

Make it Informal and Prioritize Life- Climate and Health Adaptation in the Midst of Growing Authoritarianism

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Abstract

In the wake of the Trump Administration's federal funding rollbacks and priority realignments, the public infrastructure addressing environmental health and climate change across federal agencies, that was built over decades, has been dramatically reshaped. As public health agencies navigate an uncertain era of fiscal austerity, this paper offers pathways to translate the core operational mechanics and frameworks of the US Centers for Disease Control and Prevention's Climate Ready States and Cities Initiative into communal and informal contexts. The study builds upon prior work by the primary author, to examine how formerly national networks can be scaled to the local, interpersonal, and informal levels. The formation of hyper-localized networks and capacity can assist in addressing the generational health impacts of anthropogenic climate change in low resource communities, as well as help maintain a foundation for climate and health adaptation efforts at large.

Introduction

Climate and health adaptation builds capacity through networks, collaborative planning, and relationships across sectors, agencies, and scales. These networks are often shaped by experts, or more importantly, public servants who programmatically develop and implement climate and health adaptation plans (Lemon, et al., 2023; Schramm, et al., 2021). The generation of networks across sectors and scales is the driving core aspect of climate and health plan adaptation implementation and evaluation efforts (Lange, et al., 2025). However, considering the substantial funding cuts and policy reorientations as witnessed so far in 2025, climate and health adaptation efforts must take a localized, informal, and radicalized (Miraftab, 2009) approach to keep a workable foundation.

The field of climate and health adaptation in the best of times was woefully underfunded in comparison to the scale of anthropogenic climate change threats (Mallen, et al., 2022; Ebi, et al., 2019). Under the second Trump administration, federal departments, grant cycles, and programs face significant retrenchments of funding and personnel

along with institutional overhauls which further constrain their ability to address the impacts of climate change on health. Prominent examples include the US withdrawal from the Paris Climate Accord, and from the World Health Organization, as well as deep funding cuts to multiple federal agencies overseeing public health, climate adaptation planning, environmental health programs domestically and internationally. Budgets of the National Science Foundation (NSF), the National Institutes of Health (NIH), the Environmental Protection Agency (EPA), the Department of Health and Human Services (DHHS), the Federal Emergency Management Agency (FEMA), the US Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) all face substantial program disruptions, staff terminations and funding shortfalls exceeding tens of billions of dollars (Levi, 2025; Philippidis, 2025). These financial and administrative decisions come simultaneously to the now irreversibility of anthropogenic climate change (Urban, 2024).

Most salient to my own life as a climate and health researcher was the discontinuation of funding to the US CDC's Climate Ready States and Cities Initiative (CRSCI) beyond fiscal year 2026. The CRSCI has been in operation since 2010 and I have been working in a research capacity with Florida State University's Building Resilience Against Climate Effects Program – funded by the CRSCI – since 2021. I met regularly for years with professional administrators, researchers, planners, professors, and scientists during this time as they guided state and city climate and health programs to implement interventions to mitigate the harmful public health effects of anthropogenic climate change. A core aspect of this federally led initiative was growing a substantive and empirical basis of evidence to build the observable linkages between human climate, environmental, and societal health. In turn, this field of evidence would support and guide direct planning initiatives and interventions to be later iteratively evaluated. As of December 2025, it is unclear whether Congress will continue to fund the program.

Researchers have examined the outcomes of retrenchments of social welfare programs that help the sick, poor, and vulnerable (Bleich, et al., 2025). In an era of accelerated climate change, human and non-human life alike are facing unrelenting anthropogenic existential threats that make the absence of these safety nets even more consequential (Kumar, et al., 2021). Thus, the daunting challenge of helping the vulnerable endure the burdens of anthropogenic climate change can seem hopeless and overwhelming – but there are still things that can be done to help those in harm's way *survive*. Beyond formal, institutional, and expert led climate and health adaptation systems, the human element is still very much a powerful domain - a domain that can be a basis of aid and resistance for the vulnerable and oppressed. This paper seeks to critique and translate the workings, findings, and methods of the CRSCI to informal contexts to help mitigate the collusion of anthropogenic climate change, the respective health impacts, and federal austerity within the United States.

