson and Relton (2009) consistently mention that in homoeopathic practice it is a norm or rather a golden standard to prescribe medicine that uniquely matches the characteristics of an individual's suffering. Homoeopathic remedies are highly dilute and given in minute harmless doses so to enhance the healing nature and life-force of the body to restore its normal functions thereby improving a women's quality of life. Various homoeopathic strategies utilised by homoeopathic physicians in the management of the climacteric syndrome have been mentioned in the above theme, and it was found in this study that most homoeopaths treat their patients homoeopathically using constitutional remedies with the help of phytotherapy to ease menopausal symptoms.

Two participants revealed that *Sepia officinalis* as well as *Pulsatilla pratensis* are two of the best remedies when dealing with emotional cases associated with menopause:

> It's really an emotional time, so there's a lot of time where we use *Sepia officinalis* as one of the main remedies because mothers they feel overwhelmed and they're depressed, moody, irritable. (P6)

> The female that is at that age with hormonal changes by crying when they're watching an ad, and wanting extra affection from their husband we prescribe *Pulsatilla pratensis.* (P2)

Additionally, another participant added that *Sepia officinalis* and *Thyroidinum* are essential remedies for hormone regulatory balance. Herbs, including *Agnus castus* were said to be very efficient for hot flushes and night sweats:

> *Sepia officinalis* is a hormone regulator. Things like *Agnus castus* herb and also menopause formula by A. Vogel is the big one I use for night sweats and hot flushes and works wonderfully for women that are menopausal and at a point of worrying about bone density. (P8)

> *Thyroidinum* all which have an effect on oestrogen levels, *Ovarian* the remedy and *Testosterone.* (P9)

Furthermore, dosage was emphasised as lower potencies of 9CH and or 30CH daily.

> That would be the clinical type of things, definitely *Sepia officinalis*, your snake remedies and normally will go fairly low potency like I would treat with either a 9CH or 30CH and it would be daily. (P10)

However, if the treatment overlapped with an anti-miasmatic predisposition or condition, then a different treatment approach and dosage duration was suggested.

> Constitutional remedy, if the constitutional remedy overlaps with anti-miasmatic then I'll start with anti-miasmatic and move onto the constitutional remedy. When I start anti-miasmatic I will go maybe 6-8 powders of anti-miasmatic and then wait 2-3 weeks and then start the constitutional remedy because I find it's important to get the anti-miasmatic in there as early as possible. (P3)

Bordet *et al.* (2008) confirms that *Sepia officinalis* is one of the main remedies and the best prescribed in the treatment of menopause, as this is very much an emotional time for most women experiencing menopause. In an observational study conducted by Bordet *et al.* (2008) it was concluded that remedies including *Sepia officinalis,*

Lachesis muta, Belladonna, Sulphur and *Sanguinaria* were the most effective in the treatment of hot flushes which are a result of hormonal imbalance. It was also confirmed from the study that *Sepia officinalis* and *Pulsatilla pratensis* are specific in addressing hormonal and emotional issues during this sensitive time.

Glononium, Helonias and *Magnesium phosphoricum* were suggested for clinical use as calmatives or inter-current prescriptions for ailments including candida, periodic hot flushes and issues with water retention arising in menopause. The remedy *Thyroidinum* was suggested for oestrogen levels regulation. In terms of remedy administration, data from the study and Peace Health (2012) suggest that menopausal prescriptions be kept at low potencies like 9CH or 30CH daily dosages, which may be repeated up to three times a day. Some physicians preferred to first start with an anti-miasmatic treatment before proceeding with constitutional treatment; this technique clears up inherited tendencies which may hinder the healing results of a constitutional remedy, so it is better to first remove inherited traits before targeting one troubling ailment (Das 2015).

5.3.4 Theme 4: Supplementary modalities for the management of menopausal syndrome

The British Dietetic Association (2019) highly recommends dietary and lifestyle changes during menopausal transition and more importantly during the active stage of menopause. This is because at this stage oestrogen levels decline rapidly due to functional physiological insufficiencies, while its secretion and product is in high demand. It was ascertained from the study's data that it is advisable for a consulting physician to initiate and recommend dietary and lifestyle changes as per individual's need, as these changes have a considerable impact in preventing potential harmful deficiencies and improving one's quality of life.

Additionally, physician need to help their patients establish a regular exercise routine, which may include yoga since this is a form of exercise that can have an impact on brain relaxation:

> You can recommend for a patient to be active if they're not, to just walk for 30 minutes by the beach or garden whenever it's safe for the patient to just get the blood flowing, as circulation enables them to detox, get rid of metabolites in the

body. With exercise they feel good because some serotonin goes down and they get emotional, moody and all. So they like to diet and reduce sugar because it comes with loading of weight. (P8)

I recommend anti-stress therapy where they can actually express themselves so like some yoga would be good. (P11)

Nutritional advice obviously but I actually think just like something new for them because it's a new episode in their lives, so taking on hobbies because that's when they have emptiness and distraction is good. (P11)

Diet and lifestyle modification, just to help them with losing weight because if they gained weight the hot flushes are a lot worse, but most cases we have to advocate to change diet because they have to increase the phyto-oestrogens that assist in improving the oestrogen. Homoeopathy has a very big effect in giving homoeopathic organo-therapy remedies like *Ovarian, Folliculinum* depending on what we would use. *Folliculinum* is one of the main ones that we use, so we can use organo-drainage. (P6)

I do recommend dietary modifications that work towards, and depends on the patient, if the patient is quite overweight and has insulin resistance we can pick up say metabolic syndrome, then I would want to work with banting or low carb diet. (P7)

I ask and also make sure that they eat meals that are only protein and above the ground vegetables so as to reduce carbohydrates. (P2).

In addition to homoeopathic treatment, Participants indicated that herbal remedies are also employed in the treatment of menopausal syndrome. Those herbs include *Withania somnifera* which was said to be very effective in alleviating adrenal fatigue:

…. especially with the herbs, because the herbs impact on the bloods directly, you start them on a MediHerb formulation then what happens about 8-10 weeks, you repeat the bloods. The MediHerb we give for adrenal fatigue is *Withania somnifera* and it works nicely because it's high in nutrition. (P4)

It really does help to eliminate and alleviate a lot of the symptoms … some people are happy to take it because they find that their symptoms are unbearable or not manageable and obviously they can afford it. If not, a lot of

> people just have the homoeopathic and results are obtained most often if they are treated constitutionally. (P4)

It was also noted that two participants employed Chinese medical approach additional to homoeopathic treatment as it also served beneficial to cover broad systems:

> Chinese medicine approach, cover the skin, pulses, tongue to get a pattern diagnosis and management would depend on what was presented, so if I need to see them on a regular basis for acupuncture, by weekly depending on the intensity of their symptoms and what's presenting very clearly and obviously my remedy choice based on my initial consult. So if I'm using acupuncture it would be much more regular. Treatment from using homoeopathy would be monthly assessment and progress change remedy as required. (P12)

> From the Chinese side it's the Yin – it's the lack of Yin, the female energy and when you don't have enough of it so the male heating, movement – Yang, whereas the Yin is the cool and calm so in menopause you're dropping your female essence. (P10)

Specifically, it was emphasised that these changes impact enormously in helping to lose weight since the experience of menopausal symptoms especially hot flushes is far worse if patients have more weight. In order to achieve this, it was also recommended that patients must cut down on their carbohydrate intake and rather increase their protein, vitamins and minerals consumption so to support remodelling of bones, longevity and patient's health (British Dietetic Association 2019; Cashman 2007). Following this, organo-therapy with remedies including *Ovarian* and *Folliculinum* may be used to support and assist with organo-drainage. Also from data collected in this study it was suggested that women should engage in new or different hobbies different from their usual like going for a walk for at least thirty minutes just to get their minds off things while improving their mood regulating hormone levels.

