

The Role of Architecture in the Development of Indigenous and Biomedical Collaborative Healthcare Facilities

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The Role of Architecture in the Development of Indigenous and Biomedical Collaborative Healthcare Facilities


Designing a Joint Indigenous and biomedical healthcare
centre for Durban

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A DISSERTATION SUBMITTED TO THE SCHOOL OF ARCHITECTURE, PLANNING AND
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A MASTERS IN ARCHITECTURE DEGREE

DECLARATION

I hereby declare that this dissertation is my own original work except where otherwise acknowledged. It is submitted to the University of KwaZulu Natal, School of Architecture, Planning and Housing, in partial fulfillment of the requirements for the Masters in Architecture. It has not been submitted before for any degree or examination at any other university.

Signed  February 2008

Dumisani Talent Mdakane

DEDICATION

I dedicate this work to my family: I cannot thank you enough for your love, your endless support and all the sacrifices.

To Mafikeni ka Bhomba, you are my reason for working hard in life. I owe every achievement to your wisdom and strength deeply embedded in me.

To my mother, Francisca Mdakane_Instilled in me is your humbleness and unconditional love for all people; your ideologies are my self-identity.

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My sincere gratitude to oMakhosi that kindly welcomed me to their homes and surgeries for teaching me so much about their role in the healthcare and their undisputable relevance to mankind; to all biomedical practitioners for sharing their enlightening views with me; to all key role players in the development of indigenous medicine who participated in this study for changing my preconceptions and uninformed perception of African Traditional Medicine; to Professor N. Gqaleni for his diligent guidance and intellectual support; and to his organising committee of the African Traditional Medicines Conference of 2007 for allowing me to be part of the conference and discussions of collaboration; to African heroes, Professor K. Komolafe and Dr JK Githae for sharing their wise thoughts with me and their intellectual contribution to this study; to Rodney Choromanschi, Dumisani Mhlaba and Tony Wilson for their assistance in the design process of this study.

ABSTRACT

South Africa is currently revitalising the role of Traditional Health Practitioners (THPs) in the country's healthcare provision. This undertaking is guided by Chinese Traditional Medicine which is said to be one of the most highly developed traditional healthcare systems in the world.

Programmes developed by the National Department of Health and other stake holders in the development of indigenous medicine often need to be accommodated architecturally.

Collaboration with biomedicine is one of the main programmes aimed at empowering Traditional Health Practitioners of the country.

Accordingly, this dissertation is divided into two sections, both based on the current undertakings of collaboration between biomedicine and indigenous medicine in South Africa. Due to the fact that traditional healing systems are less commonly described than biomedicine, the main focus of this study is indigenous medicine and how architecture could be influenced by alternative healthcare practices.

The first section (A) is theoretical. It investigates and compares the current architecture that accommodates THPs in rural and urban areas of KwaZulu-Natal. This unveils social, cultural, economic and political factors affecting this architectural genre. The aim thereof is to establish architectural elements to be considered when designing a health care facility for THPs. Section A also explores the current state of healthcare architecture in the country and abroad so as to establish the latest challenges to be addressed by the proposed collaborative healthcare model.

Design principles for collaborative architecture accommodating THPs and biomedical practitioners in an urban context of South Africa are then be put forward.

Section B incorporates the theories derived from section A, towards the design of a joint indigenous and biomedical healthcare centre for Durban. It gives specific spatial requirements for a collaboration between biomedical practitioners and *izinyanga*.

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Chapter 1

1.1 DEFINITION OF CONCEPTS

oMakhosi	:	A respectful Nguni word for Indigenous healer(s), also used for greeting, addressing and conversing in indigenous healers' language.
Isangoma	:	(In IsiZulu language) A spiritual diviner or psychic, also a diagnostician.
Inyanga	:	(In IsiZulu language) A medical practitioner who uses technical skills to make medicines or cure, can also refer to a specialist for a certain sickness.
Umthandazi	:	(In IsiZulu language) A healer that uses faith or prayer.
Ishashalazi	:	(In IsiZulu language) Outdoor open space used for ceremonies and rituals of indigenous healers.
Biomedicine	:	Refers to conventional medicine or the branch of medical science that applies biological and physiological principles of clinical practice.
Collaboration	:	Working jointly, especially of indigenous healers and other persons or organisations in the development of indigenous medicine (such collaborationists are referred to as partners).
Development	:	Improving by enlarging or expanding or refining of: one's impact or involvement, economy or social conditions.
Empowerment	:	Act of equipping the oppressed with his/her requirements and necessities to move to the next level of development.
Holistic Healing	:	Health care that focuses on all aspects of well being of body, mind and spirit.
African Architecture	:	Refers to indigenous ways of dealing with principles of design and construction of buildings in Africa.
Place making	:	Place making (in this study) means achieving fundamental needs of a user through creating an environment that users can identify with on both physical and metaphysical levels.
Indigenous	:	Born, originating or belonging in and characterizing particular area. (in this study "indigenous" replaces "traditional")
Indigenous medicine:		(In this study) refers to medicines and healthcare systems of African

origin, practiced by traditional healers.

Healing environment : Contributing to restoration of health or wellness, perfect balance, harmony and equilibrium of : physical, spiritual, emotional and mental state of a patient.

Key Role Players : People and organisations involved in the development of indigenous medicines of South Africa such as: NDoH, WHO, THPC, THO, MRC, CSIR and UKZN

1.2. ABBREVIATIONS USED IN STUDY:

WHO	:	Worlds’ Health Organisation
NDoH	:	National Department of Health
THPC	:	Traditional Health Practitioners’ Council
THO	:	Traditional Healers Organisation
TM	:	Traditional Medicines
MRC	:	Medical Research Council
CSIR	:	Council for Scientific and Industrial Research
THP	:	Traditional Health Practitioner
DHTC	:	Durban Herb Traders’ committee
ATMC – Dbn, 2007	:	African Traditional Medicines Conference – Durban, 2007
IKS	:	Indigenous Knowledge systems
UKZN	:	University of KwaZulu-Natal
SAMTECH	:	School of Alternative Medicine and Technology

1.3. INTRODUCTION:

The time has come for South Africa to regulate its indigenous medicine. The aim is to make use of the approximated 200 000 indigenous healers to improve the country's healthcare system. Beyond being the hub of cultural and spiritual life, indigenous healthcare's relevance has been amplified owing to its newly found role in the country's current challenges such as unemployment and economic empowerment. An example of this is the Durban Herb Traders' Market which has alone been estimated at R2.5million (US\$400 000) per annum. (WHO Worldwide Review, 2001). After the World Health Organisations' (2001) study which concluded that traditional healing systems remain a major source of healthcare for more than two thirds of the world's population, and the fact that most South Africans (80%) consult indigenous healers, it is clear that traditional medicines have value and a very important place in the healthcare.

According to biomedical practitioners, indigenous healers are the first healthcare providers to be consulted in most cases, especially in rural areas (Gqaleni, 2006). This has led to government departments, research councils, academic institutions and indigenous healers (of South Africa) joining forces towards a speedy development necessary in this healthcare field, particularly with regards to its regulation. Urbanisation is another inescapable factor calling for restructuring of the indigenous healthcare to suit an urban context.

Accordingly, numerous architectural interventions seeking to accommodate this new phenomenon have emerged. These interventions have fundamental failures which seem to result from the architects' lack of insight into TM and its indigenous architectural theories (Komolafe, 2007). An example of this is the Durban Herb Trader's market.

As a response to this architectural challenge, the information provided herein is intended to help the reader understand the working of indigenous healing in general. This includes the current challenges facing the development of Traditional Medicine. The study seeks to explicate the role of participating architects in the subject matter.

Part of the development process is the collaboration of biomedical and indigenous healthcare systems to create a better and more affordable healthcare system for the nation. Studies suggest that there is actually no conflict between the two systems especially in a case of

izinyanga. Researchers such as Hutchings (1990) argue that these systems are complementary, “where one fails the other takes over. Each needs to understand the working of the other one,” (Hutchings, A.1990:1). The two healthcare systems have one common goal, which is to improve South Africa’s healthcare provision.

THPs and biomedical practitioners have started working together. Referral systems have been established. However, at this stage the collaboration needs to be monitored very closely. Key role players have called for a facility that accommodates the two fields to facilitate the collaboration, especially teaching practitioners about its policies and procedures.

This thesis is thus aimed at creating an architectural model for a collaborative healthcare facility for biomedical and indigenous practitioners in an urban context. Crucial aspects of collaboration include education, training of practitioners and the public, research and development, plant propagation and conservation. These will form a fundamental component of section B (brief derivation and the design project).

1.4. RESEARCH BACKGROUND:

This chapter explores the current state (of socio-cultural and architectural facets) in the development of Traditional Medicine (TM) in South Africa. It establishes challenges facing this development endeavour (research problems) and the implications for architecture. Architectural questions to be asked when dealing with development in TM are put forward together with the aims and objectives of this study.

1.4.1. Current State of Development in TM:

The National Reference Centre for African Traditional Medicines (NRCATM) led by the National Department of Health (NDoH), Medical Research Council (MRC), Council for Scientific and Industrial Research (CSIR) and the Traditional Healer’s Organisation has been established. The purpose of the NRCATM is to accord TM special priority in obtaining and synthesising information to promote, regulate and register indigenous medicines. Their intention is to establish working groups and committees to address the development of African Traditional Medicine. Areas of interest include: claims for cure, intellectual property rights and patents, research and development, education and training, database development and plant propagation and conservation. (Gqaleni, 2006)

Furthermore, parliament has passed the THPs Bill which will establish the Traditional Health Practitioners Council (THPC).



Figure 1 Source: Author

THPs at the African Traditional Medicines Conference, Durban, August 2007

1.4.2. Current State of City Architecture
Accommodating Traditional Medicine:

Contrary to the aforementioned developments, the development of an architectural building type suited to the requirements of THPs has not been established. The only architectural intervention in South Africa so far has been using and adapting existing infrastructures to accommodate THPs. An example of this is Fig: 2, the Durban Herb Trader’s Market discussed in chapter 5. The general problem with these remodelled structures is that they accommodate a function for which they were not originally intended. As a result, most of them are not user friendly (Fig: 3) and they have a lot of fundamental inadequacies such as no access to water (e.g. “Muthi Bridge”). This leads to a conclusion that South African contemporary architecture has in fact not engaged in the development of the country’s indigenous healthcare field. There is a need for architectural projects that are originally intended and designed to cater for THPs. This study is therefore aimed at a suitable building for THPs. It was noted during this study that architects who have conducted research on THPs are mostly students and academic staff (Fig: 4 & 5). Undoubtedly, there is a need for practising architects to also be involved and aware of the THP’s field. This research thus aims to assist architectural practitioners in determining appropriate architectural responses to THP’s requirements.



Figure 2 Source: Author

Existing facilities for THPs in urban areas: Muthi Bridge, Durban.



Figure 4 Source: Author

Amandla Enkunzi in Queen Street (Durban) does not have a consultation suite . There is no privacy for patients consulting its two THPs.

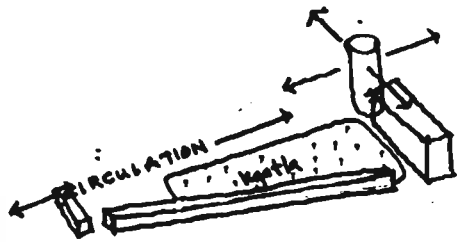


Figure 3 Source: Mpho Selepe, 2006

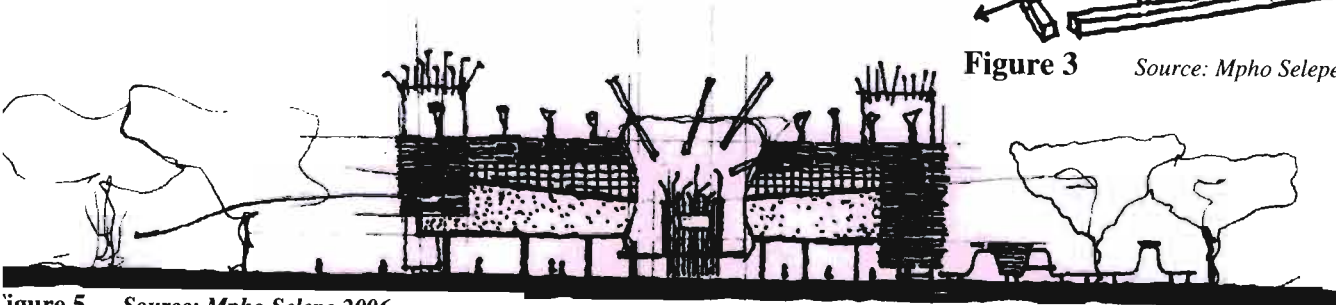


Figure 5 Source: Mpho Selepe, 2006

The Research Centre for Indigenous Traditional Medicines (4&5) is a 2006 thesis proposal from the University of Pretoria. The Community Clinic for Traditional Healers (6) is a 1997 thesis from the University of Natal. This shows that academic institutions of architecture have seen the need for architecturally designed buildings for THPs.

1.4.3 Current State of Collaboration with Biomedicine and it's implication on space:

In the early years of the post-apartheid era, the country faced a challenge of lifting a veil of secrecy which surrounded Traditional Medicine (De Zeeuw, 1997). Most THPs who were interviewed for this research believe that this secrecy resulted from the biomedical rivals who exploited indigenous knowledge to develop their own businesses (Ndelu, 2007). The current talks regarding collaboration seem to have created openness from the THP's side. However, some biomedical practitioners are still sceptical of Traditional Medicine (Komolafe, 2007). This problem was experienced by most countries that have succeeded in collaboration. It is therefore not a threat for South Africa. Addressing the conference in 2007, Dr. J.K Githae of the School of Alternative Medicine and Technology in Kenya warned THPs of a possible set back by some *partners* who feel backward and primitive if they are to be involved in deliberations to do with traditional medical practice.

For that reason, the government has set up a medical research unit to evaluate the safety and effectiveness of Traditional Medicines. According to Karen Pretorius (2006), the Institute for African Traditional Medicines will also develop new remedies for chronic conditions. It will safeguard indigenous knowledge and provide consumer information. The shortfall of this strategy is that it can only assist if remedies are voluntarily brought forward for evaluation.

Key role players in the collaboration endeavour such as Dr Githae (2007) have therefore called for programs that will encourage interaction among the two practitioners in order to change attitudes to one another (Fig:7 & 8). This concept needs



Figure 7 Source: De Zeeuw, 1997



Figure 6 Source: Edendale Hospital Management

Biomedical and Traditional Health Practitioners of Edendale Hospital negotiating referral systems.



Figure 8 Source: T N Ngwenya

Umkhanyakude Traditional Healer's Program. District THP Committee in collaboration with the NDoH.

to be engaged with architecturally so that the concept of transparency and trust can be manifested in a building that houses these programmes.

In the ATMC-Dbn 2007, hospitals that incorporate THPs such as the Edendale Hospital reported that there is a growing interest and interaction among practitioners. However, not all parts of existing biomedical hospitals are accessible to THPs.

There seems to be more opportunities to heighten the collaboration in accessible departments such as laboratory, pharmacy and X-ray where practitioners can work together simultaneously (Edendale Hospital Report, 2007). This proves beyond doubt that a physical platform for collaboration can help in changing attitudes of practitioners to one another. This in turn poses a challenge for the proposed collaborative architecture to stimulate interaction among practitioners through well coordinated spatial relationships (e.g. Fig: 9). After participating in one of the collaboration programmes Lynne Nel of KZN Department of Health said: “All I learnt was completely new information. I am more open and less sceptical about Traditional Medicine. Invite more people so that the best practice from TM can be accepted. I will recommend this to colleagues. The level of speakers was very high and a privilege to be taught by them” (Gqaleni, 2007). This calls for a brief that takes account of teaching, training and conference or lecture facilities to encourage interactions necessary for a meaningful collaboration to take place.

Inclusion of THPs into the country’s health care programme is becoming inevitable. For instance (in Fig:10) the architects of Umkhumbane Community Clinic in Cato Manor stated that the

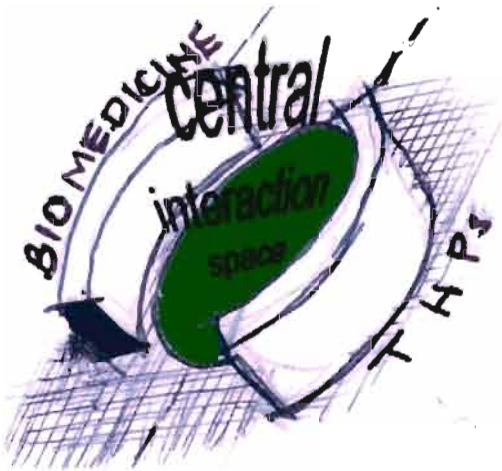


Figure 9 Source: Author

Although practitioners cannot always work in the same space, there could be spaces designed for interaction in collaborative hospitals.



Figure 10 Source: Author

Informal traders outside Umkhumbane Community Clinic. Cato Manor.

building was originally designed to cater for indigenous healers as an addition to the brief; although this concept was disputed by clients, today there are *muthi* sellers self-positioned outside the building along with informal (food and gifts) traders. It has become clear to the key role players that there needs to be hospitals that accommodate and facilitate the concept of collaboration of the two healthcare systems. These hospitals would need to be custom-designed to cater for the specific needs of THPs and their patients while exposing them to latest technology and other helpful biomedical systems (Komolafe, 2007). Key role players are calling for a place where both biomedical and indigenous health professionals practice in collaboration thus learning from one another. This approach of physical collaboration between the two healthcare systems calls for architecture that is appropriate for South Africa's transforming healthcare field. This means that new medical facilities should support the requirements of the proposed collaborative healthcare architecture as opposed to merely bringing indigenous healers to a biomedical hospital that was not designed for their needs (Fig:11 &12).

As proven in the body of knowledge gathered for this research, there is no doubt that there is an urgent need in South Africa to combine the two systems of medicine for both the practitioner and patient to benefit. This study is therefore an architectural contribution to a joint effort of different role players in the collaboration endeavour.



Figure 11 While other aspects of collaboration are being successfully addressed by relevant professionals existing hospitals are not equipped for the practice of *oMakhosi*.



Figure 12 Source: Edendale Hospital Management

Edendale Hospital is one of the hospitals that incorporates alternative medicine into its healthcare programmes.

1.5. RESEARCH PROBLEMS:

This section (1.1) will discuss challenges facing the collaboration of indigenous and biomedicine. Architectural interventions to each problem discussed hereunder will be put forward (as conclusions).

1.5.1. The Concept of Decolonising Indigenous Healthcare and its implication on Architecture:

Similarly to other colonial/Apartheid injustices, the colonial government of South Africa played a very crucial role in creating ill perceptions towards indigenous medicines. To do this, colonial government officials used every resource they had especially the media. According to Devenish (2003) attitudes to one another between biomedical and indigenous practitioners were very promising in the early years of colonialism as there was interaction and interest amongst them. The expected natural progression of this was that the two healthcare systems would merge thereby creating one unique healthcare system relevant to all people of Africa. It was only when the colonial government saw indigenous healers as a threat to colonial rule that the aspirations of collaboration were discouraged. "Government officials then decided to impose biomedicine onto African community as a way of drawing Africans away from indigenous healers" (Devenish, 2003: 32). However, the indigenous healers continued to heal people as the government lacked resources to offer biomedical services to the whole African community. This forced the government to license some traditional healers in the



Figure 13

Source: T N Ngwenya

Umkhanyakude Traditional Healer's Program. An all-inclusive committee working towards collaboration.

Natal province. Flint (2001) says the colony of Natal and Zululand were the only areas in the country where traditional healers were allowed to practice openly. In the post-Apartheid South Africa, biomedical institutions in conjunction with the government and other *key role players* have made efforts to resume the pre-colonial policy of working with the indigenous healthcare system (Fig: 13). These reformed efforts are inseparable from architecture; architects need to be informed about the “decolonised” indigenous healthcare that exists. This is necessary for understanding the design implications that this reborn medical field will present as it needs to be accommodated and facilitated by an appropriate built environment.

Collabotation also plays a role in the problem of eliminating the stigma associated with the indigenous medical system. According to Miss M. Khuzwayo, a lecturer at the Durban Herb Trader’s Information Centre, concerns around hygiene and accuracy in indigenous medicine are only due to lack of appropriate technical facilities and training for THPs. She believes that this could be changed through collaboration (Fig: 14). The pre-1994 governments of South Africa did not offer opportunities of technological growth to THPs (Ndelu, 2007). As a result, THPs have been publicised as “primitive and using non-scientific techniques” (De Zeeuw, 1997: 11). It is not surprising therefore that most ‘civilized’ people in South Africa today still have misconceptions about indigenous healers. Even the 80 % of the population that consults them is not open about it due to the stigma of primitiveness attached to TM. De Zeeuw argues that bridging the gap between the two medicines will reduce the patient’s guilt at using indigenous medicines thereby improving compliance with medication. This poses a challenge for architecture to find its own ways of eliminating the sense of



Figure 14
Indigenous Medical Practitioners health care is linked to the Department of Health. Outcomes of collaboration in **Umkhanyakude Project** include: Easy referral of patients. Improved hygienic, safe practices and infection control practices.

Source: T N Ngwenya

primitiveness that surrounds TM. Aspects such as using modern materials and an architectural aesthetic that could be associated with modern trends in healthcare design rather than outdated primitive architecture become crucial issues for architects to consider in this matter. Integration of the modern day

technology into THP's facilities may also be a relevant aspect in the attempt to eliminate the stigma of primitiveness in TM.

While their contemporaries were being oppressed, biomedical practitioners in South Africa have gained reliability, transparency and a better understanding even by the African community. This is heightened by their generally good publicity compared to THPs. Also, the scientific proof of their medicines has created clarity and openness of biomedical practitioners while THPs were (understandably) protective and secretive about their indigenous knowledge (De Zeeuw, 1997). This has made it possible for indigenous healers to understand and learn from biomedical ideologies. As a result indigenous healers are not opposed to biomedicine. According to De Zeeuw (1997) many indigenous healers show their willingness to co-operate by agreeing to work in hospitals under supervision by biomedical practitioners. However, this led to most indigenous healers interviewed for this study expressing feelings of being overlooked by the biomedical side and consequently by society at large. Mr. F.J Ndelu of the Durban Market Traditional Healers Committee accentuates the idea that healthcare providers of both fields should be treated equally with due respect and none should be seen as superior to the other.

It is evident in the existing urban facilities accommodating THP's that the concept of equal treatment for both practitioners has not been adopted by the architectural field. The extreme imbalances in the quality of the built form between the two medical fields could potentially amplify the perception of THP's as second-rate practitioners. Architecture is a powerful tool for image-making; it plays a role in propagating certain perceptions about its user through a statement or message portrayed in the built form. An example of this is a muscular design of banks which makes them seem secure. *Key role players* have expressed the need to incorporate the symbolism of THP's indigenous architecture into their urban facilities (Komolafe, 2007). Collaboration of the two medical fields is anticipated to bring about a positive influence on the image of THP's urban healthcare facilities. This is due to the expectation that it will provide room for balancing the quality of architectural design in a collaborative healthcare facility.

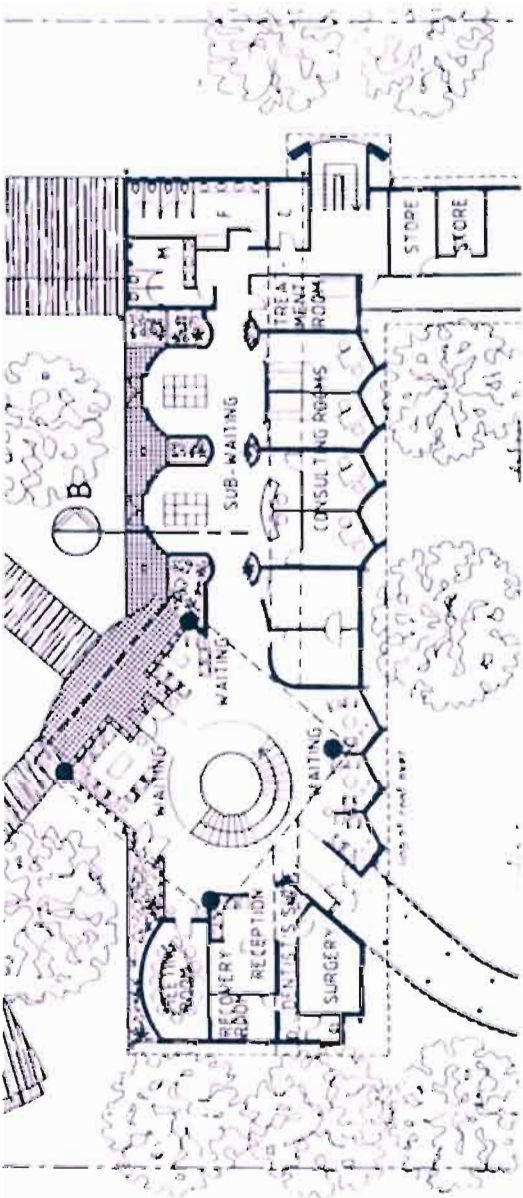
1.5.2. Architecture and Distinctions between African Wisdom and African Spirituality in Indigenous Medicine:

The extent to which colonialism disempowered indigenous healthcare by making it seem non-scientific and unreliable is so evident that even the practitioners themselves are not confident to base their findings on ancient wisdom and indigenous knowledge. To avoid the risk of appearing ridiculous to the uninformed, most practitioners seem to hide under their spiritual and ancestral shield. This means that their medical skills are portrayed as sacred and ancestral rather than technical indigenous knowledge that has been passed on from generation to generation. This makes it even harder for society to understand the system. Genuinely, indigenous healing is divided into two major forms, i.e. Spiritual and Technical: Spiritual healers have supernatural powers while technical healer's work is thought in schools of TM or through Indigenous Knowledge Systems (IKS).

It is very important to acknowledge this fact; the complexity of indigenous healthcare is often overlooked. For instance biomedicine is seen as a technical and accurate skill that is devoid of spirituality. On the same level, Western beliefs such as therapy and psychic powers are all accepted and understood as inexplicable. Compare this with indigenous healing systems where everything is put into one class and named 'traditional healing'. While recognising the fact that some indigenous healers may specialise in both spheres, the spiritual and technical specialties are very different. One would argue that if proper categories were understood or compared to Western systems a *Sangoma* (spiritual diviner) would fall in the category of a psychic while *inyanga* would be equivalent to a biomedical practitioner. Previous research in this subject has not succeeded in demonstrating this major distinction.

This worked in favour of the colonialist mission; for example, some of the key role players in the empowerment and rebirth of indigenous medicine, writers and the general public seem to be influenced by the notion of treating indigenous practitioners as if they all fall into one area of expertise i.e. supernatural or ancestral healing.

This generalisation has a direct influence on the architectural outcome. All previous architectural interventions in this subject matter, including academic work have grouped the so called “traditional healing” into one architectural resolution (Fig:15). Urban architecture has failed to differentiate between the spiritual and the technical side within TM in the same way that it differentiates for instance: psychics and nurses in Western healing. Evidence of this was established when proposed and existing architectural work visited for purposes of this study suggested consciously and sometimes unconsciously that all “traditional healer's suites” are identical. This is a misleading design approach as particular specialties of TM would actually need different spatial arrangements in the same way as biomedicine unless there is only one specialty in a building. This calls for a research that will distinguish and define appropriate architectural responses for specific specialty (-ies). As a result section B of this study focuses on *izinyanga* (as a type of THPs) and their impact on space and form.



As Dr. J.K Githae (2007) emphasises, people’s perception of a certain organisation can also make it difficult to build collaborations with any field. He argues that partners (in collaboration) may not know the purpose of a healthcare institution, its relevance in the partnership or its positive role. For example a financial donor may not see the need to fund more than one TM healthcare institutions if they are all the same. Architects should therefore not complicate this matter by designing “one size fits all” buildings. In the case of community healthcare centres, the building should be administered by a relevant local THP’s organisation in conjunction with local biomedical practitioners. The variety of practitioners and specialties that the building caters for should be specified. The building should then meet specific requirements of each practitioner (whether indigenous or biomedical).



Figure 16

Source: Author

Muthi Bridge, Durban: Lack of formal, structured and architecturally designed environments in the city make the existing shelters unusable for anything else other than trading; this perpetuates and creates a room for money-making opportunists who pretend to be qualified healers.

1.5.3. The Need for “Place Making” for indigenous medical practitioners in Cities:

Place making (in this study) means achieving fundamental needs of a user through creating an environment that users can identify with on both physical and metaphysical levels. These aspects include the functionality of place according to the user’s requirements and his/her socio-cultural facets. All other primary architectural design principles such as separation of places in terms of private and public zones are all part of place-making.

Architects who have been appointed to provide healthcare facilities for THPs in the city have not been successful in exploring the concept of place making. Conversely, during this research it was found that the concept of place-making is the driving force behind the indigenous architecture of THPs and



Figure 17

Source: Selepe, 2006

Suitable consultation rooms for THPs have not been established. Instead, THP’s rooms are treated as pharmacies (with no private space for preparation of

African architecture in general. Presumably, this failure is due to the general lack of understanding and to a degree ignorance as to the functioning of indigenous healthcare amongst architects.

Most of the existing city buildings of THPs are merely containers that only supply a person with dimensional space requirements and nothing more (Fig: 16& 17). In fact even the dimensional spaces provided in the existing inner city architecture do not satisfy any of the users interviewed in this study. In terms of professional responsibilities of an architect, it is not up to standard to design without fully understanding the needs of the user together with such facets as his/her socio-cultural factors (Heismath, 1997). Architects could easily obtain such information through researching indigenous architecture of THPs. To assist in this problem, this study will investigate and document (under case studies) the existing indigenous healthcare architecture. Buildings (particularly) in rural areas will be visited for purposes of understanding the social, cultural and economic factors affecting THP's architecture and thus establish the design implications for modern city architecture.

General perceptions also have a negative influence in the place-making for indigenous practitioners: The overview of the existing THP's urban architecture in South Africa suggests that a Traditional Health Practitioner is seen as equivalent to an informal trader rather than a biomedical doctor. An evidence of this is the emphasis on trading over the primary role of *izinyanga* which is to save and improve the life of their patients. For that reason, the indigenous healthcare architecture in cities seems to be more about sorting out the *muthi* sellers that block pedestrian walkways rather than accommodating a practice (Fig:18b). This design approach results in an untidy



environment that is also not welcoming for by-passers who may want to stop, ask questions and learn about the field of TM (Fig: 18c). Furthermore, architects participating in TM have a tendency to arrange THP's suites along narrow walkways that are inadequate for interactions amongst practitioners or visitors (Fig: 18c). The buildings do not even attempt to cater for the ancestral rituals and performances of THPs. Generally, their arrangement is similar to that of a shopping centre. Evidently, this does not assist in improving the openness and legibility of TM to uninformed communities. The fundamental architectural theories of TM (discussed in chapter 3) such as using the built form to educate society are not taken into account. There needs to be an informed architectural approach that extends beyond just trading of TM. Participating architects should at least demonstrate that they acknowledge the diversity of TM. Such an approach would be of relevance to healthcare architecture as a whole. Experts in this genre have called for a humane design approach which responds to the concerns of the community and the individuals' place within the building. (Davey, 1991)

In the case of Durban, The THO has submitted a letter of request to the M.E.C of health in KwaZulu-Natal for a much needed formal place of practice (Interview: Gqaleni, 2007). Another concern raised is that indigenous healthcare facilities such as the Durban Herb Traders Market are only found in the inner city while biomedical clinics are located within a walking distance to their users. Although THPs' are reachable by public transport, the suburbs and townships are partially deprived of this form of medical care. The practitioners that have homes in townships and suburbs are increasingly moving their practices to the inner city. It seems therefore that there needs to be a reasonably balanced distribution of THPs facilities around the city as a whole.



Figure 19

Source: Selepe, 2006

Existing TM architecture does not conform to the fundamental theories of TM as discussed in chapter 3.

1.5.4. Obstacles hindering the merger of biomedicine and TM:

Studies suggest that biomedical practitioners in general have greater resistance towards the merger of the two healthcare systems. Previous researchers argue that biomedical practitioners perceive any collaboration with indigenous practitioners as taking a step backwards in the development of modern day science and medicine.(De Zeeuw, 1997) This attitude is amplified by city developers who focus on the *muthi* trading rather than creating a place for healing. For instance it is believed that the controversial “*muthi* killings” are a result of opportunists who take advantage of the society’s’ ignorance towards understanding indigenous medicine and thereby being unable to distinguish between a healer and a witch. (Ndelu, 2007) This is accompanied by financial growth opportunities in indigenous medicine which are utilised to exploit the uninformed patients. This is why some people “...see the (indigenous) healer as a charlatan, a crafty, deceitful and unscrupulous antagonist of biomedicine who exploits an ignorant population.” (De Zeeuw,1997:13). Through this misunderstanding and subsequent bad publicity, the media does not help the situation of misconceptions yet when legitimate healers are interviewed they always make it clear that unlike witchdoctors, “healers with a spiritual calling from the ancestors cannot harm their patients or others by virtue of their calling.” Dr Maseko (Campbell,1998:24) W.H.O Advisor on Indigenous Medicine Dr. Komolafe Kolawole who spoke from his Nigerian experience in the ATMC-Dbn,2007 said that the major cause of indiscipline in the practice of Indigenous medicine in many African countries is the unethical drive for quick material gains. He said all indigenous practitioners must realise that genuine and lasting reward comes through sincere service to mankind in strict accordance with the will of God. He called attention to the fact that “It is important for us (indigenous practitioners) to accept that traditional medicine practice, like other systems of healthcare delivery should not be seen as a money-rolling business. Fundamentally, it should be seen as a humanitarian service that protects and respects life. It is the responsibility of the THPs to try and fish out the quacks among their ranks and flush them out.” (Komolafe, ATMC-Dbn, 2007)

A collaborative healthcare facility could play a role in educating biomedical practitioners and the general public about alternative medicine. A design approach that supports the concept of transparency, law and order as THPC’s collaboration strategy is necessary to help eliminate the association of TM with *muthi killings* and witchcraft.

1.5.4.1. Exploitation of THP's Indigenous Knowledge:

Dr. J.K Githae (ATMC-Dbn, 2007) warned of false stories created by negative biomedical practitioners who claim that indigenous medicine is unsafe even when they have never had a chance to work with indigenous practitioners and test their medicines. He also mentioned international Pharmaceutical Manufacturing firms whose aim is to exploit THP's indigenous knowledge for profit purposes. He cautioned that this could ultimately destroy African Traditional Medicine all together.

Such issues are to be considered when designing for THPs. For instance indigenous practitioners interviewed for this study were opposed to the idea of incorporating the so-called "New Natural African Medicine" (such as the immune boosters in the media). This is because most of it is believed to be manufactured by international pharmaceutical firms and do not benefit the owners of the indigenous knowledge being used. As a result, practitioners recommended a group-owned indigenous medicine pharmaceutical facility instead.

THPs interviewed mentioned that some of the contemporary pharmaceutical firms "collaborating" with them are only interested in exploiting their indigenous knowledge. Such matters are currently being addressed by the key role players team-working with indigenous practitioners. Nonetheless architecture can play a role in eliminating this problem. There is a need for formal hospitals administered by legitimate THPs and key role players together. These should be designed such that collaboration undertakings happen in a controlled and well monitored environment. Furthermore, focus on accommodating the practice in preference to *muthi*-selling could reduce room for opportunists who are only interested in self enrichment.

