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**WHO European Healthy Cities Network**

# **Gender and Health Survey** key findings

March 2018





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## **ABSTRACT**

This is a summary report based on the responses to the Gender and Health Survey conducted within the WHO European Healthy Cities Network during 2017.

It responds to the request of the Working Group for Gender and Health of the WHO European Healthy Cities Network to map the available data and information on gender and health at the city/municipal level. The mapping will serve to develop a tool to assess and monitor the implementation of the Strategy for women's health and well-being and the Strategy on the health and well-being of men at the city/municipal level.

## **KEYWORDS**

GENDER

PUBLIC HEALTH

HEALTHY CITIES

EQUITY

SOCIAL DETERMINANTS

SURVEY

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## PURPOSE

This is a summary report based on the responses to the Gender and Health Survey received as of 3 October 2017, including findings about (a) the available data for undertaking a gender and health assessment at the city level and (b) gender and health at the city level (for example, gender equality plans). The purpose of this report is to provide feedback to the WHO European Healthy Cities Network on the results of the Survey.

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## BACKGROUND

The 66th session of the WHO Regional Committee for Europe, held in Copenhagen, Denmark, in September 2016, endorsed the Strategy on women's health and well-being in the WHO European Region (1). The Strategy aims to enable progress towards reducing gender and socioeconomic inequities for women in the Region. It is designed to help health planners work towards improving the health and well-being of women and girls with a view beyond maternal and child health, ensuring that policies and health systems are gender-responsive and based on a life-course approach.

The Strategy is underpinned by the values of the European policy framework for health and well-being Health 2020 (2), which acknowledges that gender is a determinant of health alongside social and environmental determinants, and which identifies gender mainstreaming as a mechanism to achieve gender equity. The WHO Regional Office for Europe is currently developing a strategy on men's health from a gender perspective, with the goal of submitting this strategy for consideration by the Regional Committee in September 2018.

The Working Group for Gender and Health of the WHO European Healthy Cities Network was set up in February 2017 with the aim of guiding and piloting the development of a tool to assess and monitor the implementation of the Strategy at the city/municipal level. The first step was to map the available data and information on gender and health at the city/municipal level through the Gender and Health Survey.

WHO consultant Sarah Simpson designed the Survey and prepared this report following an analysis of its results, in coordination with the gender and human rights programme of the Regional Office.

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## RESPONSES AND PROFILE OF RESPONDENTS

Forty-nine cities submitted surveys by 3 October 2017. Of these, 40 were complete and 9 were incomplete. Where available, this report includes data from incomplete responses. The 40 completed surveys were from cities in 21 European Member States, including: Austria, Croatia, Denmark, Finland, Germany, Greece, Hungary, Ireland, Israel, Italy, Latvia, Lithuania, Montenegro, Norway, Poland, the Russian Federation, Serbia, Spain, Sweden, Turkey and the United Kingdom (England, Northern Ireland and Wales). Incomplete surveys include responses from some of these countries, as well as Czechia and Romania. The majority of respondents are members of the WHO European Healthy Cities Network, and 86% of cities/municipalities are members of a national network.

# FINDINGS

## DEMOGRAPHICS

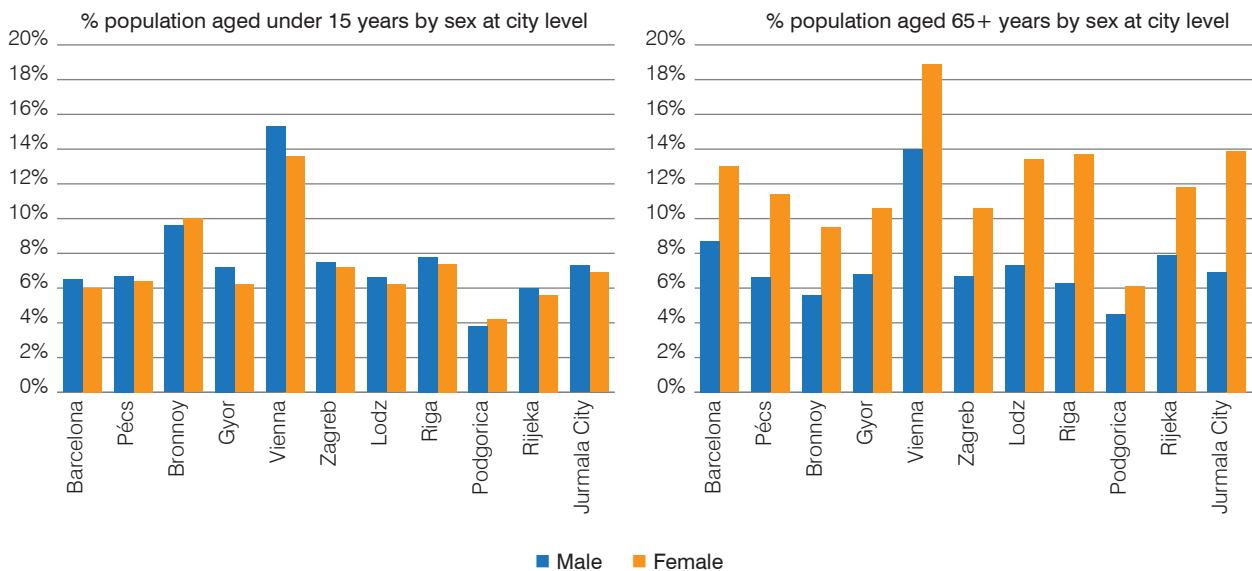
The population size of the cities that completed the Gender and Health Survey ranges from just under 2000 to 2.9 million, as follows:

- three have populations of less than 10 000;
- 15 have populations of 10 000–100 000;
- 20 have populations of 100 000–500 000;
- four have populations of 500 000–1 000 000; and
- four have populations of well over 1 million.

The geographical area covered by the cities that completed the Survey ranges from 3.3 square kilometres to 6526.0 square kilometres.

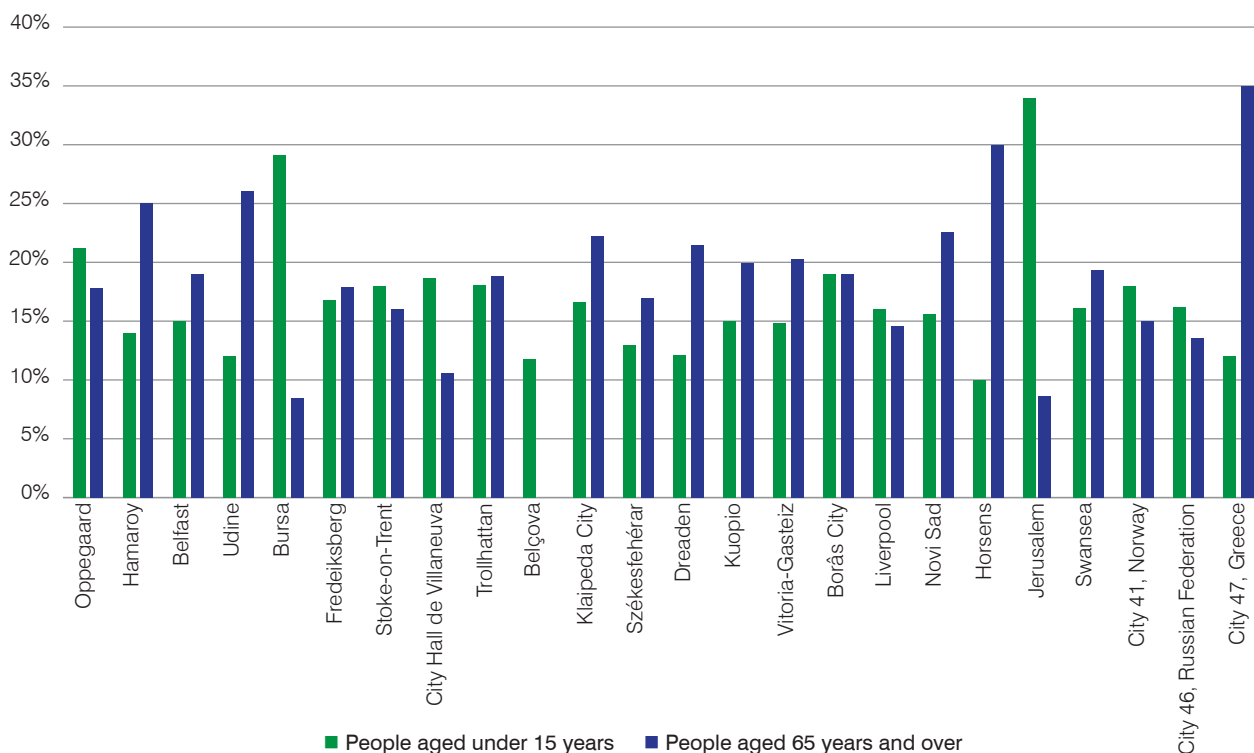
Data on age dependency (children aged under 15 years and adults aged 65 years and over) by sex show that in nine of the 11 cities that provided this information, the male population under 15 years is slightly higher than the female population under 15 years. For adults over 65 years, it is the reverse – a greater percentage of the population aged 65 years and older is female (see Figure 1). The data also show some large differences in cities' proportions of older and younger people; for example, Horsens (Denmark), Udine (Italy) and a surveyed city in Greece have much older populations, while Jerusalem (Israel) and Bursa (Turkey) have very young populations (see Figure 2).

