

H HEURISTICS

Navigating a Changing World

Human Resilience in a World of Converging Risks

Protecting Well-Being During the Age of Polycrisis

What protects health, security, connection and hope when climate, economic, conflict, health and information risks arrive together — the evidence, the four layers of protection, and a ten-year path

H Heuristics · Hunter Hughes

Research Report · October 2026

Abstract

The polycrisis is usually described in the language of systems: shocks, cascades and feedback loops. It is lived in the language of ordinary life: whether there is enough to eat, whether a night in a heatwave is survivable, whether sleep comes, whether anyone calls. This report asks what determines whether people's wellbeing is protected or eroded when climate, economic, conflict, health and information risks converge, and which strategies protect it most efficiently.

The human footprint is large and measurable. The ILO estimates that 3.8 billion people have no social protection; the UN's latest food-security assessment finds 2.7 billion unable to afford a healthy diet and 645 million facing chronic hunger; the WHO estimates that more than a billion people live with a mental disorder; UNHCR counts 117.8 million forcibly displaced; and the WHO Commission on Social Connection finds about one in six people lonely. The World Economic Forum's *Global Risks Report 2026* finds half of surveyed experts expecting a turbulent or stormy world over two years.

The report organises the problem around a wellbeing-loss identity: the wellbeing lost to converging risks is approximately the product of exposure, sensitivity, duration and the absence of buffering. Each term is answered by a family of strategy — prevent, prepare, restore and buffer. The terms multiply, so a portfolio outperforms any single programme, and the evidence shows how much depends on what stands between a hazard and a person: in a 1995 Chicago heatwave, adjacent neighbourhoods had death rates of about 33 and 3 per 100,000; in Bangladesh, cyclone deaths fell roughly a hundred-fold across three decades of warnings, shelters and volunteers.

Four findings follow. Wellbeing is the right measure because its losses persist and its domains interact. Buffers decide outcomes, yet they are thinnest where hazards are greatest: social protection covers 9.7 per cent of people in low-income countries, fewer than one in ten affected people in low-income countries receives mental-health care, and mental health receives about 2 per cent of health budgets. Resilience is common but conditional — an illustrative simulation shows the share of people beyond a distress threshold after twenty years ranging from about 53 per cent with no buffers to about 9 per cent with protection at four layers. And the most effective protections are modest, evidence-backed and under-funded: shock-responsive cash, lay-delivered mental-health care, heat and early-warning systems, and neighbourhood social infrastructure.

The report sets out what individuals and households, communities, employers and schools, governments and international institutions can each do; reviews six cases; proposes a fifteen-indicator wellbeing-resilience dashboard; sequences action over ten years; and states the trade-offs, the limits of the evidence, and the findings that would change its argument.

Keywords: polycrisis; wellbeing; resilience; mental health; psychosocial support; social protection; social infrastructure; social capital; loneliness; displacement; heat; early warning; food insecurity; climate anxiety; information environment; task-sharing; community resilience; Global South

Data and method: This report synthesises institutional and peer-reviewed research, including the World Economic Forum's *Global Risks Report 2026*; FAO et al.'s *SOFI 2026*; the ILO's *World Social Protection Report 2024–26*; WHO's 2025 mental-health reports and its Commission on Social Connection; UNHCR's *Global Trends* and IDMC's 2026 displacement report; the *Lancet* Countdown 2025 and State of Global Air 2025; the Cascade Institute's work on polycrisis; and research by Ridley, McGuire, Wollburg, Hickman, Charlson, Bonanno, Masten, Hobfoll, Holt-Lunstad, Aldrich, Klinenberg, Hess, Chibanda, Chisholm and Knippenberg and Hoddinott. Every quantitative claim about the world is attributed inline with a hyperlink. Figures 1, 4–11, 15, 17 and 18 report values from the cited sources; Figures 2, 3, 13, 14, 16 and 19 are conceptual schematics; Figure 12 is an illustrative simulation whose structure and parameters are given in Appendix A and which is not an estimate for any population. Several global figures are modelled estimates, and some values come from secondary summaries and are flagged. The report is analytical rather than predictive and is not medical advice.

Contents

Executive Summary	4
1. Introduction: What the Polycrisis Ultimately Threatens	6
2. The Age of Polycrisis: Converging Risks and Their Human Footprint	9
3. A Framework for Protecting Wellbeing: Four Terms, Four Strategies	12
4. Material Security: Food, Income and the Cost of Living	15
5. Physical Health: Heat, Air, Disease and the Fragility of Care	18
6. Mental Health: Distress, Trauma and the Gap in Care	20
7. The Social Fabric: Connection, Displacement, Trust and the Information Environment	23
8. How Risks Compound in Human Lives	26
9. What Resilience Is, and What Builds It	29
10. Strategies for Individuals and Households	33
11. Community Strategies: Social Infrastructure and Local Networks	35
12. Workplaces, Schools and Organisations	37
13. Government and International Strategies: Protecting the Systems That Protect People	39
14. Lessons from Practice: Six Cases	43
15. Measuring What Matters: A Wellbeing-Resilience Dashboard	46
16. Priorities and Sequencing: A Ten-Year Path	48
17. Trade-offs, Limits and What Would Change the Argument	51
18. Conclusion: Protecting What the Polycrisis Threatens	53
References and Further Reading	54
Appendix A: Method Note on the Illustrative Simulation	57
Appendix B: Glossary	58
About This Report	59

Executive Summary

The polycrisis is described in the language of systems: shocks, cascades, feedback loops. It is lived in the language of ordinary life: whether there is enough to eat, whether a night in a heatwave is survivable, whether sleep comes, whether anyone calls. This report is about protecting that second kind of outcome.

The problem. The world in 2026 is not short of crises; it is short of recovery time between them. The World Economic Forum's [Global Risks Report 2026](#) found half of surveyed experts expecting a turbulent or stormy world over the next two years and 57 per cent over the next ten. The human footprint is already large and is measurable: 3.8 billion people have no social protection of any kind, 2.7 billion cannot afford a healthy diet, more than a billion live with a mental disorder, 117.8 million are forcibly displaced, and air pollution, loneliness, suicide and heat are together linked to roughly ten million deaths a year on overlapping, modelled estimates (Figure 1).

The argument. Harm to wellbeing is not simply the sum of hazards. It is governed by four properties of how hazards meet people: how many reach them (**exposure**), how hard each lands (**sensitivity**), how much absorbs the blow (**buffering**), and how long it takes for normal functioning to return (**duration**). The terms multiply, so the same heatwave can kill at 33 per 100,000 in one Chicago neighbourhood and at 3 per 100,000 in the one next door. The difference lay not in the weather but in the social infrastructure around the people exposed.

The evidence. Four findings organise the report.

- **Most people are resilient most of the time, but resilience is conditional.** Decades of research show that stable functioning is the most common human response to adversity, yet that capacity depends on resources that can be depleted: income, health, relationships, safety and trust. An illustrative simulation in this report shows how strongly non-linear the stakes are: with intensifying shocks, the share of people pushed beyond a distress threshold within twenty years ranges from about 53 per cent with no buffers to about 9 per cent with buffers at all four layers.
- **The buffers are thin exactly where the risks are highest.** Only 9.7 per cent of people in low-income countries have any social-protection coverage; fewer than one in ten affected people in low-income countries receives mental-health care, against more than half in high-income countries; governments spend a median of about 2 per cent of health budgets on mental health; and the 33 countries where children face the highest climate risk emit about 9 per cent of the world's CO₂.
- **Protection works, and often costs little.** Bangladesh cut cyclone deaths roughly a hundred-fold through warnings, shelters and volunteers. Ahmedabad's heat action plan was associated with an estimated 1,190 deaths avoided per year. In a Zimbabwean trial of lay-delivered therapy, 14 per cent of participants had depression symptoms at six months, against 50 per cent under standard care. Ethiopia's safety-net programme reduced the initial food-security hit of drought by 57 per cent. Scaled-up treatment for depression and anxiety returns an estimated US\$2.3–5.7 for each dollar.
- **The heavy lifting is institutional.** Individual coping skills matter, but they are only the innermost of four protective layers. Treating resilience as a personal virtue shifts blame onto the people with the least power to change their circumstances. The strategies that move outcomes at scale are cash and services, neighbourhood social infrastructure, workplaces and schools that do not add to the load, and public systems that warn, treat and restore.

The strategy. A four-part portfolio matches the four terms: **prevent** hazards reaching people, **prepare** people to withstand them, **buffer** the blow when it lands, and **restore** functioning quickly afterwards. The report sets out what individuals and households, communities, employers and schools, governments and international institutions can each do (sections 10 to 13), draws lessons from six cases (section 14), proposes a wellbeing-resilience dashboard (section 15), and sequences action over ten years (section 16). The first priorities are modest and unglamorous: pre-arranged cash that can be released within days of a shock; mental-health care integrated into primary care and delivered by trained lay workers; heat and cold plans that reach isolated people; funded neighbourhood social infrastructure; and an information environment in which people can stay informed without being overwhelmed.

What this report does not claim. It does not claim that psychological resilience can substitute for safe housing, income or peace. It does not offer individual medical advice. It uses modelled global estimates whose uncertainty is large, and says so. Section 17 sets out the trade-offs, the limits of the evidence, and the findings that would change the argument.

1. Introduction: What the Polycrisis Ultimately Threatens

Risk assessments count hazards. Lives are made of days. Between the two lies a question that policy has been slow to ask directly: when several risks converge, what actually protects human wellbeing, and whose job is it to provide that protection?

1.1 The question this report asks

The vocabulary of the polycrisis is the vocabulary of systems. Researchers at the Cascade Institute and elsewhere describe how crises in climate, finance, food, health and politics become causally entangled through [common stresses, domino effects and inter-systemic feedbacks](#). The World Bank's [Poverty, Prosperity, and Planet report](#) is subtitled *Pathways Out of the Polycrisis*. The World Economic Forum surveys more than a thousand experts each year about which risks will materialise and how they interact. All of this is necessary. None of it answers the question that a person living through a cost-of-living spike, a flood season and a conflict one country over would ask: what will keep me and the people I love well?

This report asks that question at the level of populations. **When risks converge, what determines whether people's wellbeing is protected or eroded, and which strategies protect it most efficiently?** The question is not whether crises harm people, which is obvious, nor whether societies should prepare, which nobody disputes. It concerns mechanism: which features of a hazard, of a person and of the surrounding society turn a stressful event into lasting harm, and which interventions act on those features at the lowest cost.

1.2 Why wellbeing, and what it means here

Economic analysis of crises tends to stop at output, employment and prices. These matter, but they are poor proxies for what people experience. Output can recover faster than health, trust and childhood development do; a family can move back above the poverty line while carrying a debt, a bereavement or a diagnosis that did not exist before the shock. Wellbeing is the more demanding yardstick, because it records what persists.

This report uses a deliberately practical definition: **wellbeing is a person's capacity to meet their needs, stay healthy in body and mind, sustain relationships, and act with some sense of agency and hope.** That yields five domains, used throughout: **material security** (food, income, shelter), **physical health, mental health, social connection, and agency and hope**. The domains overlap and reinforce one another, which is the point. A loss of income is also a loss of sleep; a heatwave is also a test of whether anyone checks on the elderly neighbour; an unreliable information environment is also a source of chronic worry. Table 2 in section 3 pairs each domain with indicators that can be tracked.

1.3 The human footprint today

The scale of what is at stake is no longer speculative. Figure 1 assembles headline estimates from the most recent global assessments, separating the people affected at a point in time from the deaths attributed each year. The two panels use different units and different vintages, and several figures are modelled estimates with wide uncertainty ranges, so they should be read as orders of magnitude and not as a ledger.

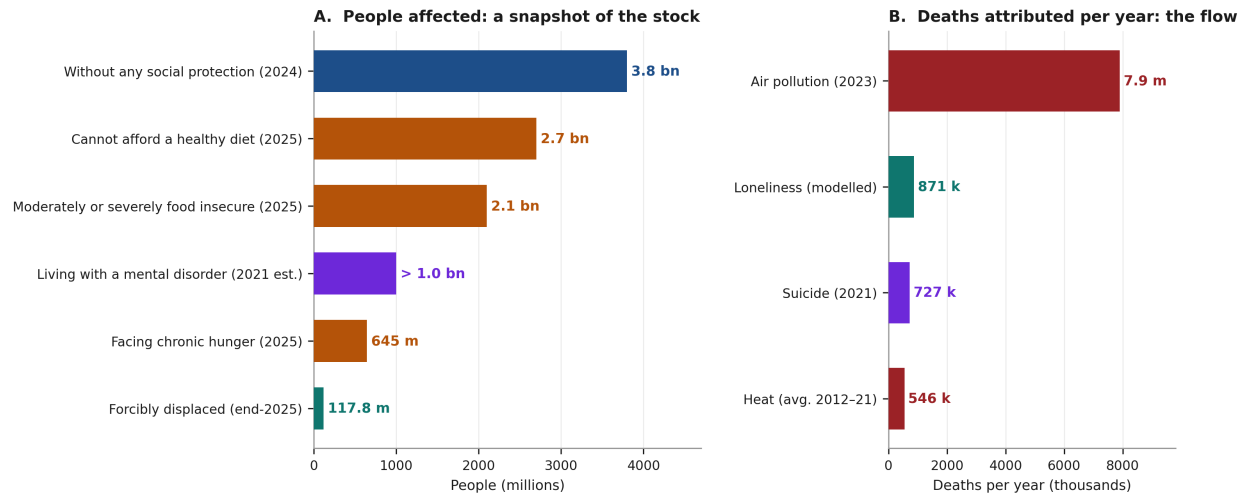


Figure 1. The human footprint of converging risks: people affected (stock) and deaths attributed per year (flow).