1.6. KEY QUESTIONS TO BE ASKED:

- What is traditional medicine? What are the implications of Traditional Health Practitioners' ideologies on space and form?
- What role can architecture play in the collaboration issues of healthcare?
- How can architecture contribute to empowering and creating a place for THPs in the post-Apartheid South Africa and the globalising world at large?
- What is the current architectural approach towards accommodating the collaboration of indigenous and biomedical practices? In what ways can these be improved?
- What design principles and theories need to be applied to create a medical facility that physically and metaphysically caters for both medicines equally?
- What are the spatial implications of combining biomedical and traditional healing practices?
- What technical, environmental and sanitation-related responses are necessary when designing for Traditional Health Practitioners in a formal urban context?

1.7. WORKING HYPOTHESIS:

Principles of THPs' indigenous architecture and their current theories can be used to address the shortfalls of their urban architecture. These could also be used with contemporary healthcare design principles to synthesise the indigenous and biomedical systems into a collaborative built environment.

1.8. AIMS AND OBJECTIVES OF STUDY:

This study is aimed at exploring architecture as a reaction to socio-cultural dynamics. The study is an investigation into socio-economic and cultural factors affecting the development of indigenous healing. It is aimed at understanding the functioning of this field and the challenges facing its development. Architectural responses to these challenges are then put forward.

In view of the renaissance of indigenous medicine, this study aims to restore the value of the indigenous healer in society while providing a platform of growth and reinforcement for international recognition.

South Africa has always used western models for the design of healthcare facilities especially in the pre-1994 era as this was relevant to the profession at the time. The current collaboration of biomedical and indigenous healthcare systems led by the National Department of Health, MRC, CSIR and indigenous medical practitioners calls for a new unprecedented architecture to accommodate this phenomenon. The aim of this study is to obtain a deeper understanding of THPs needed to achieve architecture that caters for both professions on an equal level. This study is directed at creating a new model for a post-Apartheid South African healthcare facility which architects can use as precedent as opposed to only using Western models.

Beyond defining and articulating the traditional spheres that exist within healthcare buildings such as O.P.D, emergency, wards, circulation, public, private, children and adults. The study is intended to establish sustainable architectural relationships between the workplace of indigenous and biomedical practitioners in an attempt to facilitate the merger. This will be done through exploration of various alternatives to establish the most suitable options.

Another purpose of the study is to set up an archetypal brief which provides architects with the required information for designing a medical facility that caters for indigenous healing systems in South Africa. Ultimately the study is aimed at creating a physical platform where the two types of practitioners can work in collaboration and develop through sharing skills while economising through the use of shared facilities, towards creating an affordable and effectual healthcare system for all.

1.9 CONCLUSION:

It is clear that architecture has a role to play in the challenges facing the development of TM in South Africa. Architects should at least know the architectural approaches that work against the aims and objectives of key role players in this subject.

Healthcare architecture in South Africa has not kept up with the current undertakings of collaboration. In fact very few architects in the country are informed about this continental and world-wide movement. With the architectural profession not being involved in the development of TM, one of the main concerns in South Africa is that the state may mandate the uninformed architects to design the collaborative hospitals. (Gqaleni,2007)

It is important to note that similarly to socio-cultural aspects, African indigenous *healthcare* architecture is different from general African architecture. Although the principles are similar, African *healthcare* architecture is a specialty on its own and professional architects ought to learn and be taught by the healers who have been experts in this forte for centuries.

This study forms an integral part of the existing body of knowledge gathered by other related professions and most importantly part of the strategies aimed at rehabilitating and developing indigenous healthcare. Practicality and relevance are crucial underpinning elements of this

study. However, it is intended that the practical building restrictions do not take away from the quality of the resultant building model of this study.

Chapter 2
RESEARCH METHODOLOGY:

2.1 Study Areas:

The research took place in the KwaZulu-Natal province (Fig: 20). The preliminary literature study shows that rural areas manifest a better understanding of African traditional health practice than urban areas; this is attributed to the mode of living and the character of their built environment. This study was therefore carried out in Durban and other inland areas namely: Maputaland, Bergville and Ladysmith or Zululand; that is both urban and rural areas. It is believed that Maputaland and Bergville are influenced by neighbouring countries due to their close proximity to international borders while Zululand is believed to be less influenced by other countries. These study areas were therefore intended to broaden the understanding of the architecture accommodating THPs in KZN.



Figure 20 www.sa-venues.com

KZN is said to be the leading province in the development of TM and collaboration with biomedicine. Its herbal market in Durban is the biggest architectural intervention in the country. (Ndelu, 2007)

2.2 Research Plan:

Both primary and secondary information were used in this study. Primary sources helped in the collection of first hand information on the subject of African indigenous *healthcare* architecture. Secondary sources were used to establish modern trends in medical facility design (biomedicine). This aided in the establishment of a holistic and up to date design brief for South Africa's new *collaborative* healthcare architecture. The resources and spatial arrangements required by both indigenous and biomedical practitioners to achieve collaboration were researched in both secondary and primary methods. This research plan was then used to establish the brief, relevant architectural design principles and theories.

2.3 Primary Information:

Due to the fact that indigenous healing systems are less commonly described than biomedicine, the first hand data collection focused on indigenous healing. THPs and key informants in the representative organisations (of THPs) were interviewed to establish the:

- ideal schedule of accommodation for THP's healthcare facility. This was then be compared with the conventional requirements for designing a hospital to derive a schedule of accommodation for collaboration of the two medical fields.
- traditional theories and concepts applied in THP's indigenous architecture. (The same comparison procedure as above was followed.)

A list of topics and questions were drafted as a guideline for unstructured interviews and included in the appendix of this document.

2.4 Key informants that provided relevant information for this research include:

- WHO African Region.
- National Coordinator of Traditional Health Practitioners Programmes (Mr N Dlamini)
- KZN Department of Health (office of the M.E.C)
- National Traditional Healers Organisation. (Hon. President Dr N Maseko)
- UKZN-African Healthcare Systems Research (Professor N. Gqaleni)
- Edendale Hospital Traditional Healers' Programme.
- Herb Traders Committee, Durban Metro
- W.H.O. Advisors on African Indigenous Medicine (Professor Kolawole Komolafe)
- School of Alternative Medicine and Technology (Dr. J.K Githae)

The annual international conference on African Traditional Medicine in Durban, August 2007 was attended (by author) to interview key informants. Their speeches were obtained from the organising committee; summaries thereof are added to the Appendix of the document.

A minimum of two THPs per type were interviewed.

Types of THPs: (Komolafe, 2007:4)

- Inyanga (technical doctor)
- Isangoma (spiritual diviner & diagnostician)
- Umthandazi (faith healer)
- Traditional Birth Attendant

Each of the aforementioned types of THPs has different specialties within TM. Their requirements differed from one another. Each type described its healing methodologies and the spatial requirements thereof. Each practitioner was also given an opportunity to mention any other aspects that are necessary to achieve a suitable built form for their practice.

Case studies in the study areas mentioned in 2.1 were analysed using photographs; existing drawings (plans, sections etc.); sketches and published journals for background information.

2.5 Secondary Information:

Although this research did not diverge deeply into social sciences, a literature review of research performed by social sciences researchers was carried out to establish the current status of TM in South Africa, and the challenges thereof. The aim here was ensuring the relevance of architectural intervention proposed in section B of this study. A major component of secondary information in this research is the architectural concepts and theories discussed in chapter 3, together with conventional requirements for designing a hospital.

Chapter 3

INVESTIGATION OF KEY ASPECTS TO BE CONSIDERED IN THE DESIGN OF COLLABORATIVE HEALTHCARE FACILITIES:

(A Literature Review and Theoretical Framework)

As Cox and Groves (1981) state, regionalism is very important in healthcare design. Healthcare architecture presents different problems in every country as their organisation responds to historical, social, cultural and political conditions of each country. This chapter will consequently be specific to healthcare design matters of South Africa although some aspects will be global. It will give a broad view of the collaboration endeavour in TM thus enabling a designer or reader to think holistically around this subject. Historical, social, cultural and political issues affecting the building of partnerships with indigenous medicine will be explored and architectural responses to these matters will be proposed.

3.1 The Role of Collaboration in Indigenous Medicine, A broad view:

The concept of collaboration is not new; it has been used successfully by countries such as China for strengthening and harnessing the contribution of their TM to healthcare provision. (Gqaleni, 2007) It is fundamental to understand that the concept of collaboration is not limited to the merger of biomedicine and indigenous medicine. Due to the diversity of indigenous healthcare systems that are different and unique for every country, it is necessary to collaborate with a variety of key role players for the purpose of accelerated growth for this field. The structure of partnerships is modified to suit the needs and priorities of a particular country. For example the most important partners in South Africa include Agriculture for eliminating scarcity of raw materials and Housing or Architecture to accommodate commercialisation and urbanisation of the field.

Using Dr J.K Githae's model, this section of the study is intended to give a broad overview of the concept of collaboration in indigenous medicine. It is not only aimed at highlighting who the potential clients are in TM but more importantly to give insight regarding other (nonmedical) partners to be considered in the subject of collaborative healthcare architecture.

3.1.1 Summary of Collaboration Partners and
Their Roles:

Githae’s model (SAMTECH)

Please note that this summary only consists of the partners (including nonmedical) to be considered when designing for collaboration between biomedical practitioners and THPs. It’s a short version of Githae’s holistic list of partners that THPs collaborate with:

- **National Health programmes** to influence policy, registration, information, education and communication.
- **Farmers** to influence policies, practices of harvesting, and the commercial growing of the herbs.
- **Traditional Birth Attendants** who can act as special envoys of TM in the community because they have a high level of acceptance in the community and are themselves THPs.
- **Foundations**, which could be of assistance in the provision of funding for some specific activities. E.g. Dr Githae has been assisted by international organisations to acquire a complete mobile Pharmacy unit which can do tablets and encapsulation of herbal remedies
- **Social workers** are the change agents in the community and they are very crucial in influencing a change in Knowledge, Attitudes and Practices. Knowledge, Attitudes and Practices are the levers of Developmental Change in society and by extension a change in

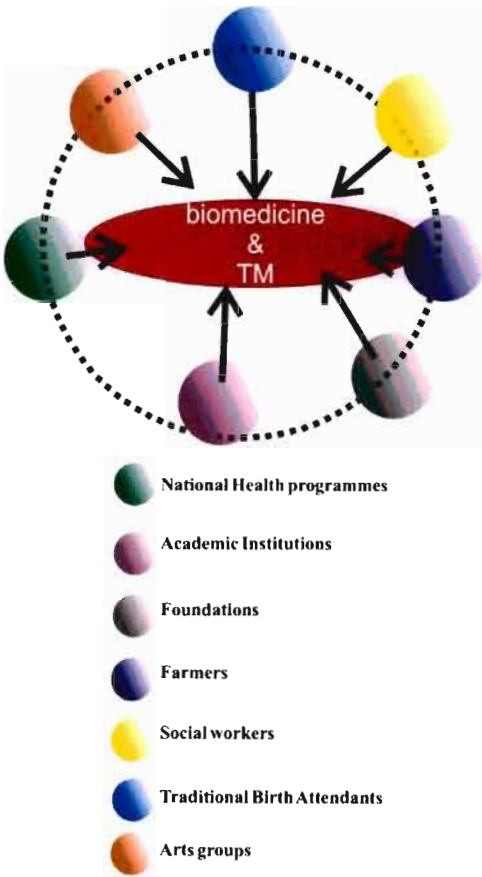


Figure 21 source: Author

Other partners to be considered when designing for collaboration between THPs and biomedical practitioners.

the knowledge, attitude and practices impeding the development and acceptance of TM in the community, regionally and internationally.

- **Arts groups** are very influential information, education and communication tools and they can be collaborated with to act as mobile community theatres that can provide information on deliberations of partnerships, provide health education and communicate messages to the relevant audiences.
- **Academic Institutions** are very crucial in providing Research and Development aspects of indigenous medicine.

According to the ATMC-Dbn (2007), this is the model that South Africa is currently using in the undertakings of collaboration. It is therefore crucial that architects use it as a guide (for design and brief derivation) so as to ensure that their interventions are relevant. Some partners such as social workers may need to be accommodated within the collaborative healthcare facility while some may only require close proximity to site (e.g. farmers). A broad understanding of partnerships therefore has a direct impact on design decisions. An example of this is explored under choice of site in chapter 6.

3.2 Reclaiming the Status of Indigenous Healthcare as an Architectural Specialty in its Own Right:

There is a variety of collaboration typologies in the development of TM in South Africa and globally. The formulation of each type depends on the priorities and the needs of the country's government, THP's organisations or community groups. Once a balanced partnership is formed, a brief consisting of all partners is given to the appointed architect to provide appropriate accommodation thereof. For this reason, Githae's model (the full version) which was developed by SAMTECH for African Traditional Medicine describes all types of collaborations involving THPs other than that of biomedicine. For instance a building designed to house collaboration between THPs and pharmaceutical firms would have a different Summary of Partners to the one in 3.1.1 (above). Also, specific types of THPs are chosen depending on the relevance of their specialties to a particular collaboration.

This further emphasises the aforesaid need for architects to be acquainted with the different types of THPs and their specific design requirements. This, of course, can only be achieved through an understanding (from the architectural profession) of the fact that THPs healthcare architecture is a specialty on its own. There is a concern that THPs architecture which is deeply embedded to their beliefs, practices and teachings is being lost as TM develops (Komolafe, 2007). Architect's involvement in the subject of development in TM would assist in truly re-establishing indigenous healthcare as an architectural specialty of the modern day.

When Professor K Komolafe was interviewed for this research he said that indigenous healers have a unique culture of their own, distinguished from the general African culture. This is not only manifested through their inexplicable multifaceted ancestral connection but also music, dance, art, fashion and architecture (Fig:22 & 23). He emphasised the need for retaining the symbolism and the aesthetics of their architecture. He described indigenous

healthcare architecture as one of the most beautiful in Africa because of the symbolism and meaning it possesses. A thorough investigation of the rich symbolism and meaning possessed in this architectural genre is thus essential for all architects involved (e.g. case study, chapter 3.1).



Figure 23
Source: De Zeeuw, 1997



Figure 22 Source: Tyrrell and Jurgens, 1983

The dress code (fashion), music, dance, art and architecture of *oMakhosi* are the main elements of their identity.

3.3 Architecture in Maintaining the Fundamental Differences of Partners:

All partners collaborating with THPs as demonstrated in Githae's model (including biomedicine) are stakeholders with a chief aim of empowering the country's indigenous medicine. TM should therefore remain a focal element in all undertakings of collaboration, including architectural design.

It is important to note that collaboration of the two health care providers does not try to Westernise African indigenous healthcare systems but rather to give it access to modern technology and other conveniences that are both relevant to indigenous healthcare and the world of today. Countries that have been successful in merging the two medical fields such as China which according to Dr. N Gqaleni is a model for South Africa have been careful around this matter. An example of a local progressive country is Swaziland. As Dr. Q Dlamini, Swaziland ministry of Health wisely states, "The two systems of primary health care are different and they should stay that way. For example, when a patient comes to a government hospital it is often in an emergency situation. They have tried the healers or the healers have taken them as far as they can go...The best way is for the patients to use their own discretion and decide when they want to go to (an indigenous) healer and when they want to use biomedicine. There is definitely a place for both and I imagine there always will be and should be the case." (Campbell, 1998:153)

This is a general view among key role players and health practitioners that are devoted to collaboration of biomedical and indigenous healthcare providers. Thus for architecture to be appropriate in the collaboration endeavour, any architectural intervention should tie-in to this basic principle. Collaborative healthcare architecture should therefore find ways of accommodating these two professions on an equal level thereby abolishing supremacy over one another. The current situation in South Africa is a total contradiction of this theory; THPs practicing in existing hospitals such as Edendale Hospital are arguably being made to conform to Western systems because the existing healthcare buildings are not suitable for the practice of *oMakhosi* (indigenous healers).

3.4 The Impact of Spoken Language to Architectural Language of Indigenous Healers:

“Language is the most important basis for communicating with others. The language that people use tells others who they are, what they do, and what they care about. Language has power – to make people feel good or bad, to bring people together or keep them apart.” (Dr J.K Githae, ATMC-Dbn, 2007) Language is undoubtedly a very important factor in collaboration as it explains the indigenous healthcare systems to potential partners; it can therefore be utilised to amplify interests in that respect.

In both spoken and architectural sense, indigenous healers have a unique use of language and specialised terminology that they use for communication with each other or ancestors and to describe indigenous medical work. As Dr Githae emphasises, partners may not be familiar with the complex specialised language. Therefore, care is taken when building partnerships to avoid the use of words, which make the field, look rather too professional and distant for the ordinary people to understand.

Architectural language is no exception to this collaboration strategy. Collaborative architecture especially in cities of South Africa will be a centre of attention and therefore an opportunity to change attitudes and create better understanding of African indigenous medicine for people of all races, cultures and backgrounds. The intensity of architectural language, symbolism and meaning should therefore be kept at a level that can be understood and appreciated by ordinary people, towards creating a strong sense of welcome. An example of this is the concept of internal privacy which is common in rural architecture of indigenous healers: Using features that were used in ancient indigenous healer’s architecture to create a sense of privacy for a consulter/ patient may be interpreted as dreadful today, it can also keep other people at a distance while using conventional architectural elements that will evoke or create the same atmosphere may be more acceptable to ordinary people. Legibility of a building and its symbolism may further assist in telling the observer about indigenous healthcare ideologies.

On the other hand, the depth of both spoken and architectural languages can be utilised to deepen understanding about specific aspects of African indigenous medicine. A single word

in indigenous medicine could have a very complex and broad meaning that can also be interpreted in architectural terms with the same level of complexity. For example *Makhosi* which means king or man of ancestors is also used to describe a house of ancestors, *eMakhosini* (the kings' or ancestors' palace). However *Makhosi* does not merely mean the aforementioned translations. It is word of respect for one another and the ancestors that guide and sustain the healers. This is a very powerful word in South Africa; it restores confidence, pride and respect for indigenous healers. The word *Makhosi* is used at all times when greeting, addressing and conversing to indigenous healers. (In essence, it is used in the same context as "Amen" in the Christian religion). Also, in Nguni speaking tribes a respectful name for indigenous healers is *oMakhosi*. Such depth in the use of language has a great impact on indigenous healthcare architecture: Similarly to the complexity of the word *eMakhosini*, the ancestral houses are humble in character demonstrating respect for humans through human scale and patients' privacy through introverted design. The cone-shaped roofs with remarkable apexes are a celebration of ancestral power and guidance.

The choice of materials is not only aesthetically pleasant but also functional and patient friendly. Buildings become a piece of art intended for psychological healing; this may be a lesson for the institutional architecture of hospitals. Already healthcare architects around the world are seeking ways of evading the archetypal harsh design of hospitals to a more 'healing environment' incorporating aspects such as patients'-breakout spaces, natural lighting and garners. Bobrow and Thomas argue that healthcare architecture should have a calming influence. The physical appearance should not amplify the stress that going to hospital is by nature. (Kliment, 2000)

3.5 Designing for Community Engagement, Visibility and Transparency of Indigenous Medical Practice

For collaboration with any of the partners to occur, there needs to be a clear understanding of indigenous medicine. Partners need to first know that it exists and that it is a sustainable benefit for them and their communities. According to Githae's theory, if the indigenous medical practice is not visible and seen to be doing something in the community, partners may not believe that it exists. The choice of site and the architectural expression should therefore be intertwined in a manner that allows for the building to engage with the community. The community engagement may be either passive or active if not a combination of both - depending on the type of partnership being accommodated. For instance a partnership that results in a pharmaceutical factory for indigenous medicine may only need a passive community engagement whereby a relationship with the community is maintained through a building being a landmark while a collaboration with biomedicine may result in a healthcare facility that needs both passive and active community engagements; in this case the building may not only accommodate health services but also functions that create room for community participation.

As evident in the interviews and speeches from ATMC-Dbn, 2007, another theory of THPs and key role players in this field is that if the practices are visible, rivals may want to cover it up because of the indoctrination by the colonialists and the neo-colonialists. Where active community engagement is possible, it is recommended that the architecture explores the concept of transparency so that observers are exposed to Indigenous Medical work as this may enable them to resist propaganda, scandals and scare stories created by enemies of indigenous medicine.

These factors are crucial for the development of African Indigenous Medicine as they may affect the extent to which the partnerships will emerge in the community, locally, regionally and internationally. (Githae, 2007)

3.6 Indigenous Healer's Approach to the Environment and the Genius

Loci:

Romans believed that each place has a special quality (the spirit of place) which they referred to as the genius loci (Righini, 2000)

Based on the case studies of this research one would argue that indigenous architecture of THPs is more about the surroundings than it is about the actual buildings; their built form melts into the existing genius loci of their location. The indigenous buildings of THPs are generally small separate units. This allows for the built form to be distributed around the site without major changes to the existing landscape or the visual form of the ground. Each unit is positioned, designed and orientated in a manner that suits its natural micro context. Because the buildings are intentionally made not to dominate their surroundings, the general character of a place is also not interrupted by the architecture.

This sensitive approach to the genius loci is supported by a number of environmental design theorists. For instance, Kevin Lynch's theory of place making includes even the sensuous form of a place; that is the intangible features that contribute to the spirit of a place.

Similarly, indigenous healers' approach to site planning is sensitive to such aspects as smell, sound and overall experience of a place. An example of this is the Tembe Homestead (discussed fully in chapter 4.1) where the built form is designed to an extent that it's camouflaged into the natural surroundings. This is done by using natural materials and keeping the built form to a small fragmented architectural fabric. In this way, the wind (and the weather in general) still flows in the same direction as there is no major deflection or blockage caused by the buildings. There is also less or no trees removed on site. The existing sensuous aspects of a place (smell and sound of rivers and trees) are thus maintained.

The buildings therefore only add character to the existing spirit of place. That is to say the built form shapes itself around the existing genius loci to enhance the factors contributing to its site's placeness. Indigenous healers then use this strong connection (of their hospitals) to nature as a tool for holistic healing. This includes teaching patients, visitors and nearby

communities about TM, African culture and other useful survival strategies such as using the soil to plant food, herbs and to grow live stock (Devenish, 2003).

It seems therefore that incorporating this indigenous design concept into urban healthcare facilities would help create a sense of belonging for both THPs and their patients.

Conforming to this principle means that buildings should not only be environmentally friendly but also site specific so that they are part of the existing genius loci.

3.7 Summary and Conclusions:

Architects are specialists in the field of design and they should not be deprived of the freedom to express architectural theories in a way that they find appropriate. It is important however that the key theories of THPs are not overlooked. Neither should they be so complex that they cannot be appreciated by ordinary people. Buildings accommodating THPs should be accessible to nearby communities thus enhancing the understanding of TM by all people. Site specificity, environmental design and a connection to nature are key concepts in indigenous architecture of THPs. Adoption of these principles could be a useful influence on urban architecture accommodating THPs.

In the case of collaboration with biomedicine, the architecture needs to demonstrate that although the two systems are different there is room for the practitioners to work together in harmony. The spatial arrangement of buildings needs to allow for interaction of THPs and biomedical practitioners. Design ideologies discussed in this chapter are crucial for the architectural interventions to achieve relevance in the development of TM and to support the collaboration strategies developed by the THPC. They present an opportunity for architects to fuse the design theories of indigenous healers with the latest trends in the design of healthcare facilities (explored in the next chapter).

3.8. The Current Design Approaches in Conventional Healthcare

Architecture: (Precedent Studies)

This section of chapter 3 will focus on modern trends in healthcare designs so as to establish the latest challenges to be addressed by the proposed *collaborative* healthcare model. The three precedent studies discussed in this chapter consist of two South African examples and one international example. These will be compared so as to understand the diverse problems facing healthcare architecture and to learn from the innovative solutions.

3.8.1. Umkhumbane Community Health Centre:

Urban Context, South Africa.

This precedent study was chosen because it uses circulation as a tool for creating clarity and legibility of the building. Its use of flexible spaces to allow for community participation is also appropriate for healthcare facilities of today. It supports the medical practitioners’ efforts to eliminate patients’ isolation. Another aspect of interest in this precedent is an economical approach to construction used for aesthetics.



Figure 24 Source: KZ-NIA

Umkhumbane Community Clinic at night.

3.8.1.1 Overview and Context:

This building was designed by Robert Johnson architect & associates and completed in November 2003. It is located in Cato Manor, the closest township to the Durban city centre. Cato Manor is a reconstructed township that was dismantled by the Apartheid Government’s policy of forced removal. The location of the township in the Durban city context could be viewed as intrusive especially since most of Cato Manor has no street names or numbers. Its historical characteristics however give the township a unique character and a diverse culture that



Figure Source: KZ-NIA Journal 1/2004

Umkhumbane Community Clinic in its pedestrian friendly context.

The design guidelines include aspects of a pedestrian responsive design/ 'built to line' edge conditions, height restriction of 2-3 storeys and a clear separation between: client, staff and service access.



41

3.8.1.2. Circulation as a Tool for Creating a Legible Spatial Organisation:

Umkhumbane Community Health Centre explores the concept of a ‘shopping mall’ for health services. The services are grouped into self-contained zones with waiting areas and are accessed from the clear and unambiguous circulation routes. The main services are located closer to the main entrance for ease of orientation. Circulation is kept straight, widened with walls kept out of the way thus creating ease of navigation and a wheel chair friendly environment. The textures and the overall approach to circulation appears as if the building was designed for the blind. All circulation areas are highlighted by the mosaics on the floor so that patients know when they are on ‘the street.’ The mosaic design also tells people about the character of the street at a certain point, for instance where the two ‘streets’ intersect there is a circular design resembling a traffic circle. This concept seems can be used for creating clarity in a larger scale building where ‘the street’ has many waiting and interaction areas juxtaposed along it. Furthermore, because the whole circulation was thought of as a shaded avenue, with places of rest and recreation (Robert Johnson, 2004) it had to be naturally ventilated and lit giving the ‘shaded avenue’ an outdoor feel with fresh air and sunshine (Fig:27). The length of the circulation corridor is reduced by the attached courtyards that make it feel like an outdoor walkway so that the patients do not feel cramped in the building. In conjunction with courtyards, the circulation area plays a very important role in natural lighting and ventilation of the building.



Figure 27
Journal 1/2004

KZ-NIA

Natural lighting and ventilation in the circulation area.
Enhancing the concept of a shaded

3.8.1.3. Technological innovation:

Industrial architecture was chosen for its cost-effectiveness in the construction of this healthcare facility. The large span monopitch roofs are supported independently thereby allowing for a flexible room configuration. The roofs meet at a central monitor where a pair of curved steel posts supports all of the members meeting at the midpoint (Fig:30). The industrial technology was also used as a vehicle for creating a modern healthcare aesthetic, thereby transforming industrial functionality into elegance (Fig:28).

The elevation articulation animates the building while the fragmentation of the building makes it look smaller. This helps in maintaining a human scale thereby creating a patient friendly architectural fabric.



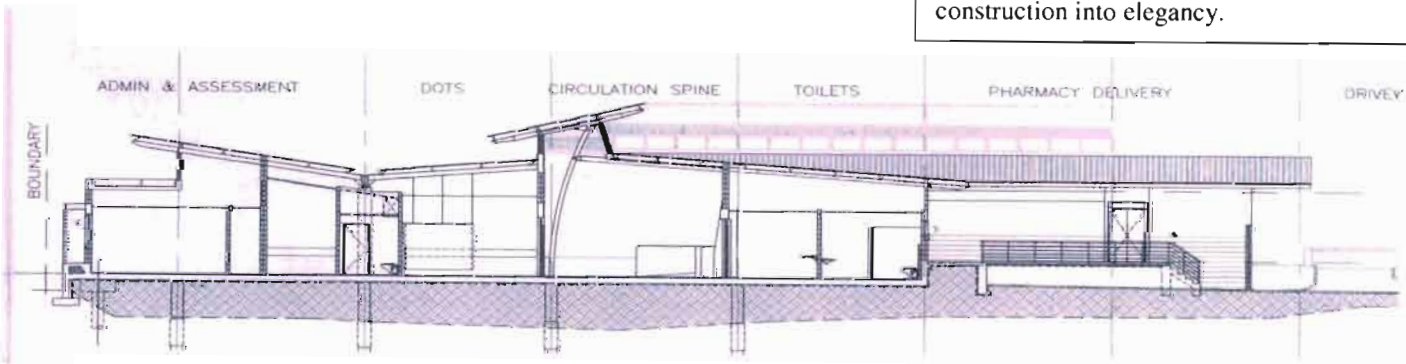
Figure 28
author



Figure 29
Journal 1/2004

KZ-NIA

Fig: 28 & 29:
The building transforms industrial steel construction into elegance.



Section A – A

Figure 30

KZ-NIA Journal 1/2004

Fig: 30. Independently supported long span roof allowing for natural lighting.

3.8.1.4. Using Flexible Spaces to Create Community Engagement

The building is made up of flexible and multifunctional spaces. For example, the waiting area was designed to accommodate community groups whilst the roofed space at the main entrance accommodates other creative activities required by the community. The openness of the street façade is intended to engage the building with the main street. This has been enhanced by the informal trading located in the main street.



Figure 31
author

The building engaging with the street.



Figure 32
A multi functional waiting area.



Figure 33
The main entrance is a flexible multifunctional outdoor space.

The building also explores architectural healing methods by incorporating aspects of natural light and ventilation and urban agriculture (gardens); these are for break out /outdoor activities with a healing effect on patients. Every patient walking in the circulation area or sitting at the general concourse has a view to the outdoor areas provided. This is a similar concept to that of the THPs' connection to nature. It can be seen therefore that a collaboration of the two medical professions could also aid the architectural profession in enhancing environmental design.

3.8.1.5. Conclusion:

There is no doubt that this new approach to healthcare design demonstrates environmental awareness. The clear and unambiguous circulation makes the building patient-friendly. There are merits in terms of planning as it allows for natural lighting and ventilation in every room. The activities are grouped to enhance efficiency by sharing facilities whilst improving the legibility of the building. The building technology used (steel construction) is not only economical and easy to construct but its articulation also brings a new aesthetic to healthcare architecture. The incorporation of creative activities (such as Zulu dancing for the community) seems to be successful in terms of changing the public view of healthcare architecture. People do not only go to the clinic because they are sick but they can go there to have meetings and to do performances. It allows the community to take ownership of its facility. This is an architectural input to psychological concerns associated with isolation of sick people. The creative use of colour in this facility enlivened the building as opposed to the monochrome healthcare facilities that do not attempt to lift the patient's spirit through the use of colour. Although the building



Figure 34

One of the courtyards seen from



Figure 35

Like most parts of this clinic, the concourse is naturally lit and ventilated.

is unique, one cannot help to notice that its architectural language relates to the surrounding buildings. Like the neighbouring buildings, this facility explores the concept of structural honesty by exposing the structure of the building (e.g. roofs). The similarities are also evident in the use of earthy colours.



Figure 36
author

Surrounding buildings



Figure 37
author

The new healthcare aesthetic.

3.8.2 Kokstad Private Hospital:

Rural Context, South Africa:

This precedent was chosen because of the similar orientation and site dimensions to the site selected for the proposed building of this study (refer to chapter 6.4). It is also designed to fulfil the client’s request for a building that will result in reduced charges for their patients. Another reason for choosing this precedent was to investigate its articulation of the roofscape to achieve natural lighting and ventilation.

3.8.2.1 Overview and Context:

The Kokstad Community Clinic was designed by East Coast Architects. Kokstad is a farming town, three hours drive from Durban. The climate is extreme with hot summers and cold winters, it also snows annually. The architecture of the town consists of agricultural and contemporary retail sheds such as *Brown’s Cash & Carry* and *Spar*. The architects were approached by an established general medical practice. The clients requested an efficient layout for an economical building as they wanted to see more patients and charge less. The long narrow site, 100m long X 40m wide presented an opportunity of having the long part of the building facing North East.

3.8.2.2. Design development:

For efficiency, the doctor’s examination rooms were grouped around a central corridor such that four resident doctors are able to oversee twelve examination rooms. One of the major elements of planning was to arrange spaces to create a logical flow of patients from reception/waiting to screening and to

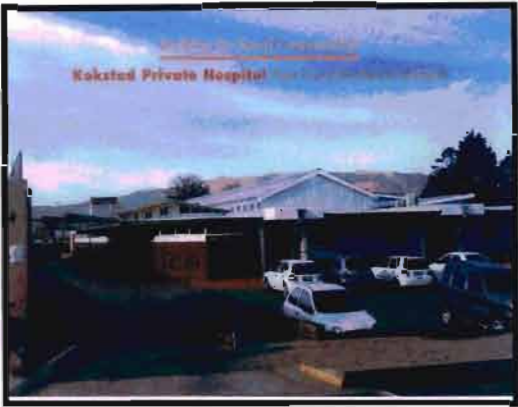


Figure 38 KZ-NIA

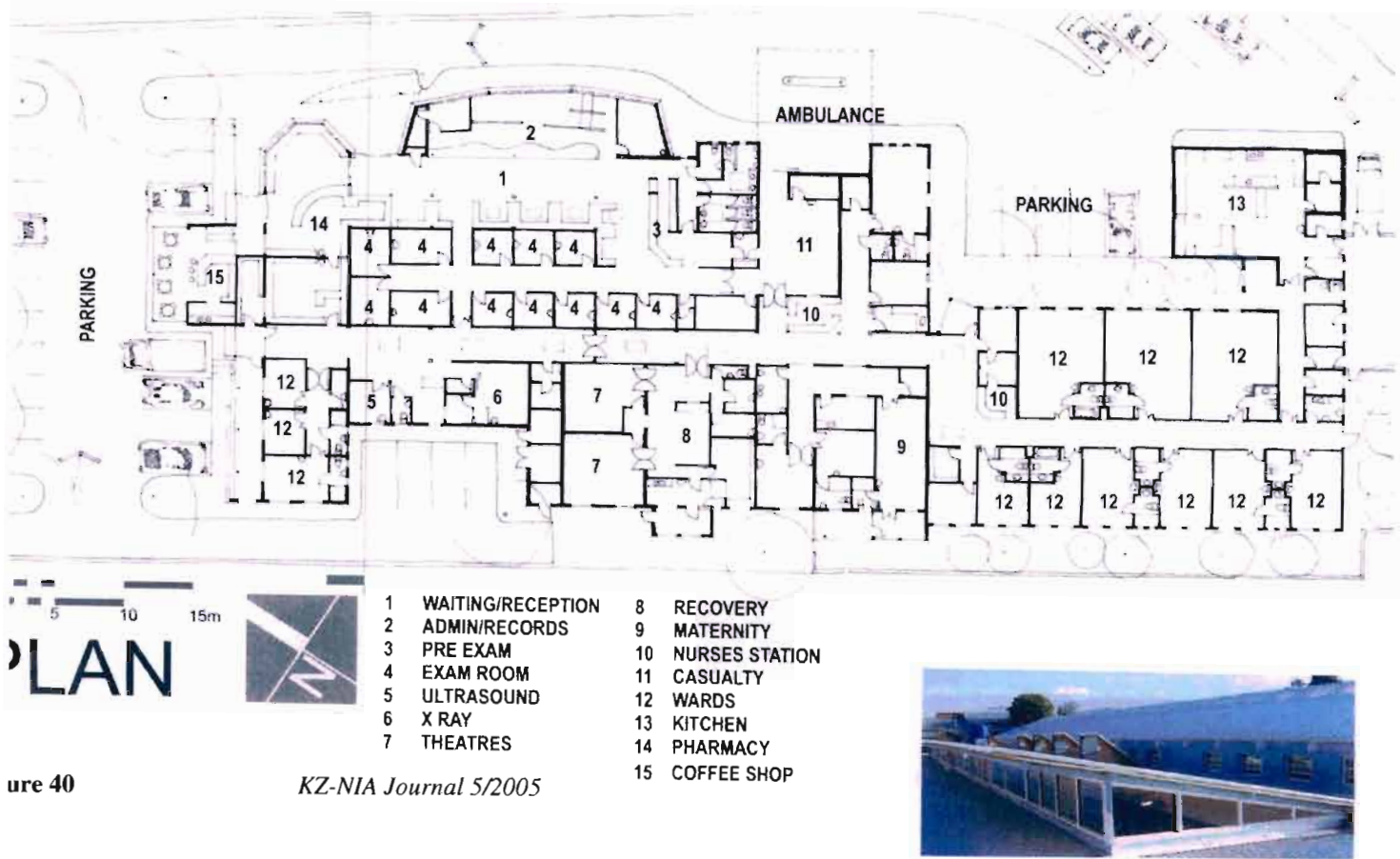
KOKSTAD PRIVATE HOSPITAL



Figure 39 KZ-NIA

View into the admission area of the

examination. The arrangement of rooms generated a square plan with interior spaces lacking natural lighting, ventilation and views.



ure 40

KZ-NIA Journal 5/2005

3.8.2.3. A response to this problem was modulation of
roofscape:

The architects introduced two broad concrete valley gutters to hold the roof. The roofscape was then rearranged to allow for natural light and ventilation through clearstory windows. They also used a combination of simple roof lights for allowing direct and reflected sunlight into passages and corridors. It seems the architects were very successful in their strategies of natural light and ventilation, Derek van Heerden (2005), one of the architects said the hospital reported that their electricity charges are lower than their previous building which is three times smaller than the new building. Attention to north-east sunlight and thermal insulation strategies provided comfortably warm spaces in winter mornings.