**Figure 1. Sex differences in population aged under 15 years and 65 years and over**





**Figure 2. Percentage of population aged under 15 years and 65 years and over**



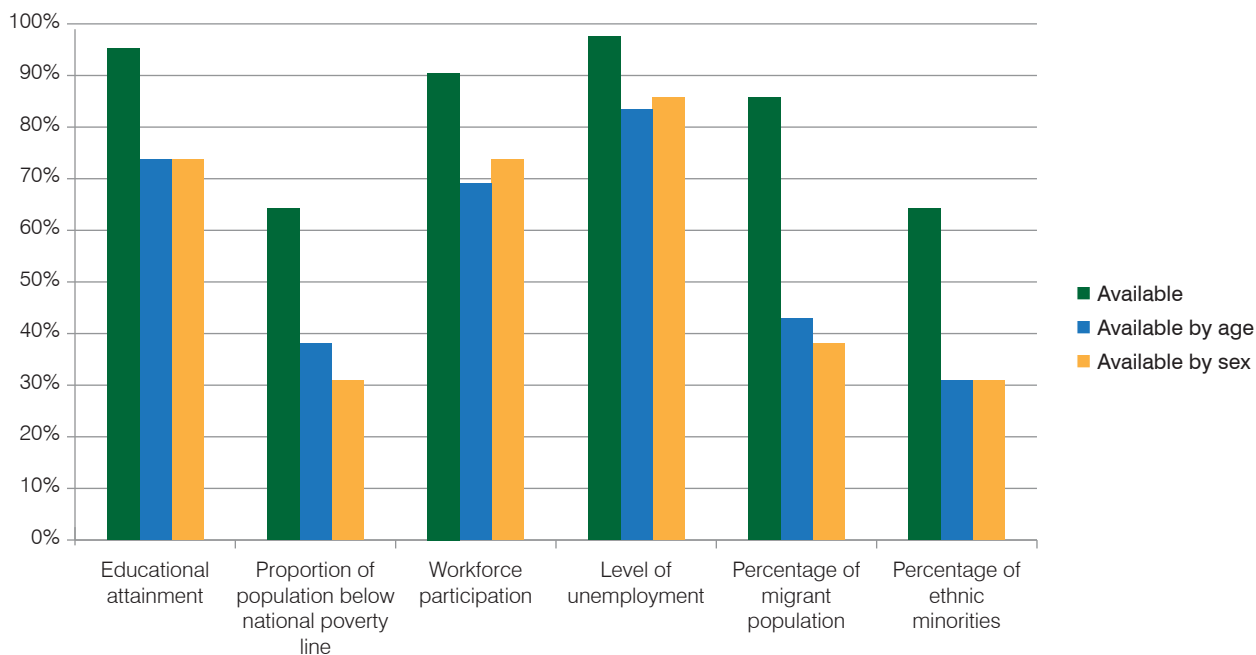
## SOCIOECONOMIC DETERMINANTS AT THE CITY LEVEL

The Gender and Health Survey revealed good overall availability of data on socioeconomic determinants at the city level. Levels of unemployment, educational attainment, workforce participation and percentage of migrant populations are the indicators most available in sex- and/or age-disaggregated format (see Figure 3).

Data on the proportion of the population living below the poverty line and the percentage of ethnic minorities are less available at the city level, and even less so in age- and sex-disaggregated formats. Some cities do not have a national poverty line or use multiple indices of deprivation. For these two indicators, 30–40% of cities have access to data disaggregated by age and/or sex. Data on migrant status and/or ethnicity are reported in a range of different ways across countries.

Key sources of data are national statistics agencies and censuses. Some cities use annual population surveys, national registries, European Union data sources (for example, European Union Statistics on Income and Living Conditions) and/or the statistical databases of other government departments (for example, for data on education, work and employment). Data on socioeconomic determinants are therefore generally available at the city level. Sometimes, access to city-level data requires a special request from the city to the national statistics agency. Where data are only collected at the regional level or not regularly collected, some cities collect information through specific surveys or qualitative methods.

