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The public health response to 'do-it-yourself' urbanism

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Commentary

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Abstract: Greater understanding of the important and complex relationship between the built environment and human health has made 'healthy places' a focus of public health and health promotion. While current literature concentrates on creating healthy places through traditional decision-making pathways (namely, municipal land use planning and urban design processes), this paper explores do-it-yourself (DIY) urbanism: a movement circumventing traditional pathways to, arguably, create healthy places and advance social justice. Despite being aligned with several health promotion goals, DIY urbanism interventions are typically illegal and have been categorized as a type of civil disobedience. This is challenging for public health officials who may value DIY urbanism outcomes, but do not necessarily support the means by which it is achieved. Based on the literature, we present a preliminary approach to health promotion decision-making in this area. Public health officials can voice support for DIY urbanism interventions in some instances, but should proceed cautiously. (Global Health Promotion, 2017; 24(3): 68–70)

Keywords: public health, urban planning, urban health, urbanization, policy, politics

Introduction

Public health officials (PHOs) applaud 'health promoting' planning and urban design interventions, particularly in marginalized, economically distressed neighborhoods, as such interventions can foster healthy behaviors and greater community cohesion (1). Research on these healthy built environments (HBE) that has examined the role of PHOs has largely focused on how public health can influence traditional built environment decision-making pathways: namely, municipal land use planning, architecture and urban design processes (2). This paper explores an alternate approach being used to improve urban environments around the world: do-it-yourself (DIY) urbanism.

In developed and developing cities across the globe, the built environment is being changed by vigilante citizens. Without permits or permission, citizens paint bicycle lanes and crosswalks, convert parking lots into recreation spaces and turn vacant lots into vegetable gardens (3,4). These interventions (and others), collectively known as DIY urbanism, are most often carried out in response to a lack of action by the government.

DIY urbanism interventions have been shown to positively transform their surroundings, often yielding health and social benefits for marginalized populations (5). As outlined in the Ottawa Charter (1986), DIY urbanism efforts fulfill one of the five identified core strategies for health promotion, as they represent a form of citizen action to create supportive environments for health (6). Further, the

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community engagement fostered by DIY urbanism efforts is one important element of this movement that contributes to its positive health-promoting effects. Nevertheless, when these changes are implemented in contravention of the law, it is civil disobedience. How then should public health agencies relate to these activities? Noted public health scholar Dr. Alfred Sommer reported that leaders in health should 'follow most, but not all, of the rules' when approaching complex issues (7). Similarly, as Bason reported (8), 'sometimes, to innovate, we need a good dose of civil disobedience'. Further, Wynia (9), in an examination of the relationship between civil disobedience and medicine, concluded 'when used within [a] professional framework, civil disobedience is a tool for repairing, not tearing, the social fabric of a good society.' In addition, some argue that these interventions create the opportunity for meaningful dialogue: 'the state should enter into dialogue with civilly disobedient citizens, whether that dialogue takes the form of police negotiations, judicial communications of censure or political debates about contested law and policy' (10). We believe this sort of dialogue could be used by PHOs. For example, when health-promoting DIY urbanism occurs, PHOs could assemble and support those involved to pursue legal means of improving the built environment.

Support for public health practice

From our review of the DIY urbanism literature, it appears PHOs face two considerations regarding DIY interventions:

1) Should PHOs get involved when a DIY urbanism intervention occurs within their jurisdiction?
2) If involved, what type of action is most appropriate and effective?

Our preliminary approach to decision-making in public heath addresses the first question by posing key questions related to population health impact, as well as the community and bureaucracy response to the intervention. The approach makes four assumptions: (i) PHOs should voice support for interventions that advance HBEs in their community and object when interventions risk creating unhealthy environments; (ii) public health agencies should avoid unnecessary risk; (iii) public health agencies have limited resources; and (iv) PHOs should not oppose all civic disobedience. Guidance regarding the second question is still unclear and, we argue, largely contextual.