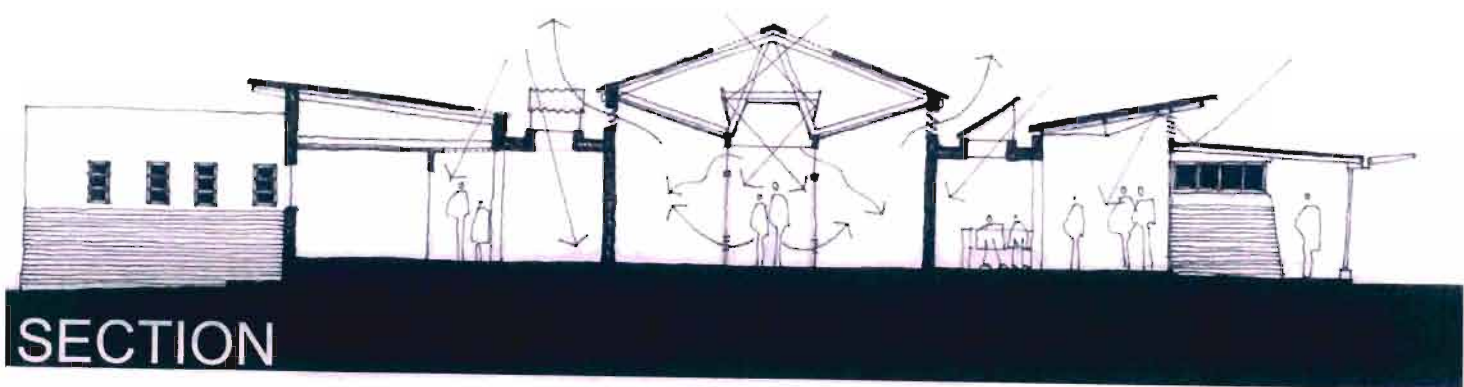


Fig: 41: KZ-NIA Journal 3/2005 modulation of
roofscape to allow for natural lighting and ventilation.

Locally sourced clay bricks, steel windows and metal roof sheeting were used for construction. The building’s aesthetics emerge from the rural shed vernacular architecture of the town.



Fig: 42: KZ-NIA Journal 3/2005 Reference to the rural shed vernacular architecture.

3.8.2.4. Conclusion:

One of the main design concepts for this building was to allow for external views from every room in the hospital however some rooms only have views to the sky. Exterior views could be achieved by introducing courtyards as seen in the previous study (Umkhumbane Community Clinic). A lesson from this precedent study is that one does not have to be limited by the unpredicted result of planning; there are infinite strategies for natural lighting and ventilation. Also, the architecture of Kokstad (agricultural and contemporary retail sheds) is celebrated through formal expression and the use of materials such as corrugated iron thereby giving the building a sense of belonging. This is a similar approach to the previous case study where the building ‘speaks’ the language of its town.

3.8.3. Bezons Clinic:

Urban Context, France

This Jean Nouvel design uses aesthetics and symbolism as healing strategies.

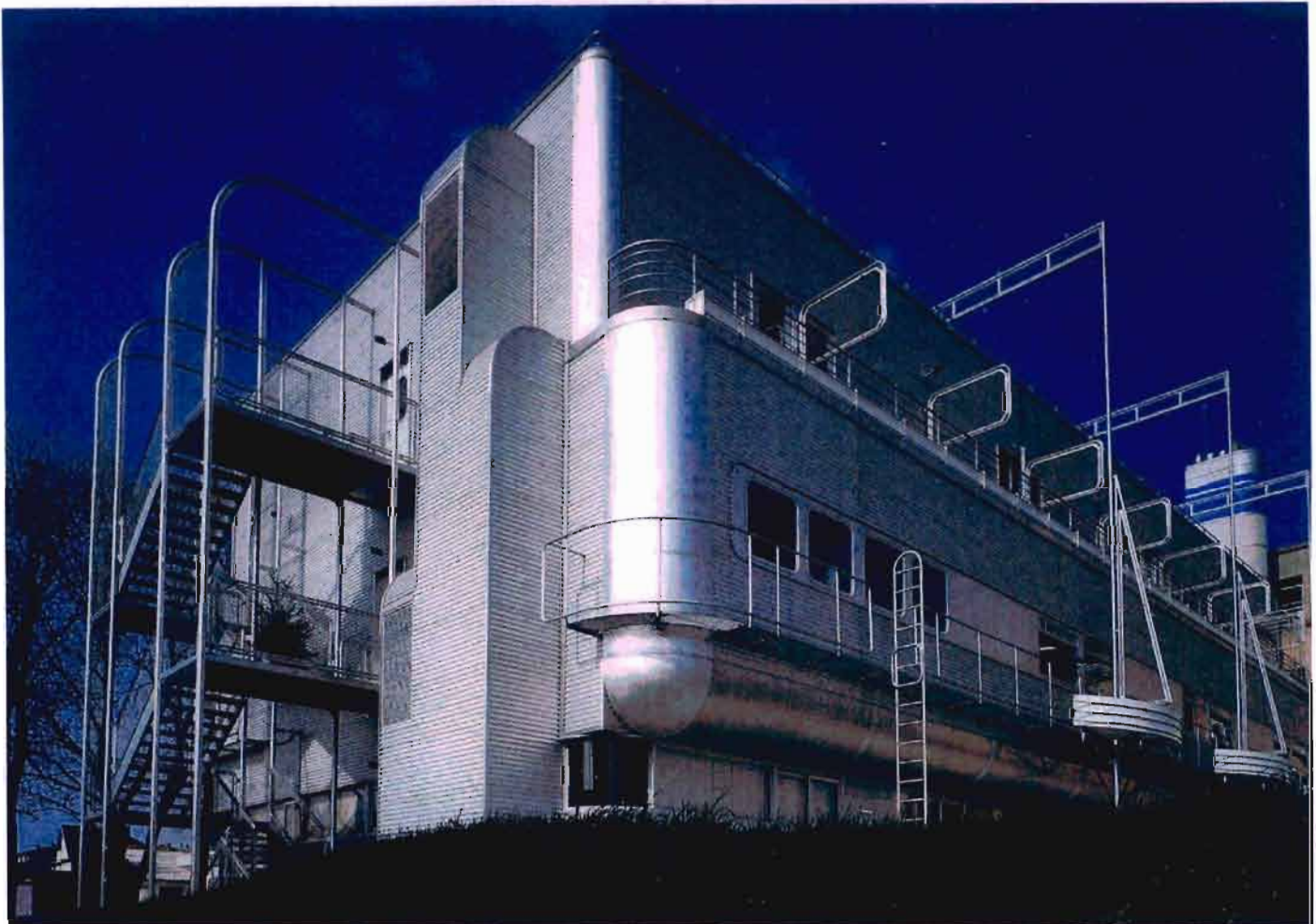


Figure 43

Source: Boissiere, 1996

3.8.3.1. Overview and Context:

The Bezons Clinic is a short term patient facility located in an area of small suburban houses, blocks of low cost houses and industrial warehouses. It is an extension to a 1950s building. It accommodates a dialysis centre, maternity unit, and post-operative convalescence ward. This clinic is known as Nouvel's first piece of architecture to attract critical attention.

3.8.3.2 Aesthetics and Symbolism:

Nouvel's (architect) chief aim was to add a note of optimism to a rather dull suburban environment. He was calling for a rehabilitation of a long vanished embellishment. His design concept is a blend of railway metaphor and nautical allusion. In terms of using aesthetics as a healing strategy, Nouvel treated the facility as a holiday resort. He created a visually striking building that contrasts the neighboring environment. The design and choice of materials strives to make patients feel like they are on a short voyage. He used metal corrugated cladding to evoke transeuropean express trains. The travel metaphor is enhanced by the nautical part of the design; the port-hole openings, masts, walkways and the bedrooms with their steel fittings and cruise liner wood paneling are not only hospitable and efficiently comfortable but also play a role in the successfulness of the metaphor. Incongruousness of the building was intended to uplift the spirits of the patients and the community of Bezons.



Fig: 44: interior view of Bezons clinic

Boissiere, 1996

The interior design of the clinic evokes an interior of a ship. The heavy concrete structures are made to seem light by means of non-natural lighting, bright blue and white ornamental motifs and cantilevered light weight round tables.

3.8.3.3. Conclusion:

In the previous precedent studies architects made an effort to unite their buildings with the existing language of their neighbouring architecture. Nouvel however, chose the opposite path. His approach is architecturally sound as he identified the need for Bezons architecture to be uplifted, as a result his response to context was rather anti-camouflage. The scale and height of the clinic are kept similar to the existing building to reduce the intrusiveness of the new clinic.



Fig: 45: The travel metaphor is enhanced by the nautical allusion; the port-hole openings, masts and light weight cantilevered walkways.

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Chapter 4:
CASE STUDIES:

Having explored the modern trends in medical facility design, this chapter unveils the architecture of THPs. Indigenous architecture that accommodates THPs in rural of areas KwaZulu-Natal will be compared to the existing urban facilities that accommodate this field. This chapter serves as an example, it clarifies the theories and other issues around the development of TM as discussed in the previous chapters.

4.1 Tembe Homestead/Hospital.
(Indigenous Architecture of THPs)

Tembe Homestead is a great example of the THPs indigenous architecture (Fig:46). Its in the North Coast of KwaZulu-Natal, sited in kwaNgwanase, the Tembe Village of Maputaland. This healthcare facility consists of consulting rooms and patients’ wards.

4.1.1. Context and Overview:

Maputaland is located south of southern border of Mozambique and east of the border of Swaziland (Fig: 47). It is characterised by the flat landscape, evergreen indigenous forest and hot humid summer climate. The loose fine sand creates difficulty of roadways and pathways.

The selected homestead, the Tembe family is a small house of seven members. The major component of the house is the medical practices of the house holders. Both husband and wife have never had formal education; the family is sustained by the medical and ancestral services provided by the Tembe family to the community.



Fig:46: Main ancestor’s house.



Fig:47: map of KZN .

4.1.2. Planning and Symbolisms:

Both the husband and wife have individual ancestral powers and are trusted THPs of the Tembe Village. Because they each practice with direct connection to their separate ancestral powers, the planning of the household is based on two separate cores defined with courts so that it allows for the harmonious separation of the two practices. The separate cores function as a partnership. Although they each have separate entrances, the husband's domain is regarded as the main core with the main entrance into the homestead. Each of the two domains has very specific functions. The husband's court has a large tree that only accommodates ceremonial functions and other important meetings (fig:50_1). All guests are received at the smaller tree of the husband's court (fig:50_1a), here wooden chairs are built-in for reception purposes. One cannot help noticing the hierarchal order, the ratio of function to volume. The trees serve as roofs of these outdoor spaces. Where there are small intimate activities such as reception, a smaller tree with less volume is used. In the same way, outdoor spaces allocated for ceremonial gatherings and performances are cantered around a bigger tree (e.g. fig:48). The wife's court (fig:50_2) is used for family gatherings and other social intimate functions.

The wife's domain is also used as an outdoor cooking place. Each domain has a tree in the center as a symbol of life. The two domains are connected by core functions i.e. kitchen and food storage. The kitchen is constructed of reeds only to allow for maximum ventilation (fig: 53) while the food store is lifted from the ground so as to avoid contact with damp

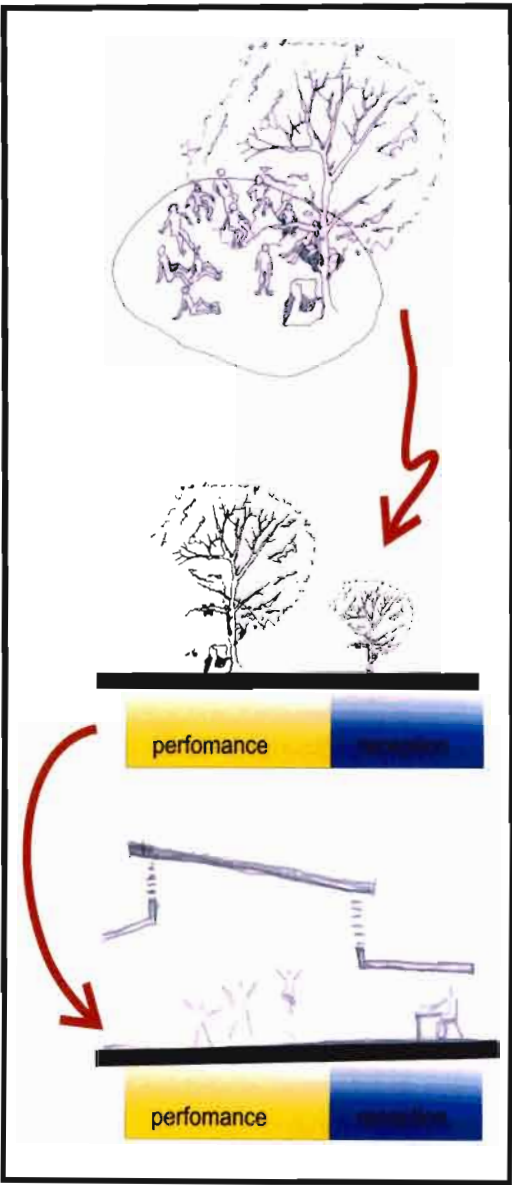


Fig:48: function:volume author

soil thus living space for the needed circulation of people and livestock on the ground. (fig:49)

The positioning of family rooms around the site is such that there is no separation between the family and patients (fig:50). This reinforces the indigenous healing ideology of treating patients as part of the community. THPs hold a belief that patients heal quicker when they are surrounded by healthy and lively people (Zungu, 2007). Accordingly, they developed this sensible architectural response to healing the minds and spirits of patients. This idea of living with patients is common in indigenous THPs' healthcare facilities, even in cases where there is enough land to separate THPs' homes to their patients' rooms. The last born daughter's house is located in the connecting zone so that the wife's zone is not completely out of surveillance as most family member's rooms are in the main domain. The actual house is organised around a small private family domain. (fig:50_ 3)

The main family room is located at the western end of the husband's domain so that it becomes a semi-public space during ceremonies while the second born son's room is located at the main entrance as a symbol of protection for both the house members and the patients.

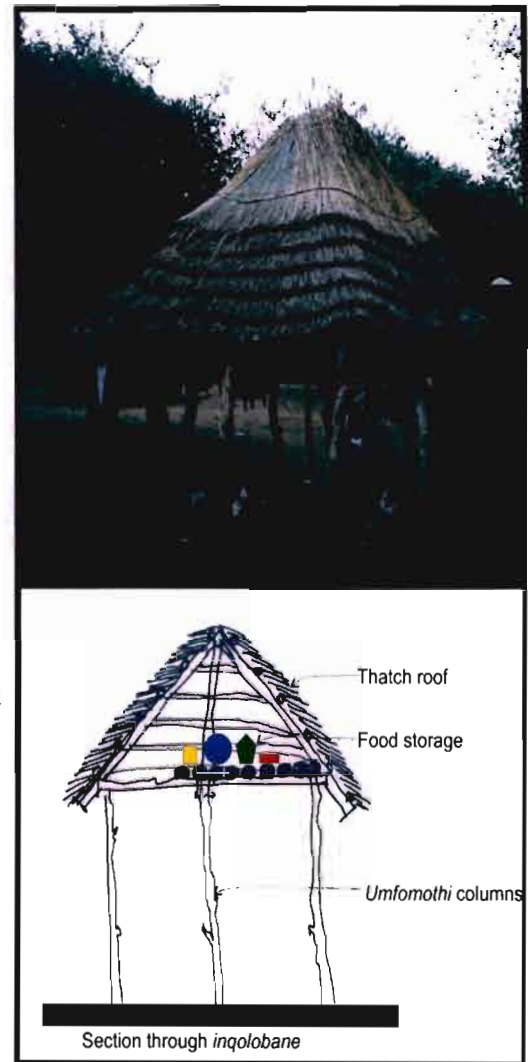


Fig:49 food storage room (inqolobane) *author*

Legend:

- Residential
- Patient's accommodation
- Ancestor's house
- Consultation room
- Kitchen
- Food store
- 1 Main court
- 1(a) Visitor's reception point
- 2 Wife's domain (with outdoor cooking area)
- 3 Son's and daughter's domain

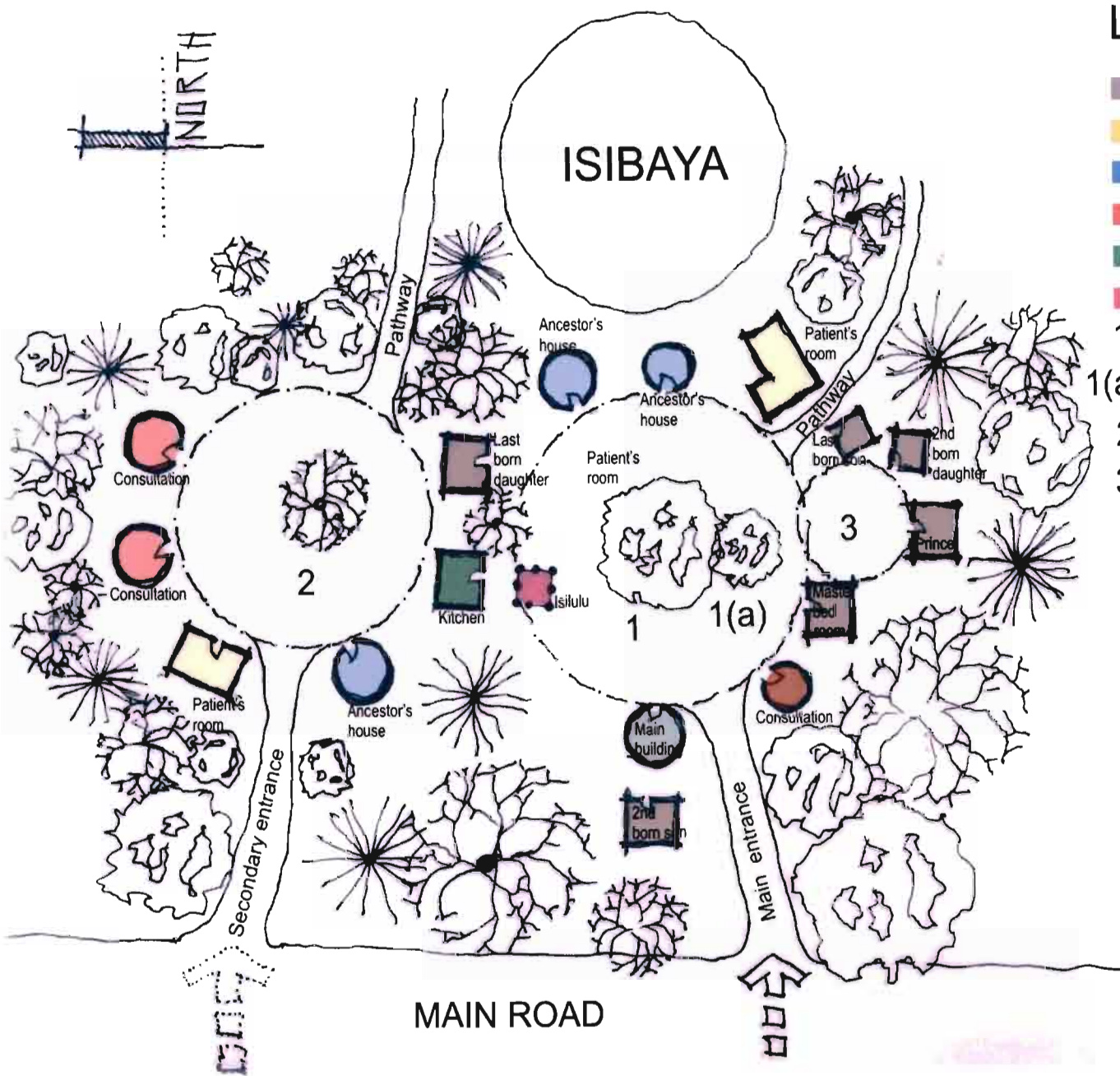


Fig:50: Plan of the Tembe Homestead.

author

It is clear from the positioning of *isibaya* at the rear east end of the homestead instead of the centre that people’s health is the first priority to the Tembe family. In addition, out of seventeen rooms only six belong to the family. This reassures us that indigenous healers are passionate practitioners serving the poorest communities of the country where government’s medical supplies do not reach. This is one of the reasons for regulation of TM in the country.

Another apparent planning/architectural element in this healthcare homestead is the fact that all buildings built for dwelling purposes are cubic in form with corrugated iron (monopitch) roofs. The circular rooms work very well for consultation as there are no beds or any other interfering furniture, they are intimate and they create a warm atmosphere for the patients. Patients sit on the floor as a sign of respect for ancestors. The orthogonal form seems to be appropriate for dwelling purposes as these rooms incorporate contemporary furniture (such as beds) which works better in cubic spaces (e.g. fig 51).

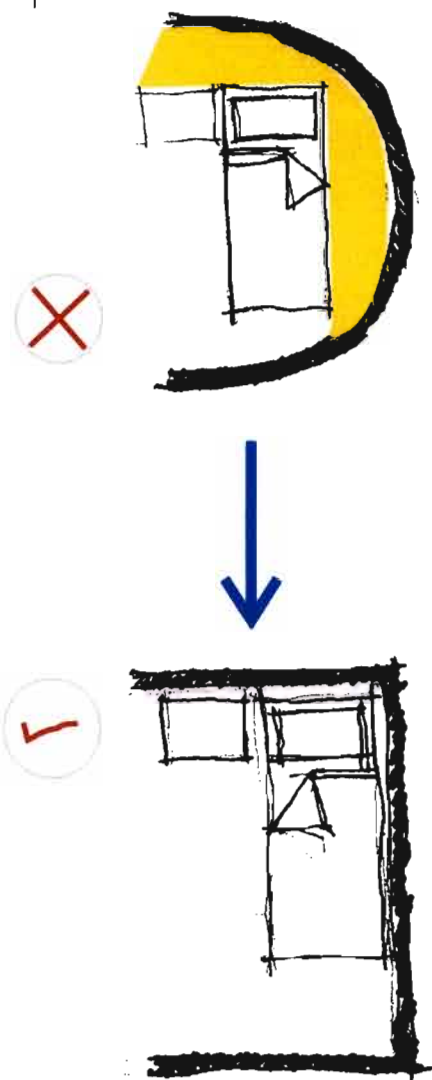


Fig:51: circular vs cubic rooms for wards. *author*

4.1.3. Response to Climate:

As discussed under the THPs’ approach to natural surrounding and the genius loci (chapter 3), it is a tradition in the area to surround the homestead with the evergreen indigenous tall thick forest. When building a house in the Tembe area only the unwanted trees are removed and the rest is left for defining the edges of the house while protecting the buildings against wind, sun and erosion. The sandy topsoil of the area also prevents rain water from flowing into buildings. As a result, the arrangement of buildings was more functional than responding to climatic conditions. However, every house in this homestead is designed around the basic architectural principles of natural light and ventilation. For instance, when approaching the ancestors house (fig:52) from the outside, it looks as if it has no windows as this was done to maintain internal privacy. It is only upon entrance that one experiences the overwhelming light and ventilation. To achieve this experience the interior walls are only plastered up to 500mm below the roof (fig:53) , the unplastered part is not only hidden form the outsiders eye and protected from rain by long overhangs. It also consists of tightly woven *izintingu* that keep unwanted objects out of the house.



Fig:52: ancestor’s house seen from outside *author*

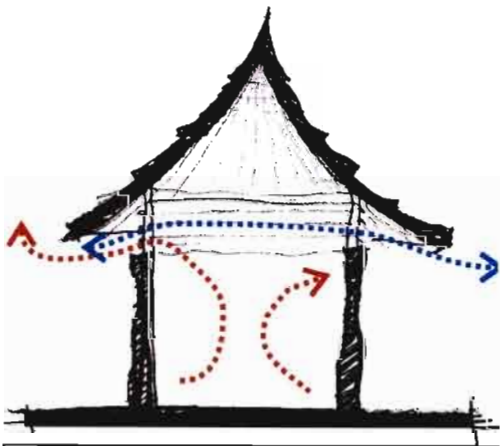


Fig:53: section of the ancestors’ house *author*

4.1.4. Construction Technology:

The most remarkable construction technique in the Tembe homestead is that of a traditional thatched cone-on-cylinder. Construction is quicker than the traditional woven *izintigo* construction:

- Plastered or exposed timber frames with reeds or stone infill.
- Interior walls are plastered up to 500mm below roof for thermal comfort.
- Thatched roofs are ribbed with *ingqongozane* grass from local rivers.

This style of construction does not require any fixing nail, screw or bolt. These architectural elements are predominant in both Swaziland and Mozambique.



Fig:53: kitchen under construction at the wife's domain. *Author*

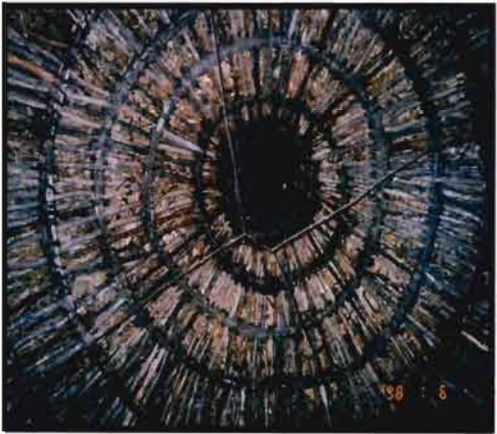


Fig:54: woven roof, consultation room. *Author*

4.1.5. conclusion:

The Tembe homestead has very rich architectural concepts which are applicable to our contemporary environment. For instance the idea of incorporating spaces for community (creative) activities such as stage plays in the design of Umkhumbane Community Health Centre is similar to the role of the husband's domain of the Tembe homestead. This provides evidence that THPs have a warm approach to patient's treatment. Patients are not seen as unsafe people who should be isolated and kept in a hospital but rather as people in need of contact with the outside world to enhance their sense of wellbeing both physically and psychologically. Patients take part in activities such as THPs' performances in ceremonial functions as this is part of THPs' holistic approach to healing. During an interview of this research, Mr. F.J Ndelu of the Herb Trader's Committee in Durban said that society's lack of respect and trust in the indigenous healthcare has deprived THPs from being part of the struggle against HIV/AIDS. He believes that THPs of South Africa are not given a proper chance to fight diseases in their own way, instead they are being forced to conform to the Western structures and approaches to healing and he sees this as a mockery to their profession. It seems a sensible architectural response to such problems would be to create an environment that at least allows THPs to perform at their best, that is to say their healthcare facility should accommodate all functions relevant to their holistic approach to healing. There are various indigenous healthcare facilities such as this one in KwaZulu-Natal. Such case studies should be used for ideas as to what schedule of accommodation would be appropriate for THPs holistic approach to healing in a contemporary building.

Design concepts such as maintaining internal privacy while allowing for natural lighting and ventilation (fig:53), placing a tree in a center as a symbol of life and making patients feel connected to the outside world through incorporating other vibrant activities in the healthcare facility are all valuable concepts that architects should take into account when designing for THPs.

4.2: Durban Herb Trader’s Market:
(Urban Accommodation of THPs)

This case study demonstrates the current state of architecture accommodating THPs in urban areas of KwaZulu-Natal and South Africa in general.

4.2.1. Context and Overview:

Like informal traders, herb traders are usually overlooked by the city councils and have very few formal shops. As a result they tend to situate themselves in nodes with high pedestrian flow, usually at transport interchanges. Trading occurs at places where there are bus ranks, taxi interchanges and market places.

Durban herb traders however have become the leaders of the commercialisation of TM in the country. They began by plying their trades along the pavements of the Warwick Junction area. This intrusion by THPs left no space for pedestrian circulation thus increasing the need for overhead pedestrian paths connecting the Victoria Street Bus terminus and the various taxi ranks. The OMM design workshop architects in partnership with the eThekwinini municipality used the incomplete Queen Street on- ramp and the Victoria Street off-ramp to create pedestrian linkages. This provided THPs with a basic sheltered roof over their trading spaces, communal toilets, and small consulting rooms for THPs.



Fig:55: location of the Durban Herb Trader’s Market.
KZ-NIA Journal 3/2001 p7



Fig:56: Pedestrian flow of Durban Herb Trader’s Market on a normal week day.
Author

4.2.1. Planning:

The shelters are positioned strategically at both edges of the existing bridge so as to allow for uninterrupted pedestrian flow on the central part of the bridge (fig:57). The most important aspect of this intervention is that the bridge creates a short-cut for pedestrians. Most pedestrians find it convenient, in this way the herb traders get maximum exposure for their business. On the other hand, the ever-growing demand for Traditional Medicines and limited provision of space has led to the central circulation space of the bridge being used for drying medicines; again this hinders the pedestrian flow on the bridge.

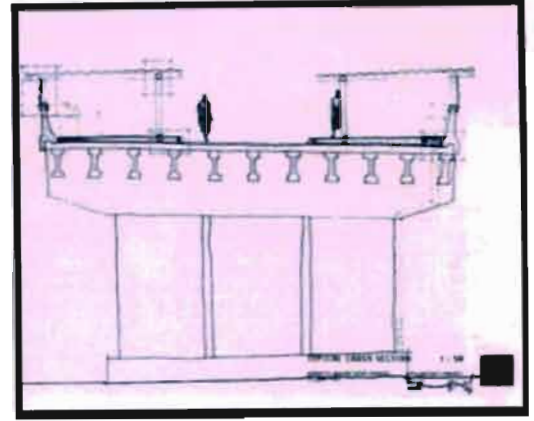


Fig: 57: Typical section through the bridge.

KZ-NIA Journal 3/2001 p9

Around the bridge the city has built a number of shops or consulting rooms for indigenous healers. The design of these spaces does not seem to follow any of the THPs' design principles explored in the previous case study. The whole arrangement is in a liner form, no additional space is available for rituals or for the indigenous healers' holistic approach to healing. The room sizes are inadequate for the basic functions needed by each practitioner, i.e. selling, consulting, *muthi* preparation and storage. Most users during the interview complained that the complex only has one communal toilet. Ablutions need to be at close proximity to THPs as they often work individually and cannot leave their shops unattended. The complex also has no water for users; the only place with water is the ablution area. According to Mr. Zungu who is *inyanga* and a shop owner, the shortage of water makes indigenous healers seem unhygienic. Most indigenous healers consider the lack of electricity and water supply in "South Africa's biggest herb market" as a sign of disrespect. To them it shows that city

officials have a wrong impression about the professionalism of their practices.

4.2.2. The Concept of a Cultural Shopping Centre:

The tourist interest in indigenous healing has resulted in the TM trading and African crafts becoming more and more inseparable. In some areas of the Herb Trader's Market circulation is obstructed by the display of African crafts made by artistic indigenous healers (Fig: 58). THPs crafts includes utensils such as short spears for *izasangoma* and long spears for cow slaughtering. The belief is that people who come to the bridge are mostly from rural areas seeking work or working in the city. They have a strong cultural background; as a result the bridge has become a shopping centre where people do not only buy medicines but other cultural necessities as well. This restores the belief that indigenous healers play a very important role in cultural preservation. The concept of a cultural shopping centre is undoubtedly valuable in an urban context of herb-trade. Due to both the tourists' attraction to the profession and the need for cultural materials associated with traditional healing, it seems inevitable that a healthcare facility for THPs should include other components such as an art gallery and selling of African crafts in an area appropriately designed for such functions.



Fig:58: Linear arrangement of shops & African art as part of the trading.
Author

4.2.3. The Information Centre:

On the upper floors of the Herb Trader’s Market there are administrative offices where THPs pay their rent. Some of the indigenous healers have never had formal education, as a result the eThekweni Municipality provided them with class rooms and teachers to give them basic education as they deal with large sums of money every day of their lives. They also have lectures and presentations from different authorities involved in the development of TM. This educational aspect is fundamental to the development of TM and collaboration with biomedicine. It is recommended therefore that all architectural interventions incorporate it.

The meeting and class rooms are all designed in a climatic responsive manner. All rooms are cross-ventilated and naturally lit. Every window has a sun control device designed specifically for its orientation. Although the placing of sun control devices on the interior wall seems aesthetically pleasant, the flexibility of space is jeopardised. The earthy colours and the patterns used on the floor of the Information Centre evoke African medicines displayed on the bridge (Fig: 59). The manager’s office has glass walls as this allows him to observe all rooms on the upper floor. There is a pleasant contrast between South African indigenous/ natural materials such as gum poles and man-made stainless steel lighting (fig:60). These contrasts are also explored in the neighbouring bridge for informal traders, designed by Langa Makhanya architects (fig:61 & 62). The bridge combines contemporary building technology with the traditional gum pole construction.



Fig:59: meeting rooms on the upper floors of the Herb Trader’s Market .
Author



Fig:60: multi-purpose class rooms for traditional healer’s basic education.
Author

4.2.4. Conclusion:

The architects in partnership with the eThekweni Municipality are to be applauded on their success of regenerating lost space into a space that benefits the people of the city. As a revitalised space, the ‘*Muthi Bridge*’ definitely solves the problem of herb traders obstructing pedestrian circulation around the Warwick Junction transport interchanges. Nevertheless, buildings provide for THPs around the bridge seem to have lost the strong architectural theories of indigenous healing. Priority is given to trading; as a consequence other functions of THPs are not catered for. The complex is purely functional with no attempt to provide a healing environment or place making for THPs.

The information centre discussed in (iv) above was designed by a different architect, Laren Beni. It is one of the most appropriate architectural interventions in the ‘*Muthi Bridge*’ complex. This is mostly because of the educational and meeting facilities it provides. The dramatic difference of the design quality between THPs’ practice facilities and the information centre negates the whole purpose of having an educational component in this complex. For instance THPs are thought about hygienic preparation of medicines yet they have no space, water or electricity to practice what they learn. Also the information centre is located too far from the actual pedestrian bridge. This seems to have a negative effect on the public-accessibility of the building.

The complex can be seen as an African Cultural Shopping Centre where tourists, researchers and people of the culture



Fig:61: informal trading bridge by Langa Makhanya architects.
Author



Fig:62: South African (contemporary) trends in construction technology *Author*

do not only buy African crafts but also enjoy the experience. This is undoubtedly a strong and valuable aspect of THPs' facilities in an urban and commercial context.

4.3: Miscellaneous Formal Shops of African Indigenous Medicines.

(Accommodating Commercial Aspects of TM)

This section of the study focuses on the commercial part of TM. Various formal shops in the Durban city are discussed with a chief aim of establishing design requirements for TM shops. Other aspects investigated in this section include numbers of patients visiting such shops per day and the general monthly income for the trade. (These additional details are shown in Appendix B.) Understanding the commercial value of TM could help architects in determining the number (or sizes) of shops necessary for the commercial component of their interventions.