This piece is built upon the work performed, and the methods therein, of Lange, et al. (2025). The function of this follow-up piece is to translate the professionalized, technical, and often inaccessible models of the CRSCI into personalized, simplified, accessible, and hyper-localized communitarian frameworks. This work is particularly timely due to the ongoing federal rollbacks. The primary goal is to assist in generating adaptation capacities in communities that have little available resources in the absence of public institutional support and leadership.

As Above So Below – The Larger Contexts of Climate and Health Adaptation at Play

The health impacts of anthropogenic climate change (ACC) are dispersed and amplified through systems of oppression and inequity (Parsons, et al., 2024; Zavala, et al., 2024; Chaudhry, 2024). Scholars argue that ACC is the planetary manifest of oppressive, extractive, and abusive actions driven by the powerful through economic/political motive (Ehsan, 2024; Pozzi, et al., 2024). Those who are poor, racial, and ethnic minorities, indigenous, women, of the LGBTQIA+ community, the young and elderly, those with disabilities, immigrants, and other underrepresented groups are those who carry, endure, and disproportionately die from the impacts of ACC (Pozzi, et al., 2024). The systems of exploitation, of labor, of politics, of land/property, of health care, of racialized and sexist intergenerational wealth, of housing, and more shapes, molds and directs this stratified loss of life. Global systems of exploitation of people, land, and environment thus has given rise to the Anthropocene. The first biologically driven mass extinction event in planetary history (Christenhusz and Govaerts, 2025; Chen, et al., 2024).

ACC will intersect and compound with every single preexisting socio-ecological issue harming people and biological life, as well as introduce new pressures and hazards. ACC will exacerbate water and vector-borne disease, extreme heat and heat-related illness/mortality, drought, floods, tropical systems, food/economic/housing/political instability, and a continued global extinction event (Saxena, 2025; Awad, et al., 2024; Radua, et al., 2024). Moreover, ACC will amplify chronic hazards such as sea level rise and systemic displacement/inundation of coastal regions and island nations globally (Butler, et al., 2021). Worryingly, there is a growing body of literature on disaster capitalism, which in essence, is the utilization of power, wealth, and economics to profit from the damage and through post-disaster redevelopment (Klein, 2007; Wright, et al., 2021). A key example of disaster capitalism, as a phenomenon, is the sale and purchase of communal land and/or low-cost properties after a catastrophic flood/storm to a developer or multi-national corporation (Loewenstein, 2015). The land is

proverbially put on sale after the razing of neighborhoods and displacement of the inhabitants. The core mechanism of disaster capitalism is the power differential between those who have been harmed and those who have power to exploit (Klein, 2007; Güney, 2024) legally and economically.

One could argue that the tipping point for action is not when environmental damage is inflicted upon black, brown, queer, disabled, indigenous bodies, women, and other minorities. It arrives when the standard of living for those who possess the most wealth – the global white elite – deteriorates. Even when their standard of living begins to degrade due to failing institutions, economic/cultural structures, and ecosystems alike – we will witness ongoing gasps to preserve the status quo and whiplash of socio-political acrimony and division (Phipps, 2021; Anderson, 2016).

Basic daily struggles are overlooked in favor of event driven hazard analyses and even public participatory processes that overemphasize adaptation strategy construction (Frazier, et al., 2013; Wescoat, 2015). Such omissions create incomplete understandings of the lived experience, realities, and struggles of lay, vulnerable, and oppressed peoples. This is a typical, and traditional, problem of hierarchical planning methods and orientations (Friedmann, 1987; Scott, 1998). In essence, how can help be properly given if resiliency methods are dislocated from the very lives in need? Thus, once this embodied domain is entered, we more fully understand how to aid, including basic human dignity and kindness (Lange, 2020; Lyles, et al., 2018), at the lived day-to-day reality which includes systems of oppression (Wescoat, 2015).

