



INFRASTRUCTURE AS A SYSTEM

What our cities need next are infrastructures that
lets them care, and be taken care of.

Cities of Care : Flourishing through transitional infrastructure for females & families

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Executive Summary

How do we build cities that make it easier for people to care, recover, connect and raise families across an uncertain future?

Our project reimagines care as critical infrastructure, an evolving ecosystem shaped by the population's life cycle. Rather than viewing declining birth rates, women's health inequities, mental health challenges and social isolation as separate policy issues, we frame them as symptoms of an urban infrastructure that was never designed to support people through the realities of life.

What if the infrastructure most needed in the coming decades is not simply infrastructure that moves people, but infrastructure that enables women, families, and communities to care, connect, and thrive from within their neighbourhood?

3 Cities, 3 Futures

BELGRADE: Integration Gaps

PARIS: Unevenly Distribution

SEOUL: Society Overworked



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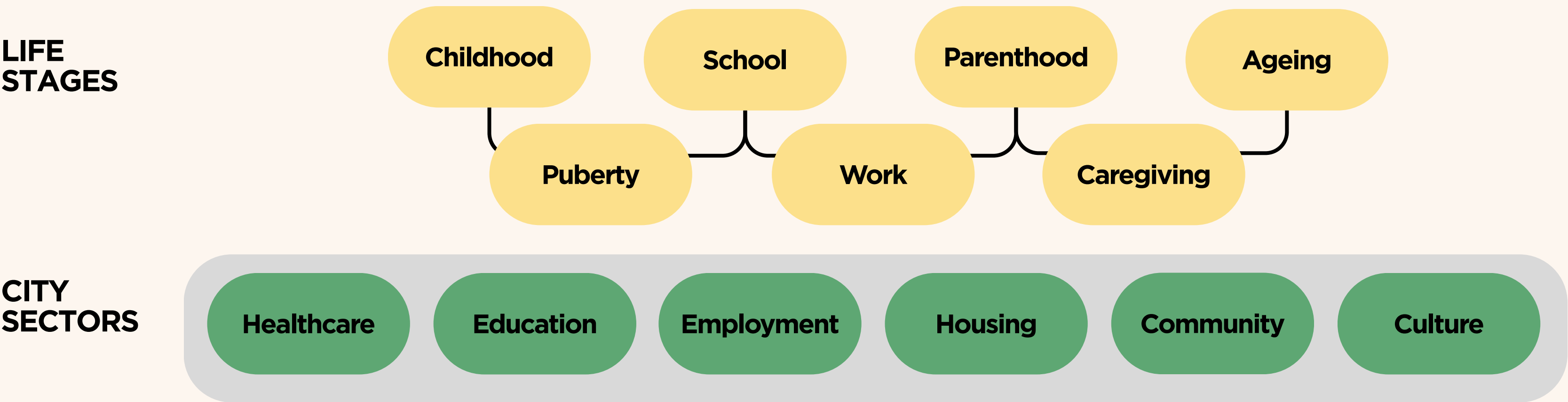


THE INFRASTRUCTURAL PROBLEM TODAY

Cities move people efficiently but were never built to support how they live.
Women's lives, moving through continuous transitions from puberty to ageing, caregiving to career, expose that gap first.
We propose care as critical infrastructure: neighbourhood-scale, shaped by the life cycle, not by institutional silos

THE PROBLEM: CITIES ARE ORGANISED AROUND SECTORS. LIFE IS ORGANISED AROUND TRANSITIONS.

Every time the life line crosses a sector boundary, there's an opportunity for support, or for someone to fall through the cracks.



Cities of today already possess extensive care assets, but remain fragmented in ownership, navigation, and continuity across life transitions. How can each layer of our infrastructure enable stewardship of care?

THE COST OF TRANSITIONS WITHOUT CONTINUITY

When no one is responsible for the transitions between sectors, individuals become the coordinators of their own care. The overall cost to wealth and health is both societal and generational, and the effects are not equally distributed, because the system has not been designed for all.

EXISTING ASSETS

- Primary healthcare
- Schools
- Libraries
- Childcares
- Employers
- NGOs
- Community centres
- Digital services

PERSISTENT GAPS

- No continuity across life transitions
- Fragmented navigation
- Reactive, with delay in response
- Weak neighbourhood integration

Care coordination is placed upon the individual.

OUTCOMES

INDIVIDUAL

- delayed diagnosis and recovery
- poorer mental wellbeing
- lower agency

COMMUNITY

- weaker social cohesion
- caregiver burden
- reduced resilience

SOCIETY

- lower workforce participation
- higher healthcare expenditure
- intergenerational disadvantage

WOMEN PAY MORE

- Social isolation
- Undiagnosed health issues
- Declining birth rates

FRAGMENTED CARE COSTS THE ECONOMY.

Women carry 55% of years lived with disability despite men having slightly higher total DALYs. Women aren't dying more, they're living in worse health longer (NASEM, 2025).

Closing the health gap is an additional \$1 trillion global GDP/year by 2040, with ~137M women back in full-time-equivalent work. Every \$1 invested in women's health returns ~\$3 in economic growth (WEF, 2024)

INVISIBLE KNOWLEDGE: WHAT CURRENT INFRASTRUCTURES IGNORE

Women's health conditions and caregiving labour are common, real, and measurable, but chronically undercounted by the systems meant to respond to them. This is not because the data doesn't exist, but because no single institution is designed to register it until it becomes a crisis.

