

Practising in Botswana, November '05 – May '06

What is this paper about?

Working in a place as foreign as Botswana offered me new perspectives on a wide variety of issues, which I feel compelled to share with other homeopaths. In the following pages, I skim through many topics (without covering any one of them in any depth) and try to present a wide array of thoughts that emerged subsequent to busy 6 months – I treated about 600 patients during this period.

The ideas are not solely mine. During my time in Maun I've shared many of these thoughts with the homeopaths who practised with me: Margaret Ecclestone, Lesley Murphy, Julia Hunn and Hilary Fairclough. Since we worked in close proximity, we often inspired each other. Hilary, the founder and clinical director of the Maun Homeopathy Project, has been a major inspiration to me. She has introduced the triad method as the main prescribing strategy in Maun, and a large part of the ideas I present here are based on her thinking. I owe her a great deal both on account of her guidance, and for giving me the chance to practice in Maun. Naturally, the thoughts that follow are based on my understanding, which would sometimes deviate from hers. I owe another great debt to the patients themselves – I feel very lucky to have been able to work with such generous and open-hearted people as the Batswana¹.

A lot of what I say here is probably half-baked, little is new, and much is speculative, but I prefer to release ideas to the ether and hopefully stir some reaction, rather than letting them ferment for a long time and lose momentum. I only send this paper to people I know, so occasionally I allowed myself to get carried away with speculations. It is for you to determine whether there's any value in these.

In any case, it felt great to put it all down in writing – it was a good way to complete a very moving experience. I hope that reading this paper will be useful in some way. Please let me know what you think...

I organized the text as paragraphs which start with discussing a concept and then flow on.

Triad prescribing

This prescribing method, involving polypharmacy and frequent repetitions, was developed by Hilary. At first I've found it too alien, but as time went by, and as I experimented with different methods, I've learnt to see its many advantages in the situation in Maun.

The model maintains that in most cases one would prescribe three remedies:

¹ Batswana are the residents of Botswana.

- Acute – addressing the physical or mental complaint that is most bothersome to the patient at present time. Examples can be side effects from allopathic treatment, chronic diarrhea, vaginal discharge, physical trauma or mental trauma
- Constitutional² - this remedy would cover the patient's current sensitivity, as well as the core issues and patterns he is burdened by; it will also cover the basic physical attributes. In short, this remedy would be chosen in a manner which is, generally speaking, 'classical'³.
- Miasmatic/ nosode prescribing – what is the patient's basic attitude towards his life's challenges? How does he react to his sensitivity? The remedy is chosen in a way similar to how Sankaran chooses the miasm in "The Sensation in Homeopathy" (although for Sankaran, choosing the miasm would be of course only a step in choosing a single remedy). The remedy chosen would be a nosode representing the miasm.

Each remedy is usually given once a week, typically for 4 weeks, with the followup scheduled to when the course is completed, or bit later.

A typical case might be an HIV+ female patient, aged 32, that has:

- Severe itching all over the body since starting the ARVs⁴ a year ago, accompanied by sensation of heat
- Peripheral neuropathy since starting the ARVs
- Severe headaches, pulsating in the temples, no other modalities, started when her partner left her with 4 children 9 months ago
- No job and no qualifications, has only had the odd temporary job as a cleaner
- Having to treat, apart from her kids, 2 other children of her dead sister, and her sick mother. Despite the difficulties, she doesn't question this commitment
- Having to endure abuse from an uncle in whose yard she is staying. He clearly dislikes her, but she has nowhere else to go with the kids. She accepts the abuse with dignity
- Palpitations when thinking about her situation
- Sleeplessness, thinking about her troubles

This type of case is very common, and often you'd even have additional physical complaints to accompany it, usually without any clear modalities. What can you do? What do you prescribe on? Try as you might, there's no one remedy that covers the totality. But you can see different pictures:

- Sulph for itching and heat. This remedy is fantastic in treating side effects from the ARVs
- You can also see Nat-c: taking care of everyone without a complaint, and with great dignity
- Finally, you can see Carc – trying to do her best against all odds and having to suppress emotions

² Hilary prefers the term 'fundamental' to the term 'constitutional'. Her differentiation assumes that what we normally call the constitutional state is often still hidden below outer layers of pathology, and will possibly be unveiled at a later stage. It is a differentiation similar to the one used by Eizayaga, but it is not identical.