The Building Resilience Against Climate Effects (BRACE) Models

In 2021, the BRACE team in Florida conducted a systematic investigation of the funded grantees/cohort of the US CDC CRSCI program. The study took place in the summer of 2021 at the end of the 2016-2020 funding cycle. The study had multiple findings, but one finding was foundational to the rest: US CDC CRSCI grantees drive forward climate and health adaptation planning through relationships that cross boundaries, sectors, and scales to see through a myriad of initiatives/interventions due to resource scarcity (Lange, et al., 2025). The foundational relationships and relational capacities constructed by grantees also permitted for interventions to be equitably tailored to geographies (Lange, et al., 2025). These implemented and maintained relationships were instrumental in carrying grantees through the five-step iterative and adaptive learning approach of the original BRACE model. The BRACE models are the programmatic conceptual frameworks of the CRSCI to guide both the US CDC staff as well as the funded cohort.

TABLE 1 – Original BRACE Five-Step Iterative and Adaptive Learning Approach

1. Anticipate Climate Impacts and Assess Vulnerabilities
2. Project the Disease Burden
3. Assess Public Health Interventions
4. Develop and Implement a Climate and Health Adaptation Plan
5. Evaluate Impact and Improve Quality of Activities

At the start of the second funding cycle, beginning in late 2021, an updated BRACE planning model was constructed. The second model was unveiled in the latter half of 2023, with plans for it to be later rolled out and implemented. This model was developed in partnership with the Prevention Research Center at the University of Massachusetts Chan Medical School, and was interdependent with a larger health equity, and climate justice focus as led by the US CDC and NIH. Overall, there is very little substantive difference between the two models. However, the one key difference is that the updated BRACE model is more explicit in its language in guiding practitioners to build relationships, capacity, and partnerships in a localized context.

The updated model captures more accurately the main operational mechanisms of the previous funding cycle. Lastly, each step in the updated BRACE model is supported with publicly available guidance documents to help break down the intricacies and challenges during operationalization. However, the target audience of the updated BRACE model is still that of professionals, experts, and scientists (i.e. a form of technical ‘medical planning’).

TABLE 2 – Updated BRACE Model Completed in 2024

1. **Get Ready, Stay Ready** – Take stock of organizational readiness, local context, and opportunities, reassess over time.
2. **Partner** – Establish and build partnerships across sectors and with communities that are disproportionately affected.
3. **Listen and Assess** – Learn about community needs and strengths and assess relevant climate threats, health impacts, and mitigation opportunities.
4. **Investigate Options** – Identify potential adaptation and mitigation strategies to promote climate resilience and health.
5. **Prioritize and Plan** – Select strategies and develop plans for action, communication, and evaluation.
6. **Take Action** – Implement plans and adjust as needed.

The updated BRACE model similarly calls for the deliberate construction of networks, relationships, and partnerships to create flexible and agile systems to promote climate

and health resilience. However, abstract resiliency models leave out the utilitarian systems of development that led to the very hazards and vulnerabilities that the BRACE model calls to collectively address. Kindness, human conscience, compassion, and justice (Lyles, et al., 2018; Forester, 2020; Lange, 2022) must be part of the conversation, especially at the local level, to buffer against historical and present-day power dynamics of oppression (Young, 1988) that are intrinsically connected and give rise to the disproportionate health impacts of anthropogenic climate change.

Despite seeking equitable and just outcomes, the updated BRACE model is still largely framed from a hierarchical, technical, and abstract perspective based in a professionalized positioning and language. Such structural positioning makes it very difficult to actually reach and intimately work with oppressed and vulnerable populations (Lange, et al., 2025; Lange, 2020). Further, in the absence of public institutional leadership and resources, how would local leaders, individuals, and even families translate such models into their own lives and communities? Thus, how do we as practitioners help downscale the updated BRACE model, with its supporting resources as listed in the respective website, for local citizens, towns, families, and leaders even further into practical guidance?