WOMEN'S HEALTH

REPRODUCTIVE HEALTH

PCOS affects 6–13% of women globally; an international survey of 1,385 women found over a third spent more than 2 years and saw 3+ providers before diagnosis, with two-thirds dissatisfied with the process. (Gibson-Helm et al., 2017)

Endometriosis/adenomyosis: average diagnostic delay of 10 years (endometriosis) and 11 years (adenomyosis) in a cohort of ~6,950 women in France (Breton et al., 2026)

POST-PARTUM DEPRESSION

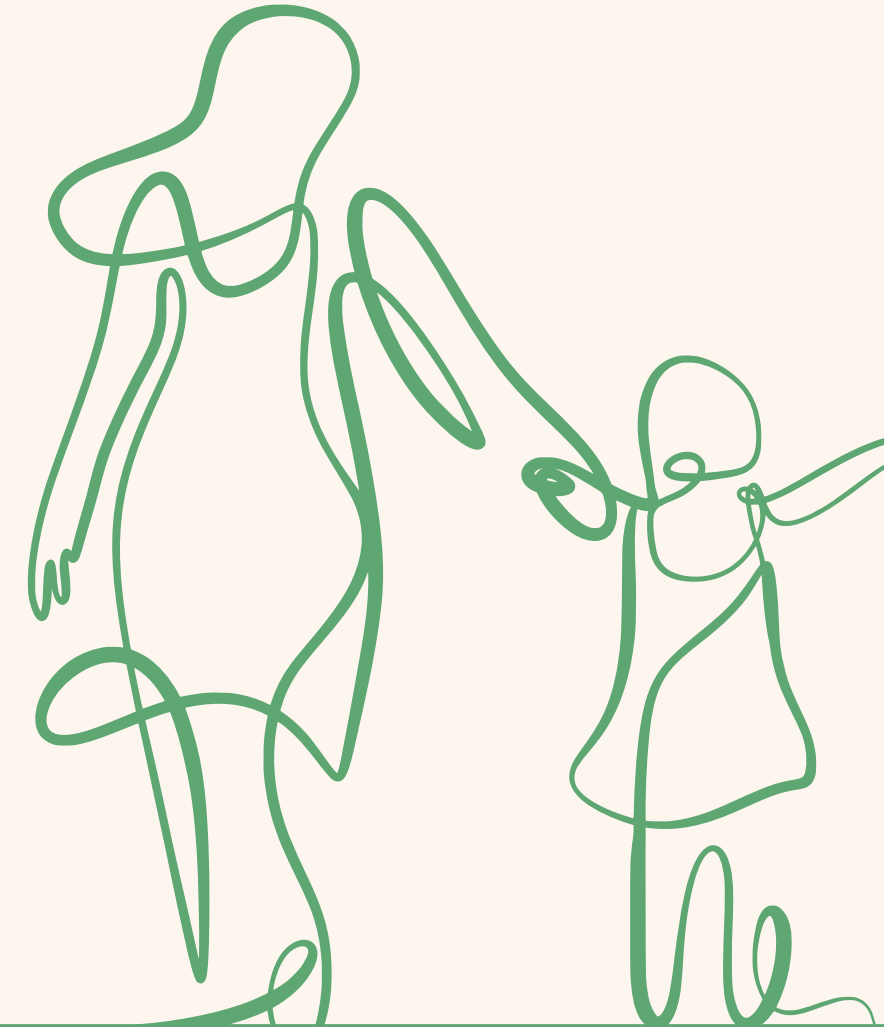
Global pooled prevalence of 17.22% across 565 studies from 80 countries. (Wang et al., 2021)

MENOPAUSE

1 in 10 UK women aged 40–55 working through menopause have left a job because of symptoms, a further 13% considered it; menopause costs the UK ~14 million working days a year. (GOV.UK, 2024)

CAREGIVING

- Women perform 76.2% of the world's unpaid care work, averaging 4h25min vs. men's 1h23m daily. (ILO, 2018)
- 708 million women are outside the labour force worldwide due to unpaid care responsibilities – 45% of all economically inactive women, vs. 5% of men. (ILO, 2024)