4.3.3. Overview:

African traditional *Muthi* shops function similarly to the biomedical pharmacies: Patients get a prescription from *izangoma* and *izinyanga* and they buy their recommended medication from the pharmacies. Similarly to biomedical practices, all medicines have names meaning that a patient takes the name of the *muthi* from *isangoma* or *inyanga* to a pharmacy of his/her choice. When the medicine is given to patients, pharmacists give directions on how the medicine should be used.

Once again, the shops sell everything associated with indigenous healing from *muthi* storage containers to attires and accessories for THPs. All shops that were visited during this study were owned by Indians. According to Mr. P Nzimande of Amandla Enkunzi Pharmacy African



Fig:63: Amandla Enkunzi Pharmacy seen from outside.
Author



Fig:64: shop owner of Amandla Enkunzi Pharmacy
Author

indigenous healing has no racial barriers; any culture or race can be taught how to put the herbs together and become *iziyanga*. He said that there are also instructional handbooks for herb preparation. However not everyone can become a *sangoma* as this is an ancestral and spiritual calling. In terms of supplies, most shops are co-owned by *iziyanga* themselves and untrained shop owners obtain their medical supplies from the local THPs. None of the visited shops were owned by a *sangoma*.

In terms of target groups, all shop owners said that they get customers from all cultures, races and backgrounds. For instance, when Amandla Enkunzi Pharmacy was visited for this study, it was full of tourists from China who did not only buy craft work but also certain medicines as well. Most of these formal shops make about R 1500 per day on traditional medicines only.



Fig:65: THPs’ attires sold at pharmacies. *Author*



Fig: 66: display of medicines at Halmont Stores. *Author*

4.3.4. Spatial Requirements:

Spaces required in formal shops are: trading area, preparation room, storage and consultation room in a case where an indigenous healer practices in the shop.

Trading area:

- Shop should get maximum exposure to pedestrians.
- Temperatures should be kept low as some of the medicine expires in hot temperature. (Temperature should be controlled.)

Preparation room:

- Due to the fact that *muthi* preparation is very physically demanding (fig:), these rooms should allow for as much ventilation as possible. Most shop owners during this study suggested a roofed outdoor space as an addition to this space.

Store room:

- Besides low temperatures, a store room requires ventilation as some of the medicines are sensitive to humidity.
- Ventilation also eliminates the odour of medicines.



Fig:67: painting showing a typical traditional healer's setting. *Author.*

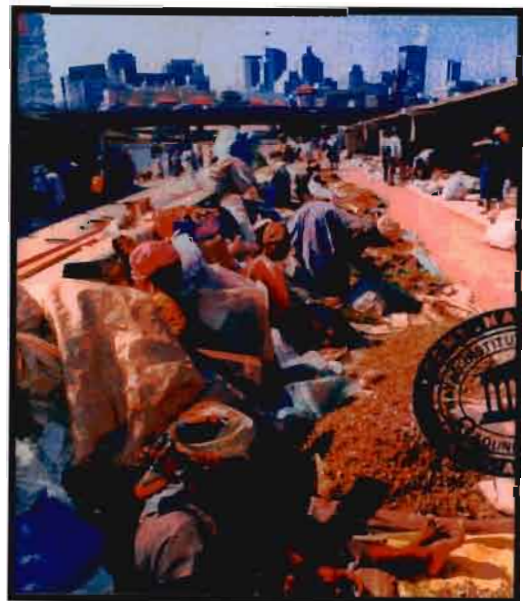


Fig:68: traders working together on their separate *muthi* preparations. *KZ-NIA Journal 3/2001 p7*

4.3.5. Conclusion:

It is clear that urban THPs are not given a platform to fully exercise their holistic approach to healing. Most facilities provided in the city are structures originally designed for other functions as a result they do not incorporate the fundamental design theories associated with indigenous healing. One would argue that the perception that urban THPs are more business minded and less passionate about patients is created solely by the fact that none of the architectural interventions truly respond to the needs of healers and their patients. For instance THPs seem to always work collectively even when they have individual practices. On the 'Muthi Bridge' the unroofed central part has been redefined by the THPs as a communal *muthi* preparation space. (Fig: 45) This concept of collectivity needs to be embraced in our architectural interventions. Buildings designed for THPs therefore need to have communal work spaces. These could be their TM gardens, laboratories or pharmaceutical facilities.

Chapter 5

CONCLUSIONS AND RECOMMENDATIONS:

South Africa is at an initial stage of developing its indigenous healthcare and the challenges therein are very different to well established countries in this field such as China. At this stage the country is still experiencing fundamental problems such as the perception that its indigenous medicine is primitive, unscientific and unreliable. While the key role players continue to create measures to bypass perceptions associated with societal readiness for change in indigenous healthcare, changing perceptions has little impact if the architecture as a physical image of this field still treats THPs as primitive people who are only accommodated in informal or old buildings of the city. Key role players in the development of African indigenous medicine such as Dr Komolafe have called for a more 'serious' architectural participation that retains the beauty, symbolism and meaning of indigenous healthcare architecture. As a result, architectural interventions that possess a sense of primitiveness are regarded as irrelevant in the attempt to change misconceptions about indigenous healthcare. It is of great importance however that participating architects draw inspiration from the rural architecture of indigenous healers and apply its design principles in manner that suits our modern day life style, culture and conventional health standards. This approach could help in changing the misconceptions about Traditional Medicine and creating a sense of belonging for city THPs.

Another important aspect of image making in a city facility for THPs is to celebrate the fact that such a building would promote African Traditional Medicine and would often house headquarters of associated organisations. The built response should be visible from long distances in an attempt to create passive community engagement which could improve acknowledgement of indigenous medical work and increase the interest of important partnerships. It is critical that community engagement also plays an active role so that the building serves as an information centre to inform ordinary citizens of indigenous healthcare systems. The built form should also manifest great integrity especially in its architectural language to ensure that patients and citizens feel comfortable in a place that not only heals but also part of their cultural heritage.

The culture of indigenous medical practitioners has fascinated tourists and encouraged their engagement in the industry especially after urbanisation of the indigenous healthcare. Of late, the tourists' interest has been amplified due to the collaborative endeavour with biomedicine. There is no doubt that the nature of the proposed building would be an attraction for both local and international visitors which in turn necessitates a legible and visitor-friendly environment to help promote awareness of genuine indigenous medical work. As seen in the case studies, most facilities accommodating *oMakhosi* in cities become vehicles of cultural preservation as they often incorporate African arts in the form of music and artwork. Trade is either formal or informal and includes other necessities of THPs' practice varying from medical tools to attires for practice. It is evident then that a building of this kind cannot avoid this component of cultural preservation, which is deeply embedded in the unique culture of *oMakhosi*. It is recommended that if formal cultural shops are not provided, a building accommodating *oMakhosi* should at least allow for sustainable informal trading of this nature and a place for associated African arts therein. *Ishashalazi* (performance platform) is a functional necessity for the practice of *oMakhosi* and should therefore form an integral part of the cultural preservation component.

The tendency for architects to conduct superficial investigations into African architecture has resulted in mimicking of ancient architecture. This seems to be irrelevant to the *current* socio-cultural factors of South Africa. Cultures evolve with time and so do peoples' needs. African healthcare architecture of today should therefore look into the current socio-cultural aspects as opposed to those of over a century ago. Indigenous architecture of the THPs in the rural parts of KZN has definitely demonstrated this evolution. For example the Tembe homestead is designed in a manner that responds to current challenges of healthcare such as ensuring that patients don't feel isolated from society (chapter 4). This means that the architectural profession needs to understand the role of THPs today in order to ensure relevance of the interventions.

Specificity is one of the prominent challenges in urban architectural interventions. Urban architecture does not acknowledge the fact that there are different specialities within Traditional Medicine. The functioning of the different types of THPs needs to be understood and catered for in the architectural interventions. The argument here is that because TM is a

complex healthcare field, its architecture should be treated as a specialty and the level of architects' awareness about this field should be at the same level as that of biomedicine.

Understanding collaboration typologies is also essential for architects designing for TM. It is clear that collaboration in indigenous medicine is a broad concept that consists of different partners with different roles in the development and empowerment of indigenous medicine. Design problems in this subject matter pose different challenges and diversities depending on the nature of the collaboration. Each type of collaboration has other inseparable role players to incorporate; in this case, collaboration between biomedicine and indigenous medicine requires involvement of W.H.O African Region, National Department of Health, THPC, MRC, CSIR, UKZN and the local THO. In practice however, the scope of partnerships is always broader and some of the key role players may need to be accommodated within a building whilst other partners such as agricultural groups may only influence the choice of site; that is to say the building may have to be located either in or close proximity to an area where sustainable farming of the THPs' herbs can occur. This link to the agricultural component of TM is necessary for ease of facilitation in as far as the THPC collaboration strategies are concerned. (Gqaleni, 2007) It could therefore be concluded that collaboration is never just about two partners.

Once the Summary of Partners is obtained from the client, architects should understand the chief aim of the given collaboration type and the architectural requirements of each partner (as demonstrated in chapter 6.2). Again, because collaborations are usually specific about the required type(s) of THPs, it is important for architects to understand the working nature of each type of the THPs' targeted for a given collaboration. For example in the proposed building for this research-outcome *izinyanga* were targeted as a group of THPs to collaborate with social workers and biomedical practitioners. A sketchy diagram showing relationships of partners is recommended for analysing spatial relationships that the building should aim to create to efficiently accommodate the given collaboration.

Also, due to the fact that South Africa is still new in the collaboration subject, designers may not always get a brief that caters for all partners involved. It is therefore crucial that participating architects are informed about collaboration-partners and their roles so that they are able to think broadly around this matter and thus capable of advising their clients on alternative ways of formulating and accommodating a well balanced partnership. Evidently,

the nation's architectural institutes could play a role in providing the THPC and other *key role players* with (architectural) advisors in the development of Traditional Medicine.

There is a need for architects to be part of the *key role players* to ensure that the indigenous theories of *oMakhosi* are incorporated into their urban facilities. The case studies revealed that the existing architectural interventions have taken the wrong path owing to the colonial influence discussed in chapter 1. The gap between existing indigenous healthcare architecture of *omakhosi* in rural areas of KwaZulu Natal and the urban architecture accommodating this field shows that the city "architecture" has no reference or apparent relationship with its supposed source (THPs ideologies). Architecture in South Africa has evidently fallen into the trap (created by colonialism) of not giving indigenous medicine the same respect and considerate attention as biomedicine. The accommodation provided in cities is inadequate in every respect especially the aspect of place making. Furthermore, these so called 'new facilities that accommodate and acknowledge the role of THPs in the post-Apartheid era' lack the most fundamental necessities of convenient health provision such as architecturally designed consultation rooms, access to electricity and water, dispensaries, kitchens and toilets. When practitioners accommodated in these shelters were interviewed they expressed the view that "this demeaning approach is precisely what the Apartheid government would have done had it been forced to accommodate *omakhosi* in urban areas" (Ndelu, interview: 2007). Existing architectural structures in cities thereby completely contradict the whole aim of the development in this field.

There is a lot of money being invested and profited from indigenous medicines in South Africa especially in Durban. The interest of financial donors has also increased as companies and different worldwide organisations begin to see the need for this field in South African healthcare (Dr N Gqaleni, ATMC-Dbn, 2007). Therefore financial constraints are not an excuse for the poor accommodation of *omakhosi* in cities.

One of the main problems regarding the quality of the THPs urban architecture is that participating architects are not acquainted with architectural ideologies of indigenous healers and often fail to distinguish between cultural and circumstantial factors affecting the architecture of *omakhosi*. As a result underdeveloped design solutions and primitive building materials have been used in city facilities in an attempt to mimic the rural architecture of the

THPs. For instance, in the Tembe Homestead underdeveloped materials were used due to financial constraints and the fact that they were readily available; in this case the actual material being utilised is due to the circumstance while the artistic and symbolic manner in which materials are used such that the physical appearance of the buildings have a calming effect that catches the attention of a patient is intentional and characteristic of *omakhosi*'s holistic approach to healing. The proposal is that all new interventions should focus on retaining the cultural aspects of indigenous healthcare buildings rather than perpetuating and celebrating the primitive circumstances of *omakhosi*. Accordingly, collaborative healthcare architecture should conform to conventional health requirements of today.

However, special care should be taken not to Westernise African indigenous medicine in the process of incorporating modern technology and the architectural requirements of modern healthcare standards. For instance it was evident in the design process for the proposed collaborative facility that some spaces such as pharmacies (of both medicines) may be similar in design due to their matching spatial and temperature requirements as indicated in the Schedule of Accommodation (chapter 6.) The consultation rooms however have very different spatial requirements although elements such as lighting and ventilation, sanitation and some of the medical furnishings are common. The resultant built form should therefore be flexible around these requirements in order to respect the rules and requirements of each medical field without imposing upon or dictating how practitioners should be accommodated.

Precedent and case studies of this research reveal that the latest design approaches in the country's healthcare have engaged with the same humane and sensitive approach as the indigenous healthcare architecture of *omakhosi*. Due to increasing environmental awareness latest trends seek to bring back the impact of nature in the design of hospitals which was lost as a result of the modern movement (De Zeeuw, 1997). Healthcare architecture of the modern movement focused on celebrating a machine functionality of buildings which led to the exclusion of nature in design. Functions such as light and ventilation were replaced by machines; this meant that architects of the time could design large wards and long passages that did not have to depend on nature for sustainability. The resultant architecture was impersonal and did not conform to the patients' need for a *healing environment*. Healthcare architecture is thus being rehabilitated as it becomes apparent that a natural environment is not only a healing mechanism for patients but also a benefit for architecture in that a climatic

conscious design composed of correct orientation, ventilating and lighting, heating and cooling is more sustainable and reliable than depending solely on electrical power. On the other hand, indigenous healthcare architecture is renowned for the fact that it's not shaped and outweighed by architectural styles but by the fulfilment of patients' needs in every way possible using the readily available resources in the same way as the making of their *muthi*. (Selepe, 2006) Every concept of their architecture is interconnected to their holistic healing ideologies. There is therefore no doubt that collaboration of the two healthcare fields will heighten the rehabilitation of medical architecture as a whole.

Chapter 6**BRIEF DERIVATION AND REQUIREMENTS FOR THE PROPOSED BUILDING:**

This chapter is intended to establish various requirements and functions necessary for a building that accommodates collaboration between biomedical and indigenous health practitioners. It will highlight other partners to be considered in both the design and site selection. A schedule of accommodation will be drawn up based on interviews of this research along with the evaluation of precedent and case studies. The schedule will include spatial requirements, functional requirements of each space and appropriate environmental conditions.

6.1 CLIENTS:

(Identification of partners)

Place based clients (to be accommodated in the building):

- Traditional Health Practitioners' Council (THPC)
- National Department of Health (DoH)
- Traditional Healers Organisation (THO)
- University of KwaZulu-Natal and Nelson Mandela School of Medicine (UKZN)
- Council for Scientific and Industrial Research (CSIR)
- The medical Research Council (MRC)

Non-place based clients:

- World's Health Organisation African Region (WHO)

6.2 ROLE OF PARTNERS AND MAIN AIM OF COLLABORATION:

6.2.1. *Main aim:*

The main aim of this partnership is to strengthen and harness healthcare of South Africa by means of creating a physical platform for biomedical and indigenous health practitioners to work in collaboration thereby drawing from skills and knowledge of one another.

The required building will cater for patients admitted as day patients and short stay patients. It should also serve as headquarters for this partnership in KwaZulu-Natal and a promoter for African Indigenous Medicine. The building should cater for a wider range of communities though extended functions that mark the facility as an educational and social resource.

6.2.2. *Roles of Partners:*

Traditional Health Practitioners' Council would be responsible for licensing and qualifying of indigenous medical practitioners trained in the facility and selection of the practitioners to work in the proposed facility. The research councils and the university's role would be to test the medicines so as to evaluate their safety and effectiveness and to participate in developing new remedies for chronic conditions and substances such as immune boosters. The THO would then supply qualified practitioners and as part of the management of the facility it would assist in the provision of accurate information to the public while providing consumer information and protection. The indigenous health practitioners' organisations are also responsible for safeguarding indigenous knowledge. In conjunction with the National Department of Health, the organisations would explore the potential of the advanced and formalised indigenous healing system to address health, economic and job creation needs of the country. The World's Health Organisation (WHO African Region) co-ordinates TM development systems (of African countries). This would also help propagate South African medicines in the continent and at a global level.

The University of KwaZulu-Natal would help in the education, research and development of the indigenous healthcare systems while benefiting through providing its students with the opportunity to experience both biomedical and indigenous healthcare systems. The university

would also provide more learning space and its residences would be used for conference accommodation during students’ vacations. Associating the project with the university would also eliminate the stigmatisation and the primitiveness of indigenous healthcare while authentically connecting the system to various university faculties, towards developing new careers associated with indigenous healing.

6.3 DEFINATION OF ZONES AND SPACES OF INDIGENOUS MEDICINE:

6.3.1. The Cultural Shopping Centre:

The Proposed Collaborative Healthcare Facility for Indigenous and Biomedical Practitioners should play a role in the economic empowerment of all the beneficiary partners at the same time as enhancing the role of indigenous healers in the preservation of African culture. The facility should therefore not only consist of pharmacies but also arts and crafts shops providing a cultural outlet to the public and acting as a crowd magnet and tourist attraction factors. These should also serve as gifts shops for patients). This zone is to be located on a public edge for exposure and ease of access. The retail component should consist of a pharmacy, cultural shops, food zone and *ishashalazi*.

6.3.1.1 Food Zone:

This zone caters for all users of the facility. It consists of fast food outlets and a shared eating area. These shops will be supplied by the THPs gardens (healthy natural food).The shops are to sell mostly African food so as to embrace the concept of a cultural shopping centre aimed at heightening the tourist attraction (refer to chapter 5.2.3). The shops are to be located on an exposed and easily accessible public edge.

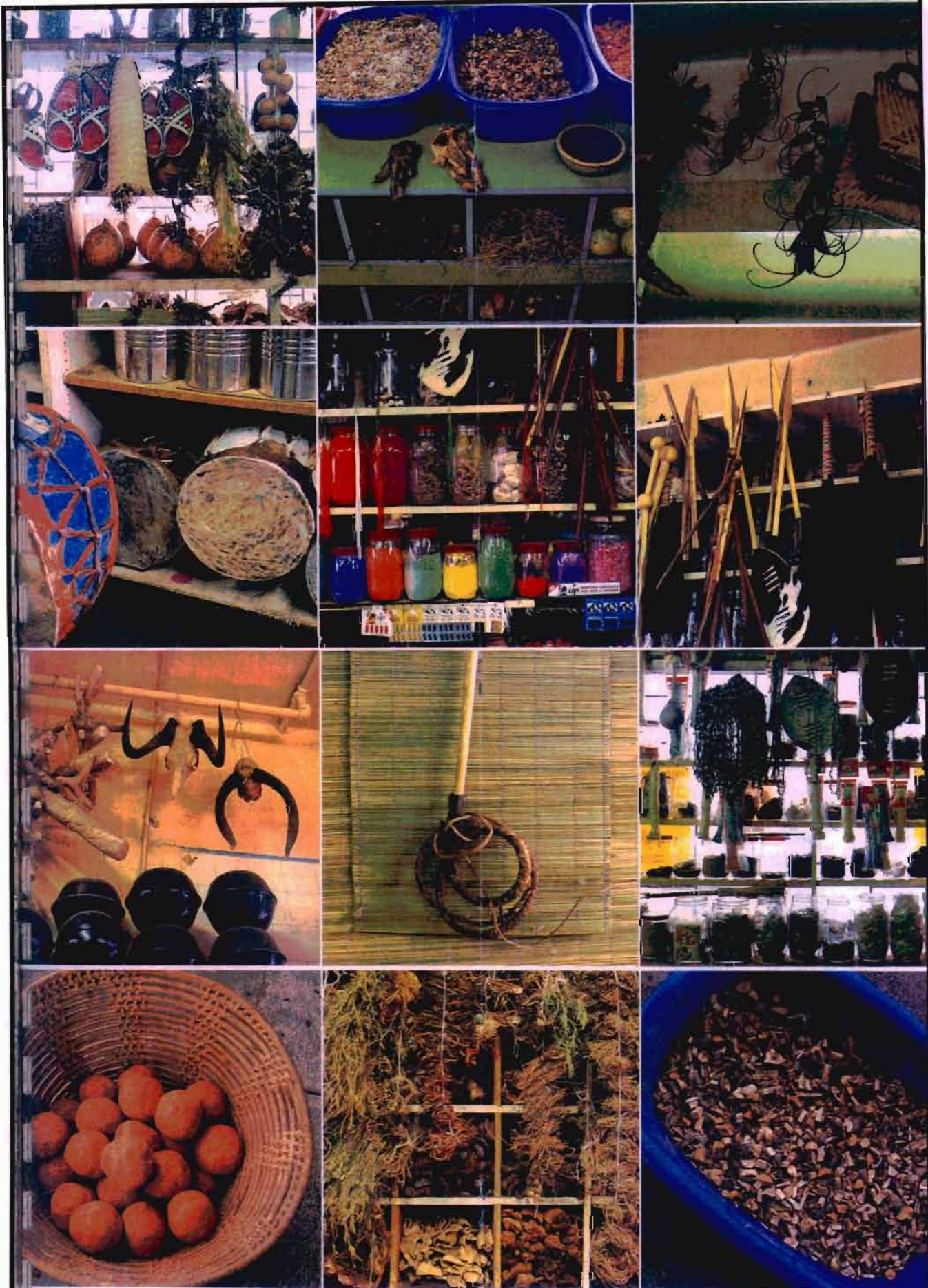
6.3.1.2 Ishashalazi:



Fig:69: THPs’ ceremonial performances. De Zeeuw. 1997

Although the targeted group of indigenous health practitioners is *Izinyanga* (technical doctors), *ishashalazi* will be open to all indigenous healers to showcase and propagate other forms of indigenous medical healing to the public. *Ishashalazi* is historically the main core in indigenous healer’s healthcare facility. They are usually outdoor central courts used for ceremonies and rituals associated with holistic healing, by definition these are performance areas open to the public. They are also essential for *Izangoma*’s initiation process known as *ukuthwasa*. According to Mr J.F Ndelu of the Durban Market traditional Healer’s Committee, the infrastructure provided for indigenous healers in cities overlook the importance of *ishashalazi*, as a result international visitors and city communities of South Africa have always been deprived of the traditional performances and customs of *omakhosi*.

In an urban context this facility needs to be more multifunctional. It should be a flexible space that can serve as a theatre, exhibition space and a flea market. Due to its association with noise this negative space should be located in a manner that does not interfere with quiet spaces such as seminar rooms and consulting rooms.



Above: The interior of Helment Stores, a herbalist shop owned by G. Govender at 24 City Market in Warwick

Fig:70: Existing THPs' pharmacies

De Zeeuw, 1997

6.3.1.3 Pharmacy:

In indigenous healthcare pharmacies (*-khemisi*) are formal shops selling prepared and packaged *muthi*. Each pharmacy consists of a storeroom and a preparation area where raw material is received. Only prepared *muthi* (powder, moulds etc.) is allowed in the shop area, patients should not see any raw materials. The arrangement in the trading space/shop is similar to that of a conventional pharmacy; that is to say all medicines have names and should be displayed in a legible manner (fig:70).

Existing: Because preparation of *muthi* is physically demanding, most practitioners prefer a roofed outdoor space instead of a preparation room. This arrangement is appropriate for the hot humid climate of Durban. The outdoor space is also necessary for drying of medicines. Preparation area is also a place of interaction among herb traders as result traders usually have a shared area where they work collectively in their separate *muthi* preparations e.g. Durban Herb Traders Market. This is one of the places where *muthi* makers share information and skills. In Durban the *muthi* preparation is dominated by women.

Proposed: In the proposed facility, all spaces accommodating medicines will have controlled temperature as some medicines expire in hot temperatures. Medicines will be prepared in the pharmaceutical factory and brought to the facility. Thus pharmacies will only do minor preparations. The preparation and packing of medicines will be done through advanced technology and machinery.

6.3.2 Consultation rooms:

This is the most private part of indigenous medicine. Each consultation suite usually has its own waiting and reception area. Consultation rooms should be naturally lit and ventilated. The openings should be arranged in a manner that maintains internal privacy and extraction of smoke during *umshunqiso* (burning of healing substances). The noise levels are to be kept as low as possible. Unlike spiritual healers such as *izangoma* and *abathandazi*, *izinyanga* (the targeted group) only treat one patient at a time. Each *inyanga* suite consist of two spaces besides its reception i.e.: consultation and THPs private room. The consultation room should

have an enclosable bed for treatment, a sink and space for seating/consulting. The private room should have a sink, stove and cupboards, is should also serve as a change room and *muthi* preparation area for the practitioner.

6.3.3 Research and Educational zone:

6.3.3.1 Seminar / Committee rooms:

These rooms are primarily for teaching indigenous medical practitioners and their assistants. *Omakhosi* are only available at certain times of the day or week; they usually have assistants or trainees running their surgeries. Their assistants are usually young people from disadvantaged backgrounds and deprived of higher or formal education. In such class rooms the assistants are taught communication skills and other useful skills associated with TM such as education communities about the collaboration and its principles. This contributes to their own personal development and prepares them for broader job opportunities with and outside TM. The basic courses for both doctors and their assistants include:

- English [for communication with tourists and different cultural groups]
- Mathematics [for accuracy in measurement of muthi and counting of money]
- Hygiene and Neatness

Using the Durban Herb Trader's Market as an example:

The ratio of teachers to students is 1:10 and the class periods are 1 hour long. The Durban Herb Trader's Market has 2 periods per day but this can vary per THPs' facility.

These rooms need to be flexible especially with regards to furniture design so as to allow for presentations and to serve as meeting rooms for partners, visiting THPs, university students and various committees of the community.

6.3.3.2 *Medical Library and Computer Laboratory:*

The library is mainly for information on this new collaborative healthcare. It will therefore serve national and international visitors.

According to Miss M Khuzwayo, principal teacher at the Durban Herb Trader's Information Centre, this component is very fundamental in such a facility as it would not only improve the quality of teaching and learning for *omakhosi* together with assistants, their biomedical contemporaries and the general public but it would also expose *omakhosi* to advanced traditional healing systems of other countries such as China.

The library is to incorporate a computer laboratory for access to internet and teaching of computer skills such as computer advertising. This is intended to heighten the globalisation of African traditional medicines.

6.3.3.3 *Laboratory:*

Main laboratories will be incorporated in the Pharmaceutical Factory, However a small laboratory of about 30 sqm is to be provided. One of the seminar rooms should be designed to also function as a laboratory that is part of the educational zone to be used for training of Lab technicians of both medicines.

6.3.4. *Day Clinic / Short-Stay Wards:*

This component is to provide a platform for biomedical and African indigenous practitioners to physically practice together.

According to the Durban Market traditional Healer's Committee, biomedical practitioners are far more skilled and effective when it comes to emergency situations such as stabilizing shot or stabbed patients. Mrs S. Zuma, a qualified social worker now practicing as a *sangoma* says although the biomedical doctors do not refer their patients to THPs yet, most of *omakhosi* refer their patients to modern doctors especially in cases of emergency. The proposed facility should therefore reinforce this cooperation; it should be designed to allow for interaction between *omakhosi* and biomedical practitioners and for official referrals to

occur in both directions as opposed to the usual indigenous –to-biomedical practitioner direction.

In terms of patient's accommodation while being held for observation or waiting for hospital transfer the two healthcare systems operate differently. As opposed to providing mere accommodation, the indigenous healthcare system connects this component to other lifestyle activities mostly related to self-development whereby patients are thought how to prepare basic homemade medicines. In *izangomas'* hospitals this component accommodates a group currently being initiated. A homely environment is required with controlled access to medical gardens (used for teaching), performance area, sports and any other function in a healthcare facility associated with a sense of well-being.

6 .3.5. Pharmaceutical Factory:

It was established during the interviews with key informants that the main cause of stigmatisation of African indigenous healthcare is the lack of appropriately designed facilities to create order. For instance at the Durban Herb Trader's Market patients are exposed to intimidating raw materials that are meant for other practitioners and not patients. According to the key role players in this field such as Rev. S.J Mtetwa, Researcher, (*Office of the M.E.C, DoH*) all raw materials are kept out of patients' view, this is a fundamental ideology of TM that cities are losing. A Pharmaceutical Factory has been proposed as a response to this outcry. The factory will be responsible for the production of medicine -form raw material to (tested and approved) well-packaged medicines. The factory is to use modern and accurate purpose-made machinery for production of *muthi*.

In The Proposed Collaborative Healthcare Facility for Indigenous and Biomedical Practitioners, the National Department of Health in collaboration with the aforementioned partners would ensure that all medicines produced and used by practitioners in the facility are tested and approved for legitimate use.

6.4 THE PROPOSED SCHEDULE OF ACCOMMODATION:

This section establishes a schedule of accommodation for the proposed Collaborative Healthcare Facility for Indigenous and Biomedical Practitioners (Durban). The facility is intended for training of medical practitioners (and other stake holders) on the development of TM and its collaboration with biomedicine. It should consist of ten [10] components namely:

A. Main Reception and General Exhibition:

This is an entrance to the facility where all visitors going to different departments go through an exhibition space that showcases the work of THPs and the collaboration endeavour.

B. Administration/THPC Headquarters:

The THPC and the NDoH establish policies for Traditional Health Practitioners of South Africa. They will use the proposed facility for testing new policies and other development strategies TM and collaboration. Once these pass they will then be applied to the whole country. Accordingly, district health co-ordinators would be invited to the facility for training workshops. The THPC and NDoH personnel would therefore manage the proposed facility.

C. Research and Educational:

Provides up to date (medical) education mainly on the new collaborative healthcare to UKZN (medical) students, staff, visiting practitioners and the general public.

D. Day Clinic and Practical Education:

The clinic should be fully functional. It should accommodate all practice-related aspects to be taught in the collaboration endeavour. All sections should be accessible to visiting groups of practitioners (trainees). It should have designated spaces for discussions and practical training.

E. Patients' Accommodation:

To accommodate patients held for observation or waiting for referrals.

F. Counselling Department:

This component should also be accessible to general public.

G. Emergency Section:

There are important collaboration policies around the emergency sections of hospitals that incorporate THPs in the country. This section will be used to demonstrate the

boundaries, and regulations established by the THPC and the NDoH in the collaboration undertakings. Emergency units of the surrounding hospitals are also inadequate for the area (refer to 7.5).

H. Diagnostic X-Ray and Minor Theatre:

To serve both the day clinic and the emergency unit.

I. Hospital Support services

J. Retail Component:

TM and biomedicine pharmacies that sell medicines that are tested, approved and (some) developed in the proposed facility. Should also incorporate informal trading, gift and snack shops.