**Figure 3. Availability of data on socioeconomic determinants and their disaggregation by age and sex**



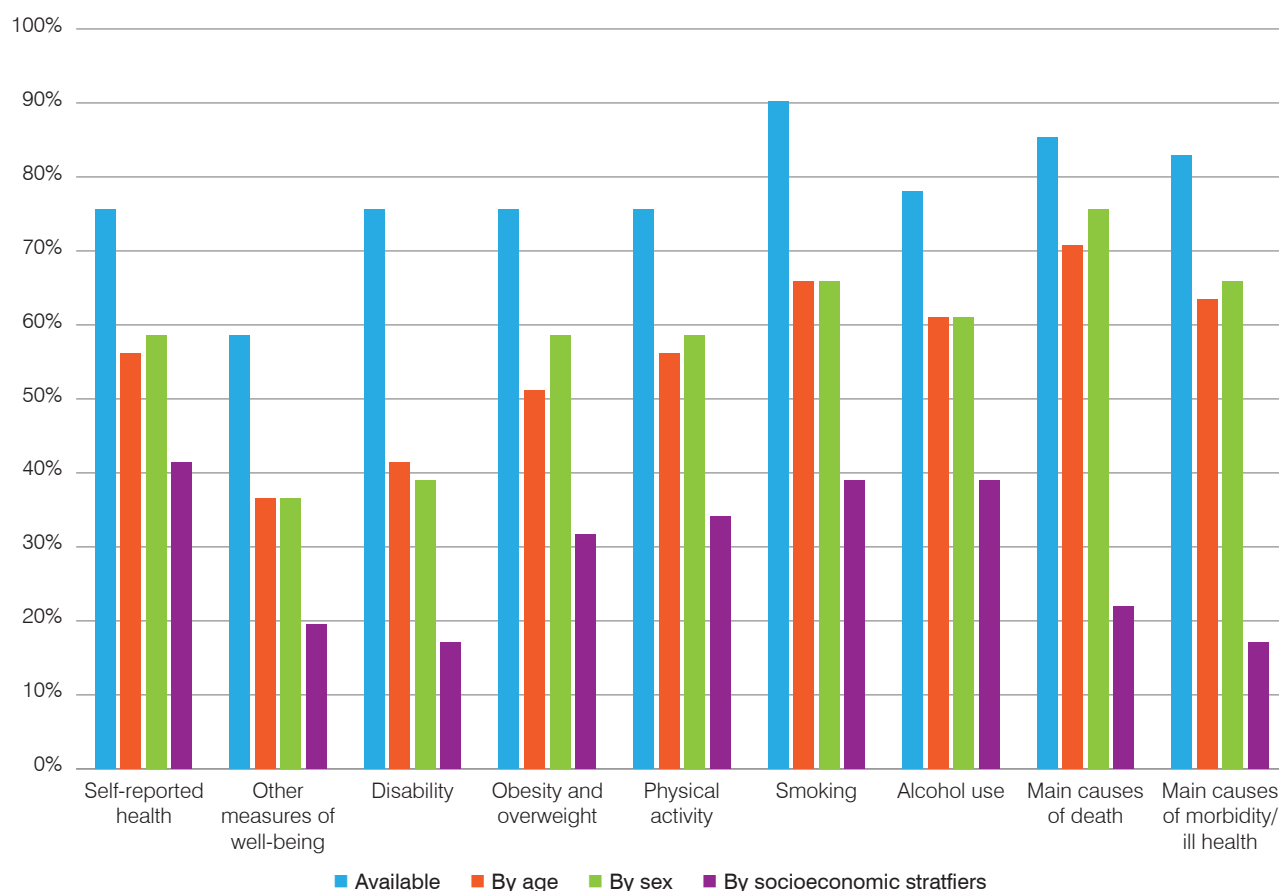
## DATA ON HEALTH STATUS AT THE CITY LEVEL

**Relevance to gender and health:** A priority area of the Strategy on women’s health and well-being is collecting and using disaggregated data to inform policies and programmes, as well as their implementation and monitoring to address gender inequities and inequities among women (1).

There is good (70% and above) overall availability of health status data at the city level for traditional indicators such as life expectancy, smoking, main causes of death and disability (see Figure 4). These indicators are less available at the city level in age- and sex-disaggregated formats. City-level data on healthy life years and other measures of well-being are less available overall, and even less so in age- and sex-disaggregated formats. Data on adolescent pregnancy and violence against women are available at the city level (in 72% and 66% of cities, respectively), with limited disaggregation by age. Nevertheless, cities have a good foundation for reporting and analysing health differences between women and men, and between different age groups.