³ Graz Baran rightly remarked that the term 'classical' is somewhat confusing. What I mean in 'classical' is similar to 'Kentian', or to 'essence prescribing': prescribing one remedy at a time according to the totality of sx's, waiting for a relatively long time before the next appraisal, and then preferring not to change a remedy unless there are clear indications for doing so.

⁴ Anti-retrovirals; "cocktail therapy" for HIV.

So I'd give the following prescription:

- Sulph 30 every Monday
- Nat-c 1M every Wednesday
- Carc 200 every Friday

For 4 weeks, to come back for followup in 5 weeks.

The clinical results in cases like these are often magical. The patient would usually return with virtually all the sxs noticeably better. The next prescription would sometime be a repeat of the previous one, and sometimes – if a new picture has emerged – slightly different. We would usually expect the improvement to continue over the next sessions.

A sketch of another case might be:

Woman, 28, on ARVs for the last 6 months. Suffers from:

- Severe diarrhea for the last 2 months, getting progressively worse
- Heaviness and drooping of the limbs, can hardly lift them, > massage
- All body painful⁵
- Coldness of the body
- Severe emaciation and debility; lies in bed the whole day
- Severe depression, feeling of death in the room

A possible prescription in such a case would be:

- Ars 200 – for the diarrhea, the resulting debility and the coldness
- Plb 1M – for the drooping paralysis and the heavy depression
- Syph 200 – for the 'gone beyond' aura of the case.

Again, each remedy to be taken once a week. Because of the acuteness of this case, I'd give the remedies for only 3 weeks, and want to see the patient as soon as the course is finished.

But what would happen if we only gave one remedy, and watched/waited, in a Kentian fashion? It is impossible to be certain, but based on what I saw in Maun, I'd assume that in the above case if I gave only the Ars, for example, the diarrhea would be better, but the depression and drooping only slightly improved; if I only gave the Plb, the diarrhea would remain; if I only gave the Syph, everything would be somewhat better, but no sx wholly removed.

So, in Maun we found that we need more than one remedy. But why give the remedies together, rather than in sequence, as a classical homeopath would do? We could give one remedy for a week, have the patient come back, and then either repeat or, more likely, give another remedy (eg, start with Ars, and when the diarrhea is better change to Plb).

One main objection would be pragmatic. Prescribing one remedy at a time is obviously much more demanding in terms of resources: if we did that, the homeopaths would be able to see far less patients, and it would also mean that people who are sometimes very poor, sick and immobile would need to travel to the clinic more often.

⁵ This was a very common complaint. People (regardless of age) would say this, and present no other concomitants or modalities, except maybe a night aggravation.

Furthermore, there're grounds to assume that, in such cases of complex pathology, prescribing a few remedies together might be more beneficial than sequential prescribing. I'll look at this possibility next⁶.

Trying to understand the triad

The triad presents a challenge to classical homeopaths: as we saw, the system is unorthodox both in terms of the frequent repetitions used, and because it utilizes polypharmacy. Furthermore, it is often the view of classical homeopaths that such a prescription method would be necessarily suppressive, and so would complicate the sxs picture and drive the imbalance inward. I'll address these three challenges one at a time, starting with the repetition issue.

In the West patients often stick to unhealthy but familiar situations which have negative consequences – these we call maintaining causes. When the right remedy is given, it often helps the patients to act out, remove the maintaining cause and become healthier: for example, when a patient finds, during treatment, the courage to move out of an abusive relationship.

Obviously, cure through action is not always possible, even in the West⁷. In Africa, it seemed to me, generating such a cure is a truly remote possibility. The Batswana generally live unhealthy lives, exacerbated by many maintaining causes, but since they have few choices they usually cannot remove these causes. There's no possibility of action and no cultural concept of choice to the extent we know in the west. The image I have when imagining the life there is as if the VF is burdened under an immense weight of pathology and circumstances, and its reaction is to give in, to sink under.