FUNCTIONAL REQUIREMENTS AND SCHEDULE OF ACCOMMODATION

ROOM NAME	FUNCTION	REQUIREMENTS	SQM	No.	TOTAL SQM
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A MAIN RECEPTION AND GENERAL EXHIBITION					
Foyer	Point of reference/ orientation	Close proximity to reception, clear and legible space linked to main circulation.High volume	100	1	100
Main Reception	Welcome and guide visitors to required departments.	Visual link to foyer and main circulation.	12	1	12
General exhibition space	Exhibition space THPs' medical work, shocases the benefits of collaborations with TM.	Close proximity to reception, clear and legible space linked to main circulation.	50	1	50
subtotal					162

B ADMINISTRATION [THPC HEADQUATERS]					
Reception	Welcome and guide visitors to required departments.	Visual link to foyer and main circulation.	12	1	12
Directors office	Administration	Close to other managerial offices, not directly accessible to public.Naturally lit and ventilated.	16	1	16
Deputy directors office	Administration	Flexible design with dry interior walls.	12	1	12
Co-ordinators' office	Administration		12	1	12
Secretary's office	Administration		12	1	12
Open plan offices for THPC workers	Administration		90	1	90
Board room	Meeting spaces for staff.	Ease of access for visitors.	20	1	20

Staff lounge & Tea kitchenette	Provides space for relaxation and interaction among staff members.	Comfortable naturally lit and ventilated space with views to the outside for visual comfort.Group privacy.	25	1	25
Staff Ablutions		(shared with research & educational)			
subtotal			199		

C RESEARCH AND EDUCATIONAL					
Foyer	Visitors wait in line for ticket sales or reception to the theatre.	Close proximity to reception, clear and legible space linked to main circulation.High volume	80	1	80
Reception/ ticket sales	Welcome and guide visitors to required departments.	Visual link to foyer and main circulation.	20	1	20
Lecture theatre	Educational lectures, presentations, public education, staff training seminars,performances by THPs/community groups.	200 seats,raked floor, projection facilities, backstage and change rooms for performers.	150	1	150
Library	Provides up to date literature to staff and visitors, archives etc.	Close proximity to THPC offices, controlled access, natural lighting.	200	1	200
Computer LAN	Teaching/computer facilities for staff,students and visiting practitioners.	Flexible space(folding doors), near library.	30	2	60
Seminar rooms	Workshops and training of visiting practitioners, meeting space for (UKZN) students,THPs' organisations and community groups.	Flexible space(folding doors), near library.	30	3	90
Ablutions		Female:4wc, 5whb, (inclu. 1 disabled) Male:5wc, 6ur, 5whb (inclu. 1 disabled)	80	1	80
subtotal			680		

D DAY CLINIC AND PRACTICAL EDUCATION					
1 ADMISSIONS					
Reception and Cashiers desk	Guide visitors to required departments and appropriate practitioners.Payments.	Visual link to foyer and main circulation.	20	1	20

		High volume, naturally lit and ventilated. comfortable space opening to outdoors and close to reception area.	35	1	35
Main waiting area	Space for patients and visitors seat and wait.				
Patient services rep	Explains hospital policies etc. to patients.	off lobby and visible to new comers	8	1	8
Medical records room	Storage, retrival and processing of patients' records.	Adjacent to admissions office	13	1	13
Ablutions			10	1	10
Kithenette			10	1	10
Accounts office		Adjecent to admissions office, administration and business office.	12	1	12
General office		Adjecent to admissions office, administration and business office.	20	1	20
Staff Ablutions			8	1	8
Dispensary	Dispensing of prescription drugs to patients.	Visible, close to entrance or exit.	12	1	12
Patient preparation	Testing of BP, urine etc.also serves as educational for visiting THPs.	Close proximity to its designated practical aducation seating.	30	1	30
Hospital laboratory	Sample testing to facilitate diagnosis, screening for AIDS,TB etc.	Near patient preparation.	36	1	36
2 BIOMEDICAL CONSULTATION					0
Sub-waiting		Close proximity to reception, clear and legible space linked to main circulation.	15	1	15
Reception	Guide visitors to required departments and appropriate practitioners.Payments.	Visual link to foyer and main circulation.	10	1	10
Doctors' rooms [biomedical]	Interview by practitioner, storage of diagnostic equipment. Examination.	Linked so that one doctor can work in more than 1 suite.	10	7	70
3 INDIGENOUS MEDICINE CONSULTATION					0
Sub-waiting	Each suite has its sub waiting and reception.	Close proximity to reception, clear and legible space linked to main circulation.	5	8	40
Reception/admisssion	Taking and storage of records, cashier and dispensary.	Visual link to foyer and main circulation.	6	8	48

<i>Izinyanga</i> consultation rooms	Interview by practitioner, storage of diagnostic equipment. Examination	Adjecent to its reception, private space for inyanga (muthi prep.), natural light and ventilation.	15	7	105
4 PRACTICAL EDUCATION					0
Laboratory	Testing medicines for effectiveness, research and experiments, intergration of indigenous and biomedicine.	Close proximity to its designated practical aducation seating, link to herb plantation, equipment store.	50	1	50
Practical education seating	Intimate group discussions and training of visiting practitioners, interviews and interaction among practitioners.	Should be located close to its designated area, high volumes, view to all activities of the (collaborative) day clinic.	160	1	160
Doctors' rooms [biomedical]	bigger consultation suite that allows a few (2) visiting practitioners to observe (and assist) at a time.	Linked so that one doctor can work in more than 1 suite.	20	1	20
<i>Izinyanga</i> consultation rooms	Interview by practitioner, storage of diagnostic equipment. Examination	Adjecent to its reception, private space for inyanga (muthi prep.), natural light and ventilation.	20	1	20
5 STAFF					0
Board room	Meetings for staff meetings and/or visitors.	Linked to the practical education zone.	40	1	40
Lounge	Dinning area for staff and visitors (trainees).	should be located close at the end of the practical education seating, link to a break-out (outdoor)space.	50	1	50
Staff ablutions		Female:3wc, 3whb, (inclu. 1 disabled) Male:2wc, 2ur, 2whb (inclu. 1 disabled)	35	1	35
Cleaners' room	Storage for cleaning tools.	Should be located on the busiest floor/area of the building e.g close to practical education.	12	1	12
Medical store room		Should be located closer to treatment rooms, allow for separation of indigenous and biomedicine.	30	1	30
Dirty utility		Should be located closer to treatment rooms.	25	1	25
Kitchen	Food preparation for staff and visitors (trainees), trolley pack space, also part of practical education.	Linked to the practical education zone, access to service.	30	1	30

Patients ablutions		Female:3wc, 3whb, (inclu. 1 disabled) Male:3wc, 3ur, 3whb (inclu. 1 disabled)	48	1	48
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subtotal

1022

E PATIENTS' ACCOMODATION					
Sub-waiting	For patients and visitors coming to the ward section	Close proximity to reception, clear and legible space linked to main circulation.	20	1	20
Nurses station	Reception and management center of the ward section.	Central to minimise distances covered by nurses, views to ward entrances, close to staff kitchenette and ablutions, views to outside.	25	1	25
Sub-waiting	For ward patients waiting to see a doctor or inyanga	Close proximity to reception, clear and legible space linked to main circulation.	3	1	3
Doctors' rooms [biomedical]	For ward patients.	Shares the reception and subwaiting with Inyangas suite, close to nurses station and other staff facilities.	20	1	20
Izinyanga consultation rooms	For ward patients.	Shares the reception and subwaiting with biomedical doctor's room , close to nurses station and other staff facilities.	20	1	20
6 bed female ward	Short stay for patients held for observation.	Allow for separation of THPs' and biomedical practitioners' patients, breakout spaces [courtyards] for interaction among patients,natural lighting and ventilation, views to outside, ablutions.	90	1	90
				1	0
4 bed male ward	Short stay for patients held for observation.	(same as above)	60	1	60

4 bed children ward	Short stay for patients held for observation.	Shared by both THPs' and biomedical practitioners' patients, breakout spaces [courtyards] for interaction among patients,natural lighting and ventilation, views to outside, ablutions.	70	1	70
2 bed isolation ward	For patients with infectious diseases.	Breakout spaces [courtyards] for interaction among patients,natural lighting and ventilation, views to outside, ablutions.	30	1	30
3 bed additional ward	Accommodates overflow patients from other wards or neighbouring hospitals.	Breakout spaces [courtyards] for interaction among patients,natural lighting and ventilation, views to outside, ablutions.	50	1	50
Kitchen	Food preparation for patients.	Linked to other hospital support services, access to service.	24	1	24
Patients breakout spaces	Outdoor' environment for ward patients, intimate small spaces of relaxation and interaction.	Views to the outside, connection to nature, flexible furniture,natural light and ventilation.	6	5	30
Staff kitchenette		Close to nurses station and inyanga /doctor's room.	8	1	8
Clean utility			10	1	10
Dirty utility			10	1	10
Hospital laundry			22	1	22
Linen store room			15	1	15
Medical store room		Should be located closer to treatment rooms, allow for separation of indigenous and biomedicine, Close to nurses station.	20	1	20
subtotal			527		

F COUNSELLING DEPARTMENT					
Sub-waiting	For patients and visitors coming to the counselling section.	Close proximity to reception, clear and legible space linked to main circulation.	10	1	10

Reception	Welcome and guide visitors to required social worker/ counsellor.	Ease of acces for the community, visitors and patients, link to main reception of the hospital.	8	1	8
Social worker's offices	Counselling for patients, visitors and community members, also releases HIV test results.	Must be easy to find.	12	2	24
Group counselling	Counselling for groups e.g family, teenage girls etc.This would usually be run by a <i>sangoma</i> .	Link to a quiet intimate garden.	30	1	30
subtotal					72

G EMERGENCY:(24 hrs)					
1 INCOMING PATIENTS					
Reception	Admission of patients and take records.	Visual link to sub waiting and main circulation.	15	1	15
Waiting area		Close proximity to reception, clear and legible space linked to main circulation.	20	1	20
Family waiting			12	1	12
Wheel chair store room	For unstable patients who should not walk.	Close to ambulance delivery space, easily accessible	18	1	18
Triage	Checking of arriving patients before treatment.	Open space with ease of circulation, curtain separations, close to the entrance, shower for cleaning incoming patients, Medicine store.	85	1	85
Resuscitation room	Procedures for the restoration of heart rhythm and maintenance of blood flow and breathing following cardiac or respiratory arrest.	Close to main entrance, ease of access, link to triage.	20	1	20
Nurses station	Management of the emmergency section.	Central to minimise distances covered by nurses, clear view to triage, close to staff kitchenette and ablutions, views to outside.	8	1	8
Procedure room.	Minor procedures such as stitching, bandaging, blood testing etc.	Adjacent to triage, access to X-ray and Laboratory.	16	1	16

Patients ablutions		Female:2wc, 2whb, Male:1wc, 1ur, 2whb Disabled: 1 X	30	1	30
Staff ablutions		2wc, 2whb, (inclu. 1 disabled)	10	1	10
Dirty utility			15	1	15
Dispensary	Dispensing of prescription drugs to patients.	Visible, close to entrance or exit.	8	1	8
2 OBSERVATION AREA/ POST TROMA					
Nurses/THPs' station	Reception and management of the observation section.	Central to minimise distances covered by nurses, view to ward the post troma observation.	6	1	6
Post troma examination room	Also checking for pregnant weman.	Close to resuscitation and easily accessible, adjacent to the herb garden used by traditional birth attendants.	20	1	20
Observation area	Short stay for patients held for post-troma observation.	Shared by both THPs' and biomedical practitioners' patients, breakout spaces [courtyards] for interaction among patients,natural lighting and ventilation, views to outside, ablutions.	60	1	60
Dirty utility			10	1	10
Patients ablutions		Female (disabled):1wc, 1whb, Male (disabled):1wc, 1whb 1ur	20	1	20

subtotal

373

H DIAGNOSTIC X-RAY MINOR THEATRE					
Waiting area		6-chairs	5	1	5
Reception			15	1	15
Radiology room	Taking of X-rays		35	1	35
Dark room	Developing X-rays	Total light exclusion.	6	1	6
Store/ viewing room			6	1	6
Change cubicle	Patient's change.		4	1	4
Minor theatre	minor operations	close to the emmergency section.	30	1	30

Theate staff change room	Wash basins for staff	7	1	7
Theate patient change room		7	1	7
Theate store change room		10	1	10
subtotal				125

I OTHER HOSPITAL SERVICES					
AC Plant /meter room		Near the pharmacies	15	1	15
Body store room	For storing of bodies to be taken to a mortuary	No site into the room from outside, close to a service entrance.	20	1	20
subtotal					35

J RETAIL COMPONENT						
1	Indigenous medicine pharmacy	Storage and dispensing of medicines, prescriptions, THPs medical tools for staff and visiting practitioners.	Office, bulk store.no direct sunlight falling on medicines, controlled temparature. Separate service entrance.	180	1	180
	Biomedical pharmacy	Storage and dispensing of medicines, prescriptions.	Office, bulk store,no direct sunlight falling on medicines, controlled temparature. Separate service entrance.	180	1	180
2	Informal trading	An outdoor space marking the public edge (& entrance),selling gifts and african crafts for visitors, also sells healthy food that requires little preparation and cooking.	Roofed area for different traders from the surrounding communities,open onto ishashalazi.	150	0	0
	3 Ishashalazi	THPs' perfomance area, also becomes a space for displaying and selling of African crafts to visitors.	Close to the entrance to draw watching crowds & bypassers into the facility (exhibition).	115	0	0
subtotal				360		

NET GRAND TOTAL	3555
Circulation 15%	533
GROSS TOTAL AREA	4088

K PARKING			
		4: 100sqm	
THPC Staff parking		Offices=120 sqm/4	30
Clinic staff parking		1.5/consultation room	24
Other staff parking		1.5X16	15
visiting practitioners parking		1/5visiting THPs	8
Other hospital visitors		40/5	20
subtotal			97
Conference parking	Open space that could be used for parking when there is a conference.	1/5 conference deligates 200/5	40
Bus parking for conference	Open space that could be used for parking when there is a conference.		1

6.5 SITE SELECTION:

The Nelson Mandela school of Medicine provides a fundamental role in the development of indigenous medicine in KwaZulu-Natal. (Gqaleni, 2007) The programmes developed by this academic institution for the Traditional Health Practitioners creates a strong need to link the proposed healthcare facility to formal education. The Cato Manor site (priority 1) was chosen for its location on university grounds with close proximity to different faculties playing a role in the development of indigenous healthcare. It was also found to be close and easily reachable to the targeted group of users. In terms of accommodating other partners for this collaboration, the selected site has enough space to accommodate both the proposed herbs plantation and the pharmaceutical factory.

Factors determining choice of site:

- **University of KwaZulu Natal property:** the site should be on university grounds as this will alleviate the cost of land. Furthermore, it is necessary to bring the proposed academic healthcare facility closer to the relevant university faculties of Medicine, Social Sciences and Humanities.
- **Public Access:** The site has to be fully accessible to the public. It has to be located within a functional public transport system. It also has to be positioned in an area that is accessible by the target group of users. This includes mostly black communities (preferably a walking distance to the day clinic), healthcare organisations, researchers and tourists. (*Tourist attraction however is a minor issue in this subject*). The site should therefore be at close proximity to the major traffic routes and other prominent phenomenon of the city for ease of orientation and navigation.
- **Exposure:** The facility is about the role of architecture in the development of South Africa's indigenous healing. It is therefore necessary that the building has enough exposure to promote indigenous healing. The exposure is also needed for the retail component of the facility. A site that is seen from long distances is thus appropriate for the proposed healthcare facility.

- **Parking:** this is essential as the facility will consist of components such as a multi-purpose auditorium for performances, lectures and conferences, offices for organisations such as Traditional Healers Organisation (THO) and a healthcare section; all these components require secured parking. The ratio of parking bays to square metres is 4:100 (for offices & clinic staff). There should be space for a taxi and bus drop –off.

There should be additional space for parking buses and cars during conferences.

- **Fertile Land:** One of the major problems facing indigenous healers today is lack of resources. It is important that the chosen site has readily available fertile land for planting trees and other herbs needed for indigenous medicines (or opportunities for recreation of such fertile land).
- **Irrigation Water:** The facility is also aimed at promoting urban agriculture, close proximity to a river or dam is necessary for the plantation to occur.
- **Healthcare Node:** The proposed facility seeks to formalise indigenous healing by means of amplifying partnership with the biomedical healthcare systems and formal education, it is therefore necessary that the site is located within an urban node that consist of both the educational and biomedical healthcare facilities.
- **Community Sense of ownership:** Although the site has to be on university grounds, it is appropriate that the site is on the public edge and not concealed by other university buildings as this will help in the creation of a psychological community sense of ownership.
- **Public Open Spaces:** The site should have potential for healing environments such as green open spaces and distant views as this will be of great assistance in the development of a holistic healing environment necessary for indigenous healing.
- **Quiet Zones:** The proposed facility will be dominated by public spaces due to the prominent aspects such as training of visiting health organisations about the collaboration, performances, trading and conferences. It is therefore important that the site has potential for creating quiet outdoor and indoor spaces for patients.
- **Pedestrian Friendliness:** This means that the site should be in a slow traffic zone or positioned such that there is potential for slowing down traffic and creating a pedestrian friendly environment. It must be located within an urban context where clear pedestrian linkages are possible.

- **Transportation Node :** The site should be accessible by public transport or should provide opportunities to integrate this aspect.

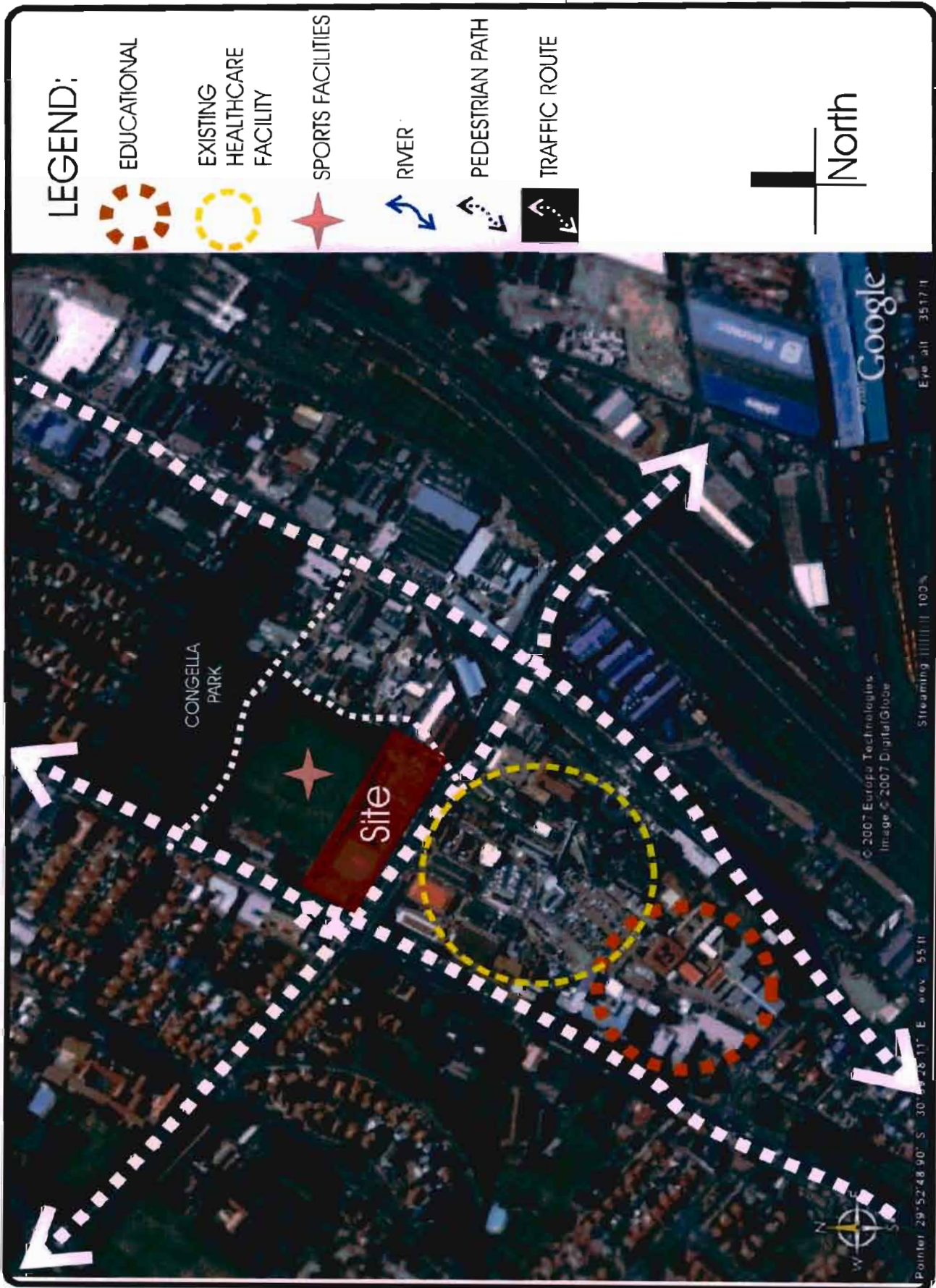


Fig:71 Site “Priority -2”: Author

The first site that was considered for the proposed facility is “Priority 2” at figure 71. This unused site was originally a sports facility. It was a place of relaxation, leisure and physical fitness for the people of Congella especially the young people working in the factories by the harbour. However, due to its sunken landscape and lack of “eyes on the street” the area became an attraction for crime which led to underutilisation and eventually deterioration.

It’s a walking distance to Nelson Mandela School of Medicine and Howard College Campus. This long and narrow site creates an opportunity for a well orientated building with its long side facing North-East. It also conforms to the concept of holistic healing because of its connection with the soccer field and Congella park located further North-East of the site.

The major negatives of the site include its location at an intersection of Umbilo Rd and Francois Rd which are both fast traffic routes, the lack of space for indigenous healers plantation, the park or existing green land which would be useful for creating patient’s “break out spaces” being too far from the site.

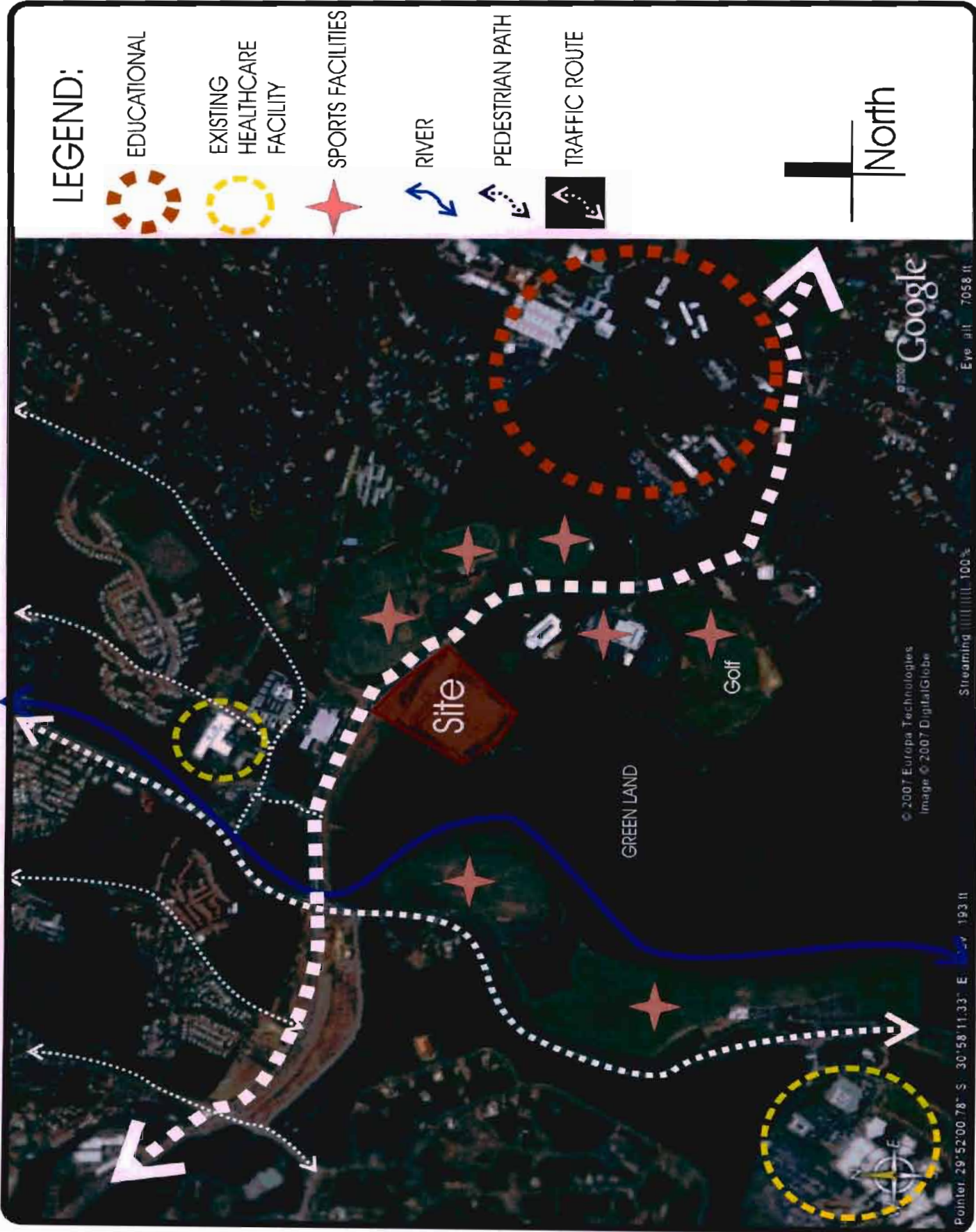


Fig:72

Priority -1: the preferred site in its context.

Author

The chosen site (fig:72) is located on varsity ground at a far South Western edge of the UKZN, Howard College Campus. It is currently used as soccer fields for the university. The field is underutilized as there are more than enough fields to accommodate Howard College soccer. It is also too far and isolated for residence student’s soccer practice.

Building on existing strengths:

The physical isolation of the site from the university creates ease of public access and a psychological sense of ownership by the community; this promises to reduce the institutionalisation of the proposed facility.

The site is slightly isolated from the built environment with its South Western part being seen from long distances, this offers an opportunity for a pronounced building that propagates the proposed healthcare facility while marking the headquarters of the Traditional Health Practitioners’ Council.

The site has two existing platforms; the first platform is closer and on the same level as the Francois Road. The second platform is at the rear South-Western part of the site and is sunken. This creates an opportunity for connecting the building to both traffic and pedestrian routes on the front platform while allowing for parking to occur behind the building. The sunken rear platform of the site could be used for additional parking during conferences. It also provides enough space for the proposed pharmaceutical facility (future expansion).The site is also clear of trees as a result no trees will be removed for the building. Instead there will be new plantation. This allows for the gardens (trees) to be designed in a manner that suits the proposed building.

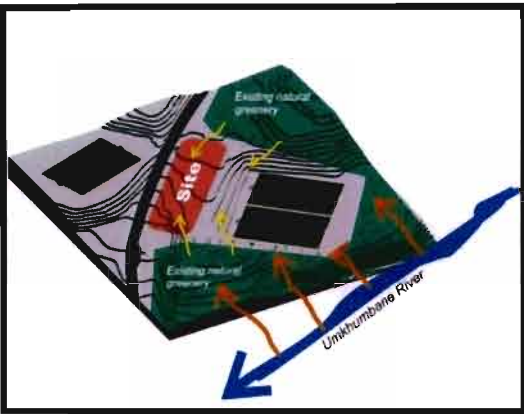


Fig:74 Natural surroundings of “priority1” Author

The site is surrounded by indigenous trees and a river (fig:74); this creates an opportunity for planting trees and other greenery needed by traditional healers. The green zone could also be rejuvenated to suit the THPs holistic approach to healing. There is an opportunity to draw on nature for design inspiration.

The site is located:

- Symbolically in-between a formal suburban setting and a typical South African township i.e. Glenmore and Cato Manor. This could help to create an awareness of the new collaborative healthcare system across different cultures.
- At close proximity to other healthcare facilities such as Inkosi Albert Luthuli Hospital and Umkhumbane community healthcare centre (fig:75). This creates an opportunity to create a healthcare diverse precinct that integrates THPs. It also means the referrals would be enhanced as this is an important matter in the collaboration endeavour (refer to Appendix A). The existing hospitals are not enough for the area especially because King Edward is a district hospital with a larger catchment area while Albert Luthuli is a referral hospital. There is a paucity of patients' accommodation and 24-hour emergency unit in the area. These could be provided in the proposed facility.
- At close proximity to other university faculties involved in the development of TM and linked to student's

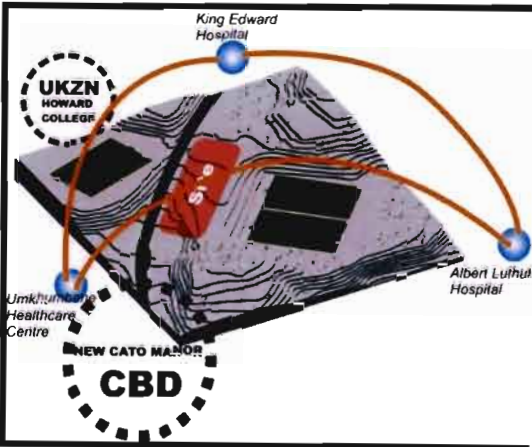


Fig:75 Creating a diverse healthcare precinct.

Author



Fig:76 Link to university sport activities.

Author

- ++++++transport route to Nelson Mandela School of Medicine, the site therefore seems to be appropriate for an academic healthcare facility.
- On Francois road which is a major traffic route connecting directly to N3; this creates a clear direction (navigation) for visitors and ease of propagating the facility.
- Within a high-quality public transport network.
- Close to university sports facilities (fig:76) both indoors and outdoors; this offers an opportunity to link the proposed healthcare facility to other life style activities as explored in the theoretical framework (Section A of this study).There is an opportunity to create patients' breakout spaces that open or visually link to the sport activities. This would reinforce the THPs theory of surrounding the patients with a sense of wellbeing.

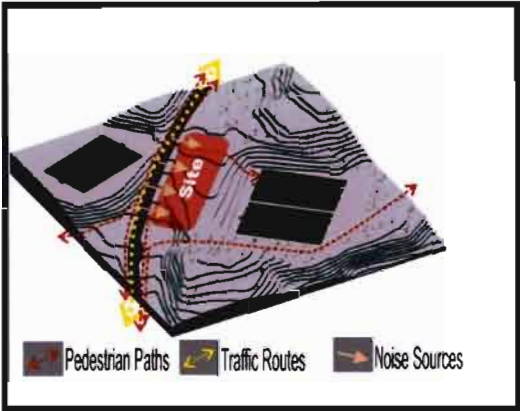


Fig:78 Routes, connections and noise sources.

Author

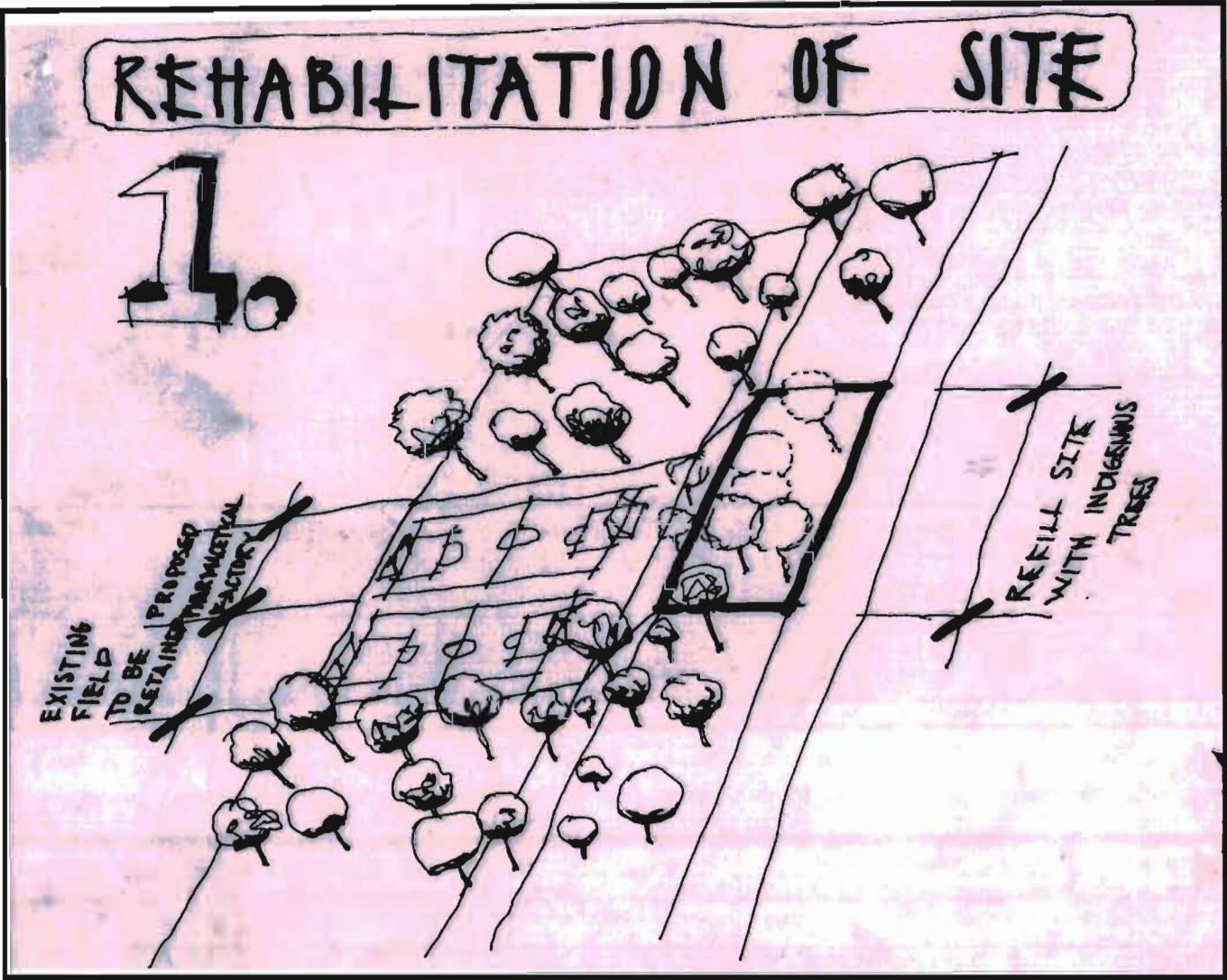
The negatives:

- François Road has very high traffic congestion during pick-hours especially because of the university gates.
- The pedestrian flow is adequate for the proposed facility, however the actual road does not have designed crossing for the pedestrians.
- The noise during pick-hours will require design solutions.

Chapter 7:

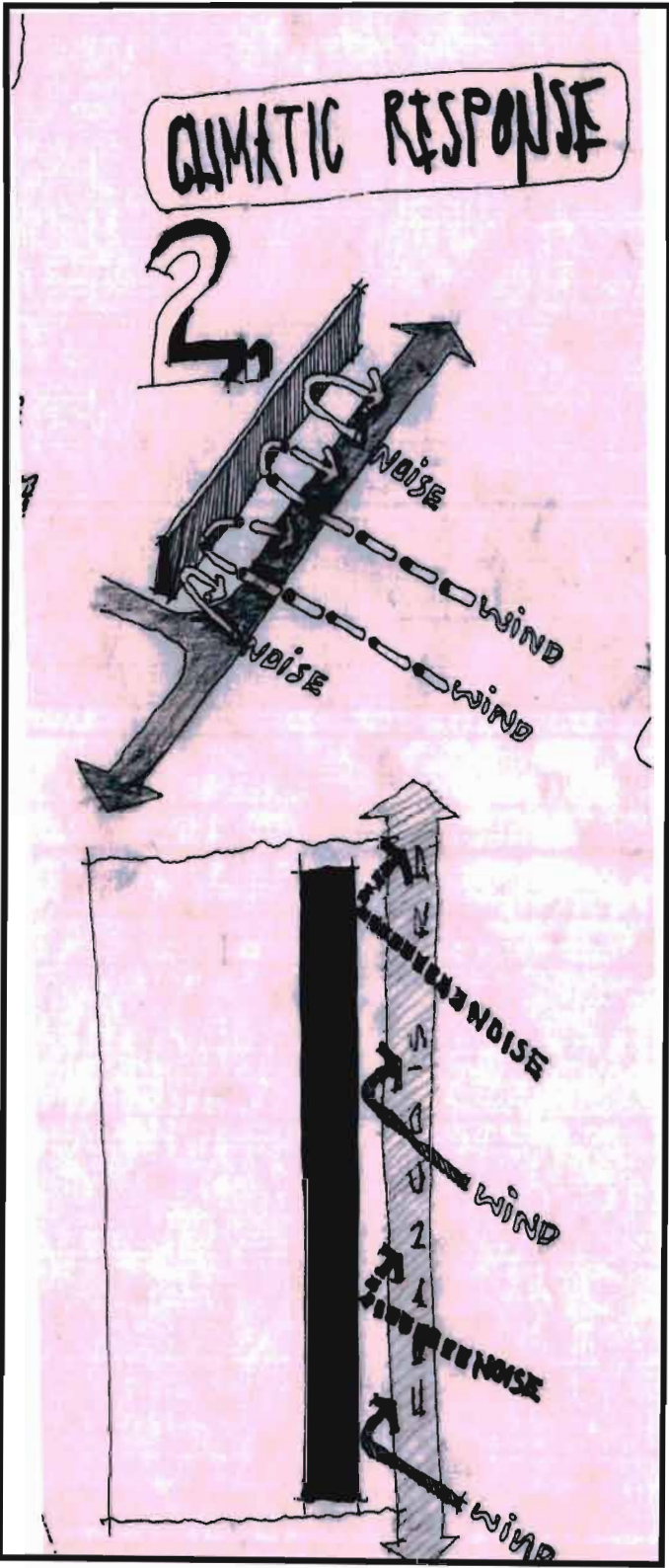
DESIGN DEVELOPMENT

7.1 Conceptual Stage 1.

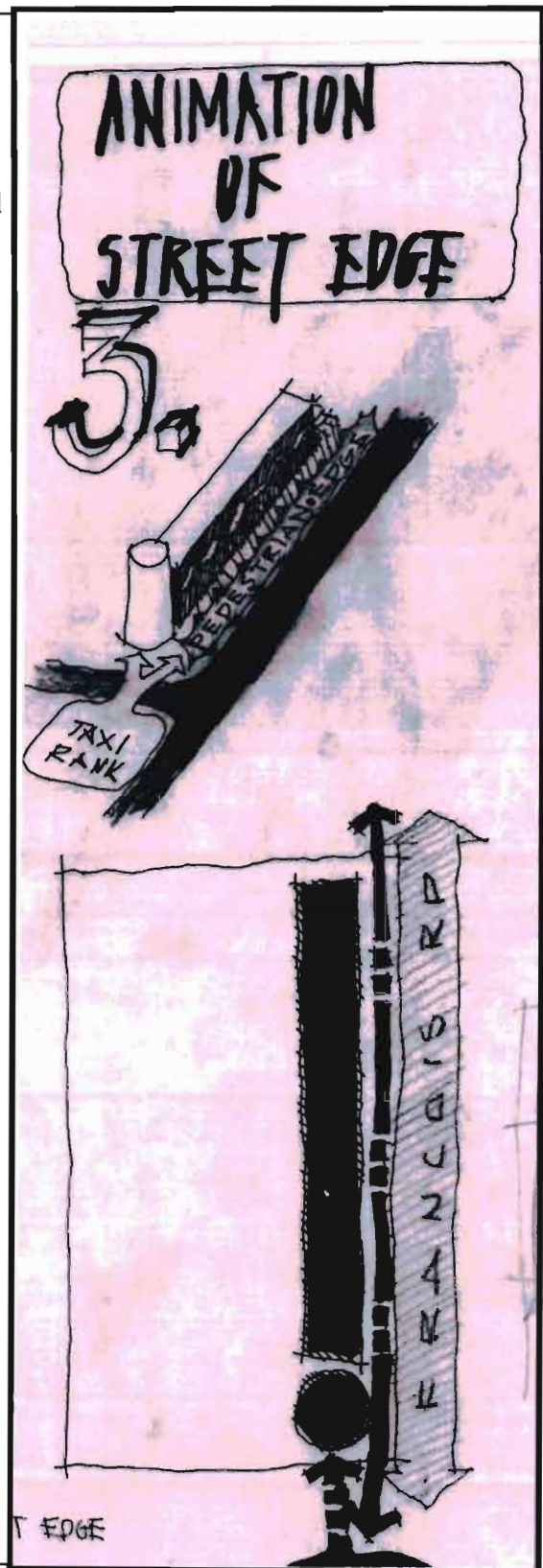


- The site is currently tree free.
- Replacing the trees would create an opportunity for a building that meanders around a green landscape, towards “MAKING A PLACE” of environmental awareness.
- Soccer fields are to be kept (in their current form/function) so that the facility is linked to lifestyle activities associated with well being.
- One soccer field reserved for future expansion (Pharmaceutical facility).

