INTRODUCTION

CHAPTER 01

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"People even in this day and age are still frightened about death. They won't talk about it and it's such a shame cause its part of life." (KENNEDY, J. 2003)

Jonny Kennedy, a terminally ill skin-cancer sufferer, created a documentary cataloguing the last days of his life. In this documentary he cut to the heart of the problem that this dissertation hopes to address; society is afraid to talk about death and the process of dying. In a country where the HIV and AIDS pandemic is reaching maturity, more and more deaths within communities ill-prepared for this influx are occurring (STATSSA 2009: 18).

Facilities such as Hospitals and Hospices that previously endeavored to provide support during the process of dying are overwhelmed. These existing Institutions have become stale, clinical and mechanical in the way in which they operate and therefore are unable to provide large portions of the population with a death in an environment that embodies "dignity and soul" (MARKUS & CAMERON 2002: 53).

The process of dying is indeed an important part of life. In fact, one should view death not as an empty ending but as it is. It allows for reconnections to happen, for families and communities to draw nearer to one another through mutual grief and suffering and to find new beginnings. Death is by far more than just empty and it should be treated as such, becoming part of our daily lives again rather than the medicalized affair it is now.

"Globally, HIV/AIDS epidemics are already having a disastrous domino effect. Millions of children are orphaned, communities are destroyed, health services are overwhelmed, entire countries face hunger and economic ruin." (COCHRANE & TALBOT 2008: 147)

Death has become a large component of our social outlook. We have become a necromantic society; a society within which death has become a predominant influencing factor of our social context, whether one openly acknowledges it or not.

With many having the certainty that their death will happen in the immediate future, as a result of cancer or an AIDS related disease, one should be able to provide an architecture that facilitates and incorporates this enormous social need. Providing an architecture that facilitates death is an attempt to embody and exemplify the process of life. This dissertation therefore is not dealing with the architecture of Death, but of Life!

"Throughout the 20th century, modern medicine has transformed the experience of dying from a part of daily life to a highly technological event... In this atmosphere of denial, many caregivers were dissatisfied. There had to be a better way to treat the dying." (CONOR 1998: 4)

Thus far caregivers believe the answer to the medicalization of death lies in the form of a Hospice. This dissertation proposes to help alleviate the problem by providing a Hospice facility in the Mamelodi community, a community rich in religious and cultural meaning. Pretoria's Thola-Ulwazi Hospice is inundated. It provides free services to 700 people with AIDS and tuberculosis in the area. The director of the hospice stated;

"there is no other place in our area were they could receive help." (NACHWEY 2010: 97)

The facility aims to provide a space which architecturally addresses the need for a more humanistic and less overtly technical environment in which to spend one's last days. Most importantly to provide and facilitate choice, in an attempt to bring dignity and recognition back into the process of death.

In order for this facility to achieve all that it aims and aspires to be, it needs an environment and community that are ready and able to collaborate and build relationships with a new intervention. Mamelodi provides not only the perfect social platform for such an architecture but also a beautiful site shaded and sheltered from harsh elements by graceful, well-established trees.

"It is important to note that as much as the built environment has a large role to play in the success of community building; it is the community that needs to build relationships... architecture is only the potential environment and it is up to the individuals to collaborate to make it a reality regardless of their culture differences." (NICE 2008: 28)

The following questions are examples of ones that will be asked throughout the design process: How can a building that houses and supports the process of dying be integrated into a community, through its architecture? How can one create a space which embodies not only life, but also to be a place in which the individual can regain a sense of meaning? And how can the choice of the individual be supported and incorporated into the built form of a Hospice? The dissertation will by means of the project brief and through theoretical discourse, provide grounds for the merits and feasibility of a life-filled architecture, delving into the realm of choice and its effect architecturally. ■

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PROJECT BRIEF

CHAPTER 02

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2.1 PROBLEM STATEMENT

The process of death has become more of a technical event rather than a physical, emotional and spiritual one. As medical technology has advanced, so too has the mechanisation of the death process and thus the spaces optimised solely for efficiency. Through the overcrowding and rapidly increasing death rate (STATSSA 2009: 18) within the country the problem has further been compounded - creating institutions and architectural environments that have become dispassionate, cold and emotionless. (MARKUS & CAMERON 2002: 53) That have lost touch with people and even the reality of the process of dying.

2.2 HYPOTHESIS

Through architectural design a space which is more than just an institution can be created: a space that embodies meaning and life, a space that facilitates choice. A Hospital or Hospice environment does not need to be mechanical and soulless; in fact it should be more of a dynamic interaction between its' function and the human spirit.