Adjunctive herbs contribute greatly in the management of climacteric phase, like *Ashwaganda (Withania somnifera somnifera)* a nervous system tonic and a traditional herb from Ayurvedic medicine. This herb is of great importance in the management of menopausal emotional irregularities and disturbances. *Withania somnifera* is effective in palliating adrenal ailments due to its high content of phyto-oestrogens (Frank and Painter 2009). Additionally, injection of *Testicomb* (Biopuncture) over the ovarian area

stimulates functional reactivity of the organs therefore effectively alleviating the rate and frequency of hot flushes (Nye 2020). Phytotherapy herbs including *Vitex agnus castus* and *Dioscorea villosa* are best in calming the deficient effects of oestrogen by reducing inflammation around joints which often leads to joint pain, myalgia, vaginal dryness and HRT withdrawal effects (Chevallier 2007; Bone and Mills 2007).

The inability of the female body's ability to calm and cool itself down is known as *Yin* deficiency. Such a deficiency allows for dominance of *Yang* which characteristically is considered as a male character with excess heat and vigour which seemingly matches the hot flush characteristics in perimenopause. Thus, *Yin* properties have significantly diminished in such a way that they can no longer counteract *Yang's* effects in the body, thereby allowing manifestation of hot flushes as described in Chinese medicine (Kwee *et al.* 2007). Chinese medicine is effective in managing menopausal syndrome especially hot flushes and weight loss, by restoring balance between the two parts of *Jing,* namely, *Yin* and *Yang* (Kayne 2002).

5.3.5 Theme 5: Advantage of homoeopathic treatment approach over HRT

As formerly stated, participants frequently emphasised their patients' awareness of HRT and its effects as a whole, and some participants undoubtedly discouraged the use of HRT and advised that treatment should rather be focused on supporting and working hand in hand with the body to heal itself:

> They will come in and ask homoeopathic care, people are now a little more aware of hormone replacement therapy and also the insinuation that it can stimulate cancerous growth in patients that are predisposed, or patients in general. So I find a lot of people who have a strong family history of cancer will come in and say is there anything I can do or is HRT my only option? (P4).

> They are not willing to take HRT or they want to try something else they've tried HRT and had side effects or they have cancer in their family or they nervous of HRT, so I don't often have to diagnose it, if I do then I'll send for blood tests. (P3)

> I do not like HRT because you're replacing it, you're putting back into the body and as soon as you stop you go straight to menopause unless your patient is going to stay on HRT forever which is unhealthy. (P2)

> I think the beauty of homoeopathy is to work with the symptoms as opposed to trying to suppress them in other ways like with HRT. So I think from a homoeopathic perspective we're not trying to cancel the menopause as the HRT does, we're trying to say let's work with it. (P7)

As previously stated in the study, menopause is a transitional stage with hormonal insufficiencies which need to be addressed with great caution. One must work hand in hand with what the body is presenting rather than trying to supress the symptoms. With that being said, it is truthful to say that homoeopathic treatment is best suited for this stage, as it is safe, gentle, deep acting and individualistic (De Schepper 2006). Therefore, it may be used without concern that it will predispose patients to experiencing adverse effects or supress symptoms like when using HRT, instead it treats the totality of individual unique symptoms as presenting in a patient who is in perimenopause or menopause. Homoeopathic treatment does not aim to replenish what has been lost but rather works with what is left in the body for it to function 'normally' and stimulate the life force for the body to heal itself and restore functional harmony in the body's system (Kent 2007).

In summary, it can be concluded that the majority of the participants were enthusiastic and satisfied with the results obtained when using homoeopathic medicine individually. Nevertheless, there is a room for greater exploration of other homoeopathic remedies other than the basic and usual. It was underlined that some respondents were more comfortable with using unusually unique smaller remedies not previously broadly explored like the snake remedies and mineral remedies. This is an explorative research topic. The researcher recommends that the respondents' insights and opinions to be utilised in future homoeopathic provings for research purposes, so to improve homoeopathic remedy knowledge thereby enhancing the quality of homoeopathic care. This chapter affirms that homoeopathic care has a good chance of improving women's quality of life in terms of menopausal syndrome.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

The aim of the study was to investigate and outline regimens utilised in the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini. The study focused on practitioners who had a history of actively managing cases concerning menopausal syndrome in their private practice.

The intention of the study was to assess the various management strategies employed by homoeopathic practitioners when managing menopausal syndrome using an interview guide with the grand tour question: *How would you describe your approach to patients presenting with menopausal syndrome?*

A qualitative research methodology was used. Detailed responses were obtained from participants by means of in-depth interviews. In the previous chapter, results obtained from the study was discussed and thereafter supported by drawing information from literature. This chapter draws from that discussion in order to suggest recommendations for future research.

This study yielded a pool of information which may be used to strengthen and improve the value and impact of homoeopathic management of menopausal syndrome. Key points explored were diagnosis of menopause, homoeopathic understanding and therapeutic approach, and additional modalities utilised in managing menopausal syndrome. Data obtained will aid in future homoeopathic management of menopause in private practice by providing reliable remedy choices and adjunctive therapy references to improve prescription choices as well as homoeopathic education.

6.1 Conclusions deduced from analysis

Findings from this study were even though the majority of the study respondents did not use homoeopathy only as their first line approach, participants were very satisfied with the results obtained from their individualistic prescriptions for each of their individual patients. This answered the grand tour question which was: how would you describe your approach to patients presenting with menopausal syndrome?

The thematic analysis further revealed that respondents were displeased with other forms of medical approaches to managing menopausal syndrome and were very enthusiastic and hopeful with homoeopathic treatment. With regards to responding to the grand tour question, which was how would they describe their approach to patients presenting with menopausal syndrome? It appeared that there was great gratification, and certainty among respondents with regards to their unique individual approach and prescriptions to managing menopause.

In terms of participant therapeutic approaches to to managing patients with menopausal syndrome, the foremost aspect of the study revealed that participants depended and trusted their unique homoeopathic remedies as well as their supporting adjunctive therapy prescriptions. The study also revealed that this intense trust and confidence in their prescriptions was encouraged by the good results obtained from a continuous influx of patients repeatedly referring others to come and seek homoeopathic help to assist with their uncomfortable perimenopausal experiences.