Consequently, it was interesting to clinically note that almost always the patients would relapse if left without a remedy for an extended period of time. It is as if the VF needed constant prodding; it is as if in order to bring the VF back into health, we needed to constantly push it and revitalize it.

When considered in the context of the maintaining causes, this clinical observation makes sense. If one needs to fight against the force of maintaining causes which cannot be removed, frequent repetitions would make a lot of sense.

Now let's look at the polypharmacy issue⁸. Imagine a person trapped in a large burning mansion, full of fumes. He is lost, suffocated, and in panic. If you gave him a map that would show him how to leave the house you still haven't helped – he won't be able to read it because of the panic and the suffocation. Moreover, standing still and trying to concentrate will probably aggravate his feeling. To be successfully helped, this person needs a few aids together: a map, a way to calm himself and oxygen.

⁶ A similar argument is put forward by Ramakrishnan and Coulter in their book "A Homeopathic Approach to Cancer"

⁷ When I make comparisons to the West I do not make a claim that there are certain situations that are only applicable in Africa. There are, naturally, similar situations in the West, only some are rare in comparison. I thank Graz Baran for her advice here.

⁸ The ideas I present are very similar to the layers model, and they have been covered by Eizayaga, Ian Watson, and others. But I repeat them here as I feel that the African practice adds an interesting context.

This is very much like the situation in Africa – people have so many problems, on so many levels. There's not one aspect of existence which is stable, no one aspect which you can use as a platform from which to leverage healing.

Here's another image: you want to uproot a bush. But the conditions to perform the action are lacking: the soil around the bush is boggy and your arms are very weak. Trying to pull out the bush without first stabilizing the soil will result in you sinking; trying to pull it without strengthening the arms will result in injury. Again, you need to address many levels, and address them in such a way that the different components can mature at the same time and complement each other.

Working with a few levels simultaneously, it would be possible to gradually ease the bush out. What we've found in Maun is that as the treatment goes on, the general level of health gradually increases, and the sx's grow less severe. We found that each (well-indicated) remedy clears some pathology in its own domain, and enables the other remedies to work, thus creating a positive cycle.

Finally, I'll address the possibility that the triad confuses the sx's picture. To be sure, the progress towards health in our Maun patients was somewhat zigzagged. I didn't experience the healing process as the crumbling down of a whole pathological structure, the way one experiences when a simillimum is given to a relatively healthy patient; this type of clarity was a rare commodity in Maun. Rather, working there felt like a constant dance. Sometimes it felt like I got the tempo right, at other times there was some treading on toes. But the general direction was almost always toward greater health.

My view was that, since one must prod the VF constantly, there's no harm in some zigzagging. The most important component of healing, in my mind, was to keep the momentum going, and hope that clarity would slowly emerge. And indeed, that was often the case. The zigzagging process might have involved some suppression, but perhaps suppression is needed sometimes. Imagine the bush metaphor again – in order to uproot the bush we need to *push in* with the foot, as well as *pull out* with the arms.

We were able to establish that the zigzag was working because, with continued treatment:

- Intervals between consultations could be gradually increased: a patient that has had to have remedies non-stop could do with 2-3 weeks breaks without any remedies before relapsing again
- The number of remedies could also be decreased. Often, as a patient got better, I didn't see 3 pictures any more, and reverted to giving only two remedies, often one being a nosode. However, it was very rare to prescribe only one remedy, and in the few instances that I did it with HIV+ patients the results were not encouraging.

Clinical results

As I mentioned, the clinical results were often nothing short of miraculous. During my time in Maun we've been often thinking about possible explanations, but came up with nothing that supplied a full answer. Here are some ideas:

The first explanation is familiar. Vithoukas gave it with regards to treating villagers in Greece. I'll give an African version of the same story.