H Heuristics, using [ILO](#) (social protection); [FAO et al., SOFI 2026](#) (food); [WHO](#) (mental disorders, suicide); [UNHCR](#) (displacement); [State of Global Air 2025](#); [WHO Commission on Social Connection](#); [Lancet Countdown 2025](#). Loneliness and heat deaths are modelled estimates.

Table 1 lists the same indicators with their sources and a note on how far each can be trusted. Two cautions apply throughout. First, almost every global figure on wellbeing is modelled from incomplete data, and the least data exist in the places where the risks are highest. Second, the numbers are revised: the 2025 edition of the UN’s hunger report estimated 673 million people undernourished in 2024; the 2026 edition revised the 2024 figure down to 8.1 per cent of the population and estimated 645 million for 2025. Direction of travel is usually more reliable than level.

Table 1. Headline indicators of the human footprint, with source and vintage

Indicator	Latest estimate	Source (vintage)
People without any social protection	3.8 billion; 52.4% of the world covered by at least one benefit	ILO, World Social Protection Report 2024–26 (2023 data)
People facing chronic hunger	645 million (7.8%)	SOFI 2026 (2025)
Moderate or severe food insecurity	2.1 billion (25.8%)	SOFI 2026 (2025)
Cannot afford a healthy diet	2.7 billion; US\$4.28 PPP per day average cost	SOFI 2026 (2025)
People living with a mental disorder	More than 1 billion; nearly 1 in 7	WHO, World Mental Health Today (2025)
Deaths by suicide	727,000	WHO (2021)
People reporting loneliness	About 1 in 6; linked to about 871,000 deaths a year	WHO Commission on Social Connection (2025)
Forcibly displaced people	117.8 million (end-2025); first fall in a decade	UNHCR, Global Trends 2025
Internally displaced by conflict or disasters	82.2 million (end-2025)	IDMC, GRID 2026
Heat-related deaths	About 546,000 a year (2012–21 average)	Lancet Countdown 2025
Deaths attributed to air pollution	7.9 million	State of Global Air 2025 (2023)

PPP = purchasing power parity. Figures are modelled global estimates; definitions and vintages differ and totals should not be added across rows.

1.4 The argument in brief

The argument rests on one observation and one identity. The observation is that the same hazard produces very different human outcomes depending on what stands between the hazard and the person. In July 1995 a heatwave killed more than 700 people in Chicago; in two adjacent, similarly poor and similarly elderly neighbourhoods, the death rates differed roughly elevenfold, a gap that the sociologist Eric Klinenberg traced to [social infrastructure, not demography](#). In 1970 the Bhola cyclone killed at least 300,000 people in what is now Bangladesh; in 2007 cyclone Sidr killed about 3,500, after decades of warning systems, shelters and volunteer networks documented by [The New Humanitarian](#).

The identity follows. Over any period, the wellbeing lost to converging risks is approximately the product of four terms: the exposure of people to hazards, their sensitivity to each, the duration of the loss, and the degree to which buffers absorb it. Section 3 develops the identity (Figure 3). Four propositions follow, and the report defends each in turn.

- **Wellbeing is where the polycrisis becomes real, and it has more than one dimension.** Material, physical, mental, social and psychological losses interact; a strategy that protects one domain while ignoring the others will leak.
- **Buffers decide outcomes.** Where social protection, health care, early warning and community ties exist, hazards of equal size cause far less harm. Where they are absent, modest shocks become lasting injuries.
- **Resilience is common but conditional, and it depletes.** People are more resilient than pessimistic accounts assume, but repeated and overlapping adversity erodes the resources that make resilience possible. The danger of the polycrisis is not any single blow but the loss of time to recover between blows.
- **The most cost-effective protections are modest and under-funded.** Cash transfers, lay-delivered mental-health care, heat and early-warning systems, and neighbourhood social infrastructure are inexpensive relative to the harms they avert, yet mental health receives about 2 per cent of health budgets and half the world has no social protection.

1.5 Scope, evidence and reading guide

The report is global in scope but attentive to the Global South, where hazards are greatest and buffers thinnest. It draws on institutional assessments (WHO, FAO, ILO, UNHCR, IDMC, WMO, the World Bank and the World Economic Forum), peer-reviewed research in psychology, public health, economics and disaster studies, and official sources on specific programmes. Every quantitative claim about the world is attributed inline with a hyperlink. Where a figure comes from an illustrative model rather than from data, the text and the figure caption say so.

The report is analytical rather than predictive, and it is not a clinical document: nothing in it is medical advice, and readers who are struggling should seek support from a qualified professional or local services. Sections 2 and 3 set out the risk landscape and the framework. Sections 4 to 7 examine four pathways of harm: material security, physical health, mental health and the social fabric. Section 8 shows how they compound, and section 9 reviews what the science says builds resilience. Sections 10 to 13 set out strategies by actor, section 14 reviews six cases, and sections 15 to 18 cover measurement, sequencing, limits and conclusions.

2. The Age of Polycrisis: Converging Risks and Their Human Footprint

Crises have always arrived in clusters. What is distinctive about the 2020s is that the clusters are denser, the buffers between them are thinner, and the information environment through which people interpret them is less trusted.

2.1 What “polycrisis” means, and what it leaves out

The term gained currency in policy debate in the early 2020s, and it has been criticised as a buzzword. The most careful definition comes from the Cascade Institute’s [Lawrence, Homer-Dixon, Janzwood, Rockström, Renn and Donges](#), who define a global polycrisis as one in which crises in multiple global systems become causally entangled in ways that cause major human harm. They identify three entanglement mechanisms: *common stresses* that hit several systems at once, *domino effects* in which a failure in one system triggers another, and *inter-systemic feedbacks* in which systems amplify one another. A drought that cuts harvests, lifts food prices, strains public budgets and prompts migration contains all three.

What the systems framing tends to leave out is the person at the end of the chain. Entanglement among global systems is only consequential because it converges on households, workplaces and neighbourhoods. A person’s experience of a polycrisis is not a sum of global indicators; it is the particular combination of price rises, health scares, safety concerns and bad news that reaches them, mediated by what they have to fall back on. This report therefore adds a human layer to the systems account, and treats the transmission from system to person as the object of study.

2.2 The risk landscape in 2026

The World Economic Forum’s [Global Risks Report 2026](#), drawing on a survey of more than 1,300 experts, ranks geoeconomic confrontation first for the immediate year, the first time it has topped the near-term list. Misinformation and disinformation ranks second on the two-year outlook; economic downturn and inflation each rose eight places; and half of respondents expect a turbulent or stormy world over two years, 14 percentage points more than a year earlier. Over ten years the outlook darkens (57 per cent expect turbulence or storms), and extreme weather and biodiversity loss are ranked most severe, while adverse outcomes of artificial intelligence rise from 30th place on the two-year horizon to fifth over ten.

Beneath these perceptions lie measured trends. The World Meteorological Organization reports that 2025 was [among the three warmest years on record](#), that the eleven years from 2015 to 2025 are the eleven warmest in the 176-year record, and that 2024 stood about 1.55 °C above the pre-industrial average. The Lancet Countdown’s [2025 report](#) finds that the average person was exposed to a record 16 additional health-threatening hot days because of climate change, and that heat-related deaths averaged about 546,000 a year over 2012–21. The Internal Displacement Monitoring Centre records that [conflict and violence caused more new internal displacements than disasters for the first time in 2025](#), a record 32.3 million, against 29.9 million from disasters. The FAO and partners warn that their latest hunger estimate may understate risk because it does not fully reflect a possible strong El Niño or recent cuts to development and humanitarian financing.

2.3 Four channels from risk to life

Figure 2 maps how converging risks reach wellbeing. Five families of risk (climate extremes, economic shocks, conflict and displacement, health shocks and pollution, and information disorder alongside

technological disruption) act through four transmission channels, each of which touches several domains of wellbeing.

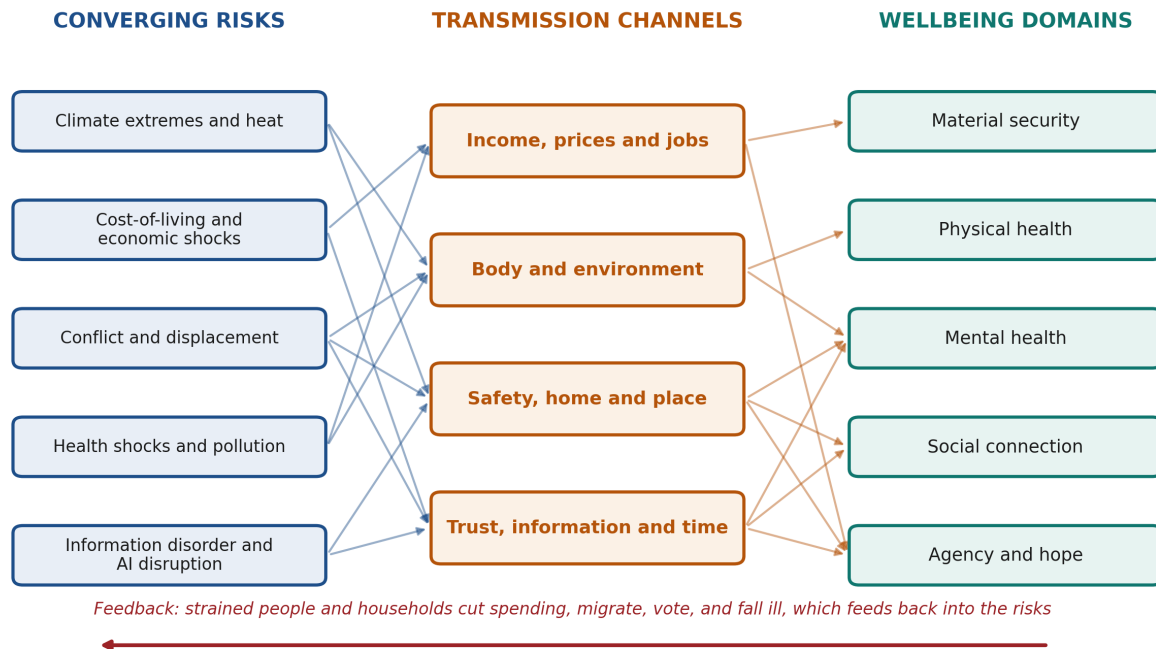


Figure 2. From converging risks to human wellbeing: five risk families, four transmission channels, five wellbeing domains.

H Heuristics. Conceptual schematic. Risk families follow the categories of the [WEF Global Risks Report 2026](#); the three entanglement mechanisms are from [Lawrence et al. \(2024\)](#). Arrows indicate principal, not exhaustive, pathways.

- **Income, prices and jobs.** Price spikes, unemployment, debt and lost remittances reduce material security directly and agency indirectly. They also raise stress, a pathway documented in [causal evidence reviewed by Ridley and colleagues](#).
- **Body and environment.** Heat, polluted air, disease and damaged health services act on physical health, and through sleep, pain and fear on mental health. The IPCC's sixth assessment found, with very high confidence, that [threats to mental health and wellbeing are increasing](#).
- **Safety, home and place.** Conflict, disasters and eviction remove the stable setting in which routine, relationships and a sense of future are built. Displacement is the extreme case, but loss of a familiar neighbourhood to flood, fire or economic decline has similar effects on a smaller scale.
- **Trust, information and time.** The constant arrival of alarming news, contested facts and fast-changing circumstances consumes attention and can leave people feeling that nothing is predictable. Trust, the willingness to rely on strangers and institutions, determines whether people share information, comply with warnings and help one another.

2.4 Three features that make the present different

Compression. Crises used to be separated by years in which households and institutions rebuilt. Overlapping shocks shorten or eliminate those intervals. The key variable for human wellbeing is the same as for economies: the ratio of recovery time to the interval between shocks. When recovery is faster than the next blow, people recover; when it is slower, losses ratchet.