"The two great professions of healthcare and architecture each have their own histories of achievement, scientific and technical advances, and a desire to improve the human experience. The interface between the two professions, occurring in the design and use of buildings that accommodate and facilitate the delivery of care, can generate a dynamic fusion in the pursuance of professional excellence." (SCHWARTZ & BRENT 1999: 281)

2.3 AIMS & OBJECTIVES

"Our buildings, I have come to believe, must be able to receive a great deal of that energy and store it, and even repay it with interest. Only then will their inhabitants feel at home, connected in space and time to the planet and the past, 'centered' as dancers say, not only with imaginations, but with their whole bodies." (MOORE 1980: 115)

This dissertation hopes to provide:

- **A design for a facility that cares for not only the dying but their family and community members as well;**
- **an architectural environment which embodies the principles of choice, life and meaning;**
- **integration into the surrounding community, through facility provision, education, interaction, architectural language and the community accessible permaculture garden and redeveloped green space.**

2.4 DELIMITATIONS

This dissertation will not be dealing with medical ethics such as issues of euthanasia or assisted suicide. Although the project aims to provide choice and assist in the patient regaining control in the process of death, it hopes to help the individual through the process rather than out of it - as it forms an important part of life.

It will also not be dealing with patients who are not in the end stages of a terminal illness.

2.5 DEFINITIONS

Demedicalization

Medicalization is the process whereby previously non-medical aspects of life come to be seen and treated in medical terms. For instance, normal life events such as birth and death. Medicalization has implications in terms of social control, power, knowledge, authority and personal liberty (BLACKWELL 2007). Therefore Demedicalization is the reclamation of the natural back into an everyday realm and the normal process of life.

Hospice

The word 'Hospice' has been derived from the Latin word Hospes, which means "to host a guest or stranger". How it became the 'Hospice' we know today begins in medieval times, during the crusades. Hurt or ill travelers would seek refuge in monasteries or nunneries. They would invariably be cared for by the monks and nuns.

But the name 'Hospice' was only first applied to the care of the dying by Mme Jeanne Garnier in France, during the World War II. Later it became the 'Hospice' we know today through Dame Saunders' new facility established in 1967, St. Christopher's Hospice. (AHS 2010)

St. Christopher's Hospice, which focused on excellence in the treatment of the dying, was first envisioned in the 1960's by Dame Saunders. She trained as a nurse, then as a social worker before finally qualifying a physician. The Hospice was opened in 1967 just outside of London. The centre included teaching and training facilities and was one of the first examples of modern palliative care (see below). This Hospice became the foundation for the world wide Hospice movement and the basis for most modern hospices today. (CONOR 1998: 5)

The current National Hospice Organization defines itself as:

"A coordinated program providing palliative care to terminally ill patients and supportive services to patients, their families, and significant others 24 hours a day, seven days a week. Comprehensive/case-managed services based on physical, social, spiritual and emotional needs are provided during the last stages of illness, during the dying process, and during bereavement by a medically directed interdisciplinary team consisting of patients/families, healthcare professionals and volunteers. Professional management and continuity of care is maintained across multiple settings including homes, hospitals, long term care and residential settings." (NHO 1993)

Palliative Care

Rather than a cure-based treatment, the objective of palliative care is to relieve the symptoms of the illness and improve the patients' quality of life (KYLE 2010). It also involves support and guidance being offered to the patient and their family members. Palliative care does not attempt to alter the course of the disease (ABTA 2010). The main focus of palliative care is to meet a person's social, emotional and spiritual needs (MOGA 2010).

Terminal Illness

An active, incurable and progressive disease which cannot be cured. Which makes curative treatments and methods inappropriate. The best option of treatment for the patient in this stage of illness becomes that of palliative care. (MOGA. 2010)

Terminal Care

The care of a person in the last days or weeks of their life, during the final stages of the process of dying. Terminal care places emphasis on making the person comfortable and as free of pain for as long as possible until the moment that they finally pass away. (MOGA. 2010)

2.6 CLIENT PROFILE

The Client will be a public-private partnership between the Hospice Organization and the National Health Department working together in order to address the present need, and relieve the pressure that is currently being placed on the existing institutions, such as the Mamelodi Hospital, to cope with the increasing death rates.