The colonialists called the Africans primitive and childish. This has a negative connotation. But in truth, the mind of most Africans, at least in Botswana, is different to ours. It has a certain simplicity and lack of clutter which has both the disadvantages highlighted by the racists, and many advantages ignored by them, such as openness, innocence and sincerity. I also felt that Africans possess an emotional intelligence which is far superior to ours – since they don't analyze as much as we do, they can sustain a much wider range of emotions simultaneously.

There's obviously a trade-off between analytic thinking and holistic thinking. Analytic thinking is epitomized by words, whilst holistic thinking is epitomized by feelings. The advantages of feeling over analyzing in Africa became evident in my mind during my time there. For example, it seemed to me that I couldn't lie to Botswana; it often seemed that people saw straight into my heart. I had the impression that often what I said received little consideration, whilst what I felt was painfully obvious.

So my experience was that, on some level, people in Africa possessed clarity that I lacked. This point can be further illustrated by a metaphor.

Imagine the human consciousness as a large plateau, maybe similar to an African savanna. In one case it is open and unmarked: quick traveling across the plateau is difficult, but the open vista can be easily appreciated. Now imagine it crisscrossed by many busy roads, going this way and the other, junctions, overflows and interchanges, in a huge complexity. Maybe even imagine the plateau divided into different countries, each with its own traffic rules. Getting around is easier in a way, as there are many more roads; but where has the plateau gone?

The barren plateau can be likened to the African mind, in which the whole overshadows the parts; the crisscrossed plateau to the busy Western mind, in which the whole is lost for the parts.

You can see the origins of the barren plateau in the way African kids are raised. The amount of stimuli they receive is so much smaller, compared to our children. Most of the time they run around playing with each other and with makeshift toys in the yard; when they have mundane difficulties, they need to sort them out themselves. No DVDs, no teletubbies, no constant "mummy, see what I painted"; these kids are much less stimulated, and much less restless. The adults, as well, have fewer options than we do, hence fewer distractions. Fewer distractions and possibilities can be likened to fewer roads. There's not a lot to keep the consciousness occupied apart from the pathology, to which the remedy is prescribed – hence the remedy would act swiftly if it covers the pathology well.

Another possible explanation for the level of clinical success is that people in Africa have an enormous need for healing – having been forsaken by the world, being so far behind in so many aspects, having such different consciousness than ours, it felt to me as if there was an enormous craving for care and for treatment. It felt as if there was a deep need to connect with people who, like us, could offer healing.

And we can also turn the story around: I feel that we, too, might need to connect with the Africans in order to make ourselves whole. Personally, I feel that I have benefited immensely from this cultural exchange – that being in Africa was an important step towards reconnecting with a long-lost simplicity. Both myself, and the

other homeopaths in Maun, found that being in touch with African values was conducive to our personal development and deeply enriching.

The level of sickness in Botswana

It takes time to appreciate the relevance and beauty of African values. Indeed, these values are very-nearly impossible to appreciate when one only sees the technicalities of the situation in Botswana, where 35% of the population is HIV+. This society, until very recently, has had a level of technological and cultural development compared to that of the Iron Age⁹. The exposure to the Western culture of the 20-21st centuries and the inability to cope with its demands has had devastating results on the Batswana. My fundamental experience of Maun was of a severely sick and hopeless place. Most people in Maun suffer from having little food, no jobs, no qualifications, no prospect for progress, no support in any form, broken down values, broken down family structures, trauma etc; the individuals as well as the society feel unhealthy and, worse still, lost. I could not imagine any way out of the situation, nor could I see many locals who have found a healthy balance between the old values and the demands of our time¹⁰.

If I pull back and try to look at the situation in Africa from a wide perspective, then it seems that the sickness is located in the deepest possible place. People in Botswana lack a sense of security in life; it feels as if they have lost the story-line for their existence. What else would a person feel if he has no way to join the flow of life, let alone comprehend or master it?

On a theoretical level we know that the deeper the disturbance is, the sicker would be the person and the weaker would be the VF. So we'd assume that people in Maun are very sick, and have a very sick vital force.