A point worthy of being brought up despite the obtained satisfactory results achieved by participants is that homoeopathy has a bright future in the management of hormonal imbalances including menopause, therefore, it still needs a lot of work to raise its profile so to introduce more people to a more natural way of managing hormonal transitions.

6.2 Recommendations

Within the restrictions of this study, it can be recommended that:

- With regards to awareness, homoeopathic interventions need more publicity so that the public can know that there are safe and deep acting harmless alternative interventions capable of restoring harmony within the body system during transitory phases.
- Further studies on perceptions of medical doctors on the management of menopausal syndrome by homoeopathic practitioners versus traditional allopathic interventions.
- The researcher recommends that forthcoming experimental homoeopathic studies be conducted on the efficacy of a homoeopathic complex made from

combining all the remedies found effective from this study on the management of hormonal imbalances.

- The researcher also recommends that homoeopathic medicine integrates with conventional medicine to the primary healthcare sector in South Africa and in the management of all basic and systematic hormonal disturbances so as to ease the load of patients seeking continuous medical help to alleviate both the symptoms and adverse effects and risks posed by HRT as the standard treatment in conventional medicine.

6.3 Conclusion

Conducting this study was an informative and deeply enriching experience as the researcher learnt a lot, some of which was not revealed during their academic phase and respondents graciously offered and shared information and their hard earned experiences in practice. Being able to view the quality and effectiveness of the health management service offered by homoeopathic practitioners in managing menopause, through practitioner's eyes, was stimulating and challenging to the researcher to continue to work hard and learn more in order to contribute regarding the benefits of the practice of homoeopathy in management all hormonal imbalance conditions.

REFERENCES

Airey, R. and Houdret, J. 2004. *The handbook of alternative healing*. London: Lorenz Books.

Allied Health Professions Council of South Africa. 2015. *Code of ethics in terms of section 54(9) of regulations no.r.127 of 12 February 2001 to the Allied Health Professions Act, Act 63 of 1982, as amended*. Government Gazette number 39531: 18 December. Pretoria: Government Printer. Available: https://ahpcsa.co.za/wp-content/uploads/2015/10/39531_18-12_NationalGovernment-1.pdf (Accessed 24 August 2020).

American Diabetes Association. 2019. Introduction: Standards of medical care in diabetes – 2019 *Diabetes Care,* 42(1): S1-S2. Available: https://care.diabetesjournals.org/content/42/Supplement_1 (Accessed 01 April 2020).

Andrade, D. C., Carmona, F., Angelucci, M. A., Martinez, E. Z. and Pereira, A. M. S. 2019. Efficacy of a homeopathic medicine of *capsicum frutescens* L. (solanaceae) in the treatment of hot flashes in menopausal women: a phase-2 randomized controlled trial. *Homeopathy,* 108(2): 102-107. Available: https://www.ncbi.nlm.nih.gov/pubmed/30736083 (Accessed 14 April 2020).

Appiah, D., Winters, S. J. and Hornung, C. A. 2014. Bilateral oophorectomy and the risk of incident diabetes in postmenopausal women. *Diabetes Care,* 37(3): 725-733. Available: https://www.ncbi.nlm.nih.gov/pubmed/24194507 (Accessed 30 March 2020).

Beers, M., Fletcher, A., Jones, T., Porter, R., Berkwits, M., Kaplan, J. (eds). 2003. *The Merk manual of medical information*. 2nd home ed. Whitehouse Station, NJ: Merck Research Laboratories.

Beers, M., Porter, S., Jones, T., Kaplan, J. and Berkwits, M. (eds). 2006. *The Merk manual of diagnosis and therapy*. 18th ed. Whitehouse Station, NJ: Merck Research Laboratories.

Berek, J. 2007. *Berek & Novak's gynecology*. 14th ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Bloch, R. and Lewis, B. 2003. *Homoeopathy for the home*. Cape Town: Struik Publishers.

Bone, K., and Mills, S. 2007. *Principles and practice of phytotherapy modern herbal medicine*. London: Churchill Livingstone.

Bordet, M. F., Colas, A., Marijen, P., Masson, J. and Trichard, M. 2008. Treating hot flushes in menopausal women with homeopathic treatment-results of an observational study. *Homeopathy,* 97(1): 10-15. Available: DOI: 10.1016/j.homp.2007.11.005 (Accessed 13 May 2020).

Borker, S. A., Venugopalan, P. P. and Bhat, S. N. 2013. Study of menopausal symptoms, and perceptions about menopause among women at a rural community in Kerala. *Journal of Mid-Life Health*, 4(3): 182-187. Available: doi: 10.4103/0976-7800.118997 (Accessed 26 September 2018).

Brand, J. S., van der Schouw, Y. T. and Onland-Moret, N. C. *et al.* 2013. Age at menopause, reproductive life span, and type 2 diabetes risk: results from the EPIC-InterAct study. *Diabetes Care,* 36(4): 1012-1019. Available: https://www.ncbi.nlm.nih.gov/pubmed/23230098 (Accessed 28 March 2020).

Breus, M. 2018. Other natural supplements for menopause and sleep *The sleep doctor* (blog). Available: https://thesleepdoctor.com/2018/02/20/natural-supplements-menopause-sleep/?cn-reloaded=1 (Accessed 05 July 2020).

British Dietetic Association. 2019. Menopause and diet: food fact sheet. *The Association of UK Dietitians* (blog). Available: https://www.bda.uk.com/resource/menopause-diet.html (Accessed 16 May 2020).

Burger, H. G, Dennerstein L., Hale G. E. and Robertson D. M. 2007. A review of hormonal changes during the menopausal transition: focus on findings from the Melbourne Women's midlife health project. *Human Reproduction Update,* 13(6): 559-565. Available: https://academic.oup.com/humupd/article-abstract/13/6/559/682984 (Accessed 13 February 2020).

Cashman, K. D. 2007. Diet, nutrition and bone health. *The Journal of Nutrition,* 137(11): 2507S-2512S. Available: https://www.ncbi.nlm.nih.gov/pubmed/17951494 (Accessed 15 May 2020).

Chancellor, P. 1995*. Illustrated handbook of the Bach flower remedies*. England: C. W. Daniel Company Ltd.

Chauhan, V. 2020. Always Ayurveda: a sister concern of planet Ayurveda. *Always Ayurveda* (blog). Available: https://www.alwaysayurveda.com/menopause/ (Accessed 12 April 2020).

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

Chevallier, A. 2007. *Herbal remedies*. London Dorling: Kindersley Limited.

Clover, A. and Ratsey, D. 2002. Homeopathic treatment of hot flushes: A pilot study. *Homeopathy,* 91 (2): 75-79. Available: https://www.researchgate.net/publication/11089235_Homeopathic_treatment_of_hot_flushes_A_pilot_study (Accessed 30 April 2020).

Creswell, J. W. (2014). *Research design: qualitative, quantitative and mixed methods approaches,* 4th ed. London: Sage Publications Ltd.