For all indicators, data disaggregated by socioeconomic stratifiers are less available. Self-reported health is the indicator most likely to be available at the city level and stratified by socioeconomic status (see Figure 4). Education is the main stratifier, followed by income. The availability of health status data disaggregated by socioeconomic stratifiers is important for an analysis of inequalities and inequities, and to ensure no one is left behind. Some cities undertake specific surveys and/or qualitative studies that include questions about social stratification to generate additional knowledge to inform action.

**Figure 4. Availability of data on health status and their disaggregation by age, sex and socioeconomic stratifiers**



## AVAILABILITY OF OTHER INFORMATION ON GENDER AND HEALTH AT THE CITY LEVEL

The Gender and Health Survey also covered some questions with specific relevance to gender and health issues, in particular: availability of services for women who are victims of violence; use of specific protocols by city-level health services for responding to violence against women; policies on informal carers; availability of child care; parental leave policies; availability of information on the proportion of time spent on unpaid domestic and care work; and sexuality education in school curricula.

### **Information on violence against women – shelters, support, and use of protocols by health services**

**Relevance to gender and health:** Strengthening the role of the health system within a national multisectoral approach to addressing interpersonal violence – in particular against women and girls – is an action area of the Strategy on women’s health and well-being. WHO estimates that one in every four women in the WHO European Region has experienced intimate partner violence during her lifetime. Girls and women need protection from gender-based violence, including intimate partner violence, sexual violence, female genital mutilation, early marriage, exploitation, abuse, and involuntary or unwanted sterilization. Violence against women persists in all countries and among all population groups in the Region, underlining the need to continue to address violence as a priority public health issue (1).

## **Shelters and support for women**

Thirty cities provided details about the number of shelters for women, facilities in the shelters and related information. Shelters range in capacity from six to eight women to more than 30, and one city has four shelters with capacity for 175 women and children. Another city mixes women geographically around the country so their location can remain confidential. Most respondents indicated that shelters have capacity for children and are linked to a range of health and social services, legal assistance, collaboration with the police and support in the form of economic advisers. Some indicated that their shelters provide specific support to women in particularly vulnerable situations (for example, undocumented migrant women and/or victims of human trafficking).

Most cities have crisis lines for women, as well as preventive or pre-emptive assistance (for example, the provision of information about available help and how to take legal action). Shelters and services are provided by government and/or nongovernment organizations, and sometimes charities.

## **Use of protocols by health services**

Nearly 60% of cities indicated that health services use protocols to detect and address violence against women; 32% did not know if this was the case. A few cities indicated that, while health services use protocols, these are not always well implemented because health professionals lack the right competencies. One city had established teams and care groups to support survivors of domestic violence, and conducts training for hospital staff. Two cities have projects on improving case detection (for example, by training for workers in substance misuse services to raise awareness on violence against women as a public health issue).

Some cities screen for violence as part of antenatal care. Cities mentioned WHO protocols as a reference point for this work, as well as nationally produced guidelines and tools. Cities provided detailed information on policies addressing violence against women, shelters and services, highlighting good availability for reporting on this issue at the city level. Some cities, however, noted that they needed to seek this information from other agencies and/or sectors.