Population health impact

The first question in the preliminary approach requires PHOs to determine whether the intervention will have a net positive or negative impact on population health. To do this, PHOs could adopt a population health perspective and consider the 'prevention paradox' as it applies to DIY urbanism, where some interventions that benefit a whole population may not necessarily benefit the individuals of that population, or may even cause harm (11). PHOs could also consider the prevention paradox as it relates to population values. Deslandes reported examples from Detroit (12), where citizens who are engaged in DIY urbanism may reflect white middle-class values as opposed to the values of the largely impoverished African-American population, further marginalizing this population.

A health impact assessment (HIA) may aid PHOs in determining the population health impact of a DIY intervention. HIA is a set of instruments involving 'a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population' (13). PHOs would also be wise to consult stakeholders and colleagues in related fields who have built environment expertise. Once the PHO has formally or informally considered the population health perspective, they should have a general idea of the intervention's net outcome.

Community/bureaucracy response

Next, PHOs could gauge the community and municipal bureaucracy response to the intervention. Through examples reported in the literature, there appear to be three possible responses: the community and bureaucracy may agree in (i) rejecting, or (ii) permitting the intervention, or (iii) they may have conflicting responses. These responses can be determined by monitoring media coverage (e.g. public protests), civic meetings and community

meetings. It may again be useful to consult stakeholders and colleagues in other fields to determine the response; however, we suggest that behaviors and artifacts are stronger indications of the response.

Action or no action

We suggest there are two scenarios where PHOs should act: (i) where a DIY intervention with a net positive population health impact is being rejected, and (ii) where a DIY intervention with a net negative population health impact is being permitted. The rationale for action is tied to the first assumption: PHOs have a mandate to advance HBEs. When there is disagreement between the community and bureaucracy responses, we suggest PHOs align with the bureaucracy's stance and defer to their public sector colleagues' expertise. Until further research is done, each PHO will need to exercise judgment as to which action(s) will be most effective and appropriate given the circumstances.

Conclusion

DIY urbanism creates a challenging scenario for PHOs who may be aligned with the goals of a DIY intervention, but not with the illegal means by which they are being implemented. We have presented a simple decision-making approach to assist PHOs, based on a consideration of both the population health impact and the community and bureaucracy response to each DIY intervention. Our presented approach to decision-making in health promotion and more broadly in public health under these circumstances is based on a small body of literature and represents a cautious strategy. More research is needed to know how best to support PHOs in this novel area.

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Conflict of interest

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References

1. Dannenberg AL, Frumkin H, Jackson RJ. Making Healthy Places: Designing and Building for Health, Well-Being, and Sustainability. Washington: Island Press; 2011.
2. Jackson RJ, Dannenberg AL, Frumkin H. Health and the built environment: 10 years after. Am J Public Health. 2013; 103: 1542–1544.
3. Keffer R. DIY urbanism: testing the grounds for social change. SPUR. 2010; Sep: 496. Available from: www.spur.org/publications/article/2010–09–01/diy-urbanism (accessed February 11, 2015).
4. Ho CL. Spontaneous interventions: design action for the common good. Architect. 2012: 20.
5. Pagano C. DIY urbanism: property and process in grassroots city building. Marq Law Rev. 2013; 97: 335–469.
6. Ottawa Charter. Ottawa Charter for Health Promotion. Health Promotion Int. 1986; 1: ii–v.
7. Sommer A. Ten Lessons in Public Health: Inspiration for Tomorrow's Leaders. John Hopkins University Press; 2013, p.31.
8. Bason C. Leading Public Sector Innovation: Co-creating for a Better Society. Bristol: The Policy Press; 2010, p.252.
9. Wynia M. Civic obligations in medicine: does professional civil disobedience tear, or repair, the basic fabric of society? Virtual Mentor. 2004; 6. Available from: http://virtualmentor.ama-assn.org/2004/01/pfor1–0401.html (accessed February 11, 2015).
10. Smith W. Civil Disobedience and Deliberative Democracy. New York: Routledge; 2013.
11. Rose G. Strategy of prevention: lessons from cardiovascular disease. Br Med J. 1981; 282: 1847–1851.
12. Deslandes A. Exemplary amateurism: thoughts on DIY urbanism. Cult Stud Rev. 2013; 19: 216–227.
13. European Centre for Health Policy. Health Impact Assessment: Main concepts and suggested approach. Brussels: European Centre for Health Policy, 1999.