The systems lens: Reinforcing loops

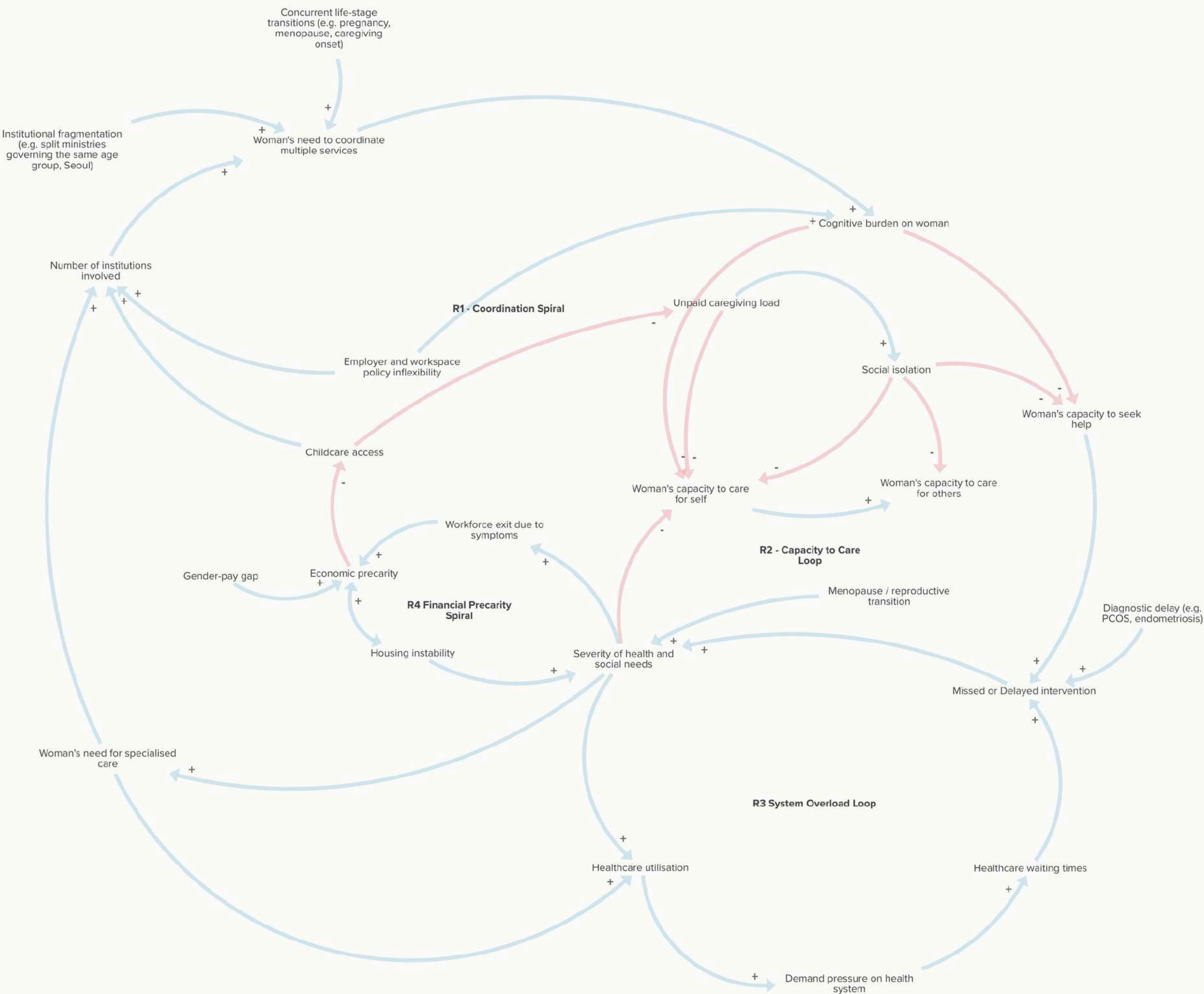
Fragmentation compounds. When no one owns the handoff between institutions, the burden a woman carries today becomes the crisis she faces tomorrow.

Four interlocking cycles, one root cause: a coordination burden that starts with the individual (R1) erodes her capacity to care for herself and others (R2), overwhelms the health system that was supposed to help (R3), and drains the financial security she needs to weather it (R4). None of these loops exist in isolation, each one feeds the others, which is exactly why fixing one institution at a time hasn't worked.

Legend

Adds to / same direction

Subtracts from / opposite direction



Design Principles & Methods

What does it mean to create a network of centres of care that can adapt to the uncertain futures ?
Our goal is to connect the dots, from the bottom-up, activating individual & collective agency and bringing transitional awareness to the systems that help them.

We design for impermanence, movement, and portability:
modular, scalable, flexible, reversible, low-cost set-ups adaptable to available environments

Physical Modularity

We design with understanding of what women, children, and family need developmentally in each stage of their lives, to ensure physical and mental health is cared for.

Biological Consistency

We design for trust, connection and revitalising the 'village':
lowering barrier of access, third spaces for organic exchange, and local network-based expansion

Sociocultural Connectivity

We design as a way of sensing and shifting with living ecosystems, and rather than blindly and reactively. We proactively map and respond to constantly changing system needs, resources, and opportunities.

Systems Awareness

PROJECT VISION

Enabling every layer of care stewardship, for life's transitions

Care is critical infrastructure that we design for, like transport or energy. Successful infrastructure is care embedded in daily life, not a separate errand. Individuals, communities, and civic systems are interdependent in providing the care required.

WEAVING INFRASTRUCTURES

Care navigation, stewardship governance, partnerships, funding-financing, trust-building protocols, education and training

Soft & Cultural

Neighbourhood proximity space, mobile units, digital coordination, life-cycle management, wayfinding

Hard & Technical

TO SUPPORT LAYERS OF CARE STEWARDSHIP

Personal

The individual and their families

Community

The local network that activates
Neighbourhood, schools, libraries, GPs, NGOs & employers

Civic

Ensures the network exists & performs
Municipality, health authority, funding bodies, policy



THE SOLUTION SPACE / HARD INFRASTRUCTURE

The Proximity Space: A Distributed Network

Inspired by the 15-minute city, the Proximity Space network ensures every woman can access essential, quality care within neighbourhood reach.

Embedded in the city

Instead of one central clinic, Proximity Spaces are integrated across the city in existing public spaces

Convenient Care

Care is brought closer to women reducing the need to travel across the city; childcare assistance is provided during the sessions

Social infrastructure

Places where women can regularly meet and build lasting support networks.

Mobile & Satellite Reach

Mobile units extend the same core team into thinner-density areas on a rotating schedule; app coordinates in-person and online practitioner & community meetings



IN THE PROXIMITY SPACE

- 1 shared space, 3 core professionals: women's health, mental health, childcare
 - A childcare zone
 - A private consultation area
 - A self-service access point: contraception, pregnancy tests, menstrual products, etc
- A digital/telehealth point: where the app handles booking, reminders, and lets her care history follow her between the navigator and any specialist she sees
- Active community programming with workshops and peer groups

THE SOLUTION SPACE / SOFT INFRASTRUCTURE

What makes the Proximity Space work?

Soft infrastructure turns a shared room into a system a woman can trust and move through more than once.

HUMAN

Role of Care navigation

An invisible '4th role' shared by practitioners, matched by fit of need at first contact. they coordinate for continuity in referrals and follow-ups across the patient's transitions. 35-40 caseload per person.

Trust-building protocols

Drop-in hours available to lower 'patient' barriers, consistent staff presence, and explicit confidentiality to what is shared. Feedback is frequently captured, & word-of-mouth recommendations encouraged.