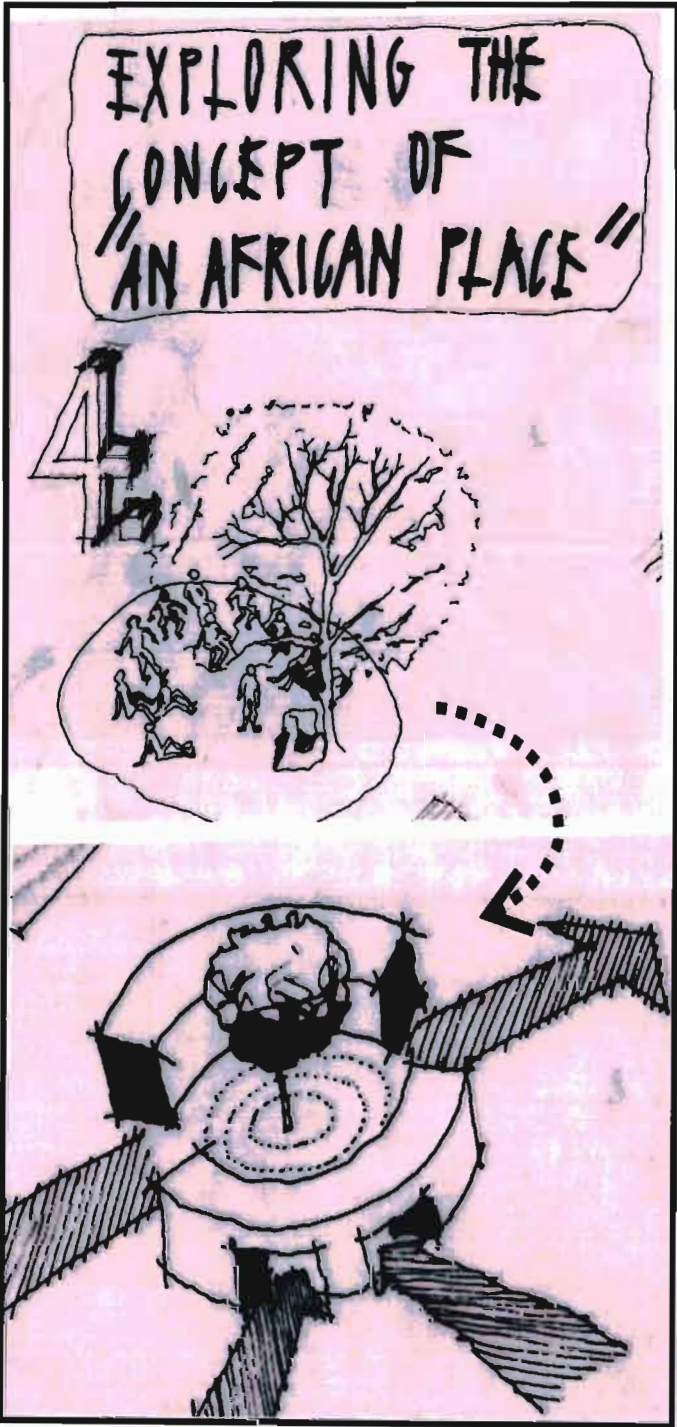
- THE FACE _the skin responding to climate and the environment.
- Defining the street edge.
- The face will have to be designed to prevent noise going into the consultation suites.
- Because of the topography, the wind is blocked before getting to site. There is therefore an opportunity to create views to the street (eyes on the street).
- “The facial expression” has to talk about the character of the building.



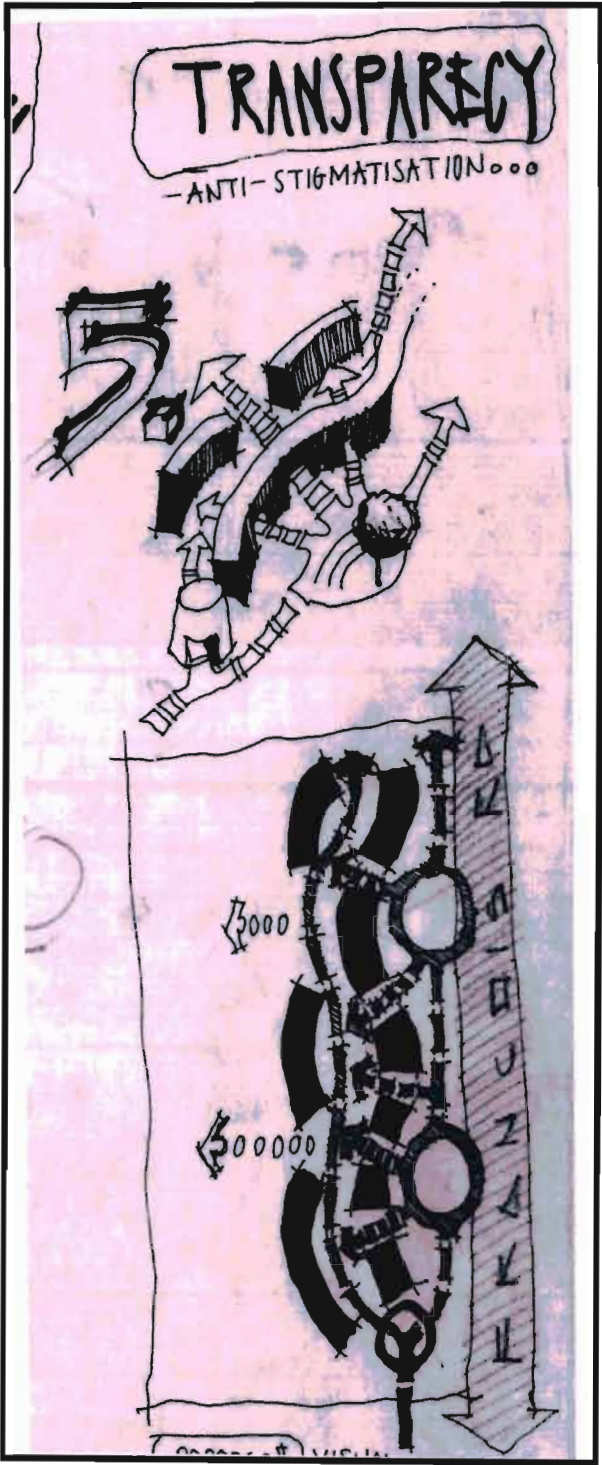
- The site has a readily available pedestrian flow.
- This should be enhanced by locating public activities on the face of the building.
- THPs ishashalazi (outdoor performance area) could be incorporated into this vibrant pedestrian path.
- Opportunity to draw the by passers into the site, towards embracing the concept of COMMUNITY PARTICIPATION.
- The prominent corner creates an opportunity for passive community engagement (Githae,2007)

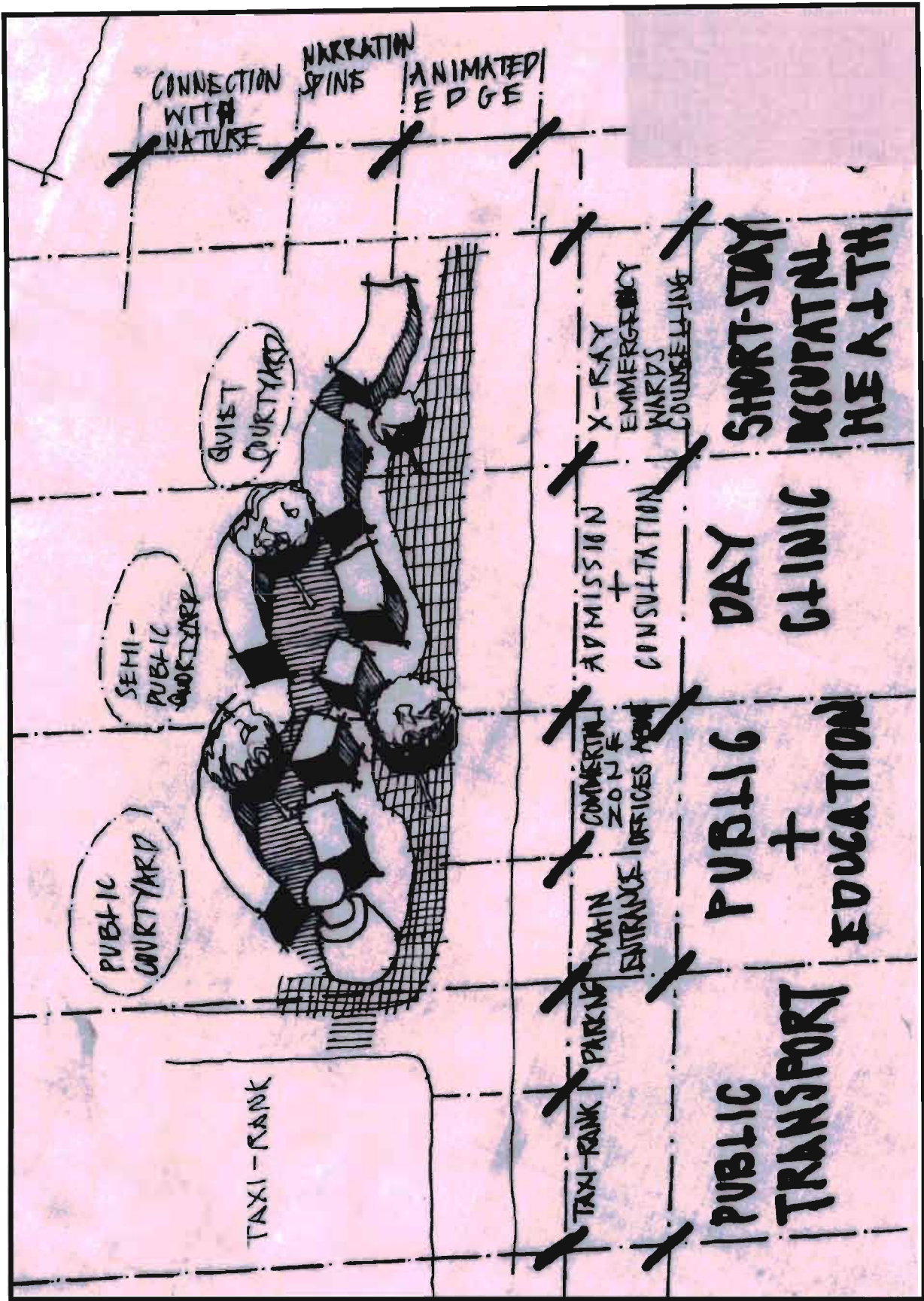


- An architectural interpretation of THPs theories.
- Embracing the concept of a tree as a symbol of life and connection with the ancestral powers.
- The centre of THPs indigenous healthcare architecture is a sacred tree that houses ceremonies and educational activities.
- “MAKING A PLACE” of cultural awareness.



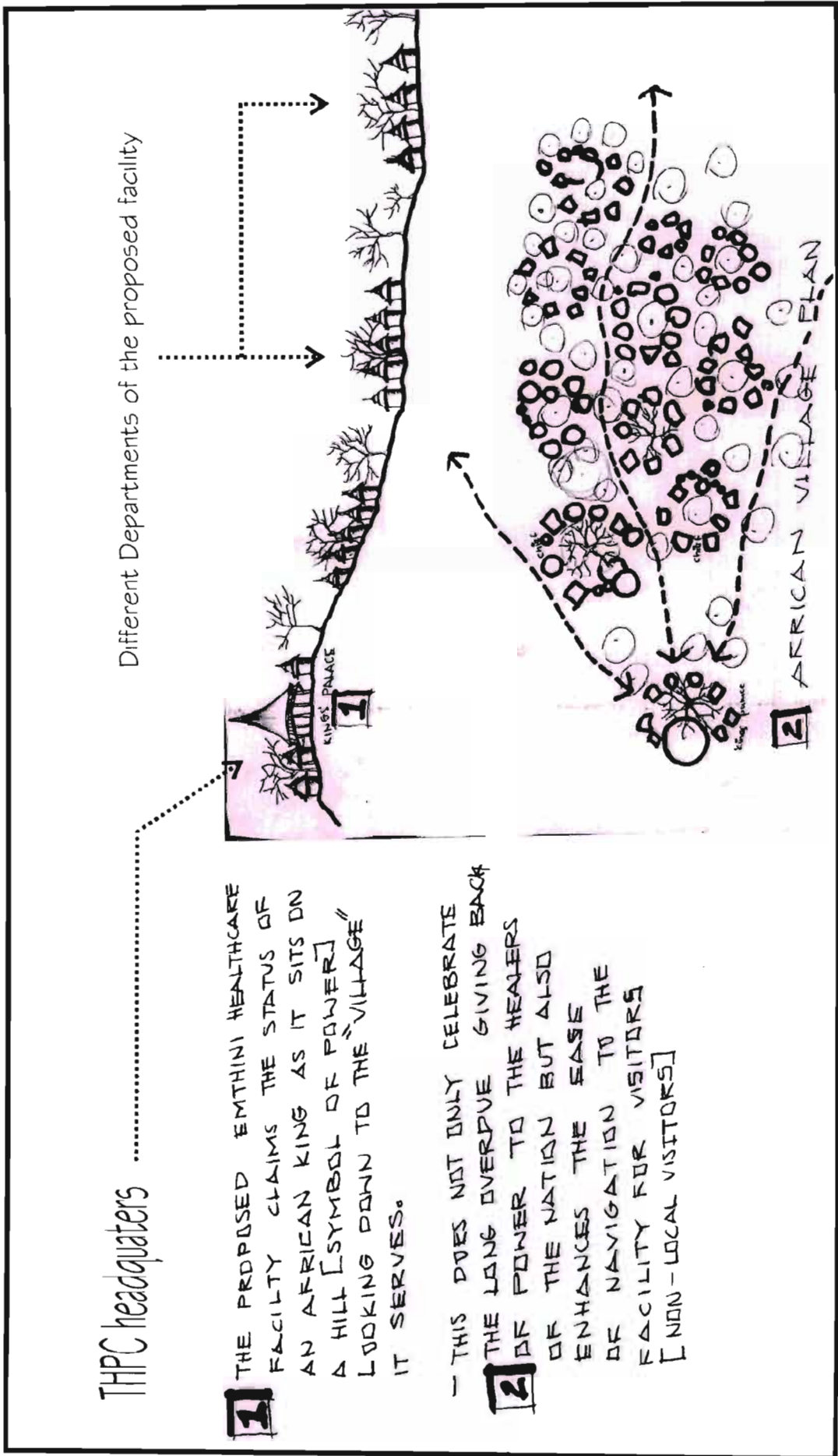
- In the pre-1994 era THPs were secretive; this was a strategy to protect their indigenous knowledge form the colonial government (Devenish,2003) .
- The reborn TM is should be known by society of all cultures/races.
- The proposed facility should be an inviting COMMUNITY PLACE.
- Transparency in design: a platform propagating the new healthcare system.

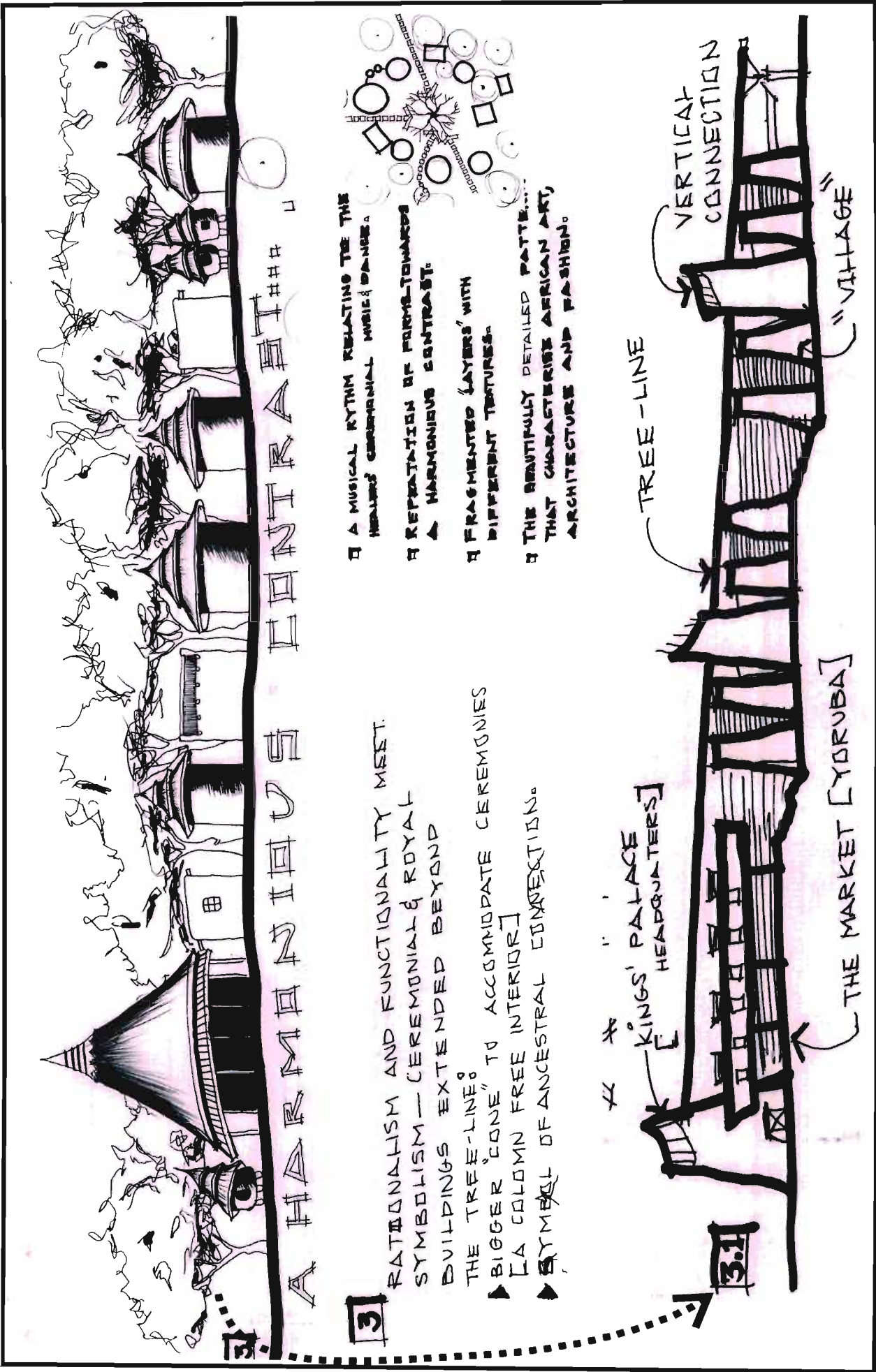


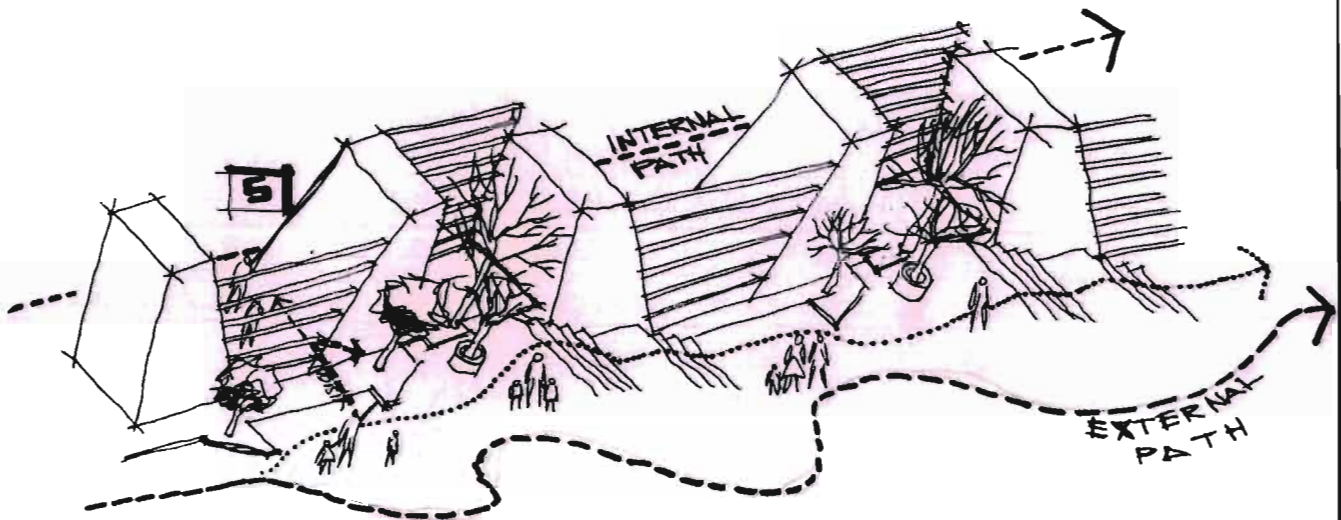
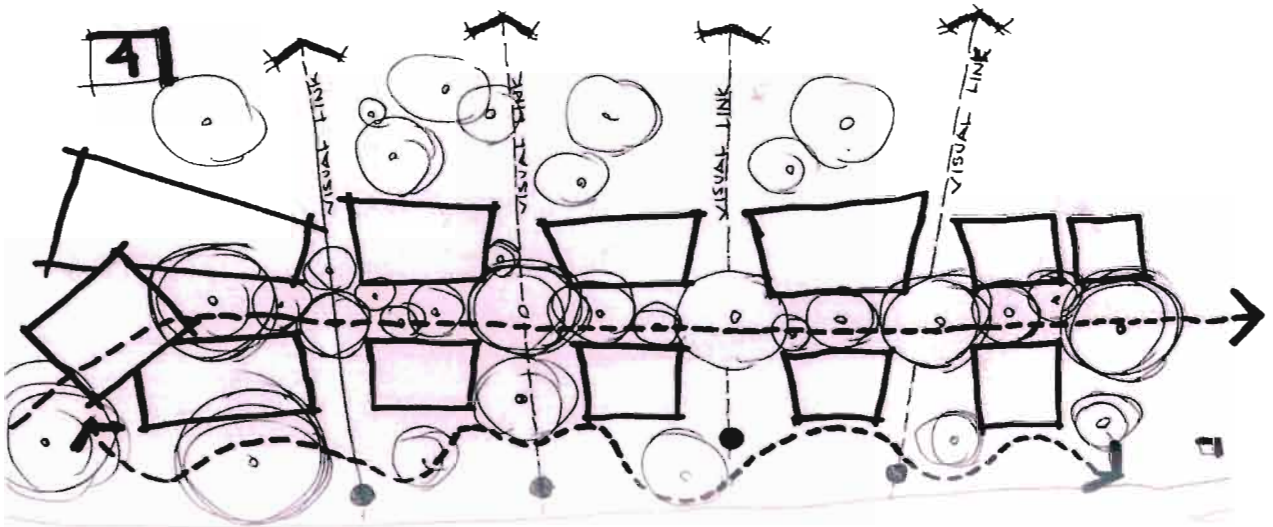


Zoning: first draft.

7.2 Conceptual Stage 2.





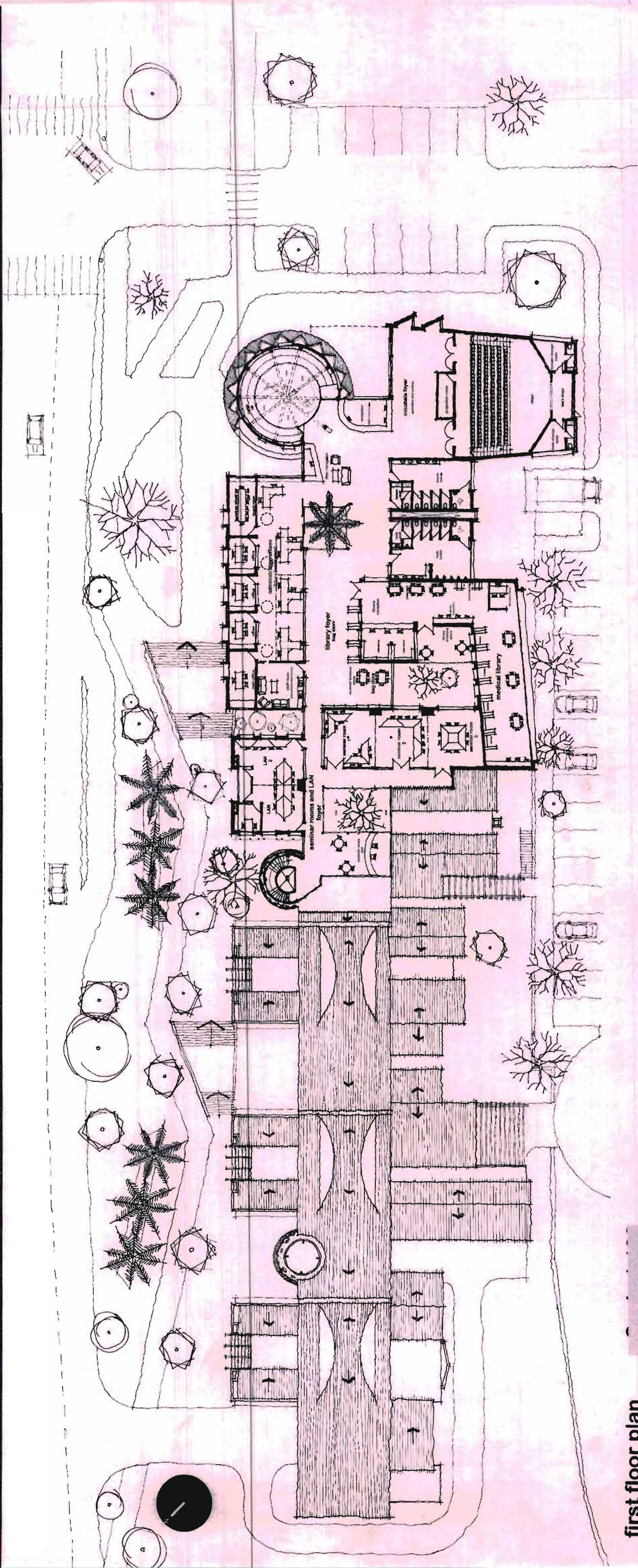


4: INTERNAL SPINE: A shaded African ‘avenue’ with compounds juxtaposed to it.

- A pedestrian path connecting compounds of the village.
- Creates a clear unambiguous circulation.
- Fragmented layout (of an African homestead or THPs facility) allows for natural lighting and ventilation & visual linkages into the courtyard.
- External street creates inquisitiveness among by-passers; *a silent invitation*.
- 5. All ‘homestead’ open onto their courtyards.
- Internalised planning of THPs indigenous facilities=internal privacy+ glimpse into their work place.
- Music and performances of the THPs _the holistic healing ideologies are expressed through built form. *Rhythm*.
- **An educational journey in an African village.**

7.3

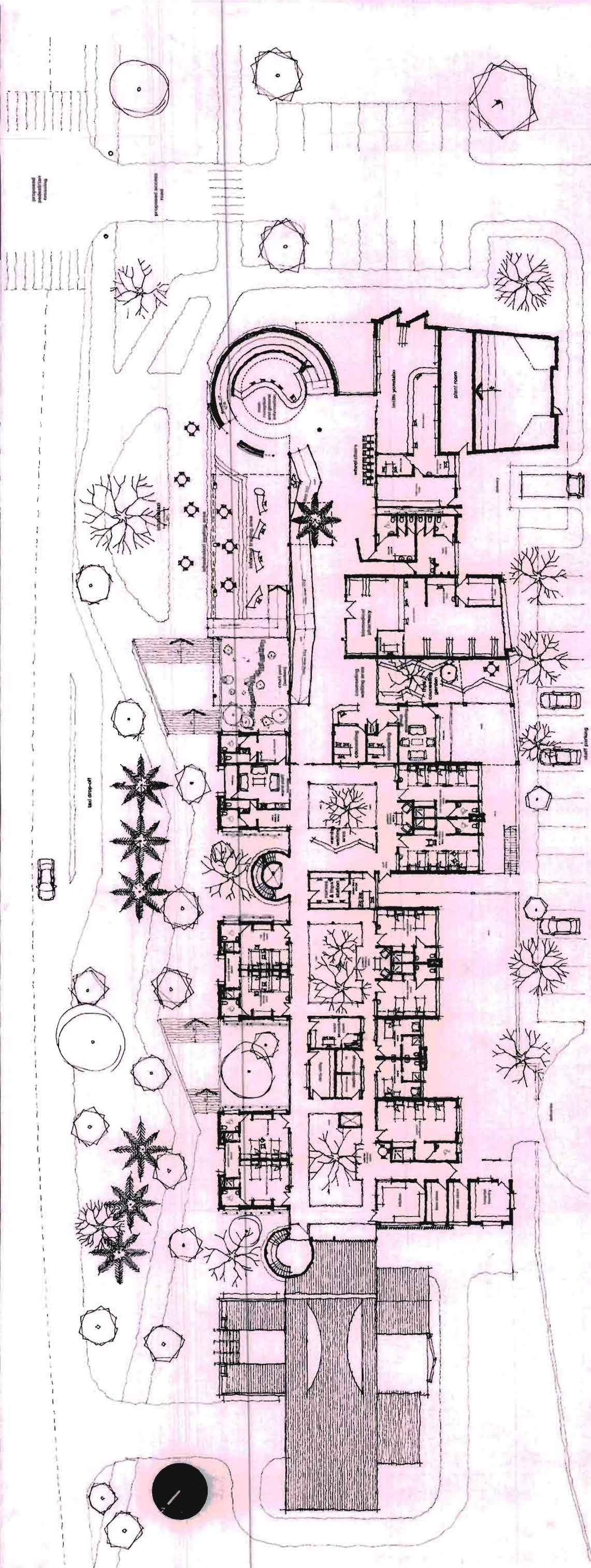
The Proposed Building...



first floor plan



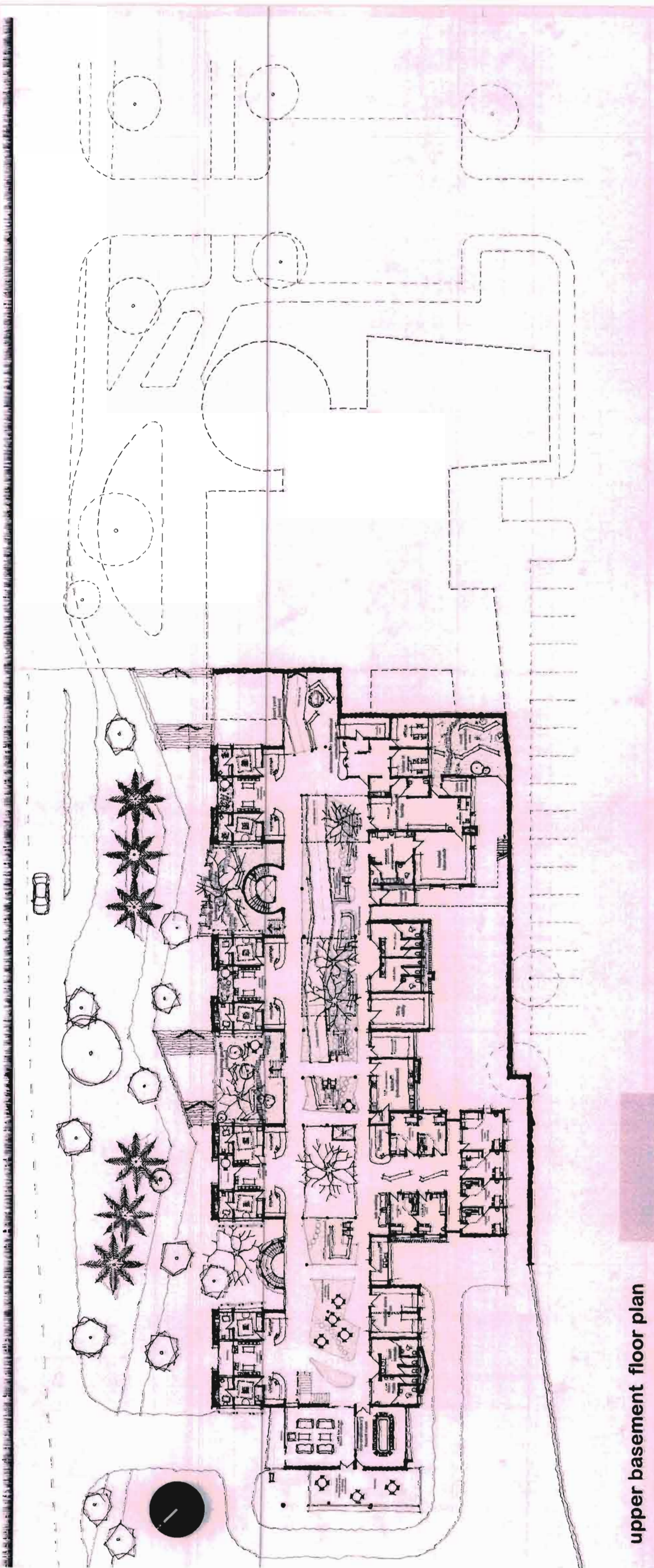
20m 10m 5m Scale



ground floor plan



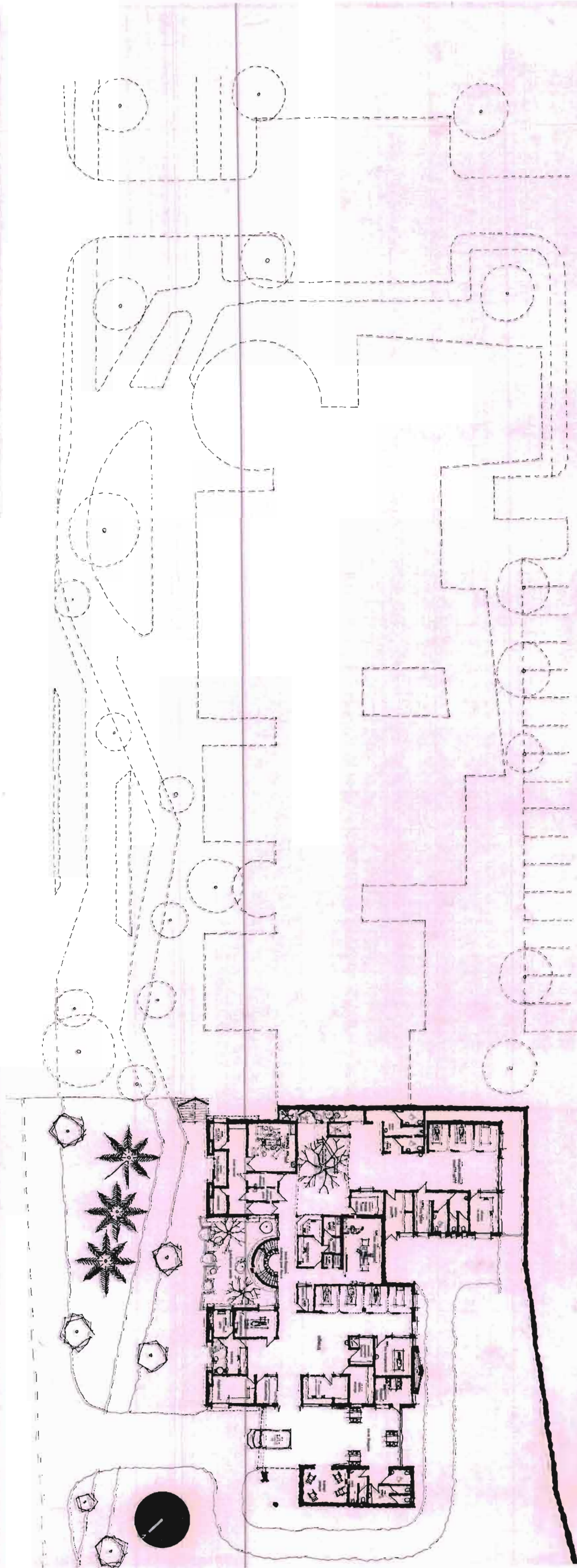
20m 10m 5m Scale



upper basement floor plan



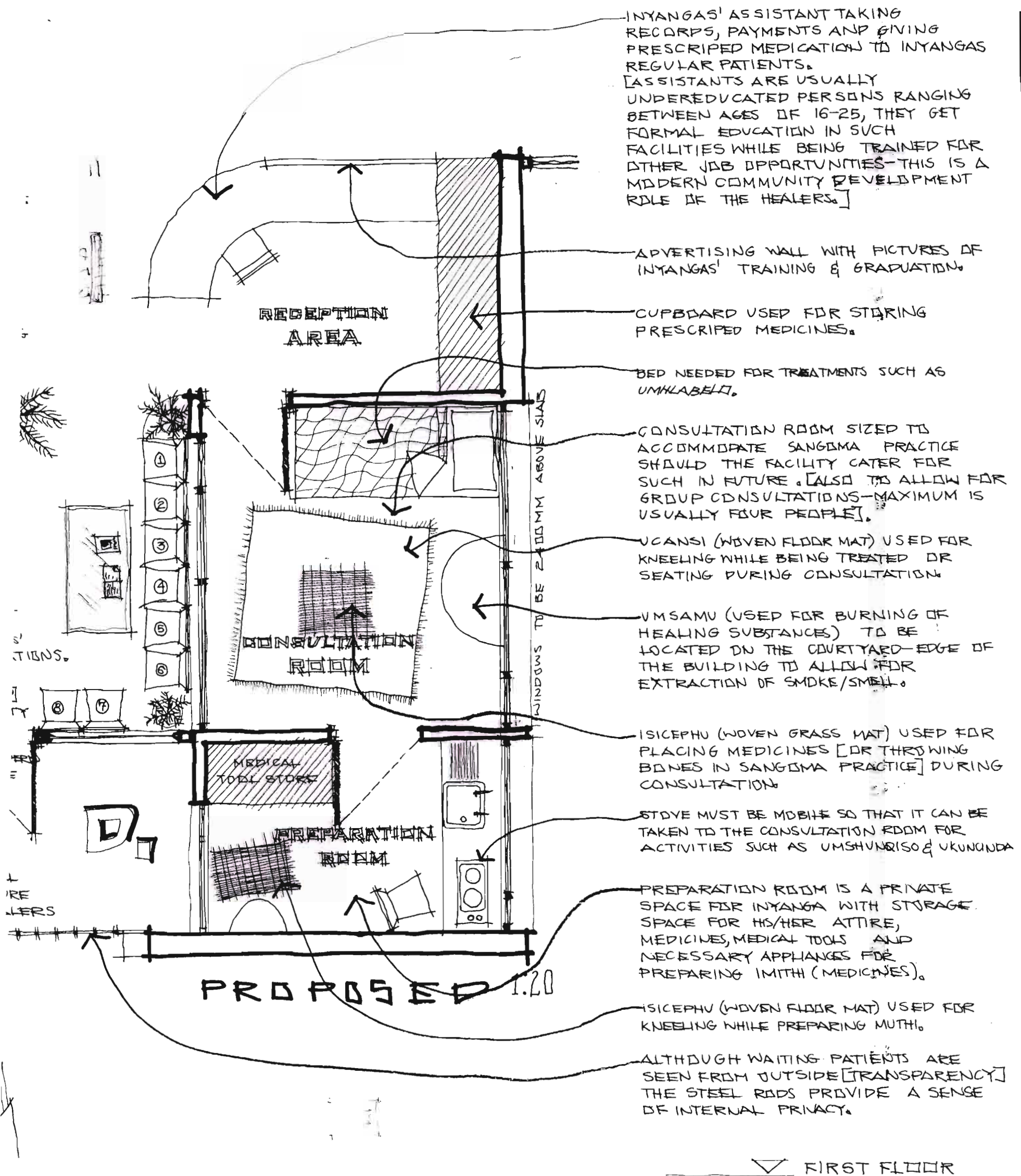
20m 10m 5m Scale



lower basement floor plan



20m 10m 5m Scale



- ADVERTISING WALL WITH PICTURES OF
INYANGAS' TRAINING & GRADUATION.

