1 A Holistic Vision for Sustainable Urban Health. Introduction by the Editors

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The future of cities represents one of the great challenges of the twenty-first century. Today, more than half of the world's population already lives in urban areas; by 2050, this proportion is expected to rise to nearly two thirds. This profound demographic, spatial and potentially political transformation offers opportunities for innovation, economic dynamism and cultural diversity, but it also entails challenges for global health, social equity and environmental sustainability.

In line with the World Health Organization's (WHO) definition, health is a state of complete physical, mental and social wellbeing. In the urban context, it also serves as an indicator of the resilience of both a city and its inhabitants, as well as a strategic lever for sustainable development. However, health is more than the mere absence of disease. A holistic understanding of health encompasses physical, mental, social, cultural and ecological dimensions. The philosopher Hans-Georg Gadamer described health as a 'feeling' of being able to do what one wishes to do and is capable of doing. In this sense, a person – or even a population – 'feels good' in a healthy city.

Promoting sustainable and healthy cities requires an integrative perspective that extends far beyond the remit of any single sector and embraces a 'Health in All Policies' approach to urban governance. Urban planning, architecture, environmental and climate protection, mobility, social infrastructure, education, public health and health care, food systems, digital transformation, cultural participation, economic resilience and mental health are all inextricably interconnected and directly or indirectly linked to health. Sustainable solutions can only emerge when these fields are addressed collectively within a holistic systems approach to urban governance, grounded in scientific evidence and informed by evidence-based decision-making.

The interdisciplinary nature of urban health requires dialogue and collaboration across scientific disciplines, institutions and sectors. Scientific academies and international networks can contribute to such exchanges by bringing together expertise from different fields, facilitating transdisciplinary dialogue and supporting the development and communication of evidence-based knowledge. International cooperation among scientific institutions can also help to connect research findings and experiences from different regions and make them accessible for broader scientific and public discourse.

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Global frameworks such as the United Nations Sustainable Development Goals (SDGs), the WHO Healthy Cities programmes, the New Urban Agenda and the strategic guidelines of UN-Habitat, together with the analyses and recommendations of the Lancet Commission on Healthy Cities, clearly demonstrate that urban health is a cross-cutting issue that affects all major areas of policy, science, architecture and engineering. This broad spectrum extends from the design of public spaces and the promotion of active mobility to the protection of natural resources, the reduction of health inequities, the equitable distribution of economic opportunities and the strengthening of cultural identity.

It should be self-evident that frequently used terms and concepts such as Planetary Health and One Health must be aligned if we are to develop a truly holistic conceptualisation of how best to achieve urban and global health. Urban health may even be regarded as an important point of entry, a guiding compass and a measure of success for all 17 SDGs. Concepts such as creative placemaking, participatory cultural projects and citizen-driven urban design have been shown to have positive effects on wellbeing, social cohesion, collective identity and democratic participation. They create spaces for encounter, dialogue and interaction among diverse population groups and contribute to strengthening the resilience of urban communities – in the broadest sense and particularly in times of crisis.

Evidence-based research demonstrates that community participation through the arts, culture and other areas of urban decision-making can have both direct health and mental health effects – such as stress reduction, enhanced subjective wellbeing and increased physical activity – and indirect effects, including the strengthening of social capital. In urban health research, such findings are gaining increasing prominence because they highlight that health promotion and disease prevention do not take place primarily in medical or clinical settings. Rather, they are frequently embedded – and must be embedded – in all spheres of urban life.

Future-oriented urban health strategies rest on co-creation and active citizen participation in governance and decision making. Involving local communities in planning and decision-making processes – not merely as recipients but as co-designers – enhances not only the acceptance of interventions but also their effectiveness. Participatory planning and community-based approaches foster social resilience, strengthen trust in public institutions, are important and visible examples of democratic processes, and enable the systematic incorporation of local needs, experiences and knowledge into the development and implementation of urban strategies.

Research findings from different regions of the world show that participatory processes are most successful when they are integrated into decision-making structures from the outset. This applies equally to health-related programmes and to cross-sectoral urban development strategies. Cities that adopt such integrative approaches to governance are better equipped to respond flexibly

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and equitably to emerging challenges, from climate change and migration to pandemics.