However, this presents a puzzling question when we consider the clinical results in Maun. We tend to think that a strong vital force is required if a patient is to react well to homeopathy, and so we'd assume that the patients with whom we got miraculous results have had a strong vital force to start with.

We tend to judge the health of the vital force from the vitality; indeed, as homeopaths we use both terms – vital force and vitality – interchangeably. Most of the Batswana patients seemed to possess a strong vitality. Even very sick people, on the most part, coped relatively well with their situation; they had bright eyes, good complexion, and possessed good energy considering what they were going through.

However we also tend to think that, if their vitality is strong, patients would bounce back from their sickness spontaneously and within a short time; we tend to think that patients with strong vitality would have acute rather than chronic disturbances. But we saw very few states which were exclusively acute – HIV is a chronic

⁹ Compare the situation in Africa to the situation in other third world areas like South-East Asia or South America. Let's take relatively less-developed places like Indonesia and Peru as examples: these countries developed elaborate cultures before colonization, and were colonized centuries before Africa was. Botswana, on the other hand, had not had a notion of commerce, let alone writing, crafts, architecture, administration, or any of the other components of the modern culture until a few decades ago. Botswana is a unique case even in African terms, because it was never properly colonized. Consequently, it is currently one of the most stable and successful countries in Africa, but also one of the least-developed ones.

¹⁰ The situation in other places, eg the capital Gaborone, seems to be better.

condition, and as mentioned earlier, there were always underlying constitutional and miasmatic states. Even if one ignores the HIV, most of the people we treated were stuck in a certain state for a long time – a major part of their disturbances was clearly chronic and deep. Yet when treated they bounced back swiftly. So which is true? Did the very sick Africans that we turned around have a strong vitality, or a weak one? Did they have a strong vital force, or a weak one? In the following paragraphs I'll try to answer these questions through differentiating between the vitality and the VF.

Vitality and the vital force

In some spiritual traditions¹¹, a differentiation is made between prana and the higher consciousness. The prana is vitality, it is the force of life – it comes from the sun, the air, the food we eat, the exercise we take. We can strengthen it by breathing fresh air, eating organic food, doing yoga and the like.

But the prana/ vitality has no intelligence, it is energy with no direction, it can support healing but not initiate it; it is a force of life, but not the essence of life. It is similar to the concept of chi in Chinese medicine – a generic energy that is directed by some intelligence of higher order.

This intelligent force would be the higher intelligence or the VF. I suggest that the health of the VF is a reflection of the existential position of the person in the world – does the person feel that she truly belongs to the world and the society? That she is productive? That she is doing the right thing for herself? What is her level of internal friction? This type of questions would differentiate a healthy VF from an unhealthy one. A healthy VF is possessed by people who have little internal tensions on the deep level, and an unhealthy VF is possessed by people who are out of touch with the context of their lives, with themselves and with their environment.

The possible combinations of prana/ vitality and VF would be:

| | | VF | |
|----------|------|---|---|
| | | Healthy | Sick |
| Vitality | High | Very healthy people | Sick people, who can bounce back if the treatment establishes a new order |
| | Low | People whose sickness is not deep, but will improve only slowly | Very sick people |

The two extreme cases, very healthy on both accounts and very sick on both accounts, are familiar and have clear implications. The two other possible combinations are less straight forward. First is the combination of strong vitality with a strong pathological pattern. This is the situation which one encounters often in Africa: there's a severe confusion on the existential level, but the vitality is nevertheless strong.

¹¹ Eg, the tradition taught by Bart and Patricia ten-Berge. Some cranio-sacral methods are also using this differentiation.

The last combination, of healthy VF combined with a low vitality is represented by old people, or people who have just recovered from a long illness. With such people the basic disposition might be healthy, and the disturbance might be clear, meaning that the VF is relatively healthy, but we'll still use caution in treatment: we'll use low potencies, and won't repeat them too often because we know that there is not enough vitality to support a more demanding treatment. This state would specifically cover an old person who is about to pass away peacefully and in full consciousness of his state – the VF is healthy, but the vitality is gone.