Creswell, J. W. 2009. *Research design: qualitative, quantitative and mixed methods approaches*. 3rd ed. Los Angeles: CA: Sage.

Cutler, W.B. & Genovese-Stone, E. 2000. Wellness in women after 40 years of age*:* The role of sex hormones and pheromones*. Current Problems in Obstetrics, Gynaecology and Fertility*, 23(Part 1 and Part 2): 1-88.

Das, E. 2015. Principles of prescribing. *National Health Portal* (blog). Available: https://www.nhp.gov.in/Principles-of-Prescribing_mtl (Accessed 14 May 2020).

Davey, D. A. 2006. Hormone replacement therapy: a time to move on? *Menopause International,* 12(2): 75-80. Available: https://www.ncbi.nlm.nih.gov/pubmed/16776859 (Accessed 19 March 2020).

De Schepper, L. 2001. *Hahnemann revisited: a textbook of classical homoeopathy for the professional.* Santa Fe, NM: Full of life publications.

De Schepper, L. 2006. *Hahneman revisited: classical homoeopathy for the professional*. New Delhi: B. Jain Publishers (P) Ltd.

De Villiers, M. R. and De Villiers, P. J. T. 2006. The knowledge and skills gap of medical practitioners delivering district hospital services in the Western Cape, South Africa. *South African Family Practice,* 48(2): 16-16c. Available: www.safpj.co.za (Accessed 20 April 2020).

Denzin, N. K. and Lincoln, Y. S. 2011. *The Sage handbook of qualitative research*. Thousand Oaks, CA: Sage Inc.

Dibaba, D. T., Ogunsina, K., Braithwaite, D. and Akinyemiju, T. 2018. Metabolic syndrome and risk of breast cancer mortality by menopause, obesity, and subtype. *Breast Cancer Research and Treatment,* 10(9): 209-218. Available: https://doi.org/10.1007/s10549-018-5056-8 (Accessed 23 February 2020).

Domleo, S. 2002. The homoeopathic treatment of menopausal symptoms with *Folliculinum* 30ch. Dissertation, M. dip. Hom. Technikon Natal, Durban.

Durward, E. 2016. Why you need magnesium during menopause? *A. Vogel Talks Menopause*. (blog). Available: https://www.avogel.co.uk/health/menopause/videos/why-you-need-magnesium-during-menopause/ (Accessed 04 July 2020).

Ernst, H. 2019. Menopause tests and diagnosis. *Healthline* (blog). Available: https://www.healthline.com/health/menopause/tests-diagnosis#following-diagnosis (Accessed 30 April 2020).

Frank, M. and Painter, D. C. 2009. Adaptogenic herbs. *Nature's Solution to Stress*, 14(2): 336-346. Available: https://chiro.org/nutrition/FULL/Adaptogenic_Herbs.shtml (Accessed 4 March 2020).

Fushtey, I. M., Malynovska, O. Y. and Sid', E. V. 2015. The effect of combination therapy on indices of endothelial dysfunction in women with hypertension and

menopausal syndrome. *Biological Markers and Guided Therapy*, 2(1): 153-159. Available: (Accessed 20 February 2020).

Fusion Homoeopathics. 2012. Using blood as a nosode. *Autosanguis isotherapy* (blog). Available: http://www.fusionhomoeopathics.co.za/ast.html (Accessed 02 July 2020).

Gaier, H. 1991. *Thorson's encyclopaedic dictionary of homoeopathy*. London: Harper Collins.

Galib, M. B., Mashru, M., Jagtap, C., Patgiri, B. J. and Prajapati, P. K. 2011. Therapeutic potentials of metals in ancient India: a review through Charaka Samhita. *Journal Ayurveda and Integrative Medicine*, 2(2): 55-63. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3131772 /pdf/JAIM-2-55.pdf (Accessed 13 April 2020).

Gehad, M., Samia, A. and Galila, S. 2010. Effect of menopausal symptoms on women's quality of life in Benha city (Egypt) and Arar city (Kingdom of Saudi Arabia). *Medical Journal of Cairo University*, 78 (1): 319-330. Available: https://www.researchgate.net/publication/306017146_Effect_of_menopausal_symptoms_on_women's_Quality_of_life_-_in_Benha_city_Egypt_and_Arar_city_Kingdom_of_Saudi_Arabia (Accessed 23 April 2020).

Germann, W. and Stanfield, C. 2008. *Principles of human physiology*. 3rd ed. San Francisco, CA: Pearson Benjamin Cummings.

Ghattas, V. N., Ali, W. K. and Wahed, A. Y. A. 2019. Association between menopausal symptoms, quality of life and marital adaptation among working women. *IOSR Journal of Nursing and Health Science*, 8(1): 13-25. Available: www.iosrjournals.org (Accessed 6 February 2020).

Govender, N. 2003. A study comparing the effectiveness of a herbal-complex (*Arctium lappa, Berberis aquifolium, Echinacea purpurea* and *Taraxacum officinale*) as compared to homoeopathic simillimum in the treatment of Acne vulgaris. M. Tech, Durban University of Technology.

Graneheim, U. H. and Lundman, B. 2004. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2): 105-112.

Grant, M. D., Marbella, A., Wang, A. T., Pines, E., Hoag, J., Bonnell, C., Ziegler, K. M. and Aronson, N. 2015. Effective health care program. Menopausal symptoms: comparative effectiveness of therapies. *Agency for Healthcare Research and Quality*, 15(147): 1-490. Available: www.effectivehealthcare.ahrq.gov/reports/final.cfm (Accessed 25 March 2020).

Greenblum, C. A., Rowe, M. A., Neff, D. F. and Greenblum, J. S. 2012. Symptoms associated with menopausal transition and early postmenopausal and quality of life. *Menopause,* 20 (1): 22-27. Available: https://www.researchgate.net/publication/230755157_Midlife_women_Symptoms_associated_with_menopausal_transition_and_early_postmenopause_and_quality_of_life/references (Accessed 23 April 2020).

Guest, G. Bunce, A. and Johnson, L. 2006. How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1): 59-82. Available: https://doi.org/10.1177/1525822X05279903 (Accessed 12 March 2020).

Gujarathi, J. R. and Gujarathi, R. 2010. Shatavari – a boon for women. *World Journal of Pharmaceutical Research*, 2(1): 1-5. Available: https://www.researchgate.net/publication/237836655 (Accessed 3 April 2020).

Gupta, J., Kulshreshtha, D., Lamba, C. D., Gupta, P., Shinde, V., Wadhwa, B., Soren, A., Arya, J. S., Koley, M., Pramanik, A., Parveen, S. and Kumar, A. 2019. Homoeopathic medicine – *Sepia officinalis* for the management of menopausal symptoms: a multicentric, randomised, double-blind placebo-controlled clinical trial. *Indian Journal of Research in Homoeopathy*, 13(219): 1-5. Available: http://www.ijrh.org (Accessed 14 April 2020).