## ***Information on child care, parental leave, informal carer policies and unpaid work***

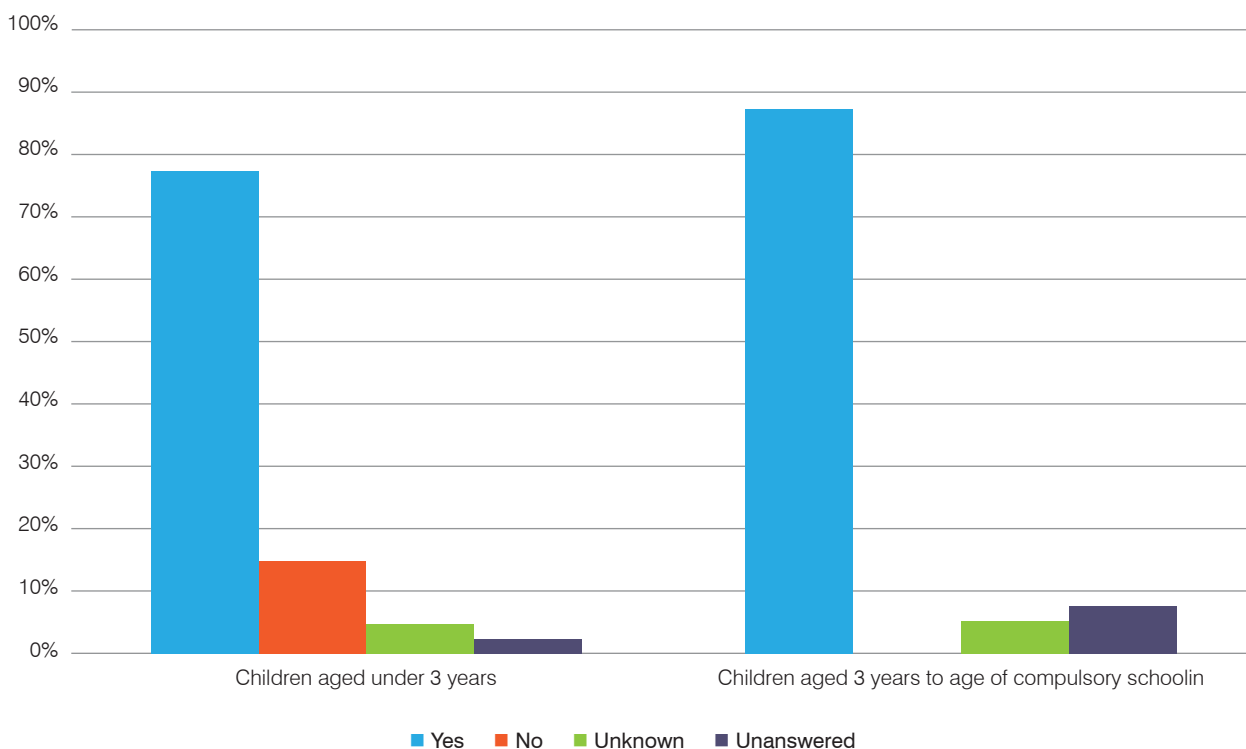
**Relevance to gender and health:** Unequal access for women and men to economic resources such as income, pensions and social transfers has health and social consequences. Women's health and well-being are affected by their levels of workforce participation, quality and type of employment (for example, formal or informal employment, high or low earnings) and types of family, child and carer policies, including how much such policies rely on women's unpaid work and support. Health and care services depend on women contributing in unpaid and informal capacities, particularly to care for children, sick family members and older people. Key actions in the Strategy on women's health and well-being include strengthening intersectoral mechanisms to reduce the negative impact(s) of precarious employment and working conditions on women's health and well-being; ensuring that women's work is valued equally to that of men; and ensuring that women's paid and unpaid contributions as carers are recognized, valued and compensated (1,3).

## **Child care and parental leave policies**

The Gender and Health Survey results show that care for children from three years of age to the age of compulsory schooling is more available (87.5%) than for children under three years of age (77.5%) (see Figure 5). Compulsory school age ranges from three years to seven years, with seven being the age in most countries. In 90% of countries, parental leave policies are in place for women and men.

Cities provided different information and levels of detail about these policies, including on: parental leave that is mandatory and regulated at the national level for children up to a specific age; differences between men and women; categories of workers (employed, government or private enterprise, self-employed); length of leave; payments made at a percentage of salary; regulations governing the exact date of leave; and related conditions, such as the number of weeks of service and specific types of leave within the overall provision.

**Figure 5. Availability of publicly subsidized child care at the city level**



### **Policies providing support for informal carers**

Of the cities surveyed, 74% indicated that they have policies providing support for informal carers of children, older people, people with disabilities and/or people with chronic conditions. Details of the policies listed, however, suggest different conceptions of what informal caring involves and/or the relevance of this information to gender and health. Cities gave examples of policies organized according to the group receiving care (children, older people, etc.), of trainings for women to be informal carers, and of carer support policies that include allowances and transport to day centres for those receiving care.

### **Proportion of time spent on unpaid domestic and care work**

Nearly 45% of cities did not know about the availability of city-level information on the proportion of time women and men spend doing unpaid care work. Others indicated that they were not able to provide this data as another agency/sector must request access to the information. In some cities where data are available, they are derived from a census or through a specific health survey; this information may only be available at national or regional levels and/or be outdated (10 or more years old). One city captures this information through carer assessment documentation and surveys, targeting only a subset of the population (that is, the carers they know about).

## **Information on sexuality education in school curricula**

**Relevance to gender and health:** Gender-based values and social and cultural norms and stereotypes that are discriminatory and/or harmful translate into practices that affect health and well-being. Developing innovative programmes and strengthening comprehensive sexuality education aimed at transforming gender norms and values is an action area of the Strategy on women's health and well-being (1), and contributes to the implementation of the Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind (4).