Obviously the VF and the vitality are entangled: low vitality cannot support the vital force, which would therefore become less active. Similarly, an unhealthy vital force would make it difficult to preserve the vitality.

Obviously, clear distinctions are difficult here. For example, alongside the pain and sadness we encountered a lot of joy in Maun. Joy is a reflection of a healthy VF, and is not wholly dependent of vitality. Does this example render the model invalid? Maybe it does, to some extent. Still, for me this model is important, as it clarifies what I believe to be a confusion of terms between vitality and vital force.

Sheila Ryan suggested that it is useful to look at the scheme as a spiral rather than a rigid grid; that we need to consider the flow within the different states, and that we need to emphasize the possibility of transformation that is naturally encapsulated in any edge state. It is possible that the dead-end state in Maun can also lead to an expansive transformation. This is potentially true, although how this might happen is still a mystery.

Sheila's view is compatible with regarding the VF as a higher consciousness, as a force of a higher order, which could, out of the ashes, transform itself. The importance of transformation of consciousness would become evident when we go on to discuss AIDS.

AIDS

Peter Fraser, in his book "The AIDS Miasm", presents an interesting theory regarding AIDS's function. He says that the world currently undergoes an 'electronic revolution' – a transition into a global village. Taking part in this revolution demands a high level of sophistication, education and awareness.

This obviously presents a huge challenge to developing nations, especially in Africa, the least developed continent. Peter compares the situation of developing nations to the situation in Latin America during the Spanish colonization. The indigenous cultures, despite being evolved in many ways, were far less sophisticated than the invading Spaniards. Most of the natives succumbed not to the sword, but to diseases such as measles, to which they had no natural protection.

The painful hypothesis presented by Peter is that, like measles in 15th century America, AIDS is a reflection of deep cultural maladjustment. AIDS hits Africa so hard because Africa is so far behind with regards to the electronic revolution. The failure to cope is colossal and the consequent injury to one's self esteem is fundamental. This situation is a natural breeding ground to themes that came up in the proving of the AIDS nosode such as loss of identity, estrangement, feeling rejected, feeling self loathing or betrayal.

So HIV is not merely a viral infection but also as a cultural disease, a representation of a cultural crisis. Similarly, stigma is still a very prevalent factor in the spread of the disease. Many Batswana (men more often than women, it seems) are ashamed of having HIV, are denying having the disease despite clear indications to the contrary, avoid getting checked and consequently die. Denial, which is lack of consciousness to one's state, is a prominent and disturbing pattern in Botswana.

Having said that, once people do decide to expose themselves, get checked and begin treatment, they usually develop awareness to the role of denial and how it can influence them; they replace denial with consciousness and even with zeal to fight the stigma. Based on clinical experience, it seemed that developing such a consciousness is a prerequisite for the individual stopping the progress of disease. I assume that a similar change must occur also on the macro level, that in order to contain AIDS the African society as a whole must change the consciousness around the disease.

A similar process has occurred with regards to addressing AIDS within the gay community, and it might be useful to discuss what happened there.

In the early 80's, it seemed that AIDS would cause an untold damage for gays. Not only did they die in scores from a terrible, incurable disease, gays were also vilified as the bearers of the modern plague. It seemed to be an end-state for the community. But within a short time of the spread of AIDS gays rebelled at the stigma and reacted to it in a positive manner. They developed a consciousness that accepted AIDS as a fact of life, dealt with the disease, developed practical means for safe sex, and hence contained its spread.

But apart from affecting sexual practices, AIDS influenced gays in a deeper way. The process of accepting the disease and fighting it made the community more self-reliant, assertive and mature. As Jonathan Stallick says in his book "AIDS, the Homeopathic Challenge", after a period when they were marginalized and slurred, gays bounced back and said: 'yes, we are victims of a terrible disease, but we are proud to be who we are; yes, the disease is dangerous, but we can stop AIDS while maintaining our identity and dignity'. In creating such a rebound effect, the AIDS crisis has had an empowering effect on the community. Indeed, the years that followed saw a continuous process of integration of the gay community into the mainstream culture.