-CUPBOARD USED FOR STORING
PRESCRIBED MEDICINES.

BED NEEDED FOR TREATMENTS SUCH AS UNHLABELL.

-CONSULTATION ROOM SIZED TO ACCOMMODATE SANGOMA PRACTICE SHOULD THE FACILITY CATER FOR SUCH IN FUTURE. [ALSO TO ALLOW FOR GROUP CONSULTATIONS-MAXIMUM IS USUALLY FOUR PEOPLE].

- UCANSI (WOVEN FLOOR MAT) USED FOR KNEELING WHILE BEING TREATED OR SEATING DURING CONSULTATION

—UMSAMU (USED FOR BURNING OF HEALING SUBSTANCES) TO BE LOCATED ON THE COURTYARD-EDGE OF THE BUILDING TO ALLOW FOR EXTRACTION OF SMOKE/SMELL.

- ISICEPHU (WOVEN GRASS MAT) USED FOR PLACING MEDICINES [OR THROWING BONES IN SANGOMA PRACTICE] DURING CONSULTATION

STOVE MUST BE MOBILE SO THAT IT CAN BE TAKEN TO THE CONSULTATION ROOM FOR ACTIVITIES SUCH AS UMSHUNDO & UKUNUNDA

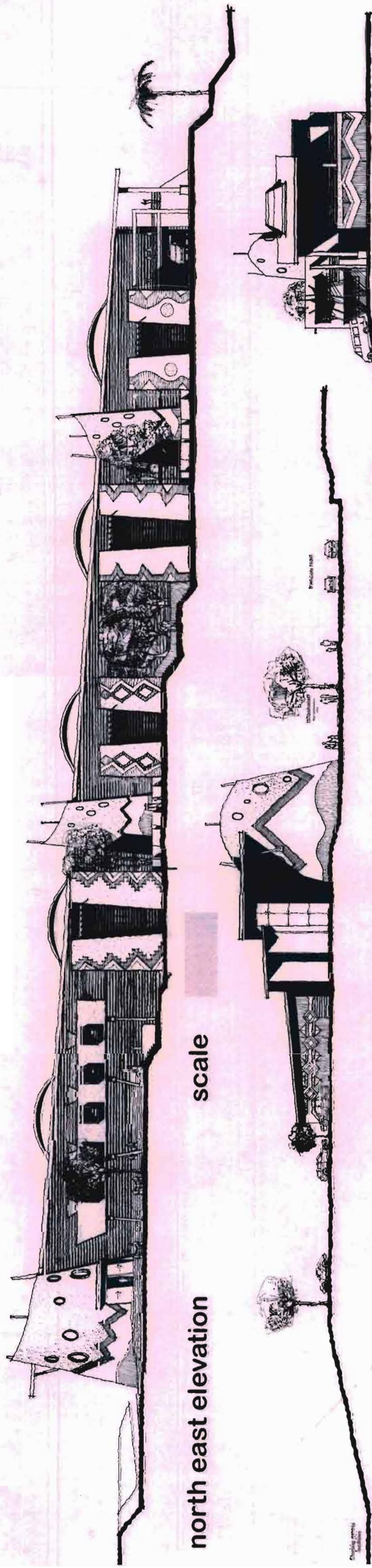
PREPARATION ROOM IS A PRIVATE SPACE FOR INYANGA WITH STORAGE SPACE FOR HIS/HER ATTIRE, MEDICINES, MEDICAL TOOLS AND NECESSARY APPLIANCES FOR PREPARING IMITH (MEDICINES).

—ISICEPHU (WOVEN FLOOR MAT) USED FOR KNEELING WHILE PREPARING MUTHI.

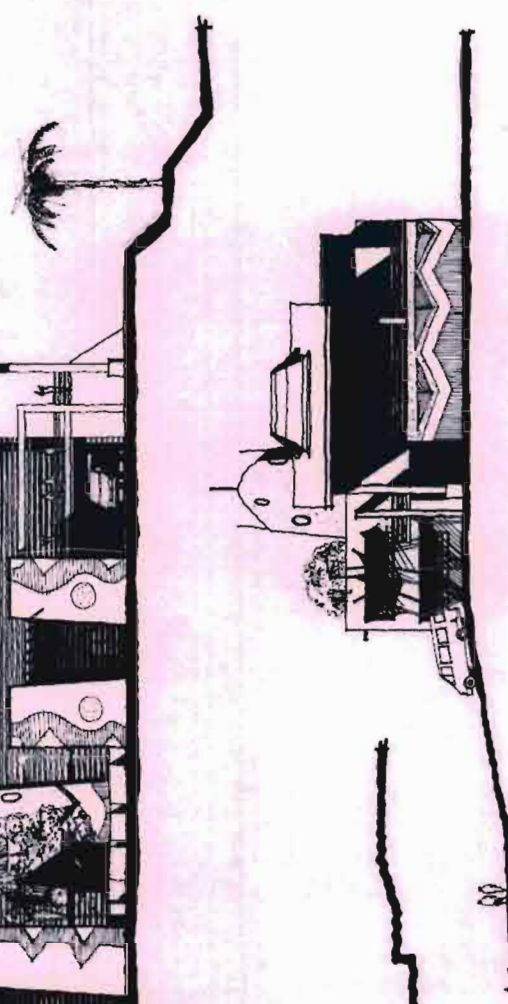
ALTHOUGH WAITING PATIENTS ARE
SEEN FROM OUTSIDE [TRANSPARENCY]
THE STEEL RODS PROVIDE A SENSE
OF INTERNAL PRIVACY.

▽ FIRST FLOOR

^{NYC} INYANGAS CONSULTATION SLIDES



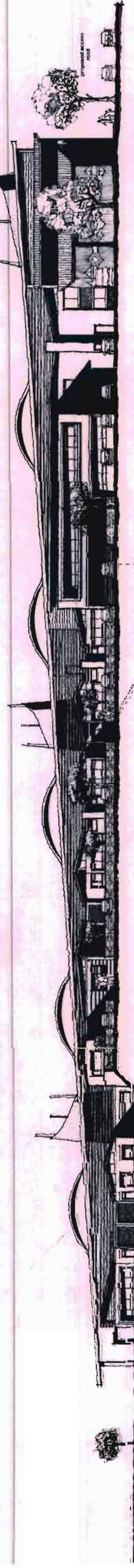
scale



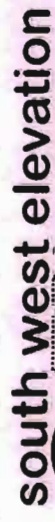
scale



scale 1:100



scale



a collaborative facility for indigenous and biomedical practitioners.

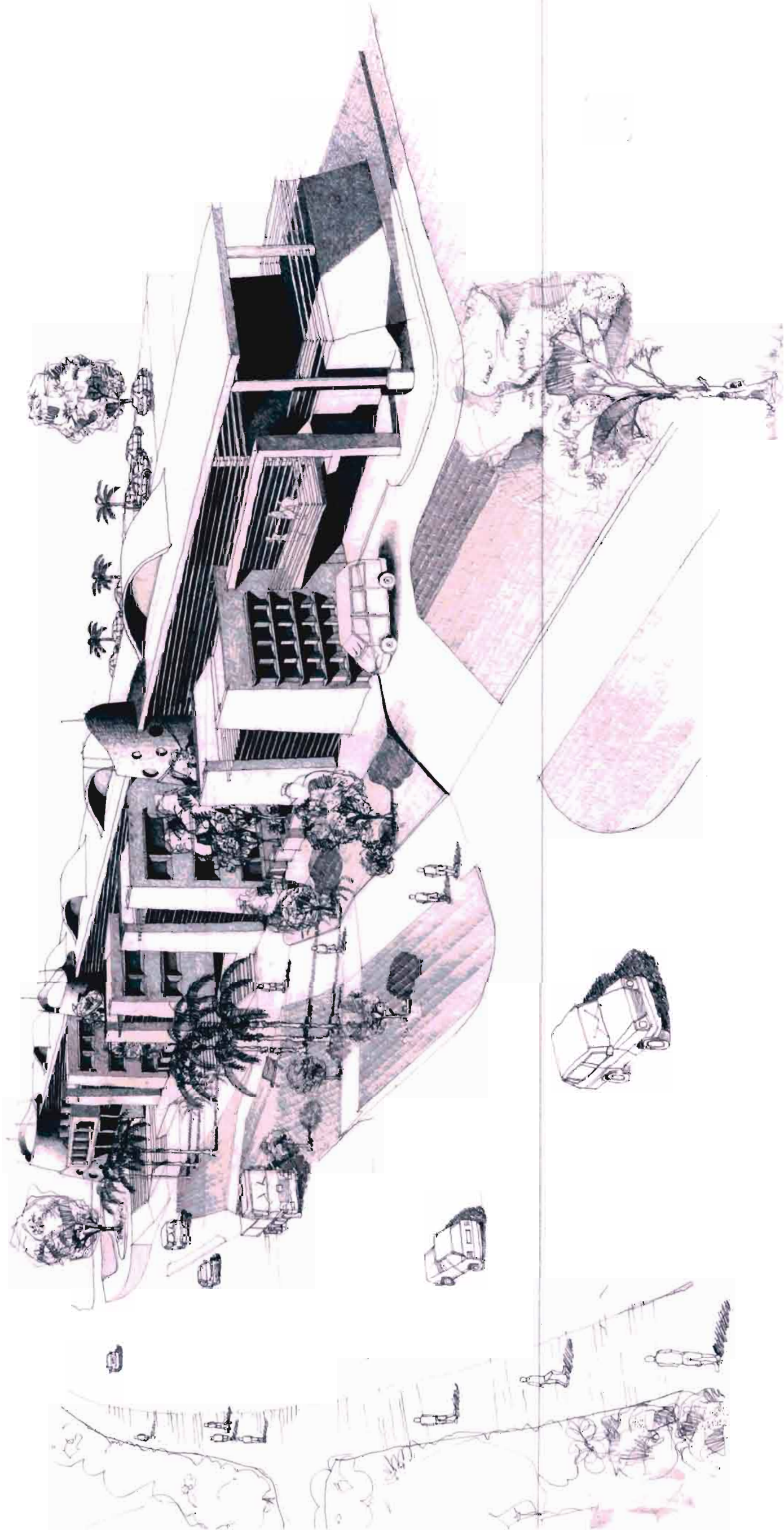
24. *Chlorophyll*

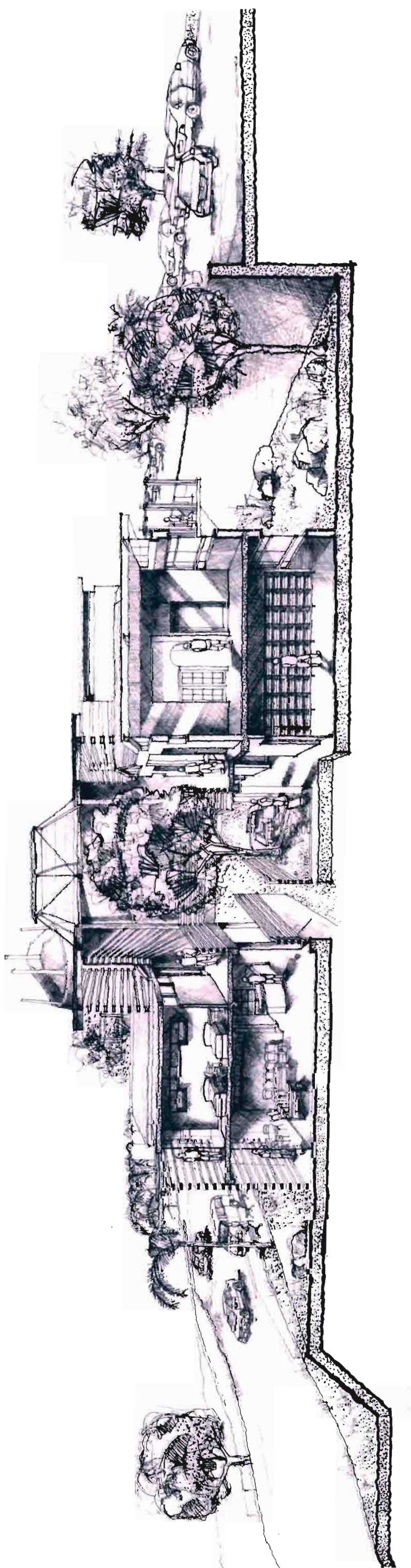
20m

10m

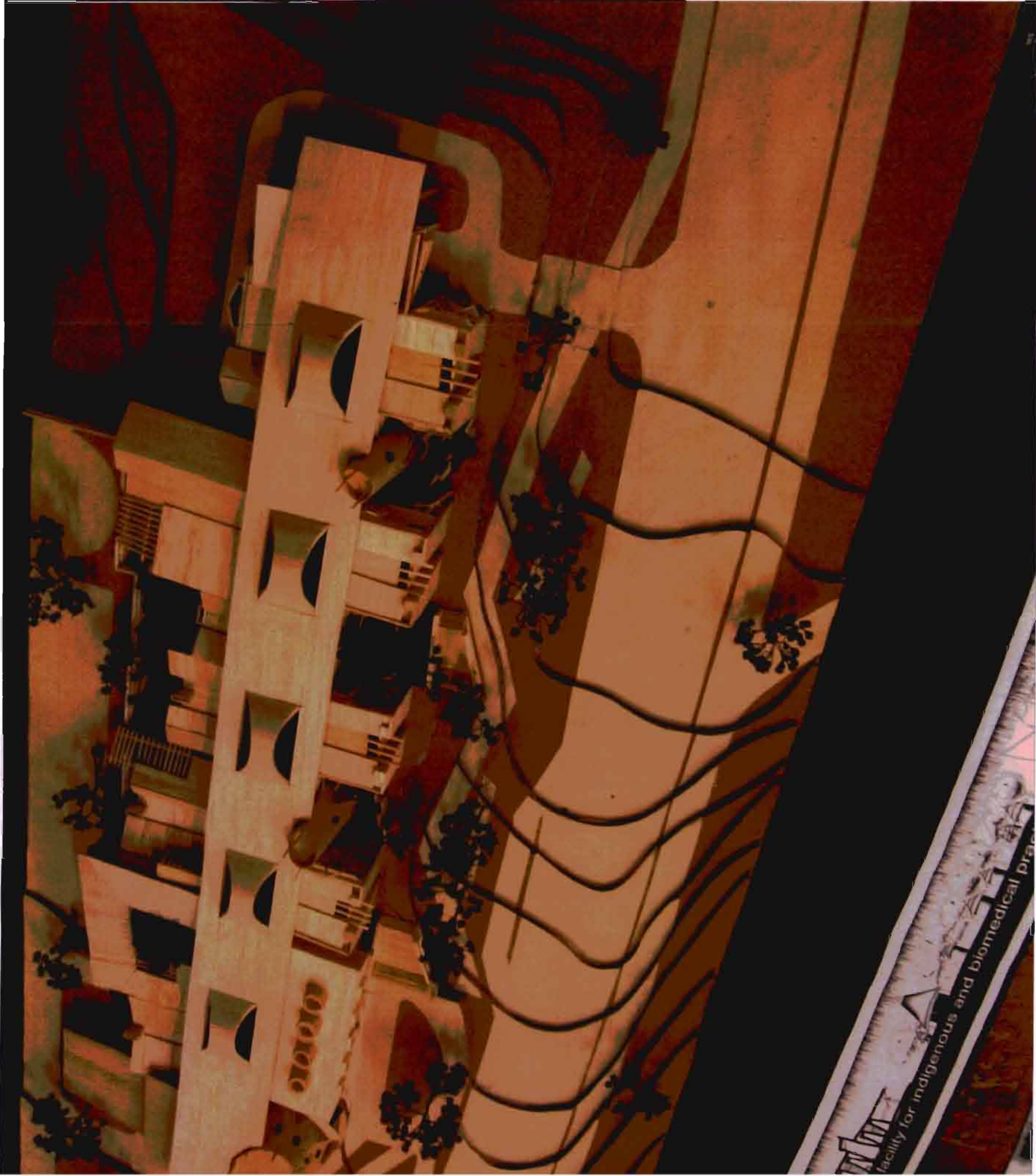
5m

Scale

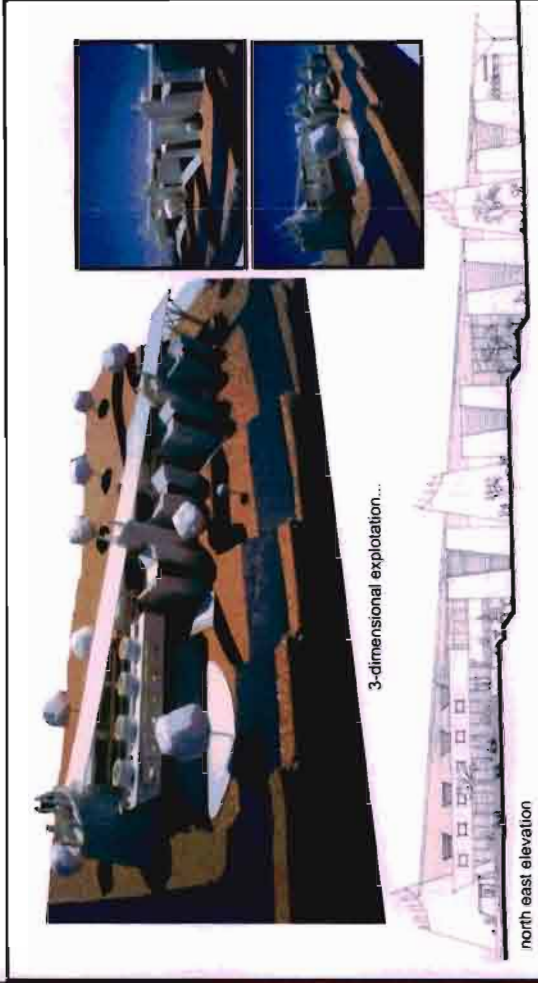




cross section

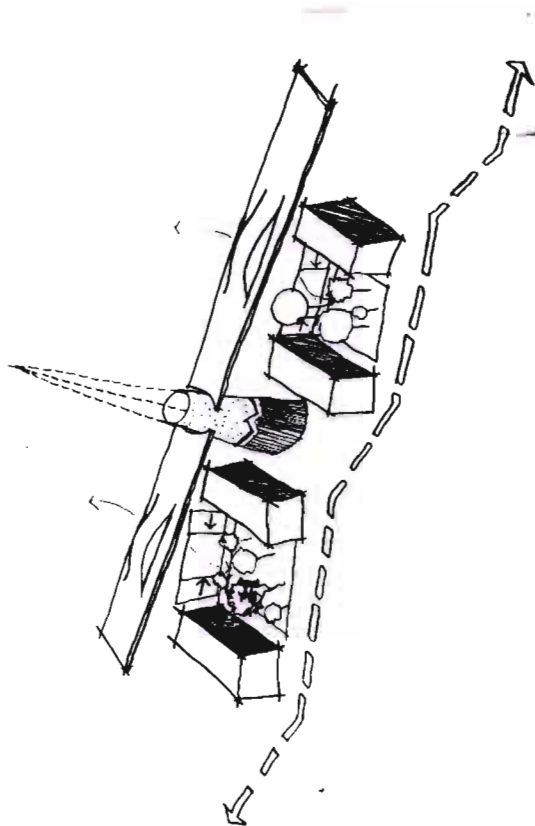


Model



3-dimensional exploration...

north east elevation





Bibliography:

Books:

- Campbell, S.S, 1998. *Called to Heal, Traditional Healing Meets Modern Medicine in Southern Africa Today*. Zebra Press. Johannesburg.
- Cox, A and Groves P. 1981. *Design for Healthcare*. Butterworths, London.
- Cox, A and Groves P. 1990. *Hospitals and Healthcare Facilities*. Butterworths, London.
- Denyer S. 1978, *African Traditional Architecture*, Heinemann, London.
- Gumede, M.D.,MV. 1990. *Traditional Healers*. Blackshaws (Pty) Ltd, Cape Town
- James, P. 1986. *Hospitals Design and Development*. Architectural Press, London
- Hudenburg R. 1967. *Planning the Community Hospital*. McGraw-Hill, Sydney
- Hutchings, A. 1996 *Zulu Medical Plants-An Inventory*, University of Natal Press. Scottville
- Kliment, A. 2000. *Building Types Basics for Healthcare Facilities*. John Wiley and Sons inc. Canada.
- La Hausse, P. 1996. *The Peoples City: African Life in Twentieth Century Durban*. University of Natal Press, Pietermaritzburg.

Thesis:

- Dlamini P.S, 2001. *Facilitating Collaboration Between Traditional Healers and Western Health care Practitioners in the Management of Chronic Illnesses in Swaziland*, Unpublished PHD thesis in nursing, University of Natal, Durban.
- Devenish, A. 2003. *Negotiating Healing: The Professionalisation of Traditional Healers in KwaZulu-Natal Between 1985 and 2003*. Unpublished masters thesis in history. University of Natal, Durban.
- De Zeeuw, J. 1997. *Community Clinic for Traditional Healers*. Unpublished BArch thesis. University of Natal, Durban.
- Flint, K .2001. *Negotiating a Hybrid Medical Culture: African Healers in South-Eastern Africa from the 1820s to the 1990s*. Unpublished Doctoral thesis in history. University of California, Los Angeles.
- Selepe, M. 2006. *The Research Centre for Indigenous Traditional Medicines*. Unpublished M.Arch thesis. University of Pretoria, Tshwane.

Unpublished Articles from the African Traditional Medicine Conference of 2007, Durban:

Dr. JK Githae. 2007. *Strengthening and Harnessing the Contribution of Traditional Medicine Through Partnerships*, Unpublished Journal, School of Alternative Medicine and Technology, Nairobi

Gqaleni, N .2007. *South African Perspectives of African Traditional Medicine*. Unpublished Journal, Nelson Mandela School of Medicine, Durban

Komolafe K, 2007. *The Relevance of African Traditional Medicine to the Healthcare Needs of Mankind*, Unpublished Journal, Nelson Mandela School of Medicine, Durban

Websites:

EBSCO. *Traditional Chinese Medicine (TCM)*. <http://www.healthlibrary.epnet.com>, Date: 03/11/07

Karen Pretorius. *Institute for Traditional Medicines*. <http://www.southafrica.info>, Date: 12/03/07

Rajendra Kale. *South Africa's Health: Traditional Healers in South Africa: A parallel Health care System*. <http://www.bmj.com>, Date: 08/03/07

Source: News24. *Traditional Healers Recognised by South African Law*: <http://www.scidev.net>, Date: 08/03/07

Interviews:

Mr. Ndelu F.J, Durban Herb Market Comitee, 12/03/2007, Durban

Mr. P. Nzimande and Mr. Z. Mngomezulu, co-owners, Amandlenkunzi Pharmacy, 12/03/2007, Durban

Mr. L. Zungu, Inyanga, Durban Herb Market, 12/03/2007, Durban

Mr. P. Govender, shop owner, Thulisa Abakhalayo Pharmacy, 12/03/2007, Durban

Miss. M. Khuzwayo, teacher, Durban Herb Market, 22/03/2007, Durban

Appendix A

African Traditional Medicine Conference, Durban, 2007
(ATMC-Dbn, 2007)

CONTENTS:

- **Relevance to this study.....A2**
- **Collaboration and Referral Relationships..... A2**
- **Speech: Mrs. Peggy Nkonyeni, Minister of Health-KZN..... A5**
- **The Authors’ Observation and Experience.....A7**

Relevant speeches:

- **Professor Nceba Gqaleni:**
SOUTH AFRICAN PERSPECTIVES OF AFRICAN TRADITIONAL MEDICINE.....A10
- **Dr. JK Githae :**
STRENGTHENING AND HARNESSING THE CONTRIBUTION OF TRADITIONAL MEDICINE
THROUGH PARTNERSHIPS.....A11
- **Dr K. Komolafe :**
THE RELEVANCE OF AFRICAN TRADITIONAL MEDICINE TO THE HEALTHCARE NEEDS
OF MANKIND.....A19

Event : **African Traditional Medicine Conference**

Theme:

Research and Development of Traditional Medicine in World Health Organization African Region.

Place : **Durban**

Date : **29-30 August 2007**

• **Relevance to this study:**

This is an annual event where influential role players (from different countries) in the development of indigenous medicine come together to discuss the success and failures of the development systems put in place. This was not only an opportunity to interview key informants that would otherwise be unreachable due to their international research commitments but also an eye opener that broadened the understanding of the subject matter.

Topic : **Collaboration and Referral Relationships:**

Facilitator: Mr N Dlamini_DoH, *National Coordinator of Indigenous Medicines Programmes.*

Introduction by Mr N Buthelezi of the Department of Health,KZN:

In his introduction to the discussion of collaboration Mr Buthelezi (who practices in both professions) stated that collaboration is not a new concept. Indigenous healers have always referred their patients to biomedical doctors but due to the colonial system the biomedical practitioners never referred their patients to indigenous healers (unlike in China and other successful countries). “Now the referral system works both ways!” He showed and circulated a referral form from the National Department of Health. The form is for all provinces of South Africa.

Discussion and Establishment of Policies:

- Mr. N Dlamini, *DoH-National* (who is also qualified for practice and training of both healthcare practitioners) spoke about Districts; the new rule of registering and listing of all accredited healers in a District which has to be submitted to a provincial Department of Health. This makes it easy for

clinics to refer patients to the right indigenous practitioner in accordance with their specialty should they/ patient(s) wish to do so.

- All practitioners shall keep records of patients which will be submitted to the DoH. Furthermore, practitioners shall inform each other in writing of what they did to a patient so that each party knows where to take over.
- The “referrer” shall then receive a report from the “referree” stating what he/she did to the patient.
- Each District shall have a council (consisting of both parties) that supervises the referral system.
- Referrals should not only occur between different health practitioners but should involve social workers and other relevant professions as well.

Responses from the floor:

- Indigenous Health Practitioners raised that there are still biomedical practitioners who do not give them the due respect. The conclusion here was that Districts will select a team of Indigenous Health Practitioners to teach biomedical practitioners about indigenous healing. Equally important is to change the perception of those biomedical practitioners who don't see the need to learn about their coworkers.
- Another experienced misunderstanding was that biomedical practitioners are thought about human-body while Indigenous Health Practitioners' knowledge is both the human-body and the making of medicine (Chemistry); this necessitates a broader collaboration that includes such persons as pharmacists and a training of all parties involved.
- The pending policies shall state clearly where the collaboration borders are to be placed. For instance “an Indigenous Health Practitioner shall not perform activities such as *umshunqiso* (burning of healing substances) to patients in the I C U.”
- Indigenous Health Practitioners shall explicitly state their area of expertise to the local clinics/ hospitals so that both parties acknowledge each others skills and referrals are directed to relevant practitioners.
- Indigenous Health Practitioner are to be trained and given necessary facilities to check blood pressure, sugar levels and most importantly HIV status. A few Districts in the country are already doing this. A representative from the Department of Health reassured the meeting that this is possible and has been easier to do than they expected however there is a need for policies that guide this undertaking.

Conclusion by Deputy M.E.C of Health, KZN:

The deputy M.E.C spoke about societal readiness and she highlighted that Indigenous Health Practitioners should decolonize their minds and understand that the chains of oppression have been broken. The country needs them to take their place in the society; Indigenous Health Practitioner should make use of the doors that are now open for them to empower their profession.

Event : *The worlds' celebration of: African Traditional Medicine Day*

Theme:

Research and Development of Traditional Medicine in World Health Organization African Region.

Place : **Durban**

Date : **31 August 2007**

Speaker: **Mrs. Peggy Nkonyeni, Minister of Health-KZN**

Summary of matters highlighted in the Ministers' speech:

- The minister made it clear that the two healthcare systems in South Africa really need each other especially because most of the country's patients consult both biomedical and Indigenous Health Practitioners. Working together of the healthcare providers would thus highly benefit the patient and improve the country's healthcare as a whole.
- Indigenous Health Practitioners who never had the opportunity of formal education now have access to Adult Basic Education and Training (ABET) as this is one of the partners in the development of this field.
- "As a country, we can not claim to be implementing comprehensive primary healthcare if the two healthcare systems have not fully engaged in collaboration."
- "It is a well known fact that prominent members of our society, including us as ministers consult Indigenous Health Practitioners at night! Why should we hide, why are we ashamed of who we are? Discrimination against Indigenous Health Practitioners should end now!"
- Mrs. Nkonyeni said a well coordinated collaboration would lead to a better understanding of how the two systems work and patients will make a more informed and guided decision about which practitioner is relevant for their diseases. For instance XDR (the new deadly TB) should be treated by biomedical experts.
- "As biomedical doctors we must make it clear that we are not trying to take over and swallow indigenous medicine but we need your help and your knowledge to ensure a balanced healthcare system in the country. For instance the biggest phenomenon in the research and development of medicines with potential to cure HIV currently is your own *unwele*. When the national Ministry spoke of this medicine the whole country saw it as madness! Now all of a sudden biomedical

practitioners are leading this experimentation. Ask yourself, should it be successful, who is it going to benefit between biomedical and Indigenous Health Practitioners?”

- [Unlike biomedicine, Indigenous healing is not only physical] The testing of indigenous medicine has always been done differently to Western medicines or Western science. The collaboration should therefore allow these differences to take place where necessary. There should be laboratories designed for Indigenous Health Practitioners testing of medicine as opposed to pretending that all medicines conform to Western science.
- The minister concluded by warning all key role players of the ignorant and uniformed organizations such as the so called “Doctors for life” that are going around the country trying to stop the renaissance of indigenous medicine.

African Traditional Medicine Conference 2007, Durban

The Authors' Observation and Experience

- Entering the conference venue, one could not help notice the vibrant colors and elegant outfits of the healers of different origins.
- Most of the Indigenous Health Practitioners were from the KwaZulu-Natal province, the rest were from other provinces and other countries of Africa. International researchers, academic institutions, writers and media were all part of the three-days gathering.
- There was hundreds of very well dressed Indigenous Health Practitioners were wearing T-shirts with text such as: “United Behind Health Provision” and “Indigenous medicine is a basic right”
- Local indigenous practitioners all seemed to know each other, if not they would at least know the organizations of one another.
- Organisations and Schools of indigenous medicine were seated in groups on round tables usually with similar outfits for group-identity.
- On my table the Indigenous Health Practitioners conversed about opportunists who pretend to be healers for purposes of making money. Mr. S Hlongwa who was sitting next to me said the reason why the “fly-by-night” healers were not part of the conference was that all Indigenous Health Practitioners knew each other and their authentic schools of training; this left no room for false healers as they would have no group to belong to.
- There was countless who had university qualifications in other careers but practiced as Indigenous Health Practitioners only or both. For instance Dr K Komolafe who spoke on the *Nigerian experience* is a qualified medical doctor and a specialist who only practices as an indigenous healer.
- Getting a chance to interview the Professors and other key informants who spoke at the conference was “mission impossible” as there was too much competition from journalists and researchers from different countries. However, in a short time that I got to talk to the international professors (guest speakers) as we walked out of the conference venue, the interest in an architectural intervention was so high that they gave me their contact details and copies of their speeches included herein as Appendix.
- Professor K Komolafe said that indigenous healers have a very unique culture of their own, with a distinguish from the general African culture; this is not only manifested through their inexplicable

multifaceted ancestral connection but also music, dance, art, fashion and architecture. He emphasized the point of retaining the beauty of their architecture and the associated symbolism. He described the Indigenous Health Practitioners' architecture as one of the most beautiful in Africa because of the symbolism and meaning it possesses.