Thinning buffers. Some of the buffers that matter most are weakest where hazards are strongest. Social protection covers 52.4 per cent of the world's people but only 9.7 per cent in low-income countries, according to the [ILO](#). Mental-health systems spend about 2 per cent of health budgets, and humanitarian and development financing is under pressure. The buffers are being asked to do more at the moment they are being funded less.

An uncertain information environment. Measured trust in institutions and news is low and in several markets still falling. The Reuters Institute's [Digital News Report 2026](#) records trust down in 29 of 48 markets and news avoidance at record levels in some countries. The 2026 [Edelman Trust Barometer](#) finds that seven in ten people are unwilling or hesitant to trust people with different values, backgrounds or information sources, and that trust is concentrating among those closest to us. For wellbeing the consequence is double: people are both more anxious and less able to rely on the shared institutions that would reassure or support them.

3. A Framework for Protecting Wellbeing: Four Terms, Four Strategies

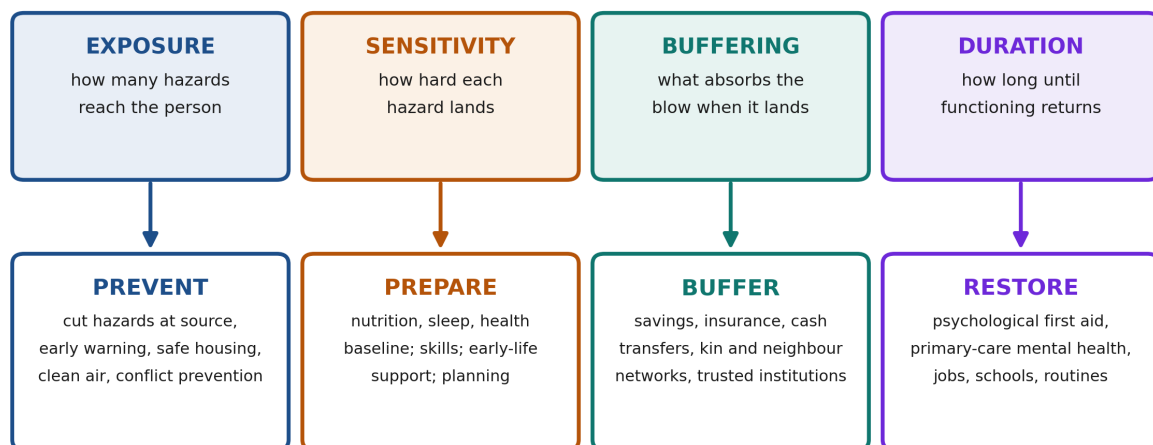
To protect wellbeing efficiently, one needs a way to see which part of the problem a given measure acts on. The framework below does that with four multiplicative terms, each answered by one family of strategy.

3.1 The wellbeing-loss identity

Over any period, the wellbeing an individual or population loses to converging risks can be approximated as the product of four terms:

- **Exposure:** how many hazards reach the person, and how often. Exposure is set by the hazards themselves and by where and how people live. It is reduced by prevention: cutting hazards at source, early warning, safe housing and clean air, and conflict prevention.
- **Sensitivity:** how hard each hazard lands on a given person. Sensitivity is shaped by age, health, nutrition, sleep, prior adversity and early-life conditions. It is reduced by preparation.
- **Buffering:** the share of the blow absorbed before it reaches the person. Savings, insurance, cash transfers, kin and neighbour networks, trusted institutions and responsive services all buffer. The term enters as $(1 - \text{buffering})$, so each increment of buffering is worth more the less buffering there is to begin with.
- **Duration:** how long it takes for functioning to return. Duration is shortened by restoration: psychological first aid, accessible primary-care mental health, rapid reopening of schools and workplaces, and a restored routine.

$$\text{WELLBEING LOSS} \approx \text{EXPOSURE} \times \text{SENSITIVITY} \times \text{DURATION} \times (1 - \text{BUFFERING})$$



Each family of strategy acts on a different term; the terms multiply, so a portfolio outperforms any single programme

Figure 3. The wellbeing-loss identity: four multiplicative terms, four families of strategy.

H Heuristics. Conceptual schematic. The identity is an organising approximation, not an estimated equation; its structure parallels H Heuristics' shock-loss identity for economic convergence.

The identity is a heuristic, not a formula to be estimated. Its value is diagnostic. It makes explicit that wellbeing can be protected from four directions, that the directions multiply, and that a strategy acting on one term cannot be judged in isolation. A heat early-warning system cuts exposure but does nothing for a household without a cool place to go; a cash transfer buffers but does not shorten a mental-health episode; a lay-counsellor programme shortens duration but does not prevent the next flood.

3.2 Why the terms multiply, and what follows

If the terms were additive, the best strategy would be whichever single lever was cheapest per unit. Because they multiply, two implications follow. First, **a balanced portfolio beats a flagship**. Halving each of four terms leaves one-sixteenth of the original loss; halving one leaves one-half. Second, **buffers have increasing returns at the margin where they are scarcest**. The first dollar of income security or the first hour of accessible care changes the outcome for a person who has nothing, far more than the thousandth does for a person who has plenty. That is why the evidence reviewed later finds that benefits are largest for people with the least, and why universal floors are more efficient than they appear in aggregate cost–benefit tables.

A third implication concerns time. The duration term links directly to the polycrisis problem. When a second hazard arrives before the first has been recovered from, the sensitivity term rises, because a depleted person is more vulnerable, and the buffering term falls, because savings and goodwill have been spent. The terms are therefore not independent; they feed one another. That interdependence is what turns a series of manageable events into a lasting injury, and section 8 explores it with a simple simulation.

3.3 Five domains and the indicators that track them

The identity applies to each of five domains of wellbeing. Table 2 pairs each with the main pathway of harm discussed in sections 4 to 7, a representative global indicator, and the protective strategies of greatest leverage.

Table 2. Wellbeing domains, pathways of harm, tracking indicators and highest-leverage protections

Domain	Main pathways of harm	Example indicators	Highest-leverage protections
Material security	Food and energy prices; job and income loss; debt; displacement	Food insecurity; share without social protection; cost of a healthy diet	Shock-responsive cash; school meals; price and supply stabilisation
Physical health	Heat, air pollution, disease, disrupted health services	Heat-related deaths; air-pollution deaths; service coverage	Heat and cold plans; clean air; resilient primary care
Mental health	Trauma, loss, chronic stress, loneliness, poverty	Prevalence of anxiety and depression; suicide; treatment coverage	Lay-delivered primary-care therapy; psychological first aid; community supports
Social connection	Isolation, displacement, polarisation, distrust	Loneliness prevalence; social trust; neighbour contact	Social infrastructure; community networks; inclusive public spaces
Agency and hope	Perceived inaction, information overload, powerlessness	Sense of control; optimism about the future; civic participation	Participation in local preparedness; honest, actionable information; visible delivery

Indicators are examples; section 15 proposes a dashboard. Protections are drawn from the evidence reviewed in sections 4 to 14.

3.4 Four layers of protection

The strategies that act on the four terms are delivered through four nested layers: the person, the household, the community, and institutions and policy. Section 9 develops this structure (Figure 14) and shows that the outer layers do more of the work than is commonly assumed. A recurring finding of the disaster literature is that recovery is better explained by social and institutional features of a place than by the size of the disaster or the amount of aid it received. The layered framing also guards against a recurrent policy error, which is to treat resilience as something individuals should build for themselves. Individuals can and should build skills and habits, but when the outer layers fail, inner ones cannot compensate.

4. Material Security: Food, Income and the Cost of Living

Material insecurity is the most direct pathway from converging risks to wellbeing and the best-documented. It is also the pathway where the case for early, predictable, unconditional support is strongest.

4.1 Food: progress, and its fragility

The UN's latest assessment of food security, [SOFI 2026](#), brings both good and bad news. Hunger declined for a third straight year: an estimated 645 million people (7.8 per cent of the population) were undernourished in 2025, about 14 million fewer than in 2024 and 43 million fewer than at the 2022 peak. But the same report finds that around 2.1 billion people (25.8 per cent) experienced moderate or severe food insecurity, that 2.7 billion cannot afford a healthy diet at an average cost of US\$4.28 per person per day, and that Africa has become the region with the largest number of hungry people. Food insecurity remains more prevalent among women and children than men, and in rural than in urban areas.

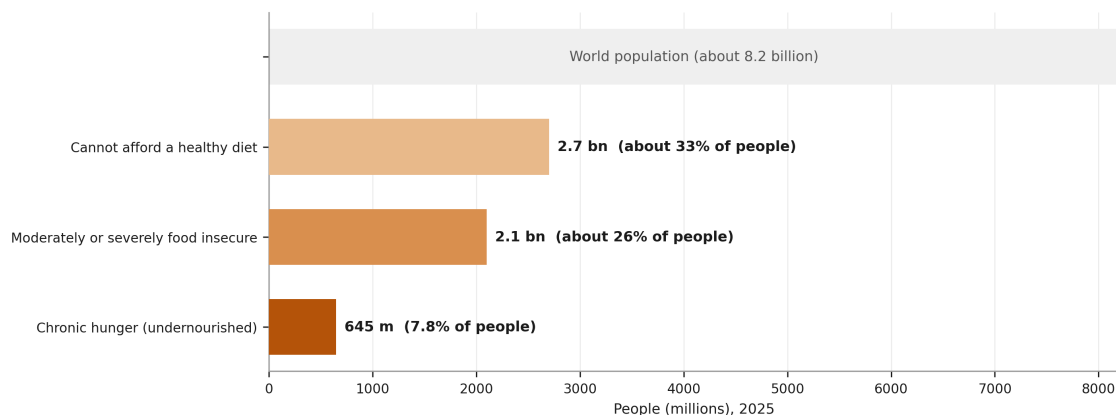


Figure 4. Three tiers of food insecurity, 2025: unaffordable healthy diets, moderate or severe food insecurity, and chronic hunger.

FAO, IFAD, UNICEF, WFP and WHO, [SOFI 2026](#) (full report [doi:10.4060/cd8306en](https://doi.org/10.4060/cd8306en)); world population rounded to 8.2 billion by H Heuristics for the share labels. Tiers overlap and are not additive.

Two features of these data matter for wellbeing. First, the gap between hunger (645 million) and unaffordable healthy diets (2.7 billion) is a gap between not having enough calories and not being able to eat well, and the wellbeing costs of the second are borne largely in health and in the stress of constant budgeting. Second, the progress is fragile. The report's authors caution that the estimate may understate risk because it does not fully account for a possible strong El Niño or for recent reductions in development and humanitarian financing. A system that is improving but exposed to multiple simultaneous shocks is exactly the profile the polycrisis literature warns about.

4.2 Income, poverty and mental health run in both directions

The strongest causal evidence on the economic roots of distress comes from the review by [Ridley, Rao, Schilbach and Patel in Science](#). It finds that the relationship between poverty and common mental illness runs in both directions: mental illness reduces employment and income; negative economic shocks cause mental illness; and anti-poverty programmes such as cash transfers improve mental health, while psychological interventions generate economic gains. Within a given location, people with the lowest

incomes are typically 1.5 to 3 times more likely than the rich to experience depression or anxiety, and depression and anxiety together account for about 8 per cent of years lived with disability worldwide.

For the polycrisis, the implication is that economic shocks are mental-health shocks, and that the two cannot be managed by separate ministries. An energy price spike that pushes a household into arrears also raises that household's probability of depression, which in turn reduces its ability to work and to adapt, which deepens the arrears. The 2026 [Edelman Trust Barometer](#) reports economic anxiety at all-time highs, with only about one in three people in the study believing the next generation will be better off, a measure of hope as well as of income.

4.3 Social protection: the largest buffer, and its gaps

Social protection (cash transfers, pensions, unemployment and disability benefits, child allowances, public works and health coverage) is the principal institutional buffer between a shock and a household's material security. The ILO's [World Social Protection Report 2024–26](#) shows both progress and its limits (Figure 5). For the first time more than half the world's population, 52.4 per cent, is covered by at least one social-protection benefit, up from 42.8 per cent in 2015. Yet 3.8 billion people remain entirely unprotected, three-quarters of children (76.1 per cent) lack effective coverage, and in the twenty countries most vulnerable to the climate crisis, 91.3 per cent of people have no social protection at all.

