This concern with cities as a theoretical and real object of study is found in his presidential address for the Population Association of America, "Population Density and the City" (1972). Here Hawley makes the point that social density and spatial density are increasingly separated, with emphasis on the increasing importance of social density. This emphasis keeps with the theme of the primacy of organizational over spatial aspects.

This work also suggests Hawley's increasing interest in the study of change itself, which culminates in his 1978 Presidential Address at the ASA, "Cumulative Change in Theory and in History." Here Hawley carefully explicates types of change and argues that the study of change in social systems should focus on patterns that are nonrecurring and irreversible because these two patterns lead to accumulation of further change.

Although retiring in 1976, Hawley continued to serve actively as mentor and adviser on theses, dissertations, and independent study, shaping several generations of students. His scholarship continued, unabated, resulting in additional explorations of human ecological theory (see "Human Ecological and Marxian Theories," 1984) and a number of influential edited volumes. These volumes brought together macrosocial researchers to encourage, shape, and expand ecological approaches on such topics as the analysis of social change, nonmetropolitan change, metropolitan trends, and environmental issues.

During this time period, Hawley pursued his final sociological book, a culminating work of the essence of his approach to ecological theory: *Human Ecology: A Theoretical Essay* (1986). In his more recent reflective essay, "The Logic of Macrosociology" (1992), Hawley notes the completion of his neo-orthodox revolution in human ecology shifted interest from spatial patterns to the change, functioning, and structure of the social system in environmental context and as a result, "Human ecology takes its place as one of several paradigms in the inclusive field of sociology."

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See also Factorial Ecology; Human Ecology; Urban Sociology

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Healthy Cities

Healthy Cities is a worldwide movement developed by the European office of the World Health Organization. It has been implemented formally through WHO in many cities, and others have adopted the model. Grounded in 11 qualities that range from housing to economy and social characteristics such as a supportive community, Healthy Cities goes well beyond the definition of health as an absence of disease. This entry looks at its development and implementation around the world.

Historical Context

Population health and urbanization have been inseparable twins since the dawn of humankind. Cohen,

in his 1989 masterpiece of paleo-epidemiology, demonstrates that the shift from nomadic to sedentary and eventually urban lifestyles impacts on occurrence of disease. Still, rural etiology and population pathology differ considerably from urban patterns. Urban organization, on the other hand, allows for different types of interventions, and it is no surprise that the emergence of modern public health can be traced back to urbanization (from public toilets in ancient Rome to sewage systems in industrializing Britain, and from city-state "Health Police" in medieval Germany to surveillance systems in contemporary megacities). In the late 1990s, Porter and Hall even maintained that the shape of twenty first-century cities is dictated by health considerations.

Clearly, they find that modern public health is a direct result of sanitarian programs emerging in mid-nineteenth-century industrializing nations. The Health of Towns movement in Britain (established in 1844) is a direct precursor to Healthy Cities. Modern cities, however, seem to have failed to recognize the most recent shifts in health and disease patterns and their unique potential urban assets to address these.

The etiological shift has moved from predominantly parasitic to microbial infectious and currently chronic diseases; public health interventions have moved from surveillance (such as quarantine) via high-tech pharmaceutical and other clinical interventions to addressing social determinants of health (e.g., inequity and community development). Urban environments are uniquely impacted by such social determinants but are also in a historically unparalleled position to deal with them.

This was recognized as early as 1963 by Duhl and colleagues. In describing what would later become the Healthy Cities movement, they laid down the tenets for analysis and intervention in, for, on, and with social, natural, economic, and built urban environments for the promotion of human and ecosystemic health.

Foundations

The first city to truly adopt these principles became Toronto, more than two decades later (1984). In a serendipitous confluence of global and local developments, the city celebrated emergent emancipatory health promotion approaches by the World Health Organization (WHO) and a decade of innovation in Canadian health policy (the Lalonde Report); its leaders had the ambition to take a radical stance on the health of city dwellers.

The model was quickly taken up by the European Office of WHO, engaging Duhl and Toronto health entrepreneur Hancock to launch an urban health demonstration project. In collaboration with a small group of European cities, they developed 11 qualities a healthy city should attempt to achieve:

1. a clean, safe physical environment of high quality (including housing quality)
2. an ecosystem that is stable now and sustainable in the long term
3. a strong, mutually supportive, and nonexploitive community
4. a high degree of participation and control by the public over decisions affecting their lives
5. the meeting of basic needs (food, water, shelter, income, safety and work) for all people
6. access to a wide variety of experiences and resources, for a wide variety of interaction
7. a diverse, vital, and innovative city economy
8. the encouragement of connectedness with the past and heritage of city dwellers and others
9. a form that is compatible with and enhances the preceding characteristics
10. an optimum level of appropriate public health and sick care services accessible to all
11. high health status (high levels of positive health and low levels of disease)

The original ambition of WHO to run a small-scale demonstration project exemplifying the potential of urban administrations to deal with late twentieth-century health and disease demands was quickly challenged by its enormous popularity. Within the first five years, hundreds of European cities had expressed an interest in joining the project, and cities outside Europe used guidelines to establish their own. This put a demand on WHO at a global level. In Europe, a small group of WHO-designated cities (meeting strict entry requirements into the project) were to be hubs for national, language-, or topic-based networks of Healthy Cities.