Warm-Handoffs

When a referral is needed, the navigator introduces her to the next provider directly by phone or video whenever possible, ensuring follow-up.

TECH

Data continuity and research enablement while preserving privacy

Shared and secure databases that allow for viewing, updating of medical records between primary care practitioners and the Proximity Space is key. This enables effective coordination of care. Willing participants can share data without revealing sensitive information to participate in related studies, bridging the research gap.

App & web-enabled community and practitioner activation and accountability

While physical systems are preserved for those without access, individuals can find in-app/web guidance and reminders post-consultation, book or request services, connect to nearby community groups to meet & discuss on women's and family health, as well as explore other practitioners and related services in their area. The virtual layer allows for organic, forum-like exchange and telehealth support.

THE SOLUTION SPACE / BETWEEN HARD & SOFT INFRASTRUCTURE

Stakeholder Alignment

Every Proximity Space depends on multiple parties agreeing to specific roles before it opens.

HOST BUILDING

Holds operating licence

The library, community centre, or public building where the room physically sits. Responsible for day-to-day access and upkeep of the shared space and already has community trust and foot traffic, which is why sites are embedded rather than built from scratch.



MUNICIPALITY

Provides space, backs funding

Allocates the physical site and channels public financing (see Financing Logic by Phase). Also the accountable party if a site needs to scale, relocate, or close and the entity a jury or funder actually holds responsible for outcomes.



LOCAL PANEL

Sets service menu

Decides the neighbourhood's local-addition slot (per the same-shell, different-mix model) and gives the site legitimacy with the community it serves.



PRACTITIONERS

Share data, provide continuity

The GPs, specialists, and existing health system partners who participate in the shared record and referral network; without their buy-in, the whole informational-continuity mechanism doesn't function.



FUNDING

EU / philanthropic / national

Each with different time horizons and conditions (Prove It → Replicate → Institutionalise → Share It) named explicitly so no single funder failing stalls the whole model.



WHAT FORMALISES THIS: PARTNERSHIP AGREEMENTS

MOUs between host building, municipality, and local health/education providers: who's responsible for what, made explicit before a site opens, and crisis preparation.

3 Cities, 3 Futures

How can the model we propose enable care better into each city, respective to the future scenarios they lean into?

Proximity Space Model

- **One** room, three professionals — women's health, mental health, childcare
- Childcare as the **access key** that unlocks everything else
- **Modular, low-infrastructure**, embedded in existing buildings
- Local panel sets the **service menu**

How can we weave care into existing structures where life already happens?

Belgrade, Serbia

- **What's missing:** Integration
- **Entry point:** Build onto the existing dom zdravlja network
- **Funding source:** EU Reform & Growth Facility
- **Core proof point:** Care exists, but doesn't talk to itself

Paris, France

- **What's missing:** Navigation & Equity
- **Entry point:** Stitch together an already-strong but fragmented ecosystem
- **Funding source:** Municipality + host health centre
- **Core proof point:** Care exists, but costs time to reach

Seoul, South Korea

- **What's missing:** Rest
- **Entry point:** Redirect existing investment toward daily-life barriers
- **Funding source:** National budget / medical-desert-style category
- **Core proof point:** Money exists, but doesn't reach the right problem

SCENARIO 1: A CITY EMPTYING FASTER THAN IT CAN ADAPT / THE INTEGRATION GAP

BELGRADE, SERBIA



60,845 births vs. 98,230 deaths in 2024 — a natural decrease of over 37,000 people in a single year. Projected to fall from 6.6 to 5.2 million by 2052.



What exists

The dom zdravlja (community health house) network already delivers gynaecology, paediatrics, and preventive care at neighbourhood scale, closer structurally to a Proximity Space than anything in Paris or Seoul.

What's missing

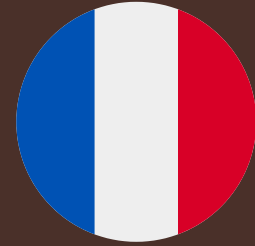
Integration: Women's health, mental health, and childcare remain siloed even within a system that's already spatially distributed. Maternal mortality runs 20–50% higher than the EU average; mental health care is still largely hospital-based.

Entry point & Funding

Build directly onto the existing dom zdravlja network — established buildings, staff, and trust already in place. Funding can be from the EU Reform and Growth Facility financing, earmarked for human-capital development.

SCENARIO 2: EXCELLENCE, UNEVENLY KEPT / THE NAVIGATION & EQUITY GAP

PARIS, FRANCE



Five independently-funded women's health clinics (Jeen, Gynea, La Clinique des Femmes, Sorella Care, Celene) have opened in the last ~4 years as proof of real demand for exactly this model.



What exists

One of Europe's strongest women's healthcare ecosystems: five specialised private clinics plus public sexual health centres, covering gynaecology through menopause support.

What's missing

Navigation & equal access to care: These exist as separate destinations. A woman still has to organise childcare, travel across the city, and manage multiple providers around work. The private clinics cluster in wealthier arrondissements, leaving the equity gap unsolved.

Entry point & Funding

Stitch together an already-strong but fragmented ecosystem; our proposed Proximity Spaces would mean shifting from a city that offers excellent healthcare in select locations to one where healthcare is woven into everyday life. Funding can come from the municipality + host health centre partnerships.

SCENARIO 2: A NATION OVERWORKED / THE REST GAP

SEOUL, SOUTH KOREA



South Korean women aged 20–39 have the highest suicide rate in the world — nearly four times the global average — despite living in a country with extensive clinical infrastructure. By 2072, the 65+ share of the population rises from 19.2% to 47.7%, while the working-age population falls from 70.2% to 45.8%.