Methods

The research proposal for Lange et al., (2025) (STUDY00002383) was approved and granted exempt status by the Florida State University's Office of Human Subjects Protection. The research proposals for Lange (2020; 2020; 2022) (HSC No. 2018.25691, and HSC No. 2019.26952) were approved and granted expedited status. Per research protocols, and in accordance with the Declaration of Helsinki, the authors utilized consent with research participants after providing a full pre-interview study information disclosure. Informed verbal consent was obtained from all the participants for Lange et al. (2025) as in accordance with the exempted status of researching and working with public officials (STUDY00002383). Verbal consent was hand documented and recorded via Zoom. Interview data is not shared here from Lange (2020; 2020; 2022).

As public health agencies navigate a new era of retracted federal support, what little resources there were to help oppressed and vulnerable populations are now fractional and highly dependent upon state and local resources and politics. Thus, how do we as climate and health public practitioners provide theorization and practical guidance for low resource and rural communities to generate adaptation capacity from the bottom-up in hyper-local and communicatively based processes? These communities were, for the

most part, out of reach when climate and health infrastructure was in full effect (Lange, et al., 2025). Further, public health infrastructure and local health departments are already highly dependent upon local champions and non-profits to act as mediums to share what resources are available and to create communicative pathways across scales and sectors (Lange, et al., 2025).

This paper differs from Lange et al., (2025) in its intent, interpretation, and purpose – as well as introduces significant data – though it is not dislocated from its data collection and analysis methods. The work performed in Lange et al., (2025) was a part of an overall investigation into the working realities and efforts of the CRSCI practitioners across the program at the end of the 2016-2020 funding cycle. The data collection was performed through a multi-method qualitative approach of semi-structured interviews and climate and health adaptation plan analysis. The research questions were:

1. What factors facilitated and/or constrained adaptation plan development within public health agencies?
2. What were the institutional contexts of practitioners and how did they influence the planning processes?
3. What mechanisms support or hinder the implementation and evaluation of climate and health adaptation actions?

In short, what were the practitioners' programs doing, what were they facing, and how were they progressing through the BRACE framework? The most powerful insights did not come from the plan analyses or the interview coding, but rather from the intensive discussions about climate and public health planning praxes, realities, challenges, and exploratory perspectives shared by practitioners on the state of the field at large. They spoke from actively working in, and working to progress the deliberate linkages of climate, health, people, policy, and society.

Climate and Health Adaptation Plan Analysis

Out of the 18 grantees at the time of study, 11 had climate and health adaptation plans. These plans were collected and then dissected/coded along the following 12 attributes to enhance conversations between plans, grantees, literature, and society at large (Guest, et al., 2020):

1. Plan Type
2. Priority Hazards
3. Plan Process
4. Goal(s)
5. Strategies

6. Supporting Documents
7. Implementation Instruments
8. Partners
9. Equity Considerations
10. Vulnerable Populations
11. Challenges
12. Data/Indicators

The collected data from the plans was utilized to generate the interview instrument.

Interviews with US CDC Grantees

A total of 17 interviews, averaging one hour each, were performed across 25 practitioners representing their individual funded programs. The interviews leaned heavily into plan/strategy construction and implementation, collaborative apparatuses, limitations/challenges, and overall discussions of the field at large. One grantee was not available for interview due to COVID-19 time and labor demands. Interviews were performed over Zoom for recording and transcription purposes. The resultant transcripts were cleaned and open coded. After open coding, associative coding (Williams and Moser, 2019) was performed for the thematic construction as seen in Lange et al. (2025).

Knowledge/Theoretical Translation

In order to address the overarching question of “How to provide professional guidance through communicative and behavioral pathways for lay and informal contexts?” this paper is supplemented through the knowledge, experience, and perspectives of the authors’ time of working in the CRSCI with other practitioners, researchers, and scientists, the work performed in Lange et al., (2025), as well as the primary author’s historical research looking into informal and communicative behavioral change processes in the rural American South. The historical work of the primary author (Lange, 2020; Lange, 2020; Lange, 2022) sought exploratory pathways of addressing cultural wounds such as racism and class through storytelling methodologies in informal and hyper-localized contexts. Methods of behavioral and cultural change that generatively provide new avenues and resources in rural and impoverished communities to address local problems. In essence, the creation of working solutions generated outside the domains of policy, legislative funding, and bureaucracy.