- One of the most exciting and informative experiences was being in a hall full of prominent Indigenous Health Practitioners discussing my topic research topic: *collaboration and referral relationships*. I would have never gained so much insight into the subject matter had I not attended the conference.
- **Language:** Indigenous Healers have a unique use of language and ways of communication (spoken words and signs involving clapping of hands). Their language is so full of meaning that it could be a thesis on its own. The most fascinating use of word for me was *Makhosi* which means king or man of ancestors. It was only then that I fully understood why the houses of ancestors in all the indigenous healthcare facilities I had visited during my research were referred to as *eMakhosini* (the kings' palace or place of ancestors). This is similar to the architecture of the Zulu speakers being referred to as Zulu architecture. However *Makhosi* does not merely mean the aforementioned translations. It is word of respect for one another and the ancestors that guide and sustain the healers. This is a very powerful word in South Africa; it restores confidence, pride and respect for indigenous healers. Such words as "*sawubona*" had even disappeared from one's conscience after the conference. The word *Makhosi* is used at all times when greeting, addressing and conversing to indigenous healers, it is used in precisely the same way as "Amen" when speaking to indigenous healers. This enlightenment completed the picture for me, It suddenly made perfect sense why when I was growing up all my contemporaries whose parents were indigenous healers insisted on referring to their parents as *Makhosi* and never as "mom" or "dad". In Nguni speaking tribes a respectful name for indigenous healers is *oMakhosi*.
- **Language and Nomenclature:** Rev. S.J Mtetwa, Researcher, *Office of the M.E.C, DoH* said the language used by key role players in the renaissance of indigenous medicine should be correct as it will have an impact upon self-identity of the new generation of indigenous healers. Language is a tool of power. Self definition of healers is important for them to understand what is theirs and what is imposed on them.
- Respect and African values are all integral parts Indigenous Health Practitioners role in society, the most humbling experience for me was when indigenous healers including those of very high-caliber

stood up every time the M.E.C of Health walked in or out of the venue as a sign of respect her as an appointed leader.

- Healers sang both gospel music and exclusive songs of initiation accompanied by cultural dances that are specific to indigenous medicines only.

South African Perspectives of African Traditional Medicine

Professor Nceba Gqaleni, DST/NRF Chair of Indigenous Health Care Systems Research
Nelson R Mandela School of Medicine, University of KwaZulu-Natal

Traditional medicine is popular and its use reported to be on the increase in South Africa. For this reason a regulatory framework to recognize and regulate the practice of TM in accordance with WHO guidelines has been established in South Africa. The Traditional Health Practitioners Act, in the process of being enacted is intended to formalize this age old profession. There are an estimated 200 000 traditional healers in South Africa. This figure requires a review by Statistics South Africa through its annual household surveys. There is growing evidence of co-operation between traditional healers and other health practitioners and this trend is expected to grow.

It is encouraging to note that there is an increase in funding of scientific and clinical research of traditional medicine by government and research organisations. This will facilitate the registration of these products by the Medicines Control Council. There are proposals to review legislation on prescribed minimum benefits to pave the way for TM to play a larger role in the screening and detection of diseases thereby positively influencing health outcomes.

The value of the trade in medicinal plants is estimated to be approximately R520 million per year in raw material trade. An additional R2.6 billion is added in value as the plants are prescribed by healers. In total, the trade in RSA is estimated to be worth R2.929 million per year (in 2006 prices). Most of this value does not enter into the formal trade and therefore is an addition to the Gross Domestic Product.

The current annual value of the medicinal plant trade in RSA is equal to 5.6% of the National Health budget, or equal to the whole Mpumalanga health budget, or equal to the KZN provincial hospital budget. Importantly, there are at least 133 000 income earning opportunities generated by the trade in traditional medicinal plants. Strategies toward integration of clinically proven traditional medicines in the South African health care system, has to involve the active participation of the patient to help create a powerful healing force for our world.

The School of Alternative Medicine and Technology

(SAMTECH)

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PRESENTATION ON: STRENGTHENING AND HARNESSING THE
CONTRIBUTION OF TRADITIONAL MEDICINE
THROUGH PARTNERSHIPS.

PRESENTED TO: KWAZULU-NATAL CONFERENCE ON TRADITIONAL
MEDICINE (SOUTH AFRICA) ON 29TH – 31ST AUGUST 2007

PREPARED & PRESENTED BY: DR. JACK KAGUU GITHAE
AUGUST 2007.

INTRODUCTION

African Traditional Medicine

The sum total of all knowledge, wisdom and practices used in diagnosis, prevention and elimination of physical, mental or societal imbalance. It relies exclusively on practical experience handed down generations.

Herbs

- Products whose active ingredients are plant materials whether in crude state or as a presentation.
- Medicines containing plant material without with chemically defined substances are not considered herbal.

Partnerships in Traditional Medicine

Working with others to achieve what we cannot achieve on our own as medical practitioners. Partners work together.

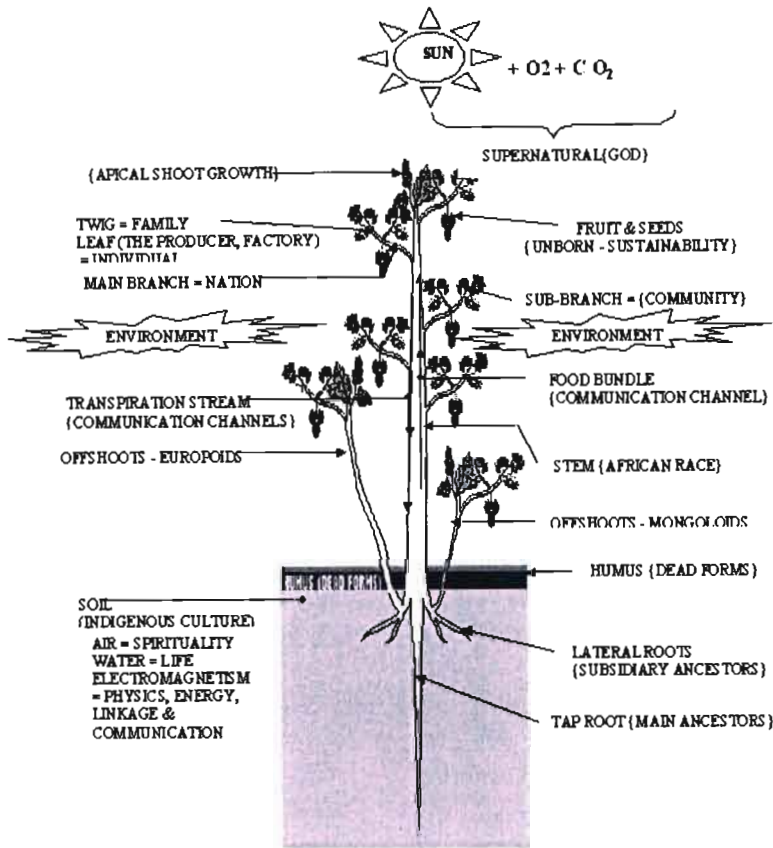
Building partnerships is about relationships that are in-depth, involve a few carefully selected targets, and have specific, *practical goals*

Since time immemorial, African societies have built partnerships to enable them better practice Traditional Medicine for Health and wellbeing of the society. Historical records, for example, show how the people of Ghana learned of ideas of Medical Surgery from Egypt. This was made possible by partnerships.

PS. Refer to the table at the end of the document.

2. INHERENT PARTNERSHIPS IN AFRICAN TRADITIONAL MEDICINE

2.1. An analogy of Tree of life and African World View to illustrate inherent partnerships.



The Tree of life represents traditional healing in the management of Health and well-being of the individual, household, community and the human race as is labelled in the Diagram. Thus in perfect balance and harmony as the Tree of life

illustrates, a conscious solidarity/Partnership is formed between the individual, household members and beyond to include the ancestors.

The stem and its structures

Represent the shared traditions, customs and language and the whole culture that expresses of these ties. It is also believed that members are the same in being. Thus joy, pain and disease experienced by one is immediately transmitted to all the others as the Tree of life illustrates through the communication channels of the Transpiration stream, food bundle and the apical shoot through photosynthesis to the sunrays and hence to God.

Transmitters

Facilitate communication with the supernatural on the pain and joy being experienced upon which they respond appropriately.

The dead

The highest elders on earth, closer to God, and enjoy reverence that forms the culture of our communities' religion. Ancestors, because of their psychic and metaphysical knowledge and wisdom, mediate between God and man through the Traditional healers and clergy. This partnership illustrates the potency, power, vital energy highlighted by its capacity to rejuvenate the society through offshoots or vegetative growths of the cut Tree. It is therefore grossly unwise to despise, ignore and underrate our partnership with our ancestors because they mediate in emergencies and guide through seers and Traditional healers. Thus, there is also a need to form a partnership with not only the living but also the dead in the undertakings of African Traditional Medicine.

The Environment and the Ecosystem

Tree of life and African Traditional Medicine can only exist sustainably if in perfect balance, harmony and partnership with the environment and the ecosystem (Earth). The reason for people set apart sacred places eg. mountains, caves, waterfalls, rocks which they observe and treat as sanctuaries. This is not worship of nature but an acknowledgement that nature has to be respected, held sacred and used responsibly. With this balance, harmony and partnership, sustainability is assured because the Tree of life will produce Fruit and seeds to propagate the human forest (community) and enable the passing on of the apprenticeship, knowledge and wisdom of traditional healing/ spiritualism.

Application

I compliment the 3 intertwined disciplines of a professional scientist, a Traditional healer as well as a Traditional clergy in the management and prevention of disease I gained this Knowledge and wisdom, from my Grandmother, through a Genealogy of such interactions of the African societies.

As a scientist I have studied through the protocols of experimentation and observation to understand and explain why things to include disease and herbs work the way they do in the universe and the human body. Through this, I have been enabled to derive certain technologies for performing certain tasks to include the prevention and management of disease.

As a traditional clergy, I am obliged to sustainably link my community (the living), the future (unborn) to our ancestors (the dead) and God. I therefore strive to embody my society's unity (partnership) and single-mindedness' even during the time of disease. This enables me to intercede and prevent illness and disease in the community.

As a traditional healer I manage disease with the Rain- forest-drug store; herbs. I got the indigenous knowledge in traditional healing from my paternal grandmother. For the last 36 years, I have utilised this knowledge to cure several diseases in my outreach clinic networks, which have operated in Partnerships with other several organizations in Kenya, regionally and internationally. I have managed several patients from all over Africa.

3. WHY PARTNERSHIP IN TRADITIONAL MEDICINE?

The table below illustrates how I was to have an *adjacent segment penetration approach*, rather like the *adjacent segment encroachment approach* common in commercial undertakings through partnerships.

- To widen and sustain the impact of African Traditional Medicine work locally, regionally and internationally.

- To gain a wide variety of resources that we need to carry out our work well eg. The media, donor funding, influence, knowledge and skills etc
- To gain a wider and more coordinated response-a better referral system among different organisations, other Traditional Medical Practitioners and a few Conventional Health practitioners
- Better support and policies for the Traditional Medical Practice.
- More financial and technical resources.
- Stronger services and increased access for vulnerable communities.
- Fewer political constraints because of the potential of the partners to speak with one voice on pertinent issues to do with Traditional Medical Practice.
- More effective and creative Traditional Medical Practice programmes – through the sharing of lessons and experiences.

4. WHOM DO YOU COLLABORATE WITH IN TRADITIONAL MEDICINE PARTNERSHIPS?

- Local Government Departments
- National Health Programs
- Lawyers and lawyer Associations
- The African Union
- United Nations bodies
- International donors
- Human rights groups
- Presidents and other political leaders
- Social workers
- Art groups
- Youth groups
- Conventional health professionals
- Academics
- Law enforcement officers
- Women's groups
- Lobbying/Advocacy groups
- Civil servants
- Farmers' leaders
- Midwives' groups and Traditional Birth Attendants

- Traditional and opinion leaders
- Business leaders

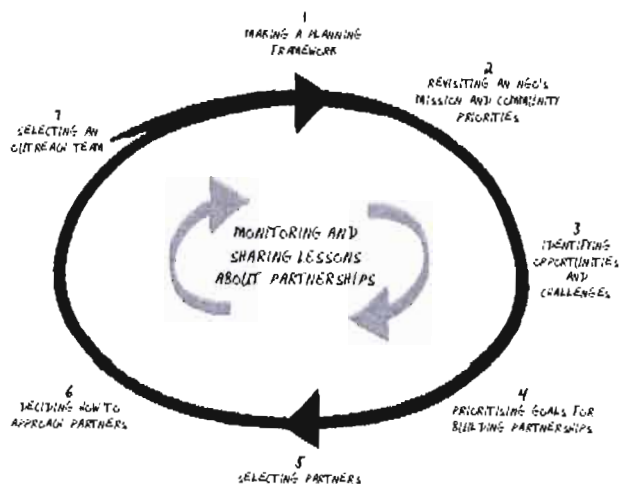
5. WHAT TRADITIONAL MEDICINE ISSUES AFFECT THE BUILDING OF PARTNERSHIPS?

○ TRADITIONAL MEDICINE ISSUES

- Personal Attitudes and Beliefs
- Institutional Practices, Policies and Beliefs
- The Visibility of Traditional Medical Practice in a Community
- Language and Jargon
- Scandals and Scare Stories
- Competing Priorities
- Subject-Matter Fatigue

⊖ INSTITUTIONAL ISSUES

- Negative Images of Institutions
- Perceptions about Institutional Resources
- Institutional Reputation
- Balance with other Areas of the Institutional Work
- Competition Among Institutions



HOW DO YOU DEVELOP A PARTNERSHIP PLAN?

Karati Rural Service Centre																			
Envisaged physical facilities, Operations and Personnel Distribution summary																			
Centres code	Centres location	Physical facilities	operations										Personnel Distribution						
BI	1.	Nairobi –Kenya	ID	A 1	A 2	A 5	B 1	B 2	B 3	B 4	C 1	C 2	MO 1	PLO 1	SM 1	SPO 1	RTO 2	CLO 1	SS 5
BI	2.	Nyeri-Kenya	AD	A 1	A 2	A 3	A 4	A 5	B 1	B 2	B 3	B 4	-	1	1	1	2	3	50
BI	3.	Mombassa-Kenya	NE	A 1	A 2	A 5	B 1	B 2	B 3	C 1	C 2	-	1	1	1	1	1	1	10
BI	4.	Naivasha-Kenya	NE (P)	A 1-5	B 1-4	C 1-4	D 1-4	E	-	-	-	-	1	1	1	1	5	3	200
BI	5.	Malaba-Kenya/Uganda border	NE	A 5	A 1	B 1	B 3	-	-	-	-	-	1	1	1	1	0	1	1
BI	6.	▪ Namanga/Migori-Kenya/TZ border ▪ Arusha-TZ	NE	A 5	A 1-2	B 1	B 3	-	-	-	-	-	1	1	1	1	0	1	2
BI	7.	Moyale-Kenya Addis-Abbaba-Ethiopia	NE	A 2	B 1	A 5	-	-	-	-	-	-	1	1	1	0	1	1	-
BI	8.	Rumuruti/Ngarua-Kenya	NE	A 2	B 1	B 2	-	-	-	-	-	-	1	1	1	1	1	20	-
BI	9.	Johannesburg-S.Africa Swaziland	NE	A 2	B 1	A 5	-	-	-	-	-	-	1	1	1	0	1	5	-

KEY

MO-Medical Officer/Superintendent

NE-Facilities Non-Existent

SPO-Sales Procurement/ Production Officer

P-To be purchased

CO-Clerical Officer

NC-New Construction

AD-Adequate Facilities

LH-LeaseHold

PLO-Public Relations Officer

TZ- Tanzania

RTO-Research/Training Officer

SS-Support Staff

ID-Inadequate facilities

**THE RELEVANCE OF AFRICAN TRADITIONAL MEDICINE TO THE
HEALTHCARE NEEDS OF MANKIND**

PAPER DELIVERED

BY

DR. KOMOLAFE KOLAWOLE

AT

THE AFRICAN TRADITIONAL MEDICINE CONFERENCE IN KWAZULU-
NATAL

KINGDOM OF SOUTH AFRICA

DATE: 30TH SEPTEMBER 2007

VENUE: OCEANIC CONFERENCE CENTRE, DURBAN

**THE RELEVANCE OF AFRICAN TRADITIONAL MEDICINE TO THE
HEALTH NEEDS OF MANKIND**

INTRODUCTION

The chairman of this occasion, the Minister of Health, distinguished officers of the Health Department, chieftains of traditional institutions, my dear colleagues in the practice of Traditional Medicine, representatives of the press, distinguished ladies and gentle men, it is a pleasure for me to be present at this unique and honorable conference on Traditional Medicine. It is unique and honorable not only because it is a welcome event in the development of Traditional medicine in South Africa but also because it has incorporated the celebration of the Traditional Medicine Day in its programs.

My sincere thanks goes to the Honorable Minister of Health – Mrs. Peggy Nkonyeni and all the officers of the Department of health who have facilitated my

presence here today. I am here with best regards from my Traditional Medicine colleagues in Nigeria.

The topic of my address to this distinguished gathering is: The Relevance Of Traditional Medicine To The Healthcare Needs Of Mankind. I have chosen this topic with the hope of rejuvenating the consciousness of all of us stakeholders towards a more realistic development of African Traditional medicine. In many conferences of this nature many stakeholders often make laudable statements and comments in support of the development of Traditional Medicine, only to go back to their offices and score it low on the drawing board of budget and development. With the interest that many of us frequently exhibit in the development of Traditional Medicine, one can see that the neglect that health planners and budget executors give Traditional Medicine development is not born out of hatred for the system. I think it is time for those concerned to try and find out more fundamental reasons why apparently positive attitudes towards Traditional Medicine are not effectively translated into practical reality. In the year 1996, the total global sale for traditional Medicine was about us\$14 billion dollars. While countries like China and India are at the top of the lucrative market, Africa is yet to derive the expected benefits.

CHALLENGES

There are many challenges that militate against the relevance of Traditional African Medicine. There is urgent need for the challenges to be aimed at achieving the following objectives:

- Well developed national policy
 - Proper implementation of national policy
 - Enactment of legislation on the practice and code of conduct
 - Establishment of controlling bodies (councils or boards)
 - Uniting the associations of Traditional medicine practitioners
 - Effective discipline and control among the rank and file of TMPs
 - Cooperation between Traditional Medicine Practitioners and their conventional counterparts.
 - Adequate room for training/capacity building.
 - Adequate hygiene and production technology
 - Proper documentation
 - Good dosage standardization
 - Adequate funding of policy implementation
 - Sincere political will

When policy makers and budget executors consider these myriads of challenges, they develop the impression that Traditional Medicine is either irrelevant or at least much less relevant than the conventional medicine. In order to further confirm the relevance of African Traditional Medicine to the healthcare needs of our citizens, I want us to remind ourselves of following supportive issues:

HYSTORY

The use of herbs and other forms of traditional materials to promote the health of mankind is older than recorded history. According to the elders of the Yoruba kingdom in Nigeria the first known professional herbalist in the world was a sage called Osanyin. Stories in a Yoruba pedagogy (Ifa) inform us that Osanyin used hundreds of plant species to prepare potent medicines that were used to treat many diseases successfully. We are told that Osanyin lived 15,000 to 20,000 years ago. We have also read about Inhotep who was the most ancient of the Egyptian Herbalists. Inhotep was recorded to have lived 2,980 years B. C. Another herbalist was Hippocrates who has been popularly acclaimed as the father of modern conventional medicine. He lived in the Greek Island of Coz a couple of centuries before Christ. He was said to have used many medicinal herbs for the treatment of diseases. Galen and Dioscorides were also ancient Greek herbalists who made records of many of the herbs that they used for the treatment of their patients. If we conduct proper research, we may discover that KwaZulu-Natal and some other African communities may have histories of traditional medical practice that are longer than those already mentioned. Many important sources of medicinal history indicate that the African continent has the oldest history of human existence and the use of plants as medicine. The obvious but silent fact is that the modern and conventional medicine of today has evolved from the ancient use of herbs.

HEALTH COVERAGE

World Health Organization sources tell us that African traditional medicine covers about 70% of the healthcare delivery services in many African countries. This means that the conventional systems of healthcare delivery give only about 30% coverage. This situation is so because Traditional medical services and material are easily accessible and affordable when compared to the conventional alternatives.

RELIABILITY

Traditional Medicine in Africa is very reliable since the materials are readily available and the practitioners do not go on strike. The services are there for the people all the time. In times of crises or war, the means of conventional drugs' production can be seriously impaired. Traditional medicines that are derived directly from natural flora are relatively easier to produce with simple tools. When conventional methods of medical treatment fail, there is always some hope that some herb or the other will eventually be discovered to achieve the required success.

ROLE OF WHO

The world health Organization (WHO) has within the past three decades given tremendous service and attention to the development and use of Traditional

Medicine. The 1978 WHO Alma-Ata (Russia) declaration opened the way for a wide range of developmental activities in global Traditional Medicine practice. The declaration, among other things advised all the nations of the world to look inwards and use the ideals in their various forms of Traditional Medicine for the benefit of their citizens. The whole world has given some good response to WHO call and I am happy to observe that many African countries have been responding satisfactorily to the WHO/AFRO initiative. We are aware that WHO has among other things developed working tools along the following lines:

- Guidelines for the formulation and implementation of National Medicine Policy
- Legal framework for the practice of Traditional Medicine
- Model code of ethics
- Guidelines for the evaluation of efficacy and safety of herbal medicine preparations
- Clinical evaluation of herbal medicine used in the treatment of HIV/AIDS
- Guidelines for the registration of Traditional/Herbal Medicine
- Regulatory framework for the production of Traditional/Herbal Medicine in the African Region
- Promoting the role of Traditional Medicine in Health Systems
- Documents on regulatory framework on the Protection of Traditional Medical Knowledge.
- Training tools in Traditional African Medicine for Health Science Students and Traditional Health Practitioners.

Despite updated efforts put into the development of African Traditional Medicine, The most challenging issues still include the following:

CAPACITY BUILDING

Much still needs to be done in the area Of training our Traditional Medicine Practitioners to improve their competence and capacity. In modern times, the notion that Traditional Medicine Practitioners should be left alone with their current level of knowledge does not help matters. Since critics continue to devalue the relevance of Traditional Medicine by saying that it lacks proper record keeping, adequate dosage formulation, transparency, hygiene, etc., we must seriously work to assist its development in these areas. Some interdisciplinary cooperation and efforts are needed in this direction. In Nigeria for instance, Selected Practitioners of Traditional Medicine from many States across the country were gathered in Abuja for some lectures in these areas of need. The trainees so selected were expected to go back to their respective states and train others in the various council or local government areas of the country. For that lecture I was mandated to give the lecture on The Clinical Management Of Patients in African Traditional Medicine. All the lectures were later reproduced in the three major Nigerian local languages. The Federal Ministry of Health was effectively assisted in planning, preparation and delivery of the lectures.

INEXPLICABLE TRADITIONAL MEDICINE

Another aspect of Traditional Medicine that appears to make policy makers and some other stakeholders feel that Traditional Medicine is not quite relevant to mankind's health needs is the spiritual, occult or inexplicable. Quite often, many scientists among us demonstrate the feeling that any thing that cannot be directly explained with known scientific methods can neither be true nor effective. However, it is important for us to remind ourselves that there are many things that science, as we know it today cannot explain. For example, what satisfactory explanation does the biological scientist have on how life is given to the fetus in its mother's womb? Where is the scientist that can give acceptable explanation on how the processes of growth of the human being in and outside the mother's womb were coded?

The truth is that science as we have it today, has much more to explain about numerous realities of life than it had done. Must we insist that it is only the tangible entity of life that can be effective? If we do, what explanation do we have for the effectiveness of the radio waves that we can neither see nor hold? After all these waves constitute the bedrock of modern technology! We can spend a lifetime asking questions about numerous things that science is yet to explain. It is also important that we appreciate that scientific methods can be used to confirm or disprove the effectiveness of the things that science cannot explain. For example, if we cannot explain how words of prayer or incantations can bring about healing, we can at least subject the results of these apparently intangible things to scientific analysis before passing the final judgment on their efficacy. There is need for us to be conscious of these facts so that we do not make the mistake of taking decisions that can deprive mankind of the yet untapped resources in nature. We can help the situation by adopting the following notions:

- Avoid undue bias against what looks unscientific
- Engage in reasonable dialog with the people involved
- Be tolerant of opinions that may differ from yours on things that cannot be scientifically explained or proven
- Promote the habit of sustainable record keeping of inexplicable actions
- Engage in the scientific analysis of recorded data
- Politely ask those involved to explain their actions if they can
- Open your mind to knowledge on things that don't look scientific
- Expose yourself to personal but safe experiences on the subject.

PROFFESIONAL DISCIPLINE

It can be observed that the lack legal bodies to control the practice of Traditional Medicine in many African countries has contributed immensely to the rampant indiscipline that exist among the rank and file of Traditional Medicine Practitioners. However, one must highlight the need for the practitioners

themselves to get organized in such a way that effective discipline can be instilled into their Practice. The Traditional Medicine Practitioner needs to know that persistent acts of indiscipline will seriously jeopardize the credibility and relevance of African Traditional Medicine.

It can also be observed that the major cause of indiscipline in the practice of Traditional medicine in many African countries is the mad drive for quick material gains. We must all realize that genuine and lasting reward comes through sincere service to mankind in strict accordance with the will of God. It is important for us to accept that Traditional medicine Practice, like other systems of healthcare delivery should not be seen as a money-rolling business. Fundamentally, it should be seen as a humanitarian service that protects and respects life. It is the responsibility of the Traditional medicine Practitioners to try and fish out the quacks/charlatans among their ranks and flush them out.

CONCLUSION

I would like to start the conclusion of this address by saying a few words about the importance of the African Traditional Medicine Day Celebration. The celebration of this important day is a good pointer to the fact that African Traditional Medicine is relevant to the healthcare needs of our people. I congratulate the people of KwaZulu-Natal Kingdom and the government of South Africa for responding impressively to the WHO initiative that has led to this day's celebration.

Finally, I am grateful for the opportunity given to me to be part of this conference and the celebration of the African Traditional Medicine Day. As I go back to Nigeria, The good memories of these great events will remain indelible in my mind.

Thank you and May God bless you all.

Dr. Komolafe Kolawole (Nigeria).

Appendix B

INTERVIEWS

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Interviewee(s): **Dr N. Gqaleni**

Occupation : **Medical Doctor , Researcher & Deputy Dean**

Of : ***Nelson Mandela School of Medicine, African Healthcare Systems***

Research (Chair person)

Place : **Durban**

Date : **19 June 2007**

Aim of interview:

To establish his organizations' role in the Renaissance of African Indigenous medicine.

His views on the subject matter: Challenges and Way Forward

To run the proposed schedule of accommodation past him as 'a client' and a key role player in the Renaissance of African Indigenous medicine.

- **Role of the organisation:**

Research:

The African Healthcare Systems Research consists of both biomedical and indigenous healthcare practitioners. They research and tests the efficacy of medicines. Similarly to other research organizations in this field, his organization also develops new remedies for chronic conditions; it safeguards indigenous knowledge and provide both consumer information and protection.

Regulation Systems:

Through Dr Gqaleni's leadership the UKZN is involved in establishing referral systems for collaboration purposes of the biomedical and indigenous healthcare systems.

Keeping of patients' records in accordance with the Department of Health's systems. Healers state what diseases they encounter and what medicines they prescribe for these diseases; the records are sent to the Department of Health for development of plans and strategies for problematic diseases. They also organize workshops for

teaching and training of nurses and doctors on indigenous medicine; these programmes are sponsored by WHO African Region.

There is a growing interest in the country for development of this trusted healthcare system. There is more funding from different corporations and a growing number of key role players in this endeavour.

- **Accreditation of healers:**

Indigenous Health practitioners train as an apprentice with a qualified practitioner for a certain number of years depending on the specialty. At the end of the training they have a graduation ceremony just like in the higher education system except theirs is musical and ancestral.

NEW METHOD:

To eliminate opportunist who are trying to make money through the sick- Indigenous Health practitioners' organizations set up a panel for accreditation of qualified practitioners. This is done through interviews whereby candidates are asked particular questions that every authentic Indigenous Health practitioner should know; of course questions of which accredited school or trainer the candidates went to are introductory. And training schools can be contacted through District Coordinators of any province in the country.

- **China as a model for South Africa:**

China has been very successful in developing their indigenous healthcare system, e.g. green tea. South Africa is on the right path and is guided by China in its renaissance of indigenous healthcare systems. WHO African Region funds South African researchers such as Professor Hebert Vilakazi to work in partnership with China for mentorship purposes.

- **Different Levels of Healthcare Facilities:**

- i. Clinic
- ii. Community Healthcare Centre
- iii. District Hospital (GP level)

- iv. Regional Hospital (Specialists_internal/external)
- v. Central Hospital (Super specialists_heart, kidney etc.)

Indigenous Health practitioners have specialists that can and should- through well coordinated systems and policies work in collaboration with their biomedical contemporaries.

Please note: Dr N. Gqaleni reviewed and amended the proposed schedule of accommodation to cater for all necessities of collaboration between indigenous and biomedical healthcare.

Interviewee(s): **Mr J.F Ndelu**

Occupation : **inyanga**

Of : ***Durban Herb Traders' Committee***

Place : **Durban**

Date : **24 March 2007**

- **Role of the organisation:**

Representing muthi traders of the “Muthi Bridge”.

Communication with eThekweni Municipality and other national role players in the development of indigenous medicine.

- **Comments on the accommodation provided at the “Muthi Bridge”.**

The biggest herb market in the country is a mockery to indigenous medicines. The healers are undervalued and given small spaces that felt no different to “prison cells” to practice in. Healers need laboratories and other useful resources that will improve basic healthcare in the country.

- **Scientific Proof of Medicines Hinders Collaboration:**

Biomedical practitioners must understand that indigenous African medicine existed for centuries even before Christ. They have successfully kept the people alive for so long. Indigenous practitioners create medicine they don't just put pills together and they should be given the due recognition for that.

Africans have their own way of testing their medicines that has also existed for centuries. Why should they now conform to Western ways of doing things? We don't learn science from the books our science comes from ancestral power, indigenous knowledge systems and personal experiences. The aim here is to work together not to change the way we (indigenous practitioners) do things. Some medicines can be tested but there are those that are inexplicable and can not be put in scientific terms. Why should it be indigenous practitioners that give their medicines for scientific proof if the Western doctors are not willing to also bring their medicine to our way of

testing and approving? It seems that science is now being used as a tool to shut indigenous medicine.

- **Secrecy:**

Secrecy in the current day of indigenous medicine is history. It was only relevant in the colonial era and before our recognition, rights and protection. It originated from Western medicines taking our indigenous knowledge and using it for their own benefit. Knowledge was therefore only passed on to healers' children and trusted relatives. This happened in every aspect of indigenous knowledge, For Instance none of the big firms that produce "Amahewu" are owned by people of African origin yet we all know that this drink was a drink of our ancestors for centuries.

- **Skills and Specialties:**

In African culture every house used to have a specific indigenous healer that they consult; this is still the case in all the royalties I know of. Healers are not magicians and that is why you often find that a healer only knows one medicine or area of expertise and if they refer the patients to relevant counterparts.

NOTE:

Observation during interview: Patients who go to Sangomas for specific diagnosis that izinyanga are not able to do produce a referral form or paper to inyanga before consultation.

Interviewee(s): **Mr P. Nzimande & Mr Z. Mngomezulu**

Occupation : **Izinyanga**

Of : ***Amandlenkosi Pharmacy***

Place : **Queen Street, Durban**

Date : **12 March 2007**

- **Skills:**

Making herbs of plant origin:

They learnt how to make medicine from elders, attending classes and seminars of indigenous health practitioners and reading books of African Indigenous Medicine.

- **Business/Practice Description:**

Selling of prepared and packaged muthi. Also sells attires and outfits for healers. Presrciption and directions on how medicines should be used.

- **Customers/Consultants:**

The pharmacy receives diverse cultures including tourists.

Approximate number of people per day: 100

- **Fees:**

Approximate income per day : R 800.00

Rent per month : R 18 810.00

- **Rooms and Facilities Required:**

- i. storage
- ii. preparation room
- iii. shop

- **Spatial Setting & Temperature Requirements:**

Conventional except for the store room which should be an open/ outdoor space with a roof for shelter while preparing muthi.

Temparature should be kept as low as possible because some medicines expire in high temperatures.

Interviewee(s): **Mr S Govender**

Occupation : **Muthi Seller**

Of : *Thulisa Abakhalayo Pharmacy*

Place : **Warwick Avenue, Durban**

Date : **18 March 2007**

- **Skills:**

Mr Govender sells the medicine that he buys from izinyanga. He gets a list of required medicines from patients and buys from healers in rural areas.

- **Business/Practice Description:**

Selling of prepared and packaged muthi. Also sells attires and outfits for healers. Prescription and directions on how medicines should be used.

- **Customers/Consultants:**

The pharmacy receives diverse cultures including tourists.

Approximate number of people per day: 50-70

- **Fees:**

Approximate income per day : R 1500.00

Rent per month : R 8 800.00

- **Rooms and Facilities Required:**

- i. storage
- ii. preparation room
- iii. shop

- **Spatial Setting & Temperature Requirements:**

Store room: Temperature should be kept as low as possible because some medicines expire in high temperatures.

Interviewee(s): **Mr N Zungu**

Occupation : **Inyanga & Sangoma**

Of : ***Herb Traders' Market (Muthi Brige)***

Place : **Durban**

Date : **12 March 2007**

- **Skills:**

General Practitioner:

He spent 3-years being trained by a healer that treated his sickness.

- **Business/Practice Description:**

Selling of prepared and packaged muthi. Prescription and directions on how medicines should be used.

All consultations, examinations and treatment depending on the required level of privacy because the building does not allow for private activities with patients.

- **Customers/Consultants:**

Receives mostly Zulus, diverse cultures including tourists.

Approximate number of people per day: 15

- **Fees:**

Approximate income per day : R 200.00

Rent per month : R 77.00

- **Rooms and Facilities Required:**

- i. Storage space/room (with controlled temperature)
- ii. preparation room
- iii. consultation room

Water supply to improve hygiene.

Electricity for ease of cooking/ preparation of medicine.

Ablutions are not enough for patients and staff.

- **Spatial Setting & Temperature Requirements:**

Outdoor areas for drying of medicines. (sun)

Quiet private space for consultation with maximum light.

NOTE:

Attire/ outfit of a healer is determined by ancestors through a dream and should be worn at all times during consultation.(to connect with the ancestors

Interviewee(s): **Miss M. Khuzwayo**

Occupation : **Teacher**

Of : ***Durban Herb Traders' Committee***

Place : **Durban**

Date : **22 March 2007**

- **Role of the Teachers:**

Some of the healers and assistants do not have formal education; the teachers employed by the management provide a platform for them to improve their education.

Courses include:

- English
- Basic Mathematics
- Packaging, hygiene and neatness

English courses are a demand especially since healers have a lot of tourists coming to buy or research muthi.

The idea of having formal education was initiated by izinyangas themselves.

Packaging of medicines is part of the education.

- Some traditional healers are very clean and hygienic.
- Most of them become more hygienic as they become more educated, lack of education is therefore a huge cause of untidiness and lack of hygiene. (given guidance – there is no doubt that all indigenous healers are hygienic.)

Classes and Times:

ATTENDANCE: 2 days per week

2 hours a day

NB: izinyanga are only available at certain times of the week (consultation times) and they have assistants employed to do the actual trading/running of the shop.

Observation:

Most learners are young people from disadvantaged backgrounds who do not have formal education.

- They work as assistants of izinyanga.
- They are taught communication skills and other useful skills such as writing a c.v as they are being prepared for better job opportunities.