What exists

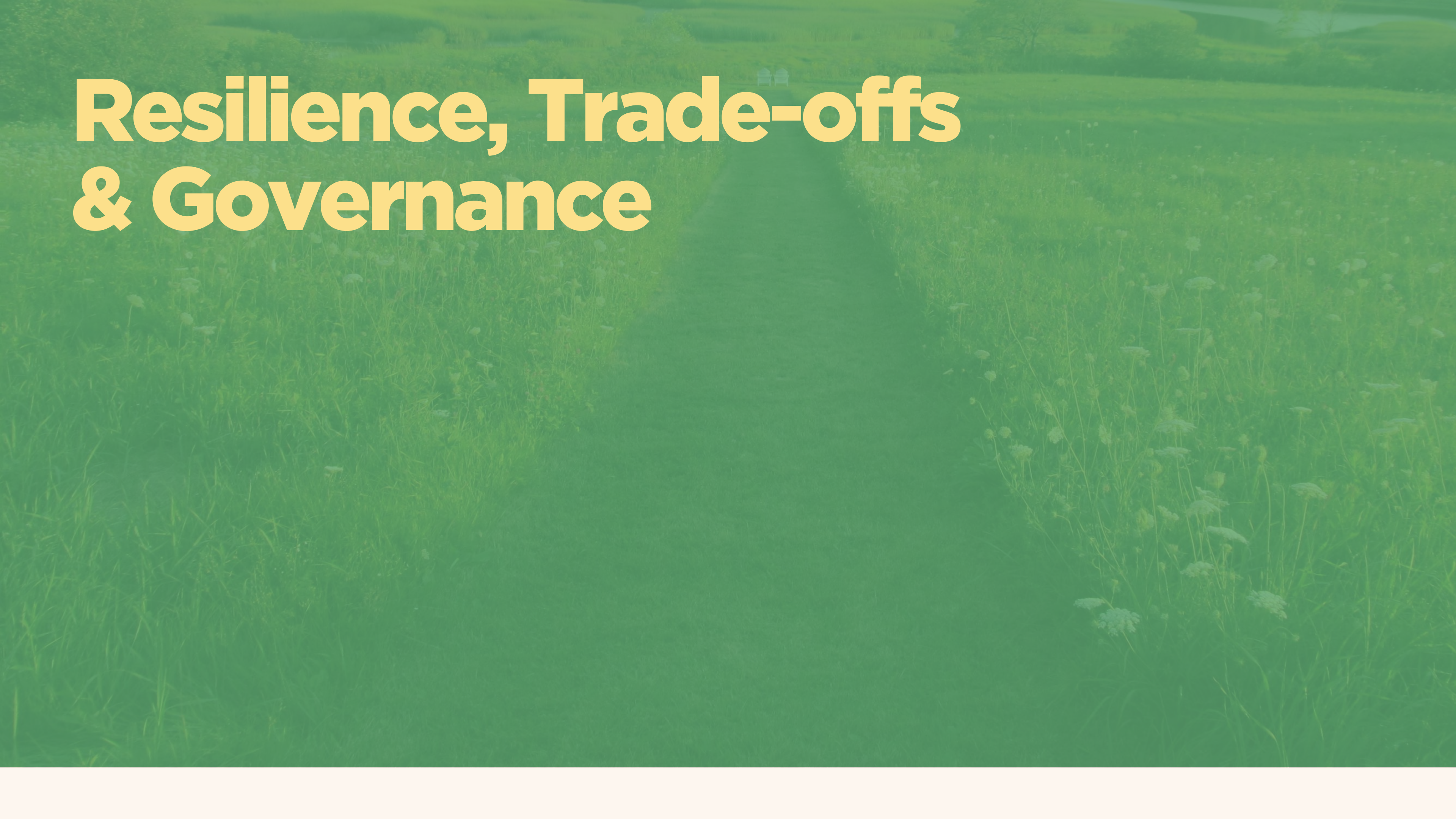
Extensive clinical infrastructure & ~two decades of aggressive government investment in birth incentives: cash grants, parental leave, housing support, est. 2006.

What's missing

A culture where rest is prioritised. A work culture averaging 1,833 hours a year, one of the longest in the OECD, 501 hours more than Germany, leaves no room to use the mental health infrastructure that already exists. Stigma keeps care underused even where it's available. None of two decades of investment touches the daily friction that makes caregiving unsustainable: inaccessible childcare, rigid hours, a childcare system split across two ministries with different rules for children of same age. Korean women earn roughly ⅔ of men's income and labour-market discrimination has been directly linked to suicidal ideation among Korean women specifically.

Entry point & Funding

Meet women at low-barrier drop-in visits as well as drop-in childcare, with a readily available telehealth system to start. An invitation to sociocultural shift towards rest and self-care through events that can shift their lens from punishment to integral care, and propose for women and caregiving-specific rest days. Funded by national budget as a medical desert, with support from pioneering workplaces.

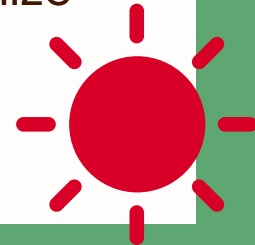


Resilience, Trade-offs & Governance

Stress tests

Stress 1: Heat & Climate

Proximity Spaces are integrated into green spaces and designed with passive cooling to serve as neighborhood refuges during extreme heat. Staff are trained to recognize and respond to heat related illness and climate change health impacts.



Stress 2: Reliance on Host Buildings

Designed as low-infrastructure, modular spaces proximity spaces can relocated if required.



Stress 3: Funding Volatility

The modular model allows Proximity Spaces to scale services up or down based on available funding, while maintaining core functions such as childcare and women's health care.