Guyton, A. and Hall, J. 2005. *Textbook of medical physiology*. 11th ed. United States of America W.B.: Saunders Company.

Hachul, H., Bezerra, A. G. and Andersen M. L. 2017. Insomnia and menopause. In: Attarian. H. P. ed. *Clinical handbook of insomnia: current clinical neurology*. Cham,

Switzerland: Springer, pp. 181-197. Available: https://doi.org/10.1007/978-3-319-41400-3_10 (Accessed 15 February 2020).

Hagen, S. 1995. Menopausal syndrome. Dissertation, M. Dip. Hom. Technikon Natal, Durban.

Hamoda, H., Panay, N., Arya, R. and Savvas, M. 2016.The British Menopause Society & Women's Health Concern 2016 recommendations on hormone replacement therapy in menopausal women. *Post Reproductive Health,* 22(4): 165–183. Available: DOI: 10.1177/2053369116680501 (Accessed 20 February 2020).

Hansa, F. 2011. The efficacy of complementary formulation of *Folliculinum* D6 and *Five-Flower Formula*^{tm} in the treatment of menopausal syndrome. Dissertation, M Dip. Hom. Durban University of Technology.

Harvard Medical School. 2019. Menopause and perimenopause. *Harvard Health Publishing* (blog). Available: https://www.health.harvard.edu/ (Accessed 30 April 2020).

Heel. 2008. The natural approach to regulating inflammation and supporting recovery. *Traumeel*® – How it works (blog). Available: https://www.traumeel.com/en/how-it-works.html (Accessed 06 July 2020).

Holloway, I. and Wheeler, S. 2010. *Qualitative research in nursing and healthcare*. 3rd ed. Chichester, West Sussex, UK: John Wiley & Sons Ltd.

Howard, J. 2005. *Bach flower remedies for women*. Vermilion: London.

Jane F. M. and Davis S. R. 2014. A practitioner's toolkit for managing the menopause. *Climacteric,* 17(5): 564-579. Available: https://doi.org/10.3109/13697137.2014.929651 (Accessed 15 May 2018).

Johnson, R. and Christensen, L. B. 2004. *Educational research: quantitative, qualitative, and mixed approaches*. 2nd ed. Boston, MA: Allyn and Bacon.

Jouyandeh, Z., Nayebzadeh, F. Qorbani, M. and Asadi, M. and 2013. Metabolic syndrome and menopause. *Journal of Diabetes & Metabolic Disorders*, 12(1): 1-4. Available: doi:10.1186/2251-6581-12-1 (Accessed 20 March 2020).

Kamini, D. and Dhiman, K. S. 2013. Menopausal syndrome: an Ayurvedic appraisal. *Unique Journal of Ayurvedic and Herbal Medicines*, 1(2): 58-63. Available: www.ujconline.net (Accessed 23 March 2020).

Kaur, H. and Goel, N. 2019. Comparative evaluation of menstrual patterns and hormonal profiles in normal and abnormal perimenopause. *International Journal of Reproduction, Contraception, Obstetrics and Gynecology* 8(9): 3556-3563. Available: http://dx.doi.org/10.18203/2320-1770.ijrcog20193775 (Accessed 19 February 2020).

Kayne, S. B. 1997. *Homoeopathic pharmacy, an introduction and handbook*. Singapore: Longman Singapore Publishers (Pte) Ltd.

Kayne, S. B 2003. Global perspectives. In: Carlston, M. ed. *Classical homoeopathy*. Philadelphia, PA: Churchill Livingston, p. 48.

Kayne, S. B. 2002. *Complementary therapies for pharmacists*. London: Pharmaceutical Press.

Kent, J. T. 2007. *Lectures on homoeopathic philosophy*. Mumbai: B Jain Publishers.

Khumalo, P. 2015. Patients' experiences of homoeopathic care rendered at a primary health care facility in the eThekwini district. M. Tech: Homoeopathic, Durban University of Technology.

Kidd, M.D. 2011. A study of the factors involved in establishing a successful homoeopathic practice in South Africa. M.Tech: Homoepathic, Durban University of Technology.

Kotsirilos, V., Vitetta, L. and Sali, A. 2011. *A guide to evidence- based integrative and complementary medicine*. Chatswood, H. P.: Churchill Livingstone.

Kwee, S. H., Marsman, A., Tan, H. H. and Wauters, C. 2007. Randomised controlled trial: the effect of Chinese Herbal Medicines (CHM) on menopausal symptoms compared with hormone replacement therapy (HRT) and placebo. *Maturitas,* 58(1): 83-90. Available: doi: 10.1016/j.maturitas.2007.06.005 (Accessed on 4 March 2020).

LaCroix, A. Z., Chlebowski, B. T., Manson, J. E., Aragaki, A. K., Johnson, K. C., Martin, L., Margolis, K. L., Stefanick, M. L. Brzyski, R., Curb, J. D., Howard, B. V., Lewis, C. E., and Wactawski-Wende, J. 2011. Health outcomes after stopping conjugated equine estrogens among postmenopausal women with prior hysterectomy, a randomised controlled trial. *Journal of the American Medical Association,* 305(13): 1305-1314. Available: DOI: 10.1001/jama.2011.382 (Accessed 20 March 2020).

Lethaby, A., Hogervorst, E., Richards, M., Yesufu, A. and Yaffe, K. 2008. Cochrane database of systematic reviews: hormone replacement therapy for cognitive function in postmenopausal women. *Cochrane Systematic Review – Intervention*, 2008(1): 1-58. Available: DOI: 10.1002/14651858.CD003122.pub2. (Accessed 19 February 2020).

Liao, L., He, Y., Li, L., Meng, H., Dong, Y., Yi, F. and Xiao, P. 2018. A preliminary review of studies on adaptogens: comparison of their bioactivity in TCM with that of ginseng-like herbs used worldwide. *Chinese Medicine*, 13(57): 1-12. Available: https://doi.org/10.1186/s13020-018-0214-9 (Accessed 4 March 2020).

Macías-Cortés, Ed. C., Llanes-González L., Aguilar-Faisal, L. and Asbun-Bojalil, J. 2015. Individualized homeopathic treatment and fluoxetine for moderate to severe depression in peri- and postmenopausal Women (HOMDEP-menop study): a randomized, double-dummy, double-blind, placebo-controlled trial. *PLoS One*, 10(3): e0118440. Available: https://www.ncbi.nlm.nih.gov/pubmed/25768800 (Accessed 14 April 2020).

Macquet-Maurel, L. 2003. The efficacy of *Dioscorea villosa* cream in the treatment of menopausal syndrome. Dissertation, M. Dip. Hom. Technikon Natal, Durban.

Maharishi Ayurveda. 2013. Ayurvedic herbs and tips for menopause*. Maharishi Ayurveda* (blog). Available: https://www.mapi.com/blog/ayurvedic-herbs-and-tips-for-menopause.html (Accessed 5 April 2020).