It is possible that progress towards containing AIDS in Africa must similarly incorporate a development of a new consciousness. Maybe Africans must reach a stage where they say 'yes, we are centuries behind, but this doesn't make us less worthy; yes, we know that we have loads to catch up on, but we are not dismayed'. The harsh reality, the inability to cope with the electronic revolution, will be there for centuries to come, so any useful change of consciousness must start by accepting the difficulties and embracing the pain. Acceptance is a precondition for regaining a sense of hope, and for making sense of the situation.

Not surprisingly, such a change of consciousness would turn around the themes of the AIDS miasm – it would replace estrangement with a sense of self worth and hence would address the disease at its roots.

So transformation is a key for all the people I mentioned above: Sheila Ryan, Jonathan Stallick, and also Peter Fraser, who stresses the possibility of positive effects derived from the AIDS crisis.

I'd like to briefly refer now to earlier discussions. It is clear that a transformation of consciousness around HIV can only occur on a deep existential level. This possibly supports the idea that I promoted in the previous section, whereby the African VF is mostly very sick – A VF whose task is to perform a feat as big as the transformation of the AIDS miasm is surely an unhealthy VF.

And, looking back at the quality of the clinical results, perhaps it is clearer now why homeopathy is so successful, and so needed, in Africa. Few other disciplines have the language and the tools that allow to access, comprehend and influence such a fundamental issue as healing the consciousness around AIDS.

The scope of homeopathy

I came to Maun full of idealism about the power of homeopathy. Especially with regards to AIDS, I realized that homeopathy is restricted.

The case that changed my perspective was that of a person close to us – his wife and occasionally himself worked for Marty, our landlady in Maun, so they were family relations of sorts. The wife and two of the couple's children were HIV+, and have been treated by Hilary for a long time, with very good results. Given the family situation, he clearly was HIV+ as well. But he refused to be checked, a shocking attitude, although not uncommon.

Finally the virus has hit him: pneumonia was followed by dementia; the virus has attacked the nervous system. We felt close and responsible for him, and for some time went to see him in the hospital, sometimes twice a day. The remedy pictures were always clear: Hyos, Stram, Con, Merc. When prescribed (we mostly gave one remedy at a time), they always helped. But the moment one picture was gone, another has replaced it; there seemed to be no movement towards better health – the patient's progress was always lateral movement between equally disturbing disease states.

In this, and in other cases that followed, it was clear that beyond a certain level of viral proliferation, and even if the person is young, there's very little homeopathy can do in order to save the person and to restore health; such cases require ARVs, and they require that the ARVs start before the viral damage is excessive¹².

Obviously, in cases of terminal pathology, when even ARVs fail, homeopathy can ease the passage into death, physically or spiritually. I've found it useful to assess how ill the person is, and to try and establish, as Kent suggests, whether we aim for 'cure' or for 'palliation'.

¹² Although here, too, there is much individual variation. I saw people with CD4 levels around 200, who died in spite of ARVs, and, on the other hand, saw a healthy patient whose CD4, when ARVs started a year earlier, was as low 0.49.

ARVs and allopathic suppression

As I just mentioned, ARVs were essential in many cases. Homeopathy alone does not seem capable of reversing an AIDS case. As for the possibility of delaying the progress of HIV into AIDS through homeopathy alone – we'll need some more time in Maun to comment on that.

Nearly all our patients were taking allopathic medication alongside the homeopathy. I haven't encountered problems working alongside the ARVs. These are clearly very powerful drugs, often accompanied by very strong side effects, and so should be considered as highly suppressive. But we've found that homeopathy works very well alongside these drugs, when prescribed as a triad.

Nosodes

I was taught that nosodes are just like any other remedy, and should be prescribed when indicated according to the totality of the sx's. My experience in Maun challenges this view. What I observed is that nosodes can be very useful when prescribed as a miasmatic intercurrent. During my stay in Maun I've grown to think of them as a metaphor for the miasm, and to look at their action as support for the other remedies prescribed.