Stress 4: Specialist Availability

Rotating clinicians and telehealth ensure specialist care remains accessible despite workforce shortages.



Stress 5: Changing Demographics

Proximity Spaces continuously adapt to changing neighborhood needs using local demographic and health data. As populations shift: through migration, ageing, or changing family structures, services are reconfigured to match demand.



Why the System Is Resilient



Distributed Network

A city network of interconnected Proximity Spaces ensures care remains accessible. Demonstrated across different urban contexts: from emerging care gaps in Belgrade to established healthcare ecosystems in Paris.

Telehealth

Digital tools improve continuity of care by integrating scheduling, communication, and patient information into one system. This allows providers to coordinate more effectively and reduces barriers

Modular Spaces

Low-infrastructure, flexible spaces can fit into existing buildings and evolve over time. Allows each city to tailor the model to local needs.

Trade-off: Expansion

Every Proximity Space has the same 3+1 professionals and the same budget.
What happens inside is decided by the neighbourhood.



City centre



Small town



Peri-urban



Rural cluster

Same shell — one space, 3-4 staff, one budget. Different mix inside:



Womens' health



Mental health



Childcare



Local addition

THE CHOICE WE MADE

Build fast, everywhere

Cheap and quick. But a service nobody helped design is the first thing a council closes.

Build slower, with the neighbourhood ← OURS

Costs us about six months per site. Buys a service local people defend when budgets are cut.

1,340+

Sure Start centres closed in England after 2010. They were neighbourhood one-stop shops — childcare, health and parenting support for families with under-fives. The closest thing to a Proximity Space anyone has built at scale. **And it worked: the IFS values its lifetime benefits at roughly twice what it cost. Being proven was not enough to save it — so we buy a second protection: local ownership.**

Trade-off: Digital & Access

Every digital function in a Proximity Space has to have a physical equivalent, or it isn't actually accessible to all. However, can we strike a balance between both?

Digital-first may be efficient,

Cheaper to run, less staff time on admin, easier to scale. But locks out exactly the population most likely to need it: only 48% of EU adults aged 65–74 used the internet in the past year, dropping to 17% among disabled or homebound older adults.

Every digital function: booking, reminders, care history, telehealth, has a walk-in, phone, or in-person equivalent. Costs more staff time, but ensures access to care for all.

but effectiveness for the whole sees digital as an addition.

Standardised	Locally tuned
App, booking & reminders	Services offered (based on Demographic priorities)
Shared care record	Staff & partnerships
Telehealth	Languages & outreach

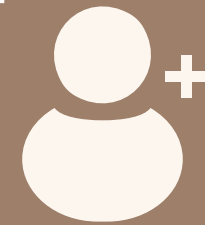
RESILIENCE, TRADE-OFFS & GOVERNANCE / MANAGING CAPACITY

What happens when a site is overwhelmed?

A proximity space that gets popular can't quietly revert to rotating whoever's available; that would undermine the exact continuity mechanism this model is built on.

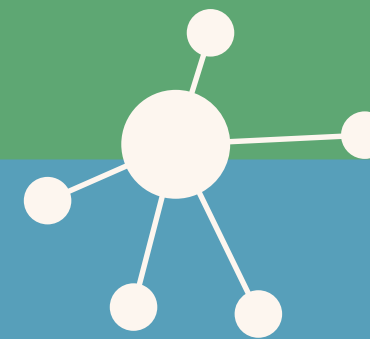
Within-site response

New patients still seen clinically; navigation shifts to app-based reminders & backup professional rather than diluting existing relationships



Network response

Overflow routes to mobile/satellite hours or telehealth already serving the area, no new infrastructure needed



Structural Response (New-site trigger)



Sustained utilisation above threshold (e.g. 1 month) signals a new baseline site to be proposed, and selected users are informed.

Backup professional as actual point-of-contact via mobile for those without reliable access



Triage during overflow by severity, not queue order.

Stakeholders, Financing & Roadmap



Five quick wins. Five bold bets.

The quick wins need one empty room and three salaries. The bold bets need somebody to change a rule.

QUICK WINS

- **One space, three professionals**

A women's health worker, a mental health worker and a childcare worker. Scale by adding rooms, rotating specialists and telehealth.

- **Childcare is the key to the door**

Nobody reaches an appointment with a toddler in tow. One free hour is not a side service — it is the entrance to every other one.

- **Move into buildings that already exist**

No heavy equipment, so a library, community centre or empty shopfront works — and the room can be handed straight back.

- **One room, four timetables**

Menopause care in working hours, perinatal groups after school, youth drop-in in the evening. Same room, different week.

- **A place to stay, not just attend**

Between appointments it is a third space where women meet each other. Loneliness is now a recognised health determinant.

BOLD BETS

- **Count care as infrastructure**

Care is budgeted as a running cost, so it is cut first. Capital budgets are protected — and can be borrowed against.

- **A care room in every new development**

Like fire escapes and cycle parking: required, not optional. Ground-floor retail becomes neighbourhood care space.

- **A care point within 15 minutes of home**

France promised mothers exactly this in 1945 through its PMI network. Make the promise a measurable entitlement.

- **Pay for outcomes, not appointments**

Funders pay for depression cases prevented and screenings completed, not for visits delivered.

- **Let telehealth count as coverage**

One rotating specialist plus a video link should satisfy provision rules in thin-density areas. Today it does not.

WHO RUNS IT

Host building holds the licence

Municipality provides the space

Local panel sets the service menu

Stakeholder Alignment

Aligns with public health goals by treating women's health as a foundation of healthier communities and societies. Proximity Spaces address life-course care gaps while responding to major unmet needs, such as menopause support affecting approximately 450 million women globally (Davidson et al., 2011; McKinsey Health Institute, 2025).