The work was performed through deep ethnography over six months in two rural counties and analyzed, sensitized, and conceptualized through constructivist embodiment (Kincheloe, et al., 2011; Charmaz, 2017; Spatz, 2017). I worked as an

embedded practitioner, learning directly from communities, the respective community leaders, and their efforts already underway to understand “What are people doing to make beneficial impacts in their communities with resources on hand?” I found that public administrative structures are largely, and historically, separate from and have difficulty staying in touch with these embodied and lived domains. However, such embodied domains are the very places in which climate, health, society, geography, and people collide. They are the richest sources of information and provide direct opportunities to address scalar issues through the impacted people themselves.

The combination of these works culminates into the theoretical foundation, of ironically, adapting climate and health adaptation into informal, interpersonal, lay, and embodied domains. Embodied domains meaning the bodies of persons (including lived experiences), the spaces between them, and the geographies they inhabit.

TABLE 3 – Conceptual Framework to Translate BRACE into Informal and Communicative Pathways

- Every community contains unique histories, geographies, cultures, and socio-economic makeup.
 - Every community contains its own unique mixture of historical and present-day problems across issues of indigeneity, race, class, gender, sexuality, and more.
 - Every community has its own mixture of available resources, knowledges, and local organizations that may be available to generate asset-based community development foundations.
 - Human beings adapt to their localized environments, whether rural or urban, through creativity and ingenuity.
 - The responsibility to address climate and health adaptation efforts will largely fall on the shoulders that are disproportionately impacted.
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Constructed Intimacy as Communicative Pathway for Capacity Building – We are Responsible for Each Other

Critical funding cuts in the public health system leave urban low resource and rural communities alike in reactive states of upheaval and uncertainty. This is particularly true for communities located in states and counties that do not supplement the loss of federal resources – or had little external aid to begin with. Thus, the labor of addressing, healing from, and surviving such hardships will fall on the shoulders of those in harm’s way (Pinderhughes, 2004; Montiel, 2000; Herman, 1992). Oppressed communities and families have long shouldered deteriorating environmental and health conditions amidst

ongoing extraction, political upheaval, and cultural/communal decay. They become the sites of resistance and reform powered by bonding and bridging social capital attachments to people and place (Newton, 2025; Sou, 2022).

It has been well documented in the planning canon and literature, as well as other disciplines, the creation of informal networks between people(s) to aid in survival (Fullilove, 2016; Chu, et al., 2021; Borck, et al., 2015; Friedmann, 1987; Frankl, 1985). Faith-based, immigrant and environmental justice seeking communities are typically the predominant case study examples of such networks (Li, 2011; Stauffer, 2021; Sanchez, et al., 2022). These activated networks are going to be more crucial with every passing year. Fear-based alienation and hyper-individuality is corrosive to social networks that buffer the impacts and abuses of both oppressive societal structures as well as the increasing environmental health impacts of climate change (Torres and Casey, 2017; Tan, et al., 2022; Fullilove, 2016). Thus, it is important to explicitly state that community engagement methodologies (ex: storytelling, theater, music, faith, holidays, etc.) serve a variety of purposes beyond data collection, strategy construction and implementation. They are quite literally lifesaving (Lange, 2022).

Listed in Table 4 are 20 ‘starting points’ for a generative framework both behaviorally and in ‘thinking’ at the community level to assist in the ongoing effort of climate and health adaptation. The table is synthesized from supplemental interview material sourced directly from CRSCI practitioners and builds upon the information provided in Lange et al. (2025). The overarching takeaway, as well as foundational understanding, is the majority of the labor needed to undertake localized climate and health adaptation falls on practices of communication, human connection, addressing basic human needs, and deep collaboration/communities of care (Agyeman and Erickson, 2012; Block, 2018).