This publication represents the proceedings of the "International Urban Health Summit 2025" in the beautiful and inspiring environment of Herrenhausen Palace in Hanover, 9–11 April 2025. The Summit was made possible through the generous support of the Volkswagen Foundation, with additional support from the Berlin-Brandenburg Academy of Sciences and Humanities (BBAW) and the InterAcademy Partnership (IAP), and with contributions from the Virchow Foundation and Charité – Universitätsmedizin Berlin.

The meeting brought together contributions from a wide range of fields, including science, civil society, architecture, nature conservation and the arts and culture, thereby offering an interdisciplinary and cross-sectoral perspective. The diversity of perspectives assembled here is intended not only to inform but also to connect, inspire and foster concrete alliances capable of translating scientific evidence into political and societal action.

The presentation of scientific papers and contributions in the poster sessions and discussion rounds at the meeting represented a mirror of the great spectrum of topics included in the broad topic of "Health in the City". This large spectrum is also represented in the collection of papers in this publication. Some papers are quite formal, detailed and reflect the summary of extensive scientific research over a long period. Other presentations are more informal and dealt with e.g. the role of music and the arts for health in general. Some presentations and publications deal with technical aspects such as architecture, the great influence and effects of landscape and soil on the character of a city or the effects of e.g. industry and air pollution on health.

More theoretical considerations on how and where to build cities and how to plan for a better and healthier future have also been included in the scientific programme and in this publication. Major events such as the Olympic Games and World Expositions can have a profound impact on the future development of cities. Past experience has demonstrated that such events can serve as powerful catalysts for urban transformation, enabling substantial improvements in sustainability, resilience, infrastructure, and quality of life through strategic planning and long-term investment.

Such major international events can provide opportunities to foster innovation, promote the development of forward-looking infrastructure, and encourage broad societal participation in shaping the future. Their long-term value depends on the extent to which they are embedded in wider urban and regional development strategies and engage civil society, public institutions, academia, cultural organisations, and the private sector in a shared process of transformation.

In this context, major events can also provide an opportunity to make sustainable development visible and tangible through concrete projects and practical examples. When linked to long-term planning and broad public participation,

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they can contribute to the development of healthier, more resilient, and highly liveable cities and regions.

We hope that these proceedings of the meeting in Hanover will provide valuable and thought-provoking material for a global readership and, perhaps, help amplify voices that have thus far been underrepresented in the international discourse on urban health. If scientific evidence, political leadership, civic engagement, and cultural creativity can be successfully brought together within a democratic framework, cities can evolve into places that are not merely survivable, but genuinely healthy, resilient, and highly liveable—for everyone, today and for generations to come.

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2 Urban Health and Global Health. New Responsibilities. How Cities Can Step Up When Multilateralism Is Eroding: Urban Governance for Health After US Withdrawal From Global Organisations and Suspension of Foreign Aid

Ole Petter Ottersen, Detlev Ganten, Roland Göhde,
Anna Mia Ekström and Evelyne de Leeuw

The global health landscape is undergoing a transformation of seismic proportions, most recently culminating in the United States' withdrawal from the World Health Organization (WHO) and from sixty-six other global organisations, including multiple UN bodies, as well as in the dismantling of USAID and reductions in the remit of both NIH and the CDC (1–6). The erosion of multilateral governance and the retreat of major powers from international frameworks have created a historic inflection point: global health agendas can no longer be driven solely through multilateral institutions. Today, more than 50% of the world's population lives in urban areas and, according to recent UN estimates, two thirds of the world's population growth between now and 2050 will take place in cities. The attainment of the Sustainable Development Goals (SDGs) will therefore depend on cities' ability to develop their infrastructure and services. While recent commentaries have argued that regionalisation (7, 8) and greater agency in the Global South (8, 9) may emerge as positive long-term outcomes of the current turmoil in global governance, there has been limited analysis of the specific implications of urbanisation for global health or of the governance instruments that cities might deploy to mitigate and adapt to these challenges.

Drawing on emerging evidence and previous work on the political determinants of health, (10) this article examines the likely impacts on cities and proposes a pragmatic urban governance agenda to address gaps left by dysfunctions in global governance. We also seek to situate our analysis and arguments within broader scientific, political and historical perspectives, considering more general questions relating to public and global health. We argue that cities and city networks (11, 12) are well-positioned to step up in a global landscape marked by the erosion of multilateralism. The efforts of UN-Habitat and other international organisations are becoming more and more important in this situation.