Health Ministries

Support a scalable model with demonstrated social and economic returns. Research estimates that every **\$1 invested in women's health generates approximately \$3 in economic growth** (World Economic Forum, 2024).

Funders

Supports healthier, more inclusive cities by integrating care into neighborhood infrastructure. Proximity Spaces respond to the ways urban design and caregiving responsibilities shape women's access to health services.

City Councils

Libraries, community centers, schools, health clinics, and local nonprofits can become anchors for Proximity Spaces. The model allows partners to activate existing spaces, extend their services, and create neighborhood based networks of care that improve women's and families' well-being.

Local Partners

Financing Channels

Healthier women, better-cared-for children, a bigger economy.

This is not a welfare cost. It is the cheapest productivity investment a city can make.

Women lose 9 years

Women spend 25% more of their lives in poor health than men. Most of it is not reproductive — it is mental health, heart disease and menopause.

Care keeps them working

Where childcare is cheap and close by, female employment passes 70% — highest in any OECD country.

+\$1 trillion a year

Closing the women's health gap adds \$1tn to global GDP by 2040 — the equivalent of 137 million women in full-time work.

Every \$1 invested in women's health returns about \$3 in economic growth.

WHERE THE MONEY COMES FROM — four channels, so no single freeze can stop us

EU investment

(RefoFacility / WBIF
rm & Growth - FROZEN, APRIL 2026)

**Municipality +
host health centre**

**Philanthropic
co-finance**

**National budget:
medical deserts**

€35,000 builds one unit - a single municipality can still afford this from its own budget.

Financing Logic by Phase

A grant ends. A budget line does not.

Four phases — and at each one the source of the money changes, because grant funding cannot pay for a permanent service.

1

YEAR 1-2

PROVE IT

€375k

Grant + council in kind

Two sites — one dense, one emptying — to show the same unit works in both.

2

YEAR 3-5

REPLICATE

€4–6m

EU investment window

40 to 60 units across a region, once the first two have produced evidence.

3

YEAR 6-8

INSTITUTIONALISE

Recurrent

National health budget

Units stop being a project and become a permanent line in the health budget.

4

YEAR 9+

SHARE IT

Partner-funded

Global coalition

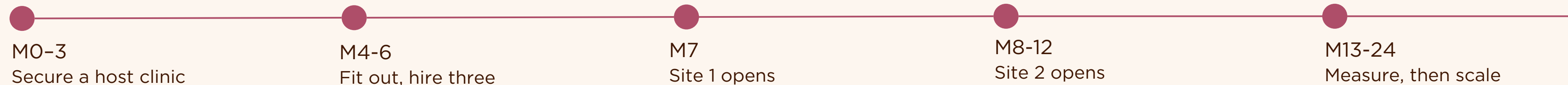
Other countries adopt the model through partnership rather than export.

Phase 3 is the one that decides everything. *And that budget category already exists: underserved areas are named and funded as “white spots” in Poland, “undersupplied areas” in Germany and “shrinking areas” in the Netherlands. We are not asking for a new category — only for a decision.*

Implementation Roadmap — Phase 1

2 sites. 24 months. €375,000.

One dense neighbourhood, one emptying town — proving the same unit works at both extremes.



€35k

to build one unit

Fit-out, clinical kit,
childcare zone, digital.
No construction.

€74k

to run it for a year

Three professionals fully
loaded, plus supplies
and supervision.

€376k

for all of Phase 1

Both sites, 24 months,
including evaluation and
contingency.

DOES IT PAY FOR ITSELF?

1 in 7 women develop perinatal depression or anxiety, and 60% are never diagnosed. In the UK, each untreated mother–child pair costs society about £74,000.

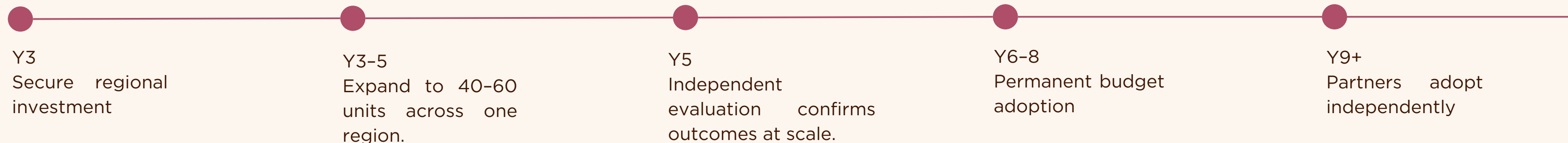
Catch one case a year and the unit has already paid for itself.

If fewer than 30% of visitors go on to use a second service, childcare is not unlocking care, and the model is wrong.

Implementation Roadmap: Phases 2-4

40–60 units by region. Permanent funding. International adoption.

Proximity Spaces evolves from a successful pilot into a permanent public service before being adopted by partners internationally.



€4–6m

to establish **40–60 units** across one region once Phase 1 has produced evidence.

Recurrent funding

Units become a permanent health service funded through the existing budget for underserved areas—not a grant.

Partner funded

Other countries implement the model through their own health systems and budgets.

NO SCALE WITHOUT EVIDENCE

We do not expand nationally until the regional network delivers consistent outcomes.

We do not promote international adoption until the service is permanently financed within one country's health system.

Budget & Impact



Impact Indicators

One number tells us if the mechanism works. The rest tell us if it matters.

1. One model, many cities - *our primary indicator*

The number of cities where the same Proximity Space model is running and performing.

Three by year five — Belgrade, Paris, Seoul. Three very different failures of care: missing integration, difficult navigation, misdirected investment. One unit answers all three, with the shell fixed and the service menu set locally.