Of the cities surveyed, 75% said that sexuality education is included in school curricula. Detailed comments highlighted challenges with this data and the importance of implementing and monitoring the quality of sexual education. One city, for example, said that it is necessary to ask each individual school to know the answer to this question. Others indicated that the quality of education is variable (for example, only 30% of schools in one city provide evaluated sexual education programmes) and/or that educators are not properly prepared, do not have the required textbooks or materials and/or are not given enough time to deliver the curriculum.

Furthermore, while school curricula can include sexuality education, schools can choose whether or not to deliver it and/or parents can opt to withdraw children from sexuality education classes. In countries where sexuality is not included in the school curricula, some cities are running programmes for sexual health promotion through local Healthy Cities initiatives.

## **USE OF DATA AND INFORMATION ON GENDER AND HEALTH**

This section of the Gender and Health Survey aimed to cover how available data and information on gender and health are used at the city level (including how national gender equality objectives are reflected in city plans), how disaggregated data and information are used in city reports on health, and whether urban planning takes into account the different needs and roles of men and women.

### **Gender equality and city plans, including urban planning**

**Relevance to gender and health:** The Strategy on women's health and well-being promotes gender-transformative policies that decrease the burden of care on women and secure greater involvement of men, challenge gender stereotypes that promote negative health outcomes for women and men, and promote gender equality (1).

Twenty-seven cities reported having a gender equality plan at the national level, 11 of which include responsibilities at the city level. Other cities reported having sectoral action plans or processes (for example, on women's health and/or gender equality in the labour market). Seventeen cities have a gender equality plan at the city/municipal level, and 10 of these cover health issues including: family health counselling centres; gender equality and health; equal treatment and care in the health system, including for the issuing of medical certification for sick leave and for rehabilitation; education on gender issues among (unspecified) personnel; improvement of health literacy; rights protected by law via sex discrimination acts; and local equity plans focused on vulnerable groups, including women.

Main city health plans in 16 municipalities include gender equality issues; plans in 20 municipalities do not. The gender equality issues identified in the plans include: the development of a local equity plan focusing on vulnerable groups, including women, Roma people and ethnic groups; the provision of more accessible consulting services and self-help initiatives to support single women,

men and families in crisis; the provision of gender mainstreaming support to all departments; the prevention of violence against women; the reduction of higher rates of smoking among adolescent girls; local action plans for healthy ageing; and the mainstreaming of gender equality to meet public-sector equality criteria.

Of the cities surveyed, 55% indicated that they do not take the different needs of women and men into consideration in urban planning. Nearly 15% did not know whether or not this is the case. Some specifically stated that they do not take different needs into account to ensure equal treatment of everyone and/or that planning is gender neutral. Cities that confirmed they have taken different needs into consideration in urban planning provided examples relating to safety (for example, good street lighting) pedestrian roads, access for people with disabilities and mothers with baby strollers, physical activity, and transport. One city reported having an urban development plan that specifically addresses gender issues.

### ***Data collection and use at the city level***

Data on gender and health are collected in different ways across cities. Several cities indicated that data are available from both city health departments and statistics agencies; others noted that some data are available at the city level; and the remainder specified that they collect data at national and sometimes regional levels through statistics agencies. Some collect no data at the city level, and others use additional or different methods including local surveys, data from other municipal departments, population surveys and commissioned datasets. The majority of cities found that data collected by statistics agencies are easily available. Some noted, however, that this depends on what data are required, as data may not be free of charge and/or a special request may be necessary.

A total of 70% of cities use sex-disaggregated data in municipal reports. About 60% include data disaggregated by socioeconomic stratifiers. Examples include annual reports on municipal co-financing of the health-care system and annual reports to monitor the city's health strategy. At least one city combines data disaggregated by sex and/or place of residence in reports on sexual and reproductive health, well-being, oral health, safety, discrimination/harassment, trust, violence, disease, stress, obesity and health behaviours (for example, tobacco use). One city indicated that they cannot link health with socioeconomic data due to security requirements, but they know that areas with higher numbers of socially disadvantaged people have lower health status.

### ***City mechanisms to coordinate intersectoral responses to violence against women***

Nearly 70% of municipalities indicated that they have a city mechanism to coordinate responses to violence against women by different sectors; 18% did not know whether or not this is the case. A range of different mechanisms to coordinate intersectoral responses at the city level exist. Some cities adhere to a national protocol, others have regional-level partnerships of key agencies with some involvement from local authorities, and some feature action led by one sector at the city level (sometimes via permanent collaboration with one or more additional departments). At a minimum, the sectors involved include police, health, justice, social services/welfare and/or nongovernment agencies.