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2.1 The Complexity and Evolution of Global Health: Past, Present and Future

Public health and global health are deeply complex enterprises, shaped as much by scientific knowledge as by political power, economic structures, cultural values and historical legacies. While they are often framed as technical or biomedical fields, their development reveals a continuous negotiation between evidence and ideology, national interests and global solidarity, prevention and care, and equity and efficiency. Understanding where public and global health come from – and where they may be headed – requires that they be situated within broader social and political transformations (13).

Modern public health emerged in the nineteenth century in response to rapid urbanisation, industrialisation and the devastating epidemics that accompanied them. Early public health was primarily local and national in scope, focusing on sanitation, clean water, housing and the control of infectious diseases. The sanitary movement in Europe and North America, inspired by figures such as Louis-René Villermé, Edwin Chadwick and Rudolf Virchow (14), recognised that disease was inseparable from social conditions. Virchow's famous assertion that 'medicine is a social science, and politics is nothing else but medicine on a large scale' captured an enduring truth: public health interventions are inherently political, as are the underlying causes of health inequities (10, 13, 14).

The late nineteenth and early twentieth centuries witnessed the rise of bacteriology, vaccination and the consolidation of state-based health systems. At the same time, colonialism profoundly shaped what would later come to be known as 'global health'. Health interventions in colonised regions of the Global South were often driven by imperial interests – protecting trade routes, armies and settler populations – rather than by concerns for equity or the well-being of local communities. This history left enduring legacies of collective trauma, power asymmetries, institutional structures and ethical tensions that continue to shape global health to this day (8, 15).

After the Second World War, international cooperation in health expanded rapidly. The creation of the World Health Organization (WHO) in 1948 symbolised a new ambition: health as a universal human right and a shared global responsibility. The mid-twentieth century also saw the rise of social medicine, primary healthcare and community-based approaches, culminating in the 1978 Alma-Ata Declaration, which emphasised equity, participation and the social determinants of health (16, 17). A brief review of these emancipatory developments through to the early 2000s reveals the growing complexity of planetary health challenges (18).

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2.2 The Present: Globalisation, Fragmentation and Polycrisis

Up until 2025, the public and global health landscape was shaped by globalisation, unprecedented scientific capacity, proliferation of published articles (albeit not always to our benefit (19) and a series of overlapping crises. Advances in diagnostics, surveillance, epidemiology, genomics, digital health, Big Data and implementation science have dramatically improved our ability to understand and respond to health threats. Life expectancy has increased globally, child mortality has declined and many infectious diseases are now preventable or treatable (20–22).

Yet these gains coexist with profound challenges. Health inequities persist both between and within countries, driven by poverty, gender inequality, racism, conflict and weak governance. The global burden of disease has shifted increasingly towards non-communicable diseases (NCDs), such as cardiovascular disease, cancer, diabetes and mental ill health, which are closely linked to the commercial determinants of health, including food systems, tobacco, alcohol and environmental pollution (23–25).

The 'double burden of disease', however, remains. Infectious diseases continue to pose a major threat, as starkly demonstrated by the COVID-19 pandemic. Despite efforts to strengthen global preparedness for infectious disease outbreaks (26), COVID-19 exposed not only weaknesses in surveillance, preparedness and health systems but also deep political fractures. Nationalism, misinformation, distrust of institutions and unequal access to vaccines undermined collective action. The pandemic highlighted a central paradox of global health: pathogens cross borders with ease, whereas solidarity and resources do not (27–29).

Institutionally, global health has become increasingly fragmented. Alongside the WHO and the UN, a complex ecosystem of actors – networks such as the G20 and BRICS, philanthropic foundations, public–private partnerships, NGOs, academic institutions and the private sector – now shapes priorities and funding. While this diversification has brought innovation and resources, it has also raised concerns about accountability, agenda-setting and the marginalisation of the voices of low- and middle-income countries (LMICs), not only in health but across most areas of human and institutional endeavour (8, 10, 30–32).

Public health at the national level faces parallel tensions. Governments must balance scientific advice with economic pressures, electoral politics and public opinion. Trust in expertise has eroded in many societies, challenged by populism and by the rapid spread of disinformation across borders through, for example, social media and by populist politicians. Public health is becoming an increasingly contested terrain in which evidence alone is insufficient without legitimacy, communication and democratic engagement (33–35).

Today, the global order is in turmoil. The relative stability of the highly imperfect rules-based international order has given way to growing tensions and

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