TABLE 4 – 20 Tips to Help Communities Begin Building Localized Climate and Health Adaptation Capacity Sourced from the CRSCI Practitioners

#	Practitioner Praxis Insight	Practical Translation Step
1	You may not have enough money for quantitative projections, but you could do qualitative projections to highlight success stories.	Work to see how individuals, families, and neighbors are already adapting to the health threats of climate change—even when they are not aware of it. Study deep histories of survival.

2	Document who your partners are, main questions, and track interventions through evaluation templates.	Stay in touch with individuals and families in harm's way. Document actions and unaddressed needs. Ask: "What would happen in the absence of this action?"
3	Target agriculture/vulnerable populations with focused storytelling regarding heat and hazards.	Language barriers will exist. Build relationships with bi/multi-lingual community members. Use song, food, theater, photography, and prayer to build mutual understanding.
4	Expand key communication materials and evaluate effectiveness of behavior changes.	Fundamentally follow up. Different demographics connect differently; letters, pamphlets, word of mouth, or newspaper ads may outperform social media for older populations.
5	Facilitate a process of selecting what is of most concern and what strategies are feasible.	Start where you are, use what you have, do what you can. Collaborate openly with neighbors to address basic mandates of living: water, food, shelter, medicine, connection.
6	Convene working teams across sectors (clinicians, nonprofits, legislators) to translate knowledge.	Communities are full of differing expertise and inter-generational experiences. Document local building, maintenance, and structural survival wisdom to share with stakeholders.
7	Integrate climate health choices into existing decision-making, education, and actions.	Build a volunteer team of those with available time to act as a climate and health adaptation team, checking in on neighbors similar to voluntary emergency response setups.
8	Implement direct intervention activities such as water supply and flood support smoothings.	Water quality and availability is a growing concern. It is important for all families to test their potable water supplies and share resources at the household level when needed.
9	Focus heavy leadership protections on children's health over their lifespan exposure.	The challenge of localized climate change impacts is here to stay. Make it a new normal. Protect future generations by sharing usable cumulative knowledge for guidance.

10	In the absence of local data, look to larger datasets and evidence-based public health literature.	Get trustworthy information from where you can. Avoid the massive amount of misinformation. Create safe informative assumptions of who is vulnerable to create actionable starting points.
11	Direct framing around climate change can lose people right away; adapt the entry point.	Climate change is divisive. Address challenges using literal and direct terminology regarding immediate hazards, while noting that impacts will worsen over time.
12	Focus on the narrative of how we are meeting challenges and listening to community stories.	Hardship is everywhere. It is equally important to uplift, revitalize, and celebrate accomplishments collectively to show our capacity to make a real difference.
13	Actively maintain local capacity for people to produce and eat local food.	Food safety, supply, and affordability is of growing importance. Community gardens, backyard gardening, simple poultry, and food pantries are lifesaving interventions.
14	Prioritizing cultural competency means taking community experiences and histories seriously.	Understand people exactly where they are and as exactly who they are. Be mindful of assumptions carried into households different from your own. Stay open-minded and open-hearted.
15	Create networks of stakeholders to support hot weather preparedness and high-risk support.	Networking and building relationships in communities can save lives. Isolation is a luxury only the wealthy can afford.
16	Balance witnessing suffering with celebrating local steps.	Build collective milestones. Joy and small wins act as armor against systemic apathy.
17	Focus on simple, direct parameters of security.	Do not overcomplicate structural actions. Ground your baseline in basic human comfort.
18	Avoid missionary-type attitudes or pushing agendas.	All efforts are strictly predicated upon permission. A simple welcoming and invitation will suffice.

19	Build deep networks face-to-face and home-to-home.	Intimacy is built through physical presence and shared time. Learn the true heartbeat of a locality.
20	Create a localized baseline of institutional knowledge.	Build documentation of efforts, strategies, and challenges on an ongoing basis. Even simple notes will suffice to guide future generations.