Majer-Julian, E. 2013. *Homeopathy for menopause: the main complaints and their homeopathic treatment.* 1st English ed. Kandern, Germany: Narayana Publishers.

Majola, S. F. 2015. The perceptions of homoeopathic doctors practicing in KwaZulu-Natal on their role in the public healthcare system in South Africa. M. Tech: Homoepathy, Durban University of Technology.

Makara-Studzińska, M. T., Kryś-Noszczyk, K. M. and Jakiel, G. 2014. Epidemiology of the symptoms of menopause - an intercontinental review. *Prz Menopauzalny*, 13(3): 203-211.Available: doi:10.5114/pm.2014.43827 (Accessed 23 August 2020).

Malhotra, J., Lal, P., Garg, R. and Sahoo, G. 2018. Emergence of metabolic syndrome out of menopausal box!!! *Journal of South Asian Federation of Menopause Societies*, 6(1): 1-7. Available: https://www.researchgate.net/publication/327795074 (Accessed 20 March 2020).

Manson, J. E. and Bassuk, S. S. 2014. Calcium supplements: do they help or harm? *Menopause,* 21(1): 106-108. Available: https://www.ncbi.nlm.nih.gov/pubmed/23880796 (Accessed 23 April 2020).

Marjoribanks, J., Farquhar, C., Roberts, H. Lethaby, A. and Lee, J. 2017. Cochrane database of systematic reviews: Long-term hormone therapy for perimenopausal and postmenopausal women. *Cochrane Systematic Review – Intervention*, (1): 1465-1858. Available: DOI: 10.1002/14651858.CD004143.pub5. (Accessed 19 February 2020).

Mason, M. 2010. Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Social Research,* 11(3): 1-19. Available: http://www.qualitative-research.net/index.php/fqs/article/view/1428 (Accessed 25 March 2020).

Mauvais-Jarvis, F., Manson, J. E., Stevenson, J. C. and Fonseca, V. A. 2017. Menopausal hormone therapy and type 2 diabetes prevention: evidence, mechanisms, and clinical implications. *Endocrine Reviews*, 38(3): 173-188. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5460681/ (Accessed 25 March 2020).

Mayo Clinic. 2020. Perimenopause (blog). Available: https://www.mayoclinic.org/diseases-conditions/perimenopause/symptoms-causes/syc-20354666?p=1 (Accessed 30 April 2020).

McTeer, T. 2003. The Efficacy of progestoNat cream in the treatment of menopausal syndrome. M.Tech:Homoeopathy, Technikon Natal, Durban.

Micozzi, M. S. 2001. *Fundamentals of complementary and alternative medicine*. 2nd ed. Philadelphia, PA: Churchill Livingstone.

Micozzi, M.S. 2001. Medical guides to complementary and alternative medicine: *fundamentals of complementary and alternative medicine*. 2nd ed. London: Churchill Livingstone.

Modi, M. B., Donga, S. B., and Dei, L. 2012. Clinical evaluation of ashokarishta, ashwagandha churna and praval pishti in the management of menopausal syndrome*. Ayu,* 33(4): 511-516. Available: http://www.ayujournal.org (Accessed 15 May 2019).

Morley, J. E. and Perry, H. M. 2003. Androgens and women at the menopause and beyond*. Journal of Gerontology,* 58A (5), 409–416*.*

Morris, E.P. and Rymer, J. 2001. Update on the risk-benefit ratio of HRT in the menopause. In: Bonnar, J. ed. *Recent advances in obstetrics and gynaecology*. (ed.) London: Churchill Livingstone, pp. 161-172.

Muhammad, A., Muhammad, B. and Muhammad T. A. 2008. Reliability and validity of qualitative and operational research paradigm. *Pakistan Journal of Statistics and Operation Research*, (4)1: 35-45. Available: https://www.researchgate.net/publication/44286439 (Accessed 19 March 2020).

Munir, J. and Birge, S. J. 2014. Vitamin D deficiency in pre and postmenopausal women. *Menopause Management: Primary Care for Midlife Health* (blog). Available: https://www.menopausemgmt.com/vitamin-d-deficiency-in-pre-and-postmenopausal-women/ (Accessed 04 July 2020).

Naftolin, F., Friedenthal, J., Natchtigall, R. and Natchtigall, L. 2019. Cardiovascular health and the menopausal woman: the role of oestrogen and when to begin and end hormone treatment. *F1000Research*, 8: F1000 Faculty Rev-1576. Available: https://doi.org/10.12688/f1000research.15548.1 (Accessed 19 February 2020).

Naik, R. R., Chandel R. S. and Abichandani L. G. 2013.: Comparative study of gonadotropin levels and clinical presentation in surgical and natural menopause*.*

International Journal of Medical Research & Health Sciences, 3(1): 1-6. Available: www.ijmrhs.com (Accessed 15 July 2019).

National Health Service UK. (2014). Sex after the menopause (blog). Available: http://www.nhs.uk/livewell/women4060/pages/sex-after-the-menopause.aspx (Accessed 22 April 2020).

Nazario, B. 2003. Dangers of Black cohosh as HRT (blog). Available: (http://www.medscape.com/viewarticle/530107 (accessed 12 November 2019).

Neville, F., Hacker, J., Moore, G. and Gambone, J. C. 2004. *Essentials of obstetrics and gynaecology*. 4th ed. China: Elsevier Saunders.

Newton, K. M., Reed, S. D., Nekhyludov, L., Grothaus, L. C., Ludman, E. J., Ehrlich, K. and LaCroix, A. Z. 2014. Factors associated with successful discontinuation of hormone therapy. *Journal of Women's Health*. 23(5): 382–388. Available: doi: 10.1089/jwh.2012.4200 (Accessed 24 August 2020).

Ngobese, V. N. B. 2018. Experiences of returning patients at a homoeopathic community Clinic. M. Tech: Homoeopathy, Durban University of Technology.

Novey, D. W. 2000. *Clinician's complete reference to complementary/ alternative medicine*. London: Mosby, Inc.

Nye, D. M. 2020. Biopuncture. *South African Society of Integrative Medicine* (blog). Available: https://integrativemedicine.co.za/biopuncture/ (Accessed 16 April 2020).

O'Reilly, W. B. ed. 2010. *Organon of the medical art*. 6th ed. New Delhi: B. Jain Publishers (P) Ltd.

Oats, J. and Abraham, S. 2005. *Fundamentals of obstetrics and gynaecology*. 8th ed. Spain: Elsevier Mosby.

Oh, G.C., Kang, K.S., Park, C.S., Sung, H. K., Ha, K.H., Kim, H. C., Park, S., Ihm, S. H. and Lee, H.Y. 2018. Metabolic syndrome, not menopause, is a risk factor for hypertension in peri-menopausal women. *Clinical Hypertension,* 24(14): 2-8. Available: https://doi.org/10.1186/s40885-018-0099-z (Accessed 20 March 2020).

Orlowski, M. and Sarao, M.S. 2018. *Physiology, follicle stimulating hormone*. Treasure Island: StatPearls Publishing.