So usually nosodes were prescribed as an extra help, as a remedy to cover the miasmatic part of the pathology. At other times, I've found them to be useful when I saw a situation but could find no remedy picture; it was useful when I saw a general pattern in life that is common to many and is born out of the circumstances, but carries little individual characteristics. If I gave a nosode in such a case, I'd often see some relief, and a more individual pattern in the next consultation. Following, I review some of the keynotes that were used to prescribe nosodes (obviously, I don't give full descriptions of the remedies, but simply mention a few attributes that were relevant in Maun).

- Carc – this was probably the most commonly prescribed remedy in Maun. Following Hilary, the way I looked at Carc is as a remedy for situations when the person is facing tough circumstances beyond her control. People in Maun live in dire conditions, both physically and spiritually, and have very little hope or resources that might improve their state. They often suffer abuse that they cannot react to. They try to do well, for themselves and for their family, but they usually fight a losing battle. Often, all they can do is suppress their difficulties. Prescribed in this way, the remedy had immense value, and almost every patient got it, at least once
- Tub – this was often prescribed on physical indications – personal or family history of TB, tendency towards respiratory complaints. And also on the mentals: tendency to feel suffocated by the circumstances, and wanting to travel away, to go somewhere else
- Med – tendency towards extremes and covering up; history of gonorrhoea, alcoholism and high living
- Psor – physical complaints that relate to the skin, general psoric attitude to life, simplicity, naive religiousness (almost everyone is very religious in Maun, and one needs to find the personal angle on it)
- Syph – destructive, hopeless attitude to life. Reality is painted in very dark colours. I've found that Syph can often seem close to Psor – both have a tendency to project their difficulties away from themselves. In both remedies

- the issue is relations with the struggle outside, and the possibility or impossibility of being saved (from the outside)
- AIDS – this was hardly ever used. I experimented in giving it to people that felt excluded and forsaken because of being HIV+, and the results were quite encouraging, but more experience is needed.

Polychrests

For obvious pragmatic reasons, we weren't able to have a big pharmacy with us in Maun – our remedy cases contained about 130 remedies, most of them in a few potencies, making about 300 remedies in total. But even with a restricted selection, we tended to stick to the main polychrests, which were prescribed on the same indications as in Europe. They were all good, loyal friends.

First between the polychrests was Sulph. I used Sulph very often, and it brought fantastic results. In the triad system, it often took the place of the acute remedy – for many patients the acute layer was composed of side effects from the ARVs, often manifesting on the skin, or as excess heat.

I tended to think of Sulph whenever there was an indication of excess heat in the body. In terms of Chinese medicine, ARVs do cause excess heat in the body, and this might be one explanation for Sulph's usefulness in treating side effects from these drugs.

Back to the heart

One of the most moving moments I remember from Maun happened when Julia rang a few days after she left back to the UK, and I, too, was about to leave. We were both starting to process the experience of practicing in Botswana, and were sharing our thoughts about it. Suddenly we both said, together and seemingly out of context, 'we owe the patients so much' – this realization, that we owe the patients at least as much as they owe us, was a key moment for me.

People in Maun really opened their hearts to us, and made it easy for us to open ours. The process of developing the ideas that I've presented above was intriguing and valuable, but the most fundamental lesson, and also the most enduring experience from Maun, is the feeling of deep contact on the heart level with so many fellow humans.

In an environment where there was no cultural common ground, no concepts and no distractions to share, it was the heart that was the key for communication between us and our patients. Experiencing and acknowledging this contact was a deep and moving process.

Deep contact can only occur when we let go of our shields. Misha Norland describes AIDS (in "Signatures, Miasms, AIDS") as resulting from a pathological loss of personal boundaries. As Misha points out not only pathology, but also healing, can occur when boundaries are torn down. So AIDS teaches us about extreme suffering and alienation, but also about the great powers of acceptance, connection and transformation.

It seems to me that the healing power of homeopathy originates on the heart level, through the power of intention, through sharing and through contact. It was

empowering to realize that, working through this level, we can do so much to influence people's lives, wherever they are in the world.