2.7 USER PROFILE

The centre will provide support, care, counseling, training and education for not only the terminally ill patients, but also for their loved ones, families and community members. Although the patient is going through a process of loss and bereavement, so are their families. In order to deal with the process of dying in its entirety, all the parties' needs should be recognized and dealt with in a manner that helps smooth the process and transition.

"It's closer to home now and all you want to do is to have somebody with you to take your hand and say everything is going to be all right." (KENNEDY 2003)

The people using the centre would be those that require a great deal of support. As Jonny said sometimes you just need someone to take your hand and be there for you.

2.8 THE SITE

The site is located in the Eastern area of 'old' Mamelodi. It borders a tributary of the Pienaars river, which divides Mamelodi into its eastern and western parts. The green space dividing Mamelodi has been scheduled for urban agriculture, the strengthening and densification of the urban edges and the redevelopment of green spaces in the linear nodal development framework proposed for this area. The site has immense potential but at the moment it is a relatively dangerous place.

It has amazing views of the local koppies and beautiful well-established trees throughout the region. Bordering the site is a self named 'shopping centre' which through an ever-growing collection of buildings, provides facilities such as a bar and restaurant, hair dressers and an ATM amongst others. However the problem with this however is that the building and auto shop businesses that have set themselves up behind this centre, have turned their back on the green space, therefore creating an environment rife with crime.

2.9 PROPOSED ACCOMODATION

The accommodation schedule is broken up into three sections.

1. An educational facility

The purpose of which is to achieve community integration, education and provide training to local community members and increase awareness of issues such as nutrition and how to care for loved ones;