Padgett, D. K. 2012. *Qualitative and mixed methods in public health*. Thousand Oaks, CA: SAGE Publications.

Park, S. K., Harlow, S. D., Zheng, H., Karvonen-Gutierrez, C., Thurston, R. C., Ruppert, K., Janssen, I. and Randolph Jr, J. F. 2017. Association between changes in oestradiol and follicle-stimulating hormone levels during the menopausal transition and risk of diabetes. *Diabetic Medicine*, 34: 531-538. Available: https://www.ncbi.nlm.nih.gov/pubmed/27973745 (Accessed 25 March 2020).

Paschou, S. A., Anagnostis, P., Goulis, D. G. and Lambrinoudaki, I. 2018. Androgen excess and post-reproductive health. *Maturitus: An International Journal of Midlife Health and Beyond,* 115: 2214-9112. Available: https://doi.org/10.1016/j.maturitas.2018.04.005 (Accessed 01 April 2020).

Patel, R.P. 2005. *What is tautopathy?* 7th ed. India: Indian books & periodicals publishers.

Peace Health. 2012. Menopause symptoms (homeopathy). *Health Information Library* (blog). Available: https://www.peacehealth.org/medical-topics/id/hn-2240002#hn-2240002-remedy-options (Accessed 01 May 2020).

Pitkin, J. 2013. Should HRT be duration limited? *Menopause International,* 19(4): 167–174. Available: doi: 10.1177/1754045313507176 (Accessed 19 February 2020).

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.

Ra, S. J., Kim, S. H. and Jeong, Y. 2019. Associated factors of ischemic heart disease identified among post-menopausal women. *Osong Public Health and Research Perspectives*, 10(2): 56-63. Available: https://doi.org/10.24171/j.phrp.2019.10.2.03 (Accessed 6 February 2020).

Robinson, D., Toozs-Hobson, L. P. and Cardozo, L. 2013. The effect of hormones on the lower urinary tract. *Menopause International*, 19(4): 155-162. Available: DOI: 10.1177/1754045313511398 (Accessed 6 February 2020).

Sagara, Y., Kosha, S., Baba, S., Dokiya, F. Tamada, S., Matsuyama, Y., Ohi, Y., Ando, M., Rai, Y., Sagara, Y. and Douchi, T. 2010. Adverse events and bone health during anastrozole therapy in postmenopausal Japanese breast cancer patients. *Breast Cancer*, 17(3): 212-217. Available: https://www.ncbi.nlm.nih.gov/pubmed/19526308 (Accessed 8 February 2020).

Sankaran, R. 2006. *The sensation in homoeopathy*. Mumbai: Homoeopathic Medical Publishers.

Santoro, N. F. and Neal-Perry, N. 2010. *Amenorrhea: a case-based, clinical guide*. New York: Springer.

Shabaan, H. A. Mohasib, S. H. and Emam, E. 2018. Factors affecting quality of life among woman with menopausal symptoms. *IOSR Journal of Nursing and Health Science*, 7(2): 81-91. Available: www.iosrjournals.org (Accessed 23 April 2020).

Shen, L., Song, L., Li, H., Liu, B., Zheng, X., Zhang, L., Yuan, J., Liang, Y. and Wang, Y. 2017. Association between earlier age at natural menopause and risk of diabetes in middle-aged and older Chinese women: The Dongfeng–Tongji cohort study. *Diabetes Metabolism,* 43(4): 345-350. Available: doi: 10.1016/j.diabet.2016.12.011 (Accessed 28 March 2020).

Simoni, M., Huhtaniemi, I., Santi, D. and Casarini, L. 2019. Follicle-stimulating hormone: fertility and beyond. *Frontiers of Endocrinology,* 10(610): 1664-2392. Available: doi: 10.3389/fendo.2019.00610 (Accessed 13 February 2020).

Singh, S., Herwijnen, I., and Phillips, C. 2013. The management of lower urogenital changes in the menopause. *Menopause International,* 19(2): 77-81. Available: DOI: 10.1177/1754045313481536 min.sagepub.com (Accessed 6 February 2020).

Smitz, J., Wolfenson, C., Chappel, S., and Ruman, J. 2015. Follicle-stimulating hormone: a review of form and function in the treatment of infertility. *Reproductive*

Sciences, 1: 706-716. Available: https://www.researchgate.net/publication/282669192 (Accessed 13 February 2020).

Spence, D. Thompson, E. and Barron, S. 2005. Homoeopathic treatment for chronic disease: a 6-year, University-hospital outpatient observational study. *The journal of Alternative medicine and Complementary medicine,* 11(5): 793- 798. Available: http://www.dcscience.net/spence-jacm-05.pdf (Accessed 22 July 2019).

Stengler, A. and Stengler, M. 2003. *Your menopause, your menotype*. New York: Prentice Hall Press.

Stoppler, M. 2016. The stages of menopause. *Women's Health* (blog). Available: http://www.medicinenet.com/script/main/art.asp?articlekey=2036 (accessed 10 January 2019).

Sturdee, D. 2003. *The facts of hormone therapy for menopausal women*. London: The Parthenon Publishing Group Limited.

Symonds, E. and Symonds, I. 2004. *Essential obstetrics and gynaecology*. 4th Ed. Spain: Churchill Livingstone.

Tan, J. K. L., Vasey, K. and Fung, K. Y. 2001. Beliefs and perceptions of patients with acne. *Journal of American Academy of Dermatology*, 44(3): 439-445

Terre Blanche, M., Durrheim, K., Painter, D. 2006. *Research in practice*. Cape Town: UCT Press.

Tesch, R., 1990, *Qualitative research: analysis types and software tools*. New York: Falmer.

The North American Menopause Society. 2000. Clinical Challenges of Perimenopause: Consensus opinion of the North American Menopause Society. *The Journal of the North American Menopause Society* 7(1): 5-13.

Thompson, E. A. and Relton, C. 2009. Designing clinical trials of homeopathy for menopausal symptoms: a review of the literature. *Post Reproductive Health*, 15(1): 31-34. Available: https://www.researchgate.net/publication/24035294 (Accessed 14 April 2020).

Toth, M. J., Sites, C. K., Eltabbakh, G. H. and Poehlman, E. T. 2000. Effect of menopausal status on insulin-stimulated glucose disposal: comparison of middle-aged premenopausal and early postmenopausal women. *Diabetes Care*, 23(6): 801-806. Available: https://care.diabetesjournals.org/content/23/6/801 (Accessed 2 April 2020).

Ulin, P. R., Robinson, E. T. and Tolley, E. E. 2005. *Qualitative methods in public health*. San Francisco, CA: Jossey-Bass.

Vithoulkas, G. 1990. *The science of homeopathy*. Reprint ed. New Delhi, India: B. Jain Publishers.

Vogel, A. and Leisegang, K. 2017. What is biopuncture? *The Art and Science of Homeopathy in Practice* (blog). Available: http://natural-med.co.za/what-is-biopuncture/ (Accessed 17 April 2020).