International Exemplars

The initiative continued to be popular in Australia and Canada; in Central and South America, it easily linked with WHO policy on SILOS (Sistemas Locales para la Salud—Local Health Systems) and the Healthy Cities equivalent in the Americas became Healthy Communities. Japan has had a long-standing relation with Healthy Cities, with Tokyo taking an early lead in the 1980s. A broad range of groups, agencies, and communities associates itself with Healthy Cities, from national networks and Agenda 21 initiatives mostly in Europe, the Civic League in the United States, a global International Healthy Cities Foundation (www.healthycities.org) providing a clearing house function, and the Asian–Pacific Alliance for Healthy Cities (www.alliance-healthycities.com). In some counts, there are close to 10,000 Healthy Cities worldwide, the smallest reputedly being l'Isle Aux Grues (Canada, population around 160) and the largest metropolitan Shanghai (China, population in excess of 20 million).

Ever since the initiative was formally launched in 1986, it has been subjected to an evidence-based health paradigm, asking whether Healthy Cities actually deliver health. This is a highly contentious issue, as a core tenet of the paradigm that embeds the movement is that health is not the absence of disease but a resource for everyday life. It is created by individuals and communities and heavily determined by public and corporate policy. It is therefore no surprise that the 11 qualities listed above have been translated by Healthy Cities into an enormous range of actions, themes, and interventions. Sofia (the Bulgarian capital) was a member of the movement for a short while in the late 1980s and used its designation to upgrade the public transport system. Liège (Belgium) addresses the high prevalence of antidepressant use by tackling general practitioners' prescription behavior while at the same time running programs in community-driven neighborhood cleanups. Kuressaare (Estonia) uses the Healthy City label to restore its tsarist-era reputation as a great spa town on the Baltic. Accra (Ghana) aims to coordinate the international aid industry's attempts to clean up its heavily polluted Korle Lagoon under the Healthy Cities banner. Curitiba (Brazil), positioning itself as an ecological city, is highly successful in generating synergy between enhanced (public) mobility, poverty reduction, and primary education. Wonju City (Korea) has established innovative programs in health promotion financing, just as Recife (Brazil) has. Noarlunga (South Australia), one of the longest running Healthy City projects in the world, has effectively addressed health inequity, multiculturalism, severe environmental degradation, and sustainability issues. Several cities around the world are involved in approaches such as community gardening, walkability, urban design, safety, and the informal economy. Virtually all cities look at equitable access to services reaching far beyond the health sector alone. An additional illustration of the range of activities that can be undertaken by a Healthy Cities initiative can be found in the directory of projects of the 199 members of the "Réseau québécois des villes et villages en santé," one of the oldest networks of such initiatives in the world situated in the province of Québec, Canada (see www.rqvvs.qc.ca/membres/realisations.asp).

Healthy Cities also has become the vanguard of other settings-based health initiatives with which the project connects locally: Healthy Marketplaces, Prisons, Workplaces, and Islands; Health Promoting Universities, Hospitals, and Schools. In itself, this is an important proxy of the effectiveness of the approach, inspiring actors and communities at many different levels and domains to be engaged with a social model of health.

Quite apart from the formal Healthy Cities movement, there is increasing attention to the impact of urban planning and design on parameters for health. This increase could be attributed to Healthy Cities, but more important, it will provide new impetus to the movement: The evidence that physical activity is directly affected by urban design parameters has become a high political priority in the early twenty-first century, when the obesity epidemic is predicted to *decrease* future population life expectancy for the first time in history. There is general agreement that the belief that the epidemic can be tackled in behaviorist manners is untenable now and that community-based, integrated, institutional, systemic, and hardware solutions must be sought—precisely the Healthy Cities tenets launched over 40 years ago.

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See also Sustainable Development; Urban Climate; Urban Planning

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Heritage City

The notion and designation of the Heritage City conflates two distinct concepts: city and heritage. City status involves not just size but symbolic importance as well, with the latter a function of history and institutional and political processes. Royal charters, cathedral cities, provincial and administrative cities, and capital cities are all examples. Heritage, on the other hand, is a more recent and fluid concept open to contestation. It involves interpretation of a legacy from the past and therefore requires the identification and valorization of an authentic provenance. This is commonly manifested in terms of buildings, monuments, the physical environment, and artifacts and occurs through individual and group collective memory. Heritage, therefore, is sometimes passed down from previous generations and is of special value and thought worthy of preservation. Who controls this preservation and valuation process and what relationship such heritage has to the city—spatially, culturally, and symbolically—are of increasing concern and debate. The commodification of heritage assets creates economic benefits that accrue to property interests and the heritage tourism industry. Heritage has, therefore, moved from a benign, specialist concern to a central role in city branding and the promotion of the city to its citizenry and to the outside world.

Selectivity is key to heritage planning. A dichotomy exists between the original positivist *preservation* and the normative *heritage,* which implies a process of selection and conservation of history, memory, and relics, as well as their interpretation for contemporary consumption. The concept of *heritage,* which encompasses all historic and style periods without exception, is different from *tradition,* which is only a component of the former and requires a choice be made by (or more often, on behalf of) the public and by certain social classes. Heritage in both of these senses is socially produced.

Heritage as represented in art and architecture is also subject to assessment and valuation by the scholarly canons of art history and through codification and curation and the symbolic importance attached by heritage experts. Although such designation has been dominated by classical and iconic styles represented by historic monuments, castles, churches, cathedrals, palaces, museum quarters, and their collections—*grand projets* of the past—more recent heritage has begun to appear in designation and preservation movements. The importance of visible clues that anchor the development of cities to the past typifies the current desire to reconcile modern development and change with remnants of the city's past. This also reflects the wider democratization of social history or urban archaeology; that is, the heritage of ordinary citizens and the everyday, for example, houses, workplaces, and leisure pursuits. Industrial and twentieth-century heritage is now subject to the preservation and value judgments applied previously to the historic. Consequently, the heritage question and heritage city branding have been applied to a wider range of sites and typologies.