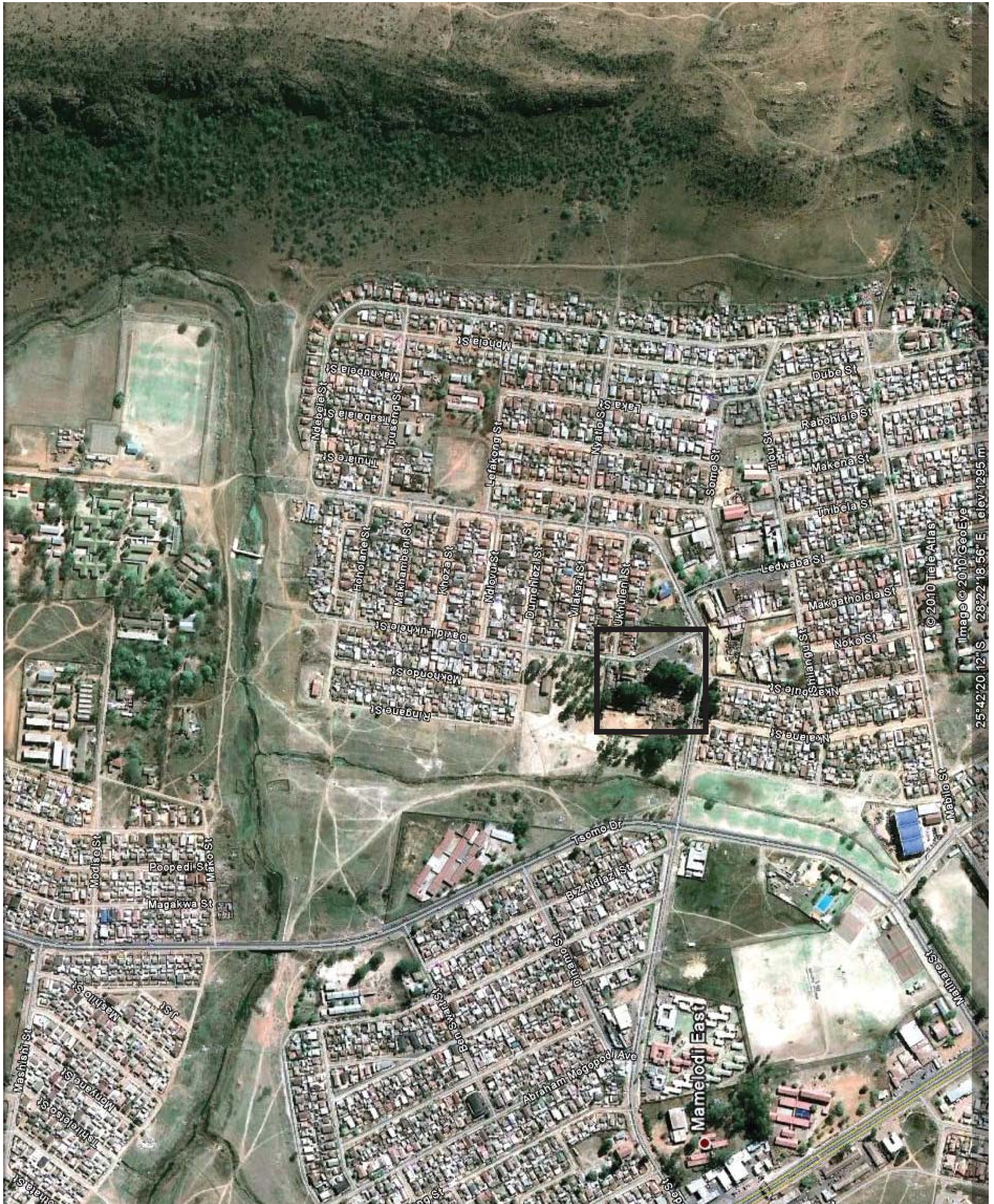
2. an end-term care facility

This will house those with terminal conditions in their last days; and

3. supporting functions

Which will provide the backbone to the centre and facilitate the running of the other functions. ■

2.10 AERIAL MAP OF SITE



1. Arial Photo of the Site

2.11 ACCOMMODATION SCHEDULE

EDUCATIONAL FACILITY FOR PATIENTS, FAMILIES & COMMUNITY	
a community hall to function as an exhibition space, a space that can be used for fundraisers and for funerals	**448 m²**
a conference facility to host fundraising functions and flexible educational classes	**128 m²**
2 multipurpose classrooms for educating community members on how to care for those who are terminally ill at home, including the importance of nutrition etc	**96 m² each**
shaded outdoor education for education pertaining to the permaculture gardens and urban agriculture	**96 m²**
Toilets - disabled, male and female	**64 m²**
a permaculture garden	**.**

END TERM CARE	
adult day room, multipurpose dining area, that can be used for crafts, visitations and multimedia screening	**96 m²**
4 single adult wards	**13.5 m² each**
4 adult wards	**40.2 m² each**
8 wet rooms, complete with disabled toilets and showers	**5 m² each**
Balconies (minimum size)	**18 m² each**
visitation areas and break off spaces	**.**
nurses stations	**8 m² each**
treatment room	**10 m²**
2 sluice rooms, 2 linen and pharmaceutical stores	**5 m² each**
paediatric day room multipurpose dining area, that can be used for play, crafts, visitations and multimedia screening	**64 m²**
2 paediatric wards	**40.2 m² each**
2 bathrooms, complete with disabled toilets, baths and changing tables	**5 m² each**
2 family rooms sleeping 2 people each with ensuite bathroom. For accommodating family members who have needed to travel a long distance to be with their loved ones, parents or grandparents of children in the wards needing to stay overnight, and when empty for staff who need down time.	**16 m² each**

OUTPATIENT FACILITY	
sub-reception to book doctor's appointments, counselling sessions and manage basic inquiries regarding the outpatient services and facility	**14 m²**
waiting for the doctor's office, dispensary and outpatient office	**40 m²**
outpatient office to organise home based hospice care for those who choose to be cared for at home or for whom there may not be space within the facility	**19.2 m²**
dispensary to full prescriptions and medical needs of those in outpatient care	**24 m²**
doctor's room for consultation and medical management	**16 m²**
large counselling room for family and community members to consult with therapists, social workers and religious leaders	**19.2 m²**
2 small counselling rooms for family and community members to consult with therapists, social workers and religious leaders	**12.8 m²**
toilets, disabled, male and female	**12.8 m²**

SUPPORTING FUNCTIONS	
Reception	**80 m²**
Offices	
meeting room	**46 m²**
open plan office	**96 m²**
management, fundraising and financial offices	**19.2 m² each**
filing and storage room	**12.8 m² each**
strong room	**6.4 m²**
staff room	**80 m²**
kitchen	**18 m²**
toilets, male and female	**19.2 m²**
A Hospice shop and commercial space for the sale of donated furniture, clothing and goods as well as excess food produced by the permaculture garden	**80 m²**
Cafe serving the communal outdoor space	**32 m²**
Services	
main kitchen	**80 m²**
waste management centre	**40 m²**
laundry including subdivisions between sluicing, dirty and clean areas	**56 m²**
Staff change room	**80 m²**
electrical and backup generator room	**48 m²**
2 equipment stores	**32 m² each**
mortuary	**32 m²**
general store	**24 m²**