Architecture_MPS

UCLPRESS

Special issue: ***Historical narratives of public health in the built environment***

Editorial

‘Unprecedented times’: historical narratives of public health in the built environment

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Publication date: 4 April 2023

How to cite
Hipwood, T. and Lee, S. ‘“Unprecedented times”: historical narratives of public health in the built environment’. *Architecture_MPS* 24, 1 (2023): 5.
DOI: https://doi.org/10.14324/111.444.amps.2023v24i1.005.

Peer review
This article has gone through editorial review.

Introduction

To say we are living in ‘unprecedented times’ has, in the last two years, become trite or banal. Yet, while the coronavirus that spread in early 2020 was novel, as the articles in this special issue demonstrate, the way the subsequent pandemic fundamentally challenged our understandings of the appropriate design, governance and inhabitation of the built environment, was far from unprecedented. Adopting a historical perspective, each of the following articles analyses how a major event such as fire, war or disease, shifted the interactions between public health and the built environment.

Impacts of Covid-19

Covid-19 was characterised as a global pandemic on 11 March 2020.[1] In the months that followed, as scientists worked to develop a vaccine, social distancing was widely adopted to reduce the spread of the virus. Our city centres emptied, and the suburbs received renewed appreciation for the lower density of occupation and greater exposure to nature and green space they afforded.[2] At building level, the suitability and adaptability of homes was re-evaluated as they were forced to accommodate not only established practices of dwelling, but also to provide opportunities for homeworking, schooling and online socialising.[3] Shared, or public, buildings and spaces became an assault course of virus-harbouring surfaces to be negotiated, resulting in increased interest in the antibacterial properties of sunlight.[4]

As measures to reduce the spread of the virus, such as lockdowns and mandatory mask wearing were enforced, attention increasingly turned to how the burden of these measures, and the impact of the virus more broadly, was not equally distributed. With many people confined to their homes, inequalities in housing were more keenly felt, raising concerns about overcrowding,[5] fuel poverty[6] and mental health and wellbeing.[7] With a significantly higher death toll among communities from minority ethnic backgrounds,[8] attention was drawn to the social and environmental influences that might impact upon the increased vulnerability of these groups. This also included a historically justifiable distrust of vaccinations in these communities, as well as other measures to prevent the virus spreading.[9]

Built environment and public health

The fields of public health and built environment share a long and intertwined history, both emerging out of a desire to control disease and improve health among urban populations,[10] with developments in the built environment often arising out of shifts in paradigms of health. By the middle of the eighteenth century, a growing recognition of the role the environment played in human health led to the British Public Health Act of 1848[11] and the subsequent Garden Cities movement by Ebenezer Howard.[12] As the driving ideology in public health later shifted to germ theory, and by the 1960s to a biomedical model, progress in health management shifted 'inward', and health issues were addressed as constituent parts, rather than in relation to the built environment.[13] This resulted in zoning land-use strategies separating residential areas from industrial zones, and dependence on mechanical and artificial systems of ventilation, heating and lighting. A more holistic approach to health promotion has only recently remerged as many countries shift from disease control to prevention of chronic conditions, including mental health concerns.[14] A historical perspective on these interactions between public health and the built environment can inform how we design, govern and occupy the latter. Each of the following articles offers a detailed analysis of a health crisis, identifying persistent themes we should be cognisant of as we move forwards in the wake of a global pandemic.

In her analysis of the 1883–1947 cholera epidemics in Egypt, Alexandra Schultz[15] describes how, in its policies to control the epidemics, the British colonial government clung to obsolete paradigms of health that obviated the need for investment in infrastructure and supported existing prejudices against the Egyptian people. The paper describes the acts of resistance performed by the Egyptian people in response to discriminatory health practices, drawing important links with resistance to Covid-19 control measures in communities where trust in government has been broken.

Similar disparities of care are evident in Nicholas Clarke's investigation[16] into the impact of the Spanish Flu pandemic of 1918–19 on the architectural history of healthcare in South Africa. While previous epidemics had disproportionately affected poor, black, marginalised communities, wealthy white populations did not escape the Spanish Flu epidemic. Clarke's article describes how these more affluent communities developed facilities to care for their own, importing contemporary ideas regarding efficiency, ventilation and sunlight. These ideas would persist until after the Second World War, when increasingly state-controlled 'health factories', employing modernist architectural language, would prioritise racial segregation and efficient systems over holistic approaches.

The merging of modernist architectural principles with an interdisciplinary approach to mental healthcare is also a theme within Christina Malathouni's study[17] of two admissions units that were added to existing mental health hospitals in post-war England. Their emphasis on access to the outdoors and social interaction as part of a wider psychosocial approach to mental health persists to this day, and

https://doi.org/10.14324/111.444.amps.2023v24i1.005

has been emphasised by the negative impacts of social distancing and lockdowns in response to the pandemic.

Finally, Susan Brandt and Anne Marie Sowder[18] analyse a series of tragic social club fires in New York between 1970 and 1990. Placing these tragedies in the political and bureaucratic context of the time, they identify the challenges to enforcing safety regulations, especially in marginalised communities. These issues remain current, both directly in relation to fire safety in the wake of the Grenfell Tower fire and subsequent inquiry,[19] but also in the wider context of mitigating risks to participants as we return to mass gatherings.

Significance

While paradigms of health and associated treatments may change, as these articles illustrate, many of the issues associated with historical interactions between healthcare and the built environment remain relevant to this day. As you read these articles, we invite you to consider the following questions: How can trust in the state's management and enforcement of public health regulations be repaired in marginalised communities? How can international cooperation between clinicians and scientists be maintained in the wake of the pandemic? What can previous global traumas teach us about how we address our current mental health crisis?

Notes

[1]World Health Organization, 'A timeline'.
[2]Kollewe, 'UK office demand "shifting to the suburbs"'; Lerner, 'Choosing the suburbs'.
[3]Hipwood, 'Adapting owner-occupied dwellings in the UK'; Duque-Calvache, Torrado and Mesa-Pedrazas, 'Lockdown and adaptation'.
[4]Ratnesar-Shumate et al., 'Simulated sunlight'.
[5]National Housing Federation, 'Poor housing causing health problems'.
[6]Cuerdo-Vilches, Navas-Martín and Oteiza, 'Behavior patterns'.
[7]Hamoda et al., 'Addressing the consequences'; Quaglieri et al., '"Stay at home" in Italy'.
[8]Office for National Statistics, 'Updating ethnic contrasts'.
[9]Hull, Stevens and Cobb, 'Masks are the new condoms'.
[10]Hu and Roberts, 'Connections and divergence'.
[11]Abrams et al., *Making Healthy Places*.
[12]Howard, '"Author's introduction"'.
[13]Hu and Roberts, 'Connections and divergence'.
[14]Hu and Roberts, 'Connections and divergence'.
[15]Schultz, 'Preserving home'.
[16]Clarke, 'Disease and design'.
[17]Malathouni, '"In line with the modern conception"'.
[18]Brandt and Sowder, 'Contextualising tragedy'.
[19]'Grenfell Tower Inquiry'.

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