A city only counts once its spaces are meeting the two measures below, so growth cannot be claimed by opening rooms that do not work. We measure transferability, because anything can succeed once — infrastructure has to travel.

2. Childcare opens the door

Of the women using the drop-in childcare, the share who go on to receive another service in the same visit.

Target: 50% by month 12. Reported alongside the total number of women reached, so the figure cannot improve simply because fewer women came.

This is the mechanism the whole system rests on, expressed as one number — and the one indicator here designed to be capable of proving us wrong. Below 30%, childcare is not unlocking care, and we redesign.

3. Care she wasn't looking for

The share of visits where a woman is helped with a condition she did not come in for.

Target: one visit in five.

Fragmented care treats only what you arrive asking about; integrated care catches the rest. We measure this against WHIT — the Women's Health Impact Tracking platform built by the World Economic Forum and the McKinsey Health Institute — so our results sit inside an independent global standard rather than one we designed for ourselves. WHIT tracks care delivery, meaning whether women can actually reach the care that exists. That is precisely the gap a Proximity Space closes.

Cost-Benefit Summary

A Proximity Space is cheap to build. The return is beyond financial: it lands on the woman & her family, the neighbourhood, the city and the economy.

This is not a welfare cost. It is the cheapest productivity investment a city can make.

The Cost

€35k
to build one unit

€74k
to run it for a year

€376k
for all of Phase 1

AND WHAT WE GIVE UP

About six months slower
per site
Dependence on a host
building
Specialist cases still refer out

The Return

THE WOMAN **Diagnosis stops taking a decade.**

Endometriosis takes 10 years to diagnose and adenomyosis 11. A third of women with PCOS wait over two years and see three or more providers. Drop-in, no referral, no appointment — the delay is the thing we remove.

THE NEIGHBOURHOOD **A third space, not just a clinic.**

Women perform 76% of the world's unpaid care work. Between appointments the room is where that load gets shared — and where isolation, now a recognised health determinant, gets interrupted.

THE CITY **Care that reuses what the city already owns.**

No construction and no heavy equipment: libraries, community centres and empty shopfronts become care space, and the room can be handed back unchanged. Earlier contact means fewer late, expensive presentations later.

THE ECONOMY **Productivity, not just welfare.**

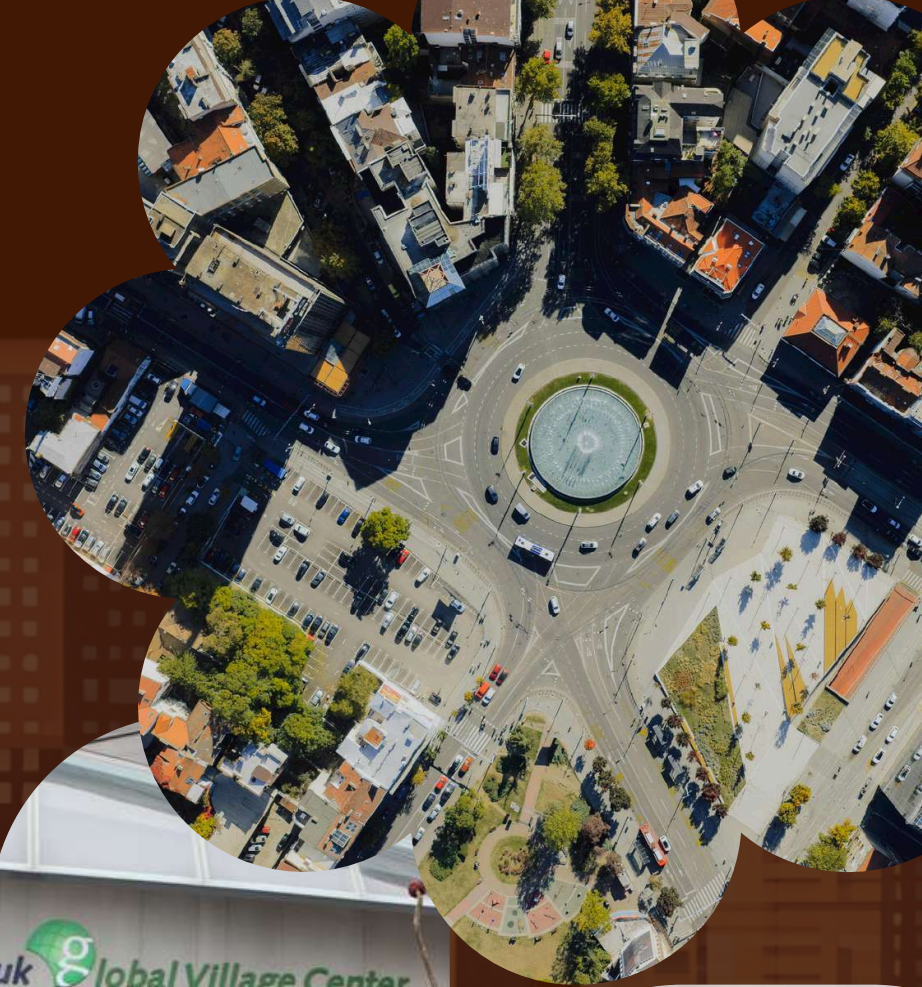
14 million UK working days lost to menopause a year; 708 million women outside the labour force because of unpaid care. Closing the women's health gap adds \$1tn to global GDP a year by 2040 — and every \$1 invested returns about \$3.

The Breakeven: Prevent or treat at least one case of perinatal depression a year, in the UK £74,000 of lifetime cost to society, and one unit has paid for itself.



Cities already *have* the buildings.
Cities already *have* the budget lines.
What's missing is the **room** where they meet.

The infrastructure our cities need next
isn't new. It just needs to be **repurposed**.



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