TABLE 5 – Building a Community Environmental Health Collective

Global grassroots organizing and social movements have shown that progress is possible with solidarity, mutual respect, and passion (Becker, 2021). As shown in Lange (2022; 2020), community resources can be accessed, used, and organized around a small team of volunteers that band together. The power to face, witness and observe structural human suffering is a powerful motivator for action and care (Forester, 2021; Forester, 2020). While small scale teams at the community level may not transform all lives, a few shared resources, a bit of ingenuity, and basic kindness can save one life at a time.

- **Build a Parallel Network:** Build a network between pre-existing community organizations (non-profits, local small businesses) that can serve as a community hub to address indoor air quality, local transportation needs, low-cost housing retrofits, indoor temperatures, and water safety.
- **Maintain the Relationship Fabric:** Work to maintain the relationships created within the network by meeting routinely. This is the bulk of the labor required. Even professional practitioners deliberately spend extensive time and energy keeping the health of relationships intact.
- **Focus on the Basics:** Keep it simple and outside the direct phrasing of climate and health adaptation. Focus entirely on the basics of water, food, shelter, safety, and human comfort.
- **Institutionalize Rituals of Care:** Human ritual, connection, and community are stunningly overlooked but are vital in addressing human suffering. Build ritual-based routines of care (potluck dinners, music) to provide structural emotional armor.

TABLE 6 – Pitfalls to Avoid in Building a Community Environmental Health Collective

- **The Bureaucratic Trap:** Replicating rigid public role-playing or citizen-versus-institution dynamics that cause alienation.
- **The Missionary Fallacy:** Forcing help onto community members without explicit invitation or local permission.
- **Hyper-Individuality:** Allowing fear-based isolation to corrode the social networks that buffer vulnerabilities.
- **The Jargon Barrier:** Using abstract, overly technical academic models that distance planning from actual lived domains.

TABLE 7 – Dig Behind the Façade of the Community Image

Trust is the dimension of shared suffering and shared joy – the essence of interdependency (Lange, 2022, Lange, 2020). However, trust is built upon the understanding of human fallibility, and the foundational compassion and empathy of seeing humanity, the human condition, in full. No community development exercise will be successful unless there is an understanding of human fallibility (Buber, 1970; Moreira, et al., 2022).

When aid is generated, judgment is not the tool to base decisions upon. Judgment and fear are the very pillars of greed, racism, homophobia, sexism, and xenophobia alike (Brow, 1990; Young, 1988; Fullilove, 2016; Sweet, 2018; Sharma, 2025; Alamgir, et al., 2024). Professional practitioners know that the lived experience of illness is far different than the abstract documentation of illness (Fisher, 2014; Agazzi, 2001). As such, the labor of trust and of climate and health adaptation alike is the ability to welcome others to share their lives with each other - treat this vulnerability with care (Erfan, 2017).

Conclusion

The only way out is through. No one can do this alone. Even professional practitioners build networks that deliberately cross boundaries and sectors for this very reason. Humanity is facing a reckoning with its place on Earth and with itself. Thus, rather than technical expertise, what we need now more than ever is a balm for burns, a sense of grace for our mistakes, and a forgiveness that gives rise to action and care. Future generations need us at this very moment to make it right in the name of life, in the name of trust, in the name of connection. The only way for us to sustain our own existence into the future is to come together now to heal, connect, and change. Though, the way through will require mourning for the generations that came before. Their souls too must have a seat at the table if we as a species, or even a nation, are to come together.

It is possible to take care of each other. It is possible to survive for generations. However, we must remember and learn that anthropogenic climate change is a planetary reflection of the microcosm of our lives and the structural inequities of centuries past that have been woven into our nations. As above, so below. These realities of structural systems of oppression and inequity are designed to create alienation, division, and dependency through smoke and mirrors. We have the power at the communal level to simultaneously address scalar impacts through simple care, connection, and compassion. For what it is worth, I hope this short piece aids in that endeavor.

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