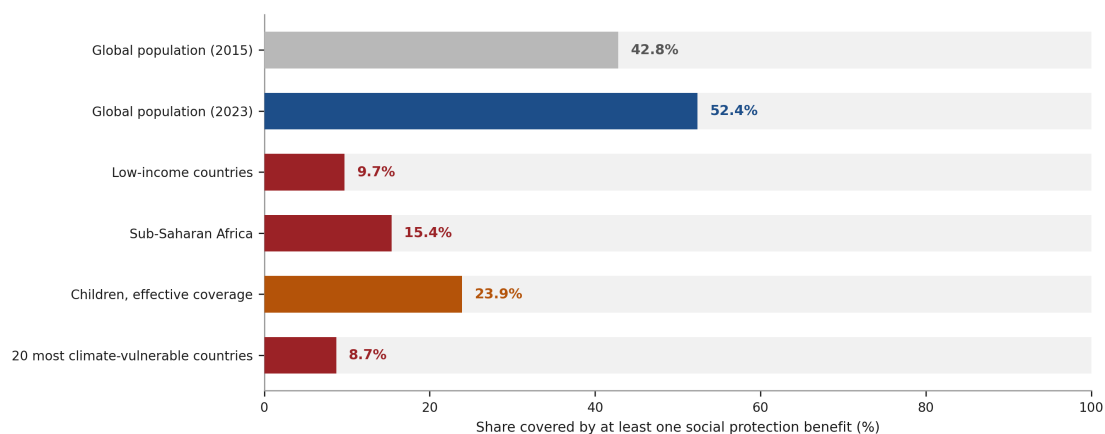


Figure 5. Social-protection coverage is lowest where climate and other risks are highest.

[ILO, World Social Protection Report 2024–26](#) and [ILO news release](#). Regional and low-income figures as reported in secondary summaries of the ILO report; children's effective coverage computed as 100 minus the reported 76.1% lacking coverage; 20 most climate-vulnerable countries computed as 100 minus 91.3%.

The pattern in Figure 5 is the opposite of what an insurance logic would prescribe. The people facing the greatest hazard have the least cover. Coverage in low-income countries stands at 9.7 per cent, and in sub-Saharan Africa at about 15 per cent, according to secondary summaries of the ILO report. The ILO's own framing is that social protection is both an enabler of climate action and a precondition for a just transition, because people who are already insecure will resist change that threatens what little they have.

4.4 What the evidence says about cash and safety nets

The evidence that cash helps wellbeing is substantial, although effects are modest in size and conditional on design.

- A systematic review and meta-analysis by [McGuire, Kaiser and Bach-Mortensen](#) in *Nature Human Behaviour*, covering 45 studies and about 117,000 people in low- and middle-income countries,

found small but significant positive effects of cash transfers on subjective wellbeing (Cohen's $d = 0.13$) and mental health ($d = 0.07$), averaged over about two years of follow-up. Transfer size, both relative to previous income and in absolute terms, was a strong predictor of the effect.

- A separate meta-analysis of randomised trials by [Wollburg and colleagues](#) in *PLOS ONE* (17 studies, 26,794 participants) found that cash transfers significantly reduced depression and anxiety (pooled $d = -0.10$). Effects were larger for unconditional transfers ($d = -0.14$) than for conditional ones, where the pooled estimate pointed the other way ($d = +0.10$), raising a caution about the possible stress of conditionality. Improvements were not statistically significant 2–9 years after programmes ended.
- In Ethiopia, [Knippenberg and Hoddinott](#) found that drought lowered households' food security for up to four years after the drought ended, and that receipt of Productive Safety Net Programme payments reduced the initial impact of drought by 57 per cent and eliminated its adverse effect within two years, with the largest gains for households with little or no land. An [ODI policy brief](#) describes the broader evidence on the programme's resilience effects as patchy, so this finding should be read as promising and not definitive.

Three design lessons follow. **Size matters:** transfers that are too small to change a household's position produce small wellbeing effects. **Predictability matters:** a transfer that can be relied on lets people plan, and the stress reduction may come as much from the removal of uncertainty as from the money. **Duration matters:** effects fade when payments end, which argues for programmes that are permanent floors and not one-off relief. Section 13 returns to these in the design of shock-responsive social protection.

5. Physical Health: Heat, Air, Disease and the Fragility of Care

The body is where several of the polycrisis's pathways meet. Heat, polluted air and disrupted health services act on physical health directly, and, through sleep, pain, fear and the strain of caring for others, on mental health as well. What the evidence shows most clearly is how much of the harm depends on what surrounds the body.

5.1 Heat: a rising exposure with a very unequal toll

Heat is the most direct physical expression of climate change for most people, and its human toll is already large. The [Lancet Countdown's 2025 report](#), produced by 128 experts from 71 institutions with WHO as a strategic partner, finds that heat-related deaths averaged about 546,000 a year over 2012–21, with the rate per 100,000 people about 23 per cent higher than in the 1990s. The average person was exposed to a record extra 16 health-threatening hot days because of climate change, a 389 per cent increase on the 1986–2005 annual average, and 84 per cent of heatwave days experienced in 2020–24 would not have occurred without climate change. The [WHO's summary of the report](#) frames it as a warning that climate inaction is claiming millions of lives.

Heat does not harm only through deaths. Hot nights disrupt sleep, one of the most basic determinants of mood, cognition and resilience. Outdoor workers lose earnings or health. Older people, infants, and people with chronic disease or on certain medicines are most at risk. And homes that cannot be kept cool convert a weather event into a household problem that lasts for the whole season. The IPCC's sixth assessment, in its chapter on [health, wellbeing and the changing structure of communities](#), concludes with very high confidence that climate-related illnesses, premature deaths, malnutrition in all its forms and threats to mental health and wellbeing are increasing.

5.2 Same heat, different outcomes

The most important finding in the heat literature for this report is that the weather is not the whole story. Two cases make the point from opposite directions: one shows how social conditions turned a heatwave deadly, the other how an institutional response made a hot city safer.



Figure 6. Same heat, different outcomes: (A) heat-wave death rates in two adjacent Chicago neighbourhoods, 1995; (B) mortality rate ratio at 47 °C in Ahmedabad before and after its heat action plan.

(A) Death rates as reported by [Axios](#) citing Klinenberg; see also [NPR](#). (B) [Hess et al. \(2018\)](#), *Journal of Environmental and Public Health*; ratio relative to mortality on a mild day; pre-plan 2007–10, post-plan 2014–15.

Chicago, July 1995. A heatwave killed more than 700 people in a few days. The sociologist Eric Klinenberg's comparison of two adjacent, predominantly Black and low-income South Side neighbourhoods is now classic: Englewood suffered roughly 33 heat-wave deaths per 100,000 residents, Auburn Gresham about 3. The populations were similar in age and income. What differed was the surrounding social infrastructure. Englewood had lost residents, shops and community spaces that bring people into contact, so fewer people were checking on one another; Auburn Gresham retained small commercial and civic establishments that draw older residents out of their homes and into public life. As the account [reported by Axios](#) puts it, the difference was less about the people than about the abandonment of the place.

Ahmedabad, India. After a deadly 2010 heatwave, the city launched South Asia's first heat action plan, combining early warning, public awareness, training for health workers and measures to reduce heat exposure. In a before-and-after evaluation, [Hess and colleagues](#) estimated that the mortality rate ratio at 47 °C fell from 2.34 before the plan to 1.25 afterwards, equivalent to an estimated 1,190 deaths avoided each year (95 per cent confidence interval 162 to 2,218). The interval is wide and the design compares periods and not randomised groups, so the figure should be read as indicating a large likely benefit and not a precise count. Even so, the direction is consistent with the Chicago finding: heat deaths are substantially a function of preparation and social connection.

5.3 Air: a chronic exposure that is easy to overlook

Air pollution is the largest environmental risk to health, and it acts quietly and chronically. The [State of Global Air 2025 report](#) attributes 7.9 million deaths to air pollution in 2023, 86 per cent of them from noncommunicable diseases, and for the first time includes dementia, with 626,000 deaths attributed to air pollution. India and China each had more than two million attributed deaths. Of the total, ambient fine particles account for about 4.9 million and household air pollution, mostly from cooking with polluting fuels, about 2.8 million; the categories overlap and are not additive. The Health Effects Institute notes that a revision lowering the estimate for 2021 [reflects improvements in methods and modelling, not cleaner air](#).

For wellbeing there are two points. First, the burden falls on those least able to avoid it: people who cook indoors with solid fuel, live beside busy roads, or work outdoors. Second, perceived risk lags measured risk. In the World Economic Forum's 2026 survey, pollution fell three places and critical changes to Earth systems seven places on the two-year outlook, a shift commentators attribute to economic worries taking priority, even as the measured toll remained at several million lives a year. A polycrisis can crowd out the slower threats that are doing the most damage.

5.4 Health systems: the shared buffer

Behind each of these exposures stands the health system, which converts a hazard into an outcome. A primary-care network that stays open through a flood, keeps chronic-disease medicines flowing and can screen for distress shortens the duration term in the identity. A system that is overwhelmed, under-staffed or unaffordable lengthens it. The IPCC and WHO both stress that adaptation of health systems, through surveillance, climate-resilient facilities, trained workers and financing, is among the highest-return protections; the WHO's [review of IPCC evidence on climate, health and wellbeing](#) is a convenient summary.

For this report, the central health-system point is integration. The cost-effective way to protect physical and mental health together is to deliver them through the same front door, the primary-care clinic or community health worker, with the same trusted staff. Section 6 shows that this is also where the gap in mental-health care is greatest, and section 13 sets out what integration means in practice.

6. Mental Health: Distress, Trauma and the Gap in Care

Mental health is both the most sensitive indicator of how converging risks are felt and the domain in which protective systems are weakest. Most distress is a normal response to abnormal circumstances. The policy problem is that when distress becomes disorder, most people in most countries get no help.

6.1 The scale of the burden

The WHO's [World Mental Health Today](#) report and its companion [estimates, released on 2 September 2025](#), put the number of people living with a mental health condition at more than one billion, nearly one in seven of the world's population. Anxiety and depression are the second leading cause of long-term disability. An estimated US\$1 trillion of productivity is lost each year to depression and anxiety, and 727,000 people died by suicide in 2021.

The COVID-19 pandemic offers the clearest recent evidence of how a global shock moves the population distribution of distress. The [COVID-19 Mental Disorders Collaborators](#) estimated in *The Lancet* that the pandemic produced an additional 53.2 million cases of major depressive disorder (a 27.6 per cent increase) and 76.2 million cases of anxiety disorders (a 25.6 per cent increase) in 2020. Women and younger people were affected more than men and older people, and the places with the highest infection rates and the largest reductions in mobility saw the greatest increases. These are modelled estimates from a limited number of studies with pre-pandemic baselines, but the pattern is consistent: when people lose routine, income and connection at the same time, distress rises, and it rises most among those already disadvantaged.

6.2 Conflict, disaster and displacement

Mass violence and disaster raise the burden further. A systematic review and meta-analysis by [Charlson and colleagues](#) for the WHO, published in *The Lancet*, estimated that the point prevalence of depression, anxiety, post-traumatic stress disorder, bipolar disorder and schizophrenia in conflict-affected populations was 22.1 per cent (95 per cent uncertainty interval 18.8–25.7), with 9.1 per cent having a moderate or severe disorder. The authors' own [summary at the University of Queensland](#) used the rounded "one in five". This is a point prevalence measured at a moment in time, using a different definition from the WHO's all-population estimate, so the comparison in Figure 8A is indicative and not like for like.

The disaster literature gives a complementary picture. Norris and colleagues' [review of 160 samples of disaster victims](#) found that samples were more likely to be impaired when they were youth rather than adults, came from developing rather than developed countries, or experienced mass violence rather than natural or technological disasters; most samples of rescue and recovery workers showed notable resilience. The consistent message is that the severity of mental-health consequences depends on the type of event, on pre-existing vulnerability, and on the resources available afterwards.

6.3 Climate distress: a reasonable response to a real threat

A new feature of the polycrisis is distress about the polycrisis itself. The largest study to date, by [Hickman and colleagues](#) in *The Lancet Planetary Health*, surveyed 10,000 people aged 16 to 25 in ten countries (Australia, Brazil, Finland, France, India, Nigeria, the Philippines, Portugal, the UK and the USA) in 2021. Fifty-nine per cent were very or extremely worried about climate change and 84 per cent at least moderately worried. More than half reported feeling sad, anxious, angry, powerless, helpless and guilty, and about 45 per cent said such feelings affected their daily lives. Importantly, distress was significantly related to perceived government inaction and associated feelings of betrayal.

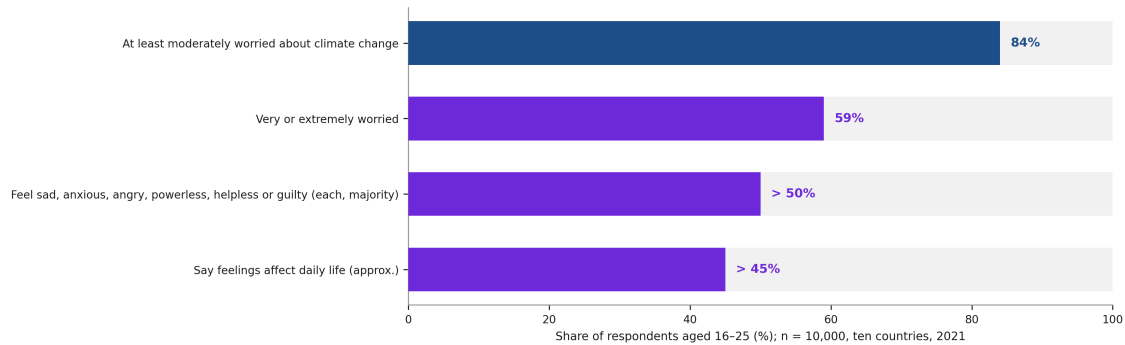


Figure 7. Climate-related worry and distress among 10,000 young people in ten countries, 2021.

[Hickman et al. \(2021\), The Lancet Planetary Health](#). Figures for the “each, majority” and “daily life” bars are from the paper’s abstract and press coverage of it; the sample is not nationally representative and the design is cross-sectional.

Two interpretive points follow. First, this is not best understood as a pathology to be treated. Worry in response to an objectively serious threat is rational, and the survey finding that distress tracks perceived institutional failure suggests that part of the remedy is visible, credible action. Second, the finding is correlational and from a self-selected online sample; it cannot show that government action would reduce distress, though it is consistent with it. The practical implication, taken up in section 10 and section 11, is that the goal is not to suppress concern but to convert it into agency: something to do, with others, that counts.

6.4 The gap in care

The most striking fact about mental health in the polycrisis is not the burden but the response to it. The WHO’s [2 September 2025 release](#) reports that in low-income countries fewer than 10 per cent of affected people receive care, against more than half in high-income countries; that median government spending on mental health is about 2 per cent of health budgets, unchanged since 2017; that there are about 13 mental-health workers per 100,000 people worldwide; and that fewer than one in ten countries has fully moved to community-based care, with most still relying heavily on psychiatric hospitals. Secondary summaries of the Mental Health Atlas put the median at about 1.5 per cent of health spending in low-income countries and 4.3 per cent in high-income countries.

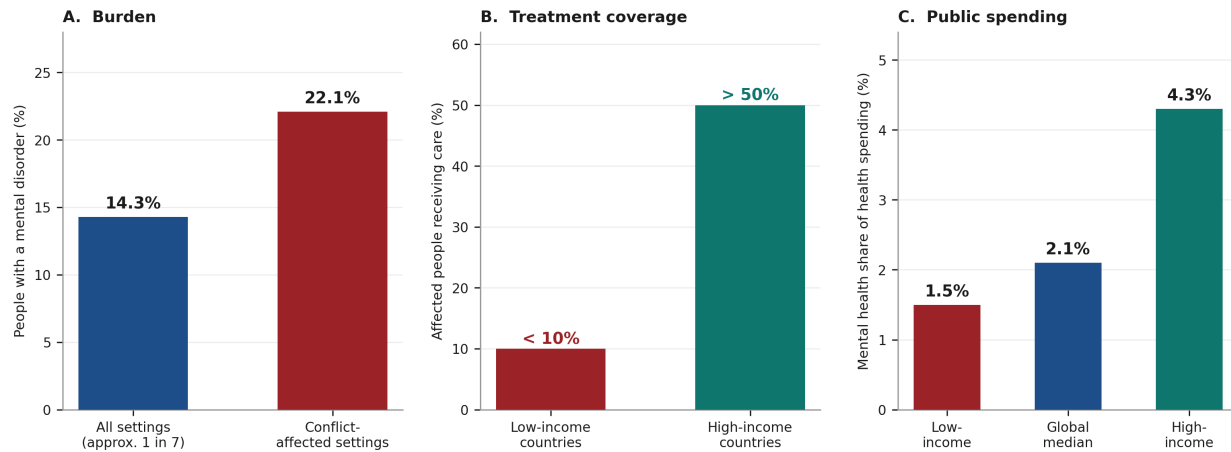


Figure 8. Burden and the gap in care: (A) prevalence, all settings and conflict-affected settings; (B) treatment coverage; (C) share of health spending on mental health.

[WHO \(2025\)](#) for all-settings prevalence (nearly 1 in 7, plotted as 14.3%), treatment coverage and median spending; [Charlson et al. \(2019\)](#) for conflict settings (point prevalence, a different measure); regional spending as reported in secondary summaries of the Mental Health Atlas 2024. Treatment coverage bars are plotted at the stated thresholds (< 10%, > 50%).

The gap matters for the polycrisis because the demand is rising as the supply is stagnant. Every shock that adds distress, whether a pandemic, a displacement wave or a price spike, lands on a system with little spare capacity. The policy response has been to emphasise scale and to move care out of hospitals. The WHO framed its findings as input to the UN High-Level Meeting on noncommunicable diseases and the promotion of mental health and well-being, held in New York on 25 September 2025, which placed mental health on the global agenda more prominently than it has usually been.

6.5 What mental-health protection should and should not mean

A report on wellbeing in the polycrisis must be careful with the language of mental health. Three distinctions matter.

- **Distress is not disorder.** Most people who lose a home, a job or a relative will experience intense distress that eases with time, safety and support. Treating every reaction as a clinical condition medicalises normal grief and consumes scarce specialist capacity. The protection that most people need is practical and social first.
- **Disorder needs care that exists.** A minority will develop depression, anxiety, post-traumatic stress or other conditions that need treatment. For them the key question is whether anyone nearby can provide evidence-based help. Section 13 shows that trained lay workers can deliver effective therapies at low cost.
- **Prevention is mostly not clinical.** Many of the strongest levers on population mental health lie outside the health sector: secure income, safe housing, functioning schools and workplaces, community ties, and trustworthy information. Health ministries cannot supply them, so mental-health strategy must be cross-government.

7. The Social Fabric: Connection, Displacement, Trust and the Information Environment

A person's wellbeing in a crisis depends on others: those who check in, share, warn, lend and listen. The polycrisis erodes that fabric in several ways at once, through isolation, displacement, distrust and information overload, and the loss is easy to miss because it is not counted.

7.1 Connection as a health determinant

The WHO Commission on Social Connection, co-chaired by Chido Mpemba and former US Surgeon General Vivek Murthy, reported in June 2025 that about one in six people worldwide experience loneliness, with the highest rates among adolescents and young adults (around one in five) and in low-income countries (nearly one in four). The Commission links loneliness to an estimated 871,000 deaths a year, about 100 an hour, and to higher risks of cardiovascular disease, type 2 diabetes, depression and anxiety (see the [Commission's page](#)). The death figure is a modelled estimate of a population-level association, not a count of recorded deaths.

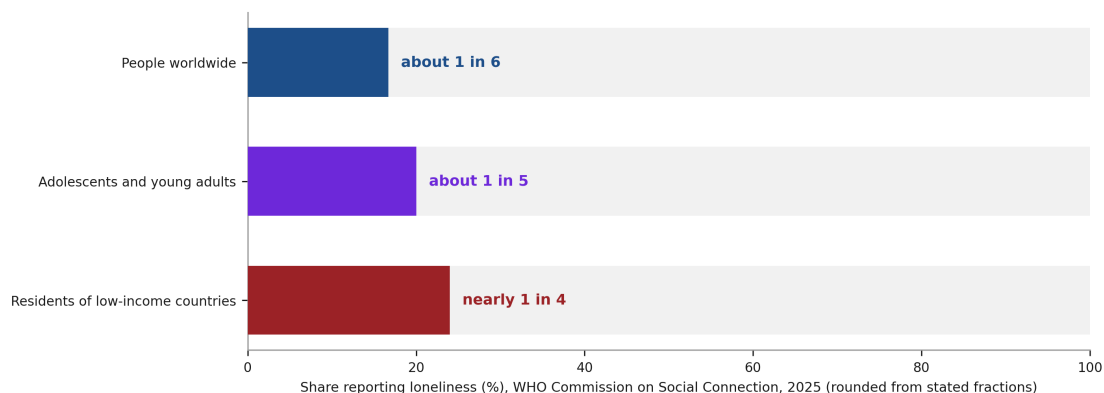


Figure 9. Loneliness is widespread, and highest among young people and in low-income countries.

[WHO Commission on Social Connection \(2025\)](#). Shares are rounded from the stated fractions (about 1 in 6, about 1 in 5, nearly 1 in 4) by H Heuristics.

The scientific base is long-standing. A meta-analysis of 148 studies and 308,849 participants by [Holt-Lunstad, Smith and Layton](#) found that people with stronger social relationships had an odds ratio of 1.50 for survival (95 per cent confidence interval 1.42–1.59), an effect comparable to well-established risk factors such as smoking, consistent across age, sex, initial health status and cause of death. An odds ratio is not the same as a 50 per cent higher survival probability, but the direction and scale are clear.

The 2026 [World Happiness Report](#) turns to social media and young people's wellbeing, and its findings are nuanced. Happiness among under-25s has declined significantly in the US, Canada, Australia and New Zealand, while young people in many other regions are becoming happier, so social media alone cannot explain the trend. Using social media for under an hour a day is associated with higher wellbeing than not using it at all; heavy use is associated with lower wellbeing, most strongly among young women; and communication, learning and content creation correlate positively with wellbeing while passive consumption correlates more negatively. The evidence is correlational and the relationships are context-dependent. The practical conclusion is that how technology is used matters more than whether it is used.

7.2 Displacement: losing place, networks and status together

Forced displacement removes the physical home and, with it, the dense web of kin, neighbours and institutions that people rely on in a crisis. [UNHCR's Global Trends report for 2025](#) records 117.8 million forcibly displaced people at the end of 2025, a first fall in a decade, made up of 41.6 million refugees, 9 million asylum-seekers and 68.7 million people displaced within their own countries by conflict or violence, with about 4.5 million stateless people. The fall is largely due to returns: 14.7 million people returned in 2025 (4.4 million refugees and 10.3 million internally displaced people), more than 90 per cent of refugee returns going to Afghanistan, Syria and Sudan, often under difficult conditions in contexts where reintegration is hard. About 65 per cent of refugees live in countries neighbouring their own.

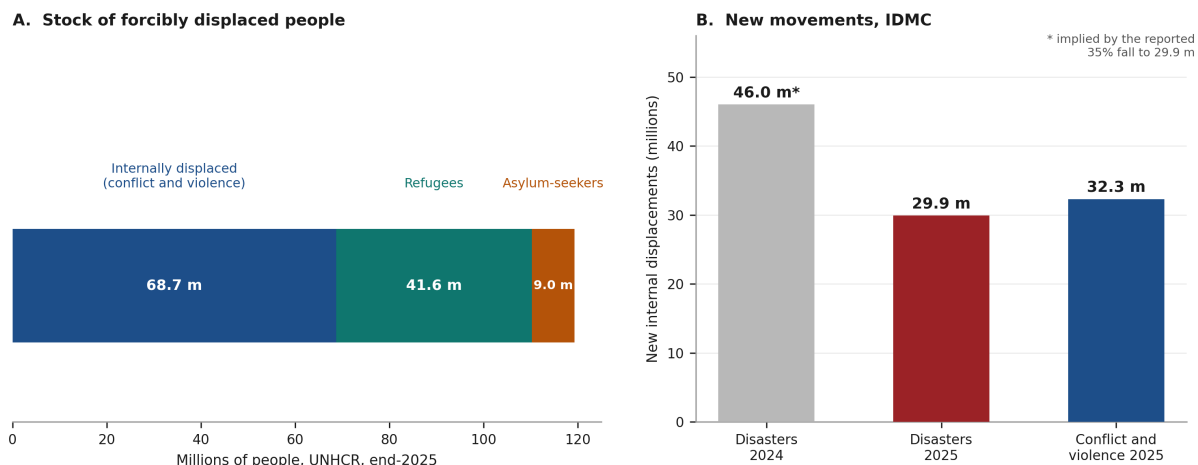


Figure 10. Displacement: (A) the stock of forcibly displaced people, end-2025; (B) new internal displacements, disasters and conflict.

(A) [UNHCR, Global Trends 2025](#); components exceed the 117.8 million total because Palestine refugees who are also internally displaced are counted once in the total. (B) [IDMC, GRID 2026](#); the 2024 disaster figure is implied by the reported 35% fall to 29.9 million in 2025. Displacements count movements, so one person can be counted more than once.

The [Internal Displacement Monitoring Centre](#) adds that 2025 saw 62.2 million new internal displacements across 146 countries and territories, with conflict-driven movements (32.3 million) exceeding disaster-driven movements (29.9 million) for the first time. At the end of 2025 more than 82.2 million people were living in internal displacement, slightly fewer than the record 83.5 million a year earlier. For wellbeing the key facts are persistence and mixed causation. Displacement can last years, and in many places conflict, disaster and economic collapse interact so that “cause” is blurred.

7.3 Trust, news and the emotional climate

Gallup's [State of the World's Emotional Health](#) series, based on more than 145,000 interviews in 144 countries and areas, found that in 2024 worry (39 per cent) and stress (37 per cent) topped the list of daily negative emotions, followed by physical pain (32 per cent), sadness (26 per cent) and anger (22 per cent). Most were below their pandemic highs but each remained well above levels a decade earlier, and women reported more sadness, worry and pain than men.

Trust shapes how those emotions are managed. The 2026 [Edelman Trust Barometer](#), a survey of nearly 34,000 respondents in 28 countries, describes a slide from grievance to “insularity”: seven in ten are unwilling or hesitant to trust someone with different values or information sources, and trust is concentrating in those closest to us, with 64 per cent trusting fellow citizens and neighbours and nearly seven in ten fearing institutional leaders deliberately mislead the public. The Reuters Institute's [Digital](#)

[News Report 2026](#) reports trust falling in 29 of 48 markets, to its lowest since the series began, alongside high levels of selective news avoidance, which is in part a coping strategy for people who feel overloaded and want to protect their mental wellbeing.

The information environment therefore poses a specific design problem. People need enough information to act, such as warnings and cost-of-living measures, but not so much alarm that they withdraw. The World Economic Forum ranks misinformation and disinformation second over two years, and the Edelman finding that trust is localising suggests that neighbours and community organisations may be better messengers than distant institutions. Section 11 returns to this.

7.4 The invisible loss

Compared with income or mortality, the social fabric has few indicators and almost no routine measurement. Loneliness, social trust and neighbour contact are measured in surveys, not administrative data. Few governments report them regularly, and few include them in disaster-risk or poverty assessments. Yet as the Chicago case shows, the difference between life and death in a hazard can be whether someone knocks on a door. Treating social connection as infrastructure, something that is built, maintained and measured, is among the most promising reframings for polycrisis policy, and one of the cheapest.

8. How Risks Compound in Human Lives

The central danger of the polycrisis for human wellbeing is not any single blow but the loss of time to recover between blows. This section shows how exposure, sensitivity, buffers and duration interact, who bears the cost, and what a simple simulation suggests about the value of protection.

8.1 Four mechanisms of compounding

The identity in section 3 treats the four terms as separate. In life they are entangled, and the entanglement is what turns resilience into fragility. Four mechanisms recur in the research on cumulative adversity.

- **Accumulation.** Stress that has not been recovered from adds to stress that arrives next. The body and mind carry a load; each episode of adversity adds to it, and recovery takes time. When events are closely spaced, the load never returns to baseline.
- **Sensitisation.** A person who has already been through adversity is typically more reactive to the next. Prior trauma, chronic illness, poor sleep and debt all raise sensitivity. The same hazard therefore costs more the second time.
- **Buffer depletion.** Savings, favours, patience and goodwill are finite. A household that spent its reserve on the last shock has less to absorb the next, and the people who helped last time may now be struggling themselves.
- **Cross-domain spillover.** Loss in one domain feeds others: job loss to anxiety, anxiety to poor sleep and health, ill health to further income loss, and so on. These spillovers explain why material, health and social losses so often cluster in the same people and places.

8.2 Who bears the cost

Compounding is not evenly distributed. The poorest, youngest and most marginal bear the largest share, and they are often the people who contributed least to the hazards. The UNICEF [Children's Climate Risk Index](#) found that about one billion children, nearly half of the world's 2.2 billion, live in 33 countries classed as extremely high-risk; 28 of the 33 are in Africa, four are in South Asia and one (Haiti) is in Latin America and the Caribbean; and an estimated 850 million children, one in three worldwide, live in areas where at least four climate and environmental shocks overlap. Those 33 countries together emit about 9 per cent of global CO₂, while the ten highest-emitting countries account for nearly 70 per cent.

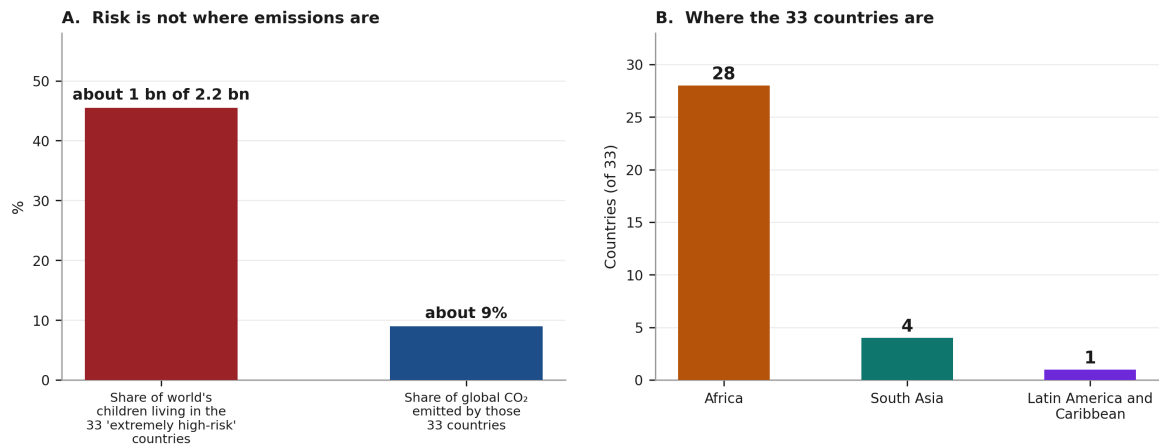


Figure 11. *Unequal exposure: children in the 33 highest-risk countries are nearly half of the world's children but those countries emit about 9% of CO₂.*

[UNICEF, Children's Climate Risk Index \(2021\)](#). Share of children computed by H Heuristics from "about 1 billion of 2.2 billion". This is the 2021 index; no later edition was identified.

Within countries, the same logic applies. People in the lowest income brackets are 1.5 to 3 times more likely to experience depression or anxiety than the richest in the same location ([Ridley et al.](#)); women, young people and the already unwell were most affected by the pandemic's mental-health impacts ([COVID-19 Mental Disorders Collaborators](#)); food insecurity is more prevalent among women and children ([SOFI 2026](#)); and, as in Englewood, abandoned places suffer more than their demographics alone would predict. The equity implication for policy is that universal floors, with extra support targeted to those most exposed, are more effective than either universalism or targeting alone.

8.3 An illustrative simulation of stress accumulation

To show how the four mechanisms interact, this report uses a deliberately simple simulation. It is not an estimate for any population; its purpose is to illustrate structure, not to forecast.

Model. A population of 6,000 simulated people each carries a stress load that starts at zero. Each year, a random number of adverse events arrives, with a mean rate that rises from 0.23 per year to about 0.46 by year 20, representing intensifying hazards. Each event has a random size (lognormal, median 0.36) that is amplified by 40 per cent for each unit of current load, which represents sensitisation, and reduced by a buffering fraction that depends on the scenario. Between events the load decays at a recovery rate that also depends on the scenario. A person is counted as above the distress threshold when their load exceeds one. Four scenarios add protective layers cumulatively: (A) none; (B) personal coping skills, which modestly raise recovery and absorb a little of each event; (C) plus household and community buffers, such as savings and neighbour support; and (D) plus institutions, such as social protection, accessible care and early warning.

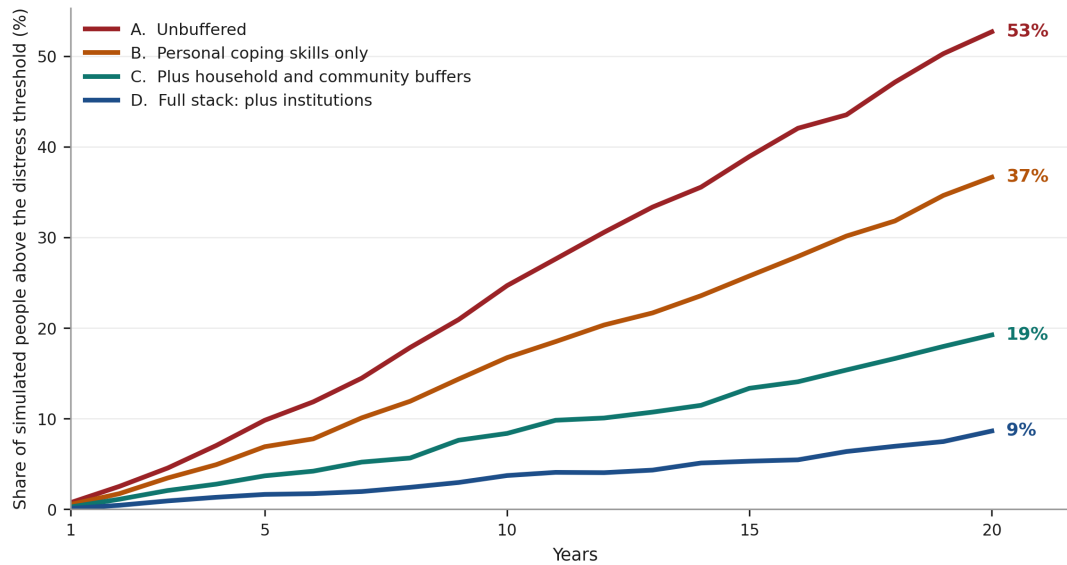


Figure 12. Illustrative simulation: share of people above a distress threshold over twenty years under four protective scenarios.

H Heuristics illustrative simulation (6,000 simulated people; seed 11). Parameters: event rate $0.22 + 0.012$ per year; median event size 0.36 ($\sigma = 0.5$); sensitisation 0.4 per unit load; recovery/absorption rates of 0.18/0, 0.22/0.07, 0.27/0.18 and 0.32/0.30 for scenarios A to D. Not an estimate for any population.

Results. In the unbuffered scenario the share of simulated people above the threshold rises to about 25 per cent by year 10 and 53 per cent by year 20. Personal coping skills alone reduce the year-20 share to about 37 per cent. Adding household and community buffers lowers it to about 19 per cent, and adding institutional buffers to about 9 per cent. Three lessons are worth stating. First, each added layer removes a comparable amount (11 to 17 percentage points by year 20), which supports the claim that no single layer is sufficient. Second, the curves diverge over time: early on the scenarios look similar, but compounding amplifies the differences, so the case for buffers is understated by short-horizon evaluations. Third, even the full stack leaves a minority above the threshold. Protection reduces harm; it does not eliminate it, and a residual need for treatment and support always remains.

The value of the simulation lies in its robustness to parameters and not in its levels. The ordering of the scenarios, and the divergence over time, hold across a wide range of assumptions about event rates and recovery. The absolute numbers do not carry over to the real world, and this report does not cite them as forecasts.

8.4 The recovery-interval ratio, applied to wellbeing

A single diagnostic summarises the compounding problem: the ratio of the typical time a person or community needs to recover from a shock to the typical interval between shocks. Where the ratio is well below one, shocks produce sawtooth dips around a stable trend. Where it is near or above one, losses ratchet. The ratio can be estimated roughly for different places and groups. Recovery from a flood may take a household years if it lost a home and savings, and the next flood may arrive in two. A community with strong networks, flood insurance and a functioning clinic may recover in months. The diagnostic suggests where to put effort: not necessarily where hazards are largest but where recovery is slowest relative to their frequency.

9. What Resilience Is, and What Builds It

Human beings are more resilient than most accounts of crisis assume. That is good news, but it comes with a condition: resilience is not a trait that people simply have, it is a capacity that depends on the resources around them, and those resources can be spent.

9.1 Resilience is common, and takes several forms

Developmental psychologist Ann Masten’s influential paper “[Ordinary Magic](#)” argued that resilience is common and usually arises from the normal functions of human adaptation systems: attachment, learning, problem-solving, self-regulation and the support of family and community. Far from being a rare gift of exceptional individuals, it is the default when basic protective systems are intact. Resilience is, in her phrase, ordinary magic, and the policy implication is that the most efficient way to promote it is to protect the systems that produce it.

George Bonanno’s work on loss and trauma added a crucial distinction. In a [widely cited paper in *American Psychologist*](#), he argued that the human capacity to thrive after extremely aversive events has been underestimated, that resilience is a distinct pattern from recovery, and that there are multiple and sometimes unexpected pathways to it. The resilient maintain stable functioning with at most a brief disruption; others suffer a marked dip and then gradually recover; some appear to cope and decline later; and some suffer chronic, sustained distress. Figure 13 sketches these four trajectories.

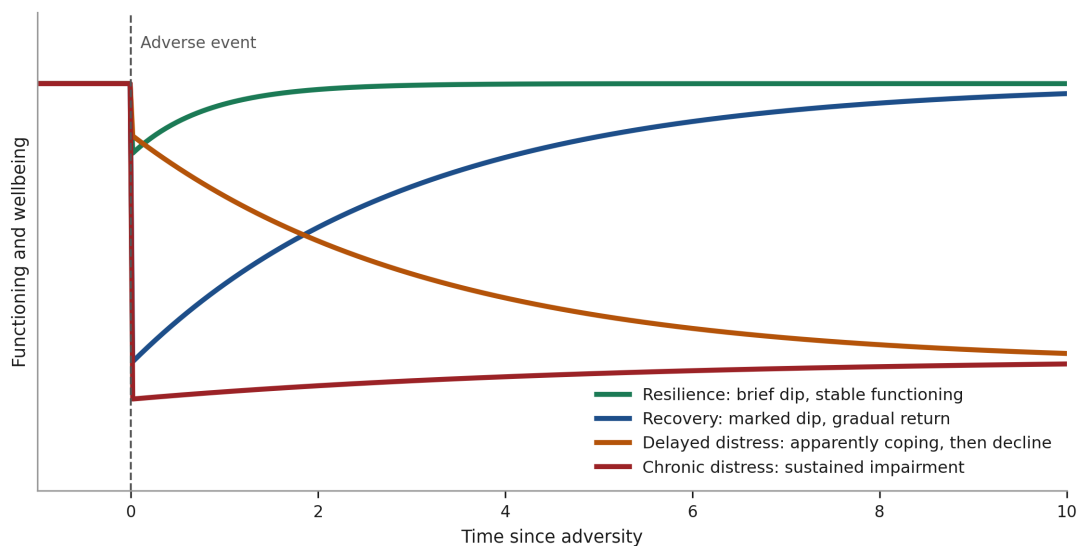


Figure 13. Four stylised trajectories of functioning after an adverse event: resilience, recovery, delayed distress and chronic distress.

H Heuristics. Stylised illustration after the trajectory framework in [Bonanno \(2004\)](#); curves are schematic and do not carry proportions, which vary by event and population.

Two implications follow. First, **most people do not need clinical intervention after most adversity**, and over-treatment wastes scarce capacity and can interfere with natural recovery. Second, **the minority on delayed or chronic trajectories are often invisible in the first weeks**. Systems should therefore combine broad, light-touch support for everyone with the ability to find and follow up the people who are not recovering.

9.2 Five principles for the aftermath of mass adversity

An international panel of twenty experts, with Stevan Hobfoll as lead author, reviewed the evidence on interventions in the early and middle phases after disasters and mass violence and reached [consensus on five principles](#): promote a sense of **safety**; promote **calming**; promote a sense of self- and community **efficacy**; promote **connectedness**; and instil **hope**. The panel noted that randomised trials across the full range of mass-trauma settings are unlikely to be available, so the principles are derived from related research. They have become the common language of humanitarian psychosocial work, and they translate readily into design criteria for any policy that aims to protect wellbeing.

- **Safety** means actual physical security and predictability, such as shelter, a place to sleep, reliable information, and protection from further harm, not just reassurance.
- **Calming** means reducing physiological arousal and acute distress: orderly services, clear communication, and time to eat, sleep and be with loved ones.
- **Efficacy** means returning agency to affected people and communities. Being able to do something, to help, decide, and organise, is protective for the individual and for the group.
- **Connectedness** means keeping people with family, neighbours and community, and avoiding unnecessary separation.
- **Hope** is not optimism about the event but confidence that the future can be navigated: credible plans, visible delivery, and fair treatment.

The WHO's [Psychological First Aid guide for field workers](#), produced with the War Trauma Foundation and World Vision International, operationalises these ideas for non-specialists: it teaches how to offer practical care and support without intruding, assess needs and concerns, help people meet basic needs, listen without pressing, comfort, and connect people with information, services and social support. It is a reminder that early help is largely about humane, practical company, and that lay people can provide it.

9.3 Social capital: the best-evidenced community asset

The disaster-recovery literature has converged on social capital, the networks, norms and trust that enable people to cooperate, as a leading explanation for why some places recover better than others. Daniel Aldrich's [Building Resilience: Social Capital in Post-Disaster Recovery](#) compares Tokyo after the 1923 earthquake, Kobe after 1995, Tamil Nadu after the 2004 tsunami and New Orleans after Hurricane Katrina. He finds that variation in recovery is not explained by the magnitude of the catastrophe or the amount of aid, but by the depth of community social capital: networks spread information and assistance quickly, overcome barriers to collective action, provide informal insurance, and limit the out-migration of people and resources. An often-cited example, reported in the [Boston Globe](#), is the Mary Queen of Vietnam neighbourhood in New Orleans, where within a year of Katrina about 90 per cent of residents were back in their homes and 90 per cent of businesses were open.

Aldrich is also clear that social capital is “Janus-faced”: the same ties that help members of a network can exclude outsiders, and in Aldrich's field interviews people connected to a local council were on the list to receive aid while those outside the network sometimes received nothing. Social capital is therefore an asset to be built inclusively. Policy that relies on it must ensure that the ties reach the isolated, the newly arrived and the marginalised, which are precisely the people whom informal networks tend to miss.

9.4 Four layers of protection

Pulling together the psychological, social and institutional evidence yields the four-layer picture in Figure 14. The person, the household, the community and institutions each absorb part of the load of an incoming hazard, and what is not absorbed reaches the person.

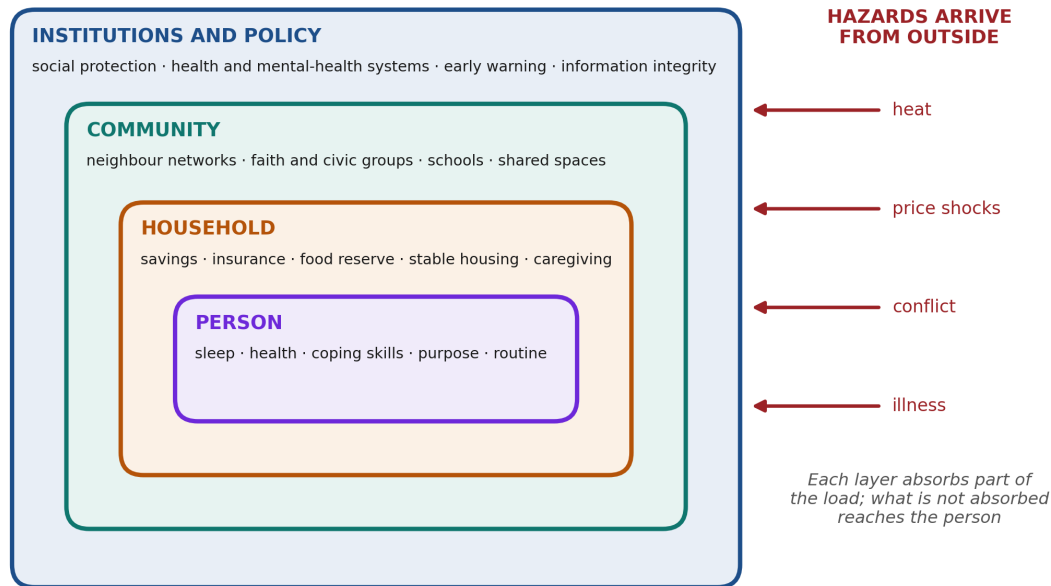


Figure 14. Four nested layers of protection between a hazard and a person.

H Heuristics. Conceptual schematic, drawing on [Masten \(2001\)](#), [Hobfoll et al. \(2007\)](#), [Aldrich \(2012\)](#) and the [IASC intervention pyramid](#).

Table 3. The four layers: what each provides, the evidence, and how each typically fails

Layer	What it provides	Evidence base	Typical failure
Person	Sleep, health, coping skills, purpose, routine	Masten (2001) ; Bonanno (2004)	Overload by repeated shocks; blame when individuals are told to “be resilient”
Household	Savings, insurance, food reserve, stable housing, caregiving	Knippenberg and Hoddinott : transfers cut drought’s initial hit by 57%	Buffers exhausted by consecutive shocks; no access to credit or insurance
Community	Neighbour networks, civic groups, schools, shared spaces	Aldrich (2012) ; Chicago heat-wave comparison	Abandoned places; exclusion of newcomers and marginal groups
Institutions and policy	Social protection, health and mental-health systems, early warning, information integrity	ILO (2024) ; Hess et al. (2018) ; WHO (2025)	Coverage gaps where risk is highest; low trust; underfunding of mental health

The layers are complementary. Strong inner layers cannot fully compensate for failure of outer layers, and the reverse is also true.

9.5 Against responsibilising resilience

There is a risk in the vocabulary of resilience: that it becomes a way of telling people to cope better with conditions they did not choose and cannot alter. The evidence reviewed above points the other way. The people who do best in crises are those with more resources, more connections and more reliable institutions, and the people who do worst are those whose circumstances were already hardest. A resilience agenda that asked individuals to meditate more while ignoring the heat, hunger and insecurity around them would be

both ineffective and unfair. This report therefore uses *resilience* in a structural sense: the capacity of a person, household, community or society to absorb and recover from shocks, which is built mostly by changing what surrounds people and only secondarily by changing people.

10. Strategies for Individuals and Households

Individuals cannot fix the polycrisis and should not be asked to. But within the limits set by their circumstances, people and households can do things that measurably improve their resilience and that of those around them. This section grades those actions by the strength of evidence behind them.

10.1 Principles

Three principles guide this section. First, **the evidence for personal actions is generally weaker than for policies**, because it is harder to randomise lives, so claims here are graded and hedged. Second, **the best personal actions are relational**: most of what protects an individual is connection to other people and to services, and the strongest evidence concerns relationships, not self-improvement techniques. Third, **nothing here is medical advice**. People who are struggling should seek support from a qualified professional or local services; where crisis lines or emergency services exist they should be used.

10.2 An evidence-graded list of personal and household actions

Table 4 sets out nine actions. “Strong” indicates consistent evidence from multiple studies of good design; “moderate” indicates plausible mechanisms with supportive but less direct evidence; “emerging” indicates suggestive evidence or reasoning without robust trials. The grading is H Heuristics’ judgement based on the sources cited.

Table 4. Personal and household actions, graded by the strength of evidence

Action	What it means in practice	Evidence and rationale	Grade
Maintain and widen social ties	Regular contact with friends, family and neighbours; join at least one local group	Holt-Lunstad et al. (2010) : odds ratio 1.50 for survival across 148 studies; WHO Commission on loneliness and mortality	Strong
Know and check on neighbours, especially in heat	Share contact details; agree who checks on whom in a heatwave or storm	Chicago 1995: death rates ≈33 vs ≈3 per 100,000 in adjacent neighbourhoods with different social infrastructure	Strong (observational)
Seek help early and know local services	Learn which clinic, helpline or community group to use; ask for help before a crisis point	Effective low-cost treatments exist (Friendship Bench trial); the gap is access, not efficacy	Strong
Build a small financial and food buffer	Even modest savings, a food and water reserve, and insurance where available	Buffers cut the initial hit of shocks: Ethiopia drought and safety-net evidence ; Ridley et al. (2020) on economic shocks and distress	Moderate
Prepare a household plan	Emergency contacts, documents, a heat and flood plan, medicines supply, a meeting point	Early-warning and heat-plan evidence: Ahmedabad ; Bangladesh . Planning shortens the time between warning and action	Moderate
Protect sleep and routine	Keep regular sleep, meals and activity, including cooling the bedroom where possible; keep routines for children	Consistent with the “calming” and “safety” principles of Hobfoll et al. (2007) ; heat disrupts sleep and health (Lancet Countdown 2025)	Moderate
Use news and social media deliberately	Check news at set times; use technology to communicate and learn more than to scroll passively	World Happiness Report 2026 : under an hour a day associated with higher wellbeing than none, heavy and passive use with lower; Reuters Institute on avoidance as coping	Moderate (correlational)

Action	What it means in practice	Evidence and rationale	Grade
Offer practical support to others	Listen, help with basic needs, connect people with services, without pressing for detail	WHO Psychological First Aid guide; five principles of Hobfoll et al.	Moderate
Turn worry into shared action	Join local preparedness, adaptation or advocacy efforts that give concern something to do	Hickman et al. (2021) : distress linked to perceived government inaction; efficacy and connectedness are protective principles. Direct trials of this approach are lacking	Emerging

Grades are H Heuristics' judgement. "Observational" and "correlational" indicate that the evidence cannot establish cause with certainty. Not medical advice.

10.3 Households under compound stress

Households are the unit through which most shocks are absorbed, and the loss of household buffers is the most direct link between one shock and the next. Four practical priorities emerge from the evidence.

- **Protect the household's ability to eat and stay cool or warm.** Food, water and thermal comfort are the immediate needs that determine health outcomes in hazards. Where possible, reserve stocks, know where cooling or warming is available, and plan for the vulnerable members of the household: infants, older people, and people with chronic conditions.
- **Keep routines for children and honest, age-appropriate communication.** Children cope better when daily routines continue and when adults explain events plainly without false reassurance or unnecessary detail. The "safety" and "calming" principles of [Hobfoll et al.](#) apply directly.
- **Spread risk across people and places.** Households with links to relatives or friends elsewhere, and with more than one source of income or support, absorb shocks better. Keeping those links alive in calm times is an investment in resilience.
- **Watch for the delayed trajectory.** As Figure 13 shows, some people appear to cope and decline later. A household member who has been 'fine' but is sleeping poorly, withdrawing or drinking more weeks after an event may need a conversation and help, not more time.

10.4 What individual action cannot do

The limits are as important as the actions. A household in a flood plain with no cash buffer, in an unsafe building, in a country without a safety net cannot plan its way out. A person facing a clinical illness cannot meditate it away. The honest conclusion from the evidence on the four layers is that personal actions are best seen as the inner layer of a system whose outer layers they cannot replace, and the next sections turn to those.

11. Community Strategies: Social Infrastructure and Local Networks

Between the household and the state sits the layer that evidence suggests does the most to separate people who recover from people who do not: the community. Its assets are not primarily money but relationships, places and local institutions, and they can be built deliberately.

11.1 Social infrastructure as a protective asset

Klinenberg's Chicago comparison made a concept central to disaster science: **social infrastructure**, the physical places and organisations that shape how people interact. Libraries, parks, markets, community centres, places of worship, schools and small shops are not public-health facilities, but they are where people meet, where isolated older residents are noticed, and where information travels. The comparison of Englewood and Auburn Gresham, with roughly eleven times the heat-wave death rate in the neighbourhood that had lost such spaces, remains the clearest illustration that these assets save lives. Communities can build and protect them as deliberately as they build drains and roads.

Four practical implications follow. **Keep the spaces open and accessible**, because shuttering a library or market to save money may cost more in health and safety. **Use them as multi-purpose hubs**, so that the same site can serve as cooling or warming centre, information point, food distribution site and meeting place when hazards arrive. **Design for people who do not usually attend**, which means going to the isolated and not waiting for them. **Fund the people, not just the buildings**: community organisers, outreach workers and volunteer coordinators are the connective tissue.

11.2 Neighbourhood networks and local response

Community-based preparedness works best when it is local, trusted and built before the crisis. The Bangladesh Cyclone Preparedness Programme, launched by the Bangladesh Red Crescent Society and the government two years after the 1970 Bhola cyclone, now has more than 200 staff and 76,000 volunteers, half of them women, who carry warnings house to house and help people reach shelters, according to [reporting by The New Humanitarian](#). In the United States, the Mary Queen of Vietnam neighbourhood in New Orleans, described in the [Boston Globe](#) account of Aldrich's research, saw about 90 per cent of residents return within a year of Hurricane Katrina, helped by tight parish and community networks.

The common features are volunteer structures, clear roles, trusted local leaders, and established channels of communication that predate the hazard. For community leaders and local authorities the practical agenda is modest: map who is vulnerable and who is connected; set up simple check-in arrangements for hot, cold and storm seasons; identify and train local volunteers in basics such as [psychological first aid](#); and rehearse.

11.3 Community-based psychosocial support

In humanitarian practice, the second layer of the mental-health and psychosocial support pyramid used by the Inter-Agency Standing Committee (IASC) is community and family support: activities such as assisted mourning ceremonies, women's groups, youth clubs, supportive parenting programmes and child-friendly spaces, as summarised in [UNHCR and Red Cross materials](#). These are not clinical interventions. They restore the connectedness, efficacy and routine that the Hobfoll principles identify as protective. Because they rely on culturally grounded practices and local people, they are also cheap and scalable. In non-humanitarian settings the same logic applies to neighbourhood groups, peer-support networks and faith and cultural organisations.

11.4 Trusted information at community level

The 2026 Edelman survey's finding that trust is concentrating among those closest to us implies that local messengers (neighbours, community leaders, health workers, teachers) are often more credible than national institutions. Effective community strategies use them: translating official warnings into local language and context, correcting rumours quickly, and explaining what people can actually do. This also helps against the sense of powerlessness that the Hickman survey links to perceived inaction.

11.5 The inclusion test

The risk in community strategies is exclusion. Aldrich's own caution is that social capital can be Janus-faced, helping insiders and shutting out outsiders. A community plan should therefore be tested against the question: who would not be reached? Typical answers include recent arrivals, undocumented residents, people with disabilities, older people living alone, minority-language speakers, and people suspicious of authorities. Reaching them requires specific outreach, accessible formats and trusted intermediaries, and should be a funded line in community plans and not an afterthought.

12. Workplaces, Schools and Organisations

People spend most of their waking lives in workplaces and schools. These institutions either add to the load that converging risks place on people or help absorb it, and they are within the control of managers and school leaders who do not need to wait for national policy.

12.1 The workplace as a wellbeing environment

Gallup's [State of the Global Workplace 2026](#), covering data collected in 2025, reports that only 20 per cent of employees worldwide were engaged at work, down from a peak of 23 per cent in 2022, with the fall driven in large part by managers, whose engagement dropped from 27 to 22 per cent between 2024 and 2025. Secondary coverage of the report adds that roughly 40 per cent of employees reported a lot of stress the previous day, about 22–23 per cent reported anger, sadness or loneliness, and 34 per cent were thriving in their overall wellbeing, up one point. The WHO estimates that depression and anxiety cost the global economy about US\$1 trillion a year in lost productivity.

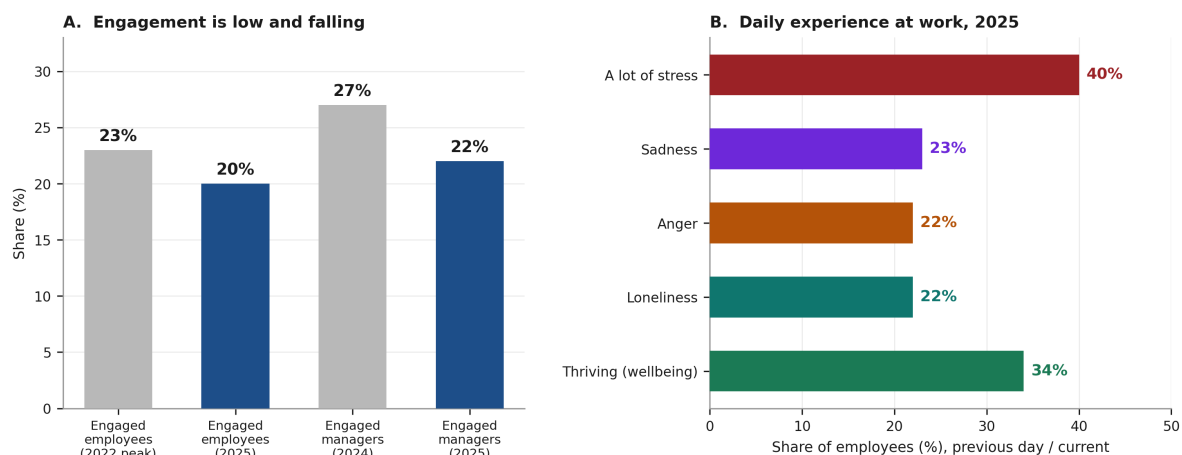


Figure 15. Work as a wellbeing environment: engagement is falling, and daily stress is widespread.

Gallup, [State of the Global Workplace 2026](#) (2025 data) as reported in the summary page and secondary coverage; daily stress, sadness, anger and loneliness percentages are from secondary reporting of the report and should be verified against the full report before reuse.

The data suggest that for many people work is simultaneously a source of income security, which is protective, and a source of stress and disengagement, which is not. The policy implication for employers is that wellbeing in a polycrisis cannot be delegated to an employee-assistance hotline. It is shaped by pay stability, scheduling, workload and the quality of line management.

12.2 What employers can do

- **Provide income stability.** Predictable hours, sick pay and emergency-loan or advance schemes reduce the financial shocks that convert directly into distress. This is the employer-level analogue of social protection.
- **Protect people from heat and hazards at work.** Outdoor and hot-environment workers bear much of the heat burden documented by the [Lancet Countdown](#). Rest, water, shade, adjusted hours and clear stop-work thresholds are low-cost protections.
- **Invest in managers.** Manager engagement is where Gallup finds the sharpest recent decline, and managers are the first point of contact for employees in difficulty. Training in recognising distress

and in practical support, including the principles of psychological first aid, is a high-leverage investment.

- **Manage psychosocial risk as a safety issue.** Excessive workload, role ambiguity, harassment and job insecurity are modifiable workplace hazards. Organisations should assess and reduce them in the same way as physical hazards, following guidance from the WHO and the International Labour Organization on mental health at work.
- **Plan for disruption.** Business-continuity plans should include people: how staff affected by floods, fires or displacement will be supported, how remote and flexible working can be activated, and how to maintain contact with those who are isolated.

12.3 Schools and children's services

Schools provide routine, safety, nutrition, adult attention and peer connection, all of which map directly onto the protective principles of safety, calming, connectedness and hope. Children are the group for whom disruption has the longest consequences, and, as UNICEF's [Children's Climate Risk Index](#) shows, are concentrated in the countries with the greatest exposure.

- **Reopen quickly and keep routine.** Reopening schools after a disaster or during a crisis restores structure and social contact for children and frees adults to work and recover.
- **Keep school meals and health services running.** For many children the school is the most reliable source of food and basic health care.
- **Equip teachers.** Training teachers to recognise changes in students' mental state and to provide first-line support is cost-effective; Ukraine's programme reports that some 209,000 educators had completed such training by August 2024, according to [official reports](#) (which have not been independently verified).
- **Give climate concern a constructive outlet.** Where students are worried about climate change, curricula and school projects that offer practical, collective action may help. Direct evidence is limited, but the Hickman finding that distress is tied to perceived inaction suggests the approach is promising.

12.4 Health, social-care and civic organisations

Health and social-care organisations are both providers of protection and workplaces under pressure. They need surge plans that anticipate hazards, and wellbeing support for their own staff, who are exposed to the same shocks as the population while carrying a heavier burden of response. Faith and civic organisations hold trust, volunteers and premises. They are often the first responders to local crises and merit partnership and resources from public authorities.

13. Government and International Strategies: Protecting the Systems That Protect People

Individuals, communities and employers can do a great deal, but the evidence is clear that the outer layer, institutions and policy, determines how far the inner layers can hold. This section sets out six government levers, the evidence for each, and what the international system can do to support them.

13.1 Lever 1: shock-responsive social protection

Social protection is the single largest institutional buffer against material and mental-health harm. The priorities are to extend coverage, especially in low-income and climate-vulnerable countries where fewer than one in ten people are covered; to build **shock-responsive** features so that benefits can expand quickly when a hazard strikes, through pre-registered households, pre-agreed triggers and pre-arranged finance; and to design transfers that are **adequate in size, predictable and not unduly conditional**, in line with the meta-analytic evidence of [McGuire et al.](#) and [Wollburg et al.](#). The ILO's [World Social Protection Report](#) argues that universal systems are both an enabler of climate action and a condition for a just transition. The Ethiopian experience suggests the payoff: transfers cut the initial hit of drought by 57 per cent and removed its adverse effect within two years for beneficiaries.

13.2 Lever 2: mental health in primary care and communities

The mental-health gap is the clearest instance of a large, cost-effective protection that is under-supplied. The solution that has the strongest evidence is **task-sharing**: training lay workers to deliver structured, brief psychological interventions in primary care and community settings under supervision. The best-known example is the Friendship Bench in Zimbabwe, described in section 14, in which trained lay health workers delivered six sessions of problem-solving therapy; at six months, 14 per cent of participants had depression symptoms against 50 per cent of controls, according to the [LSHTM summary](#) of the trial published in [JAMA](#).

The WHO's Problem Management Plus (PM+) programme uses a similar approach in humanitarian settings. The evidence is positive but not uniform: trials in Pakistan and Kenya are reported to be favourable, while a 2024 randomised trial of group PM+ among Syrian refugees in Türkiye found no significant effect on symptoms of anxiety, depression and post-traumatic stress on an intention-to-treat basis, though it found a significant reduction in functional impairment at three months. The lesson is that task-shared therapies work in many settings, but need adaptation, supervision and realistic outcome measures.

The economic case is robust. [Chisholm and colleagues](#) modelled the scale-up of treatment for depression and anxiety in 36 countries over 2016–2030 and estimated benefit–cost ratios of 2.3–3.0 to 1 on economic benefits alone and 3.3–5.7 to 1 when the value of health gains is included, with 43 million extra years of healthy life. These are modelled projections whose returns depend on assumptions, particularly about productivity gains. Even so, the core point stands: for the price of a modest share of health budgets, countries can transform access.