Through national legislation and programmes, some cities have put in place pathways that involve the police force in alerting health and social care services to violence against women. One city has no formal mechanism, but identified a range of informal coordination mechanisms to, for example, bring together experts and stakeholders, including representatives from the health sector, to exchange information on existing procedures and modes of operation, discuss good practices and challenges, and identify areas for improvement.



## OVERALL COMMENTS FROM CITIES

Seven cities provided overall comments at the end of the Gender and Health Survey. Some indicated that a tool for assessing and guiding action on gender and health needs to be flexible or modular to enable use at local levels. One also indicated that the tool needs to identify key sources of the data needed for analysis, given the variety of sources available. Another indicated that they already have a gender equity profile that they prepare for another process, and can draw on this.

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## DISCUSSION: RECOMMENDATIONS AND DIRECTIONS FOR A GENDER AND HEALTH ASSESSMENT TOOL

The findings from the Gender and Health Survey indicate good overall availability of city-level data and information on gender and health that could be used when addressing gender in policies and programmes. While data disaggregated by sex, age and/or socioeconomic stratifiers are less available, 70% of cities use sex-disaggregated data in city reporting on health and 60% use some other form of disaggregated data as well. Likewise, much information about gender and health exists at the city level related to policies, protocols and processes for gender equality; child and parental leave; sexuality education; and multisectoral approaches to addressing violence against women and providing related services.

### DESIGNING A TOOL TO ASSESS AND GUIDE ACTION ON GENDER AND HEALTH AT THE CITY LEVEL

Several cities indicated that information in some of the areas that the Survey considers relevant to gender and health is located within other agencies and/or sectors. In some cases, cities needed to formally request information from these agencies and/or sectors to answer questions in the Survey. This, together with improved knowledge on the availability of data and information at the city level, gives important directions on how to tailor a tool for assessing and guiding action on gender and health, as well as the time that needs to be allowed for undertaking a fuller gender and health assessment at the city level.

Responses to the questions about informal care, time spent on unpaid work and care, urban planning for the specific needs of women and men, and gender equality policies and plans supports the need to include further clarification and explanations on their relevance to assessing gender and health, particularly in relation to the Strategy on women's health and well-being. It is important that the tool be locally adapted and available in languages other than English. Where information is widely available (for example, on child care and parental leave), a more systematic structure for the collation and analysis of information could be included in the tool to assist cities in using a gender equality lens to determine what action to take and how.

On the basis of this, the draft gender and health assessment tool will be structured along the lines of the modules in the WHO gender mainstreaming approach (5). The tool will also include a glossary of terms, highlight relevant policy areas and how they are interconnected, and include guidance on the steps of undertaking a gender analysis and identifying and prioritizing action so as to leave no one behind.



The results of this survey will further inform the design of the gender and health assessment tool, which will be developed together with pilot cities during the first half of 2018.

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## REFERENCES

1. Strategy on women's health and well-being in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0003/333912/strategy-womens-health-en.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0003/333912/strategy-womens-health-en.pdf?ua=1), accessed 4 September 2018).
2. Health 2020. A European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0011/199532/Health2020-Long.pdf](http://www.euro.who.int/__data/assets/pdf_file/0011/199532/Health2020-Long.pdf), accessed 4 September 2018).
3. Women's health and well-being in Europe: beyond the mortality advantage. Copenhagen: WHO Regional Office for Europe; 2016. ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/318147/EWHR16\\_interactive2.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0006/318147/EWHR16_interactive2.pdf?ua=1), accessed 4 September 2018).
4. Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2016 ([http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0018/314532/66wd13e\\_SRHActionPlan\\_160524.pdf](http://www.euro.who.int/__data/assets/pdf_file/0018/314532/66wd13e_SRHActionPlan_160524.pdf), accessed 4 September 2018).
5. Gender mainstreaming for health managers: a practical approach. Geneva: World Health Organization; 2011 ([http://apps.who.int/iris/bitstream/handle/10665/44516/9789241501071\\_eng.pdf;jsessionid=57C4154F6D33C14A74374C9F66F895D4?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/44516/9789241501071_eng.pdf;jsessionid=57C4154F6D33C14A74374C9F66F895D4?sequence=1), accessed 4 September 2018).





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The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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