Wang-Cheng, R. 2007. *Menopause.* Philadelphia, PA: American College of Physicians.

Watson I. 2004. *A guide to the methodologies of homeopathy*. Revised ed. Totnes, Devon, England: Cutting Edge Publications.

West, W. O. 1958. Perforation and hemorrhage from duodenal ulcer during the administration of *Rauwolfia serpentina*: report of five cases. *Annals of Internal Medicine,* 48(5): 1033-1039. Available: DOI: 10.7326/0003-4819-48-5-1033 (Accessed 20 April 2020).

Yazdkhasti, M., Keshavarz, M., Merghati, K. E., Hosseini, A. F., Smaeilzadeh, S. E., Pebdani, M. A. and Jafarzadeh, H. 2012. The effect of structured educational program by support group on menopause women‘s quality of life. *Iranian Journal of Public Health,* 41(11): 78-84. Available: http://ijph.tums.ac.ir (Accessed 23 April 2020).

APPENDICES

Appendix A: Letter of information

LETTER OF INFORMATION

Title of the Research Study: A study on the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini municipality

Principal Investigator/s/researcher: (Nondumiso Thusi, Master's Degree student)

Co-Investigator/s/supervisor/s: (Dr. M. Maharaj, M.Tech. Homoeopathy)

Brief Introduction and Purpose of the Study: This study aims to explore the management regimes utilised by homoeopaths on managing menopausal syndrome. To the researcher's knowledge no similar research has been conducted.

This study will be conducted throughout the eThekwini area. The study population will consist purely of homoeopathic practitioners who are registered with the Allied Health Professions Council of South Africa and are practicing. Participants will only be selected to be part of the study if they meet the inclusion criteria.

Outline of the Procedures: The researcher will use purposive (snowball) sampling to recruit interested participants. A minimum of twelve participants will be selected to be part of the study. These participants will only be selected to be part of the study if they meet the inclusion criterion. Then they will be notified about the research through email or a phone call. An appointment will be made with them and the researcher will travel to the location that is suitable to them. A semi-structured interview is well suited for this research as it will allow the researcher to find out the management regimes you utilise in approach to managing menopausal syndrome. The semi-structured interview will be conducted using an interview

guideline and is expected to take approximately 30 minutes. The semi-structured interview will be audio-recorded and kept in storage where only the researcher and the supervisor will have access to. The semi-structured interview will be audio-recorded as to ensure that the words are purely theirs and are not skewed in any manner. During the semi-structured interview there will be themes and open-ended questions, to allow for a variety of responses to be gathered. Participants have the choice not to take part in the study as well as not to complete the semi-structured interview.

Should they wish to take part in the study they will be given a copy of a consent form.

Risks or Discomforts to the Participant: There are minimal risks due on participating in this study, hence there are no known or anticipated risks. Should you find a question difficult to answer or feel uncomfortable answering, we can (a) discuss the situation, (b) take a break, or (c) stop. If you choose to stop, we can either finish the interview another day or you can terminate your participation in the study. The risk of this study is very low and I will make every effort to protect you from this risk.

Benefits: There are direct benefits to you (the participant).

Reason/s why the Participant May Be Withdrawn from the Study: The researcher may stop you from participating in the study at any time if she believes it is in your best interest or if the study is dismissed. Also, you may choose to withdraw from the study at any time with no confrontational consequences.

Remuneration: You will not be remunerated for taking part in the study.

Costs of the Study: Participants will not be expected to cover any costs in the study.

Confidentiality: The privacy of all the participants in this study is secured. Data will be collected and stored in a safe place that is located at the Durban University of Technology. The place in which the data is stored will only be accessed by the researcher and the supervisor. Stringent confidentiality and anonymity will be adhered to. You will be assigned a code and only the researcher will hold access to it. Your confidentiality will be maintained even on the final dissertation. The data collected will remain in storage for five years at the

Durban University of Technology, Department of Homoeopathy and then be destroyed. The data will be analysed and placed in the final dissertation. The outcomes of the dissertation will be available at the Durban University of Technology library.

Research-related Injury: Due to the nature of the research there is no foreseen risks for injury related to research. No reimbursement will be made for such claims.

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

Please contact the researcher: Nondumiso Thusi (072 458 9014), my supervisor Dr. M. Maharaj (083 388 2688) or the Institutional Research Ethics Administrator on 031 373 2375. Complaints can be reported to the DVC: Research, Innovation and Engagement Prof S Moyo on 031 373 2577 or moyos@dut.ac.za.

Appendix B: Informed consent form

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher Nondumiso Thusi, 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, Nondumiso Thusi herewith confirm that the above participant has been fully informed about the nature, conduct and the 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 C: Interview Guide

Interview Guide for the qualitative research study:

A qualitative study on the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini municipality

Demographic Data

Please fill in with the appropriate information

1. **Age:** _____
2. **Gender:** _____
3. **Practitioner:** _____
4. **Area:** _____
5. **Number of years in practice:**_____

Grand Tour Question

1. **How would you describe your approach (how you diagnose and clinically manage) to patients presenting with Menopausal syndrome?**

Sub Questions

1. **Describe your understanding of Menopausal syndrome from a homoeopathic perspective.**
2. **Explain how you diagnose Menopausal syndrome in your practice?**
3. **What is your therapeutic approach to managing patients with Menopausal syndrome?**

4. **What type of homoeopathic treatment do you prescribe for patients presenting with Menopausal syndrome?**
5. **What additional modalities do you employ or recommend for patients presenting with Menopausal syndrome?**

Appendix D: Ethics approval

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

P O Box 1 334, Durban, South Africa. 400 1

Tel: 03 1 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research(institutionai research ethics

www.dut.ac.za

6 September 2019

Ms N C Thusi P. O. Box 51965
Osizweni 2952

Dear Ms Thusi

A study on the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini municipality

I am pleased to inform you that Full Approval has been granted to your proposal.

The Proposal has been allocated the following Ethical Clearance number IREC 124/19. Please use this number in all communication with this office.

Approval has been granted for a period of ONE YEAR, before the expiry of which you are required to apply for safety monitoring and annual recertification. Please use the Safety Monitoring and Annual Recertification Report form which can be found in the Standard Operating Procedures [SOP's] of the IREC. This form must be submitted to the IREC at least 3 months before the ethics approval for the study expires.

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 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

Dr M A Sathar
Deputy Chairperson: IREC

Appendix E: Editing certificate

DR RICHARD STEELE
BA, HDE, MTech(Hom)
HOMEOPATH
Registration No. A07309 HM
Practice No. 0807524
Freelance academic editor
Associate member: Professional Editors' Guild, South Africa

110 Cato Road
Bulwer (Glenwood), Durban 4001

031-201-6508/082-928-6208

Email: rsteele@vodamail.co.za

EDITING CERTIFICATE

Re: **Nondumiso Charity Thusi**
Master's dissertation: **A study on the management of menopausal syndrome by registered homoeopathic practitioners in eThekwini municipality**

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 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 Homoeopathy 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
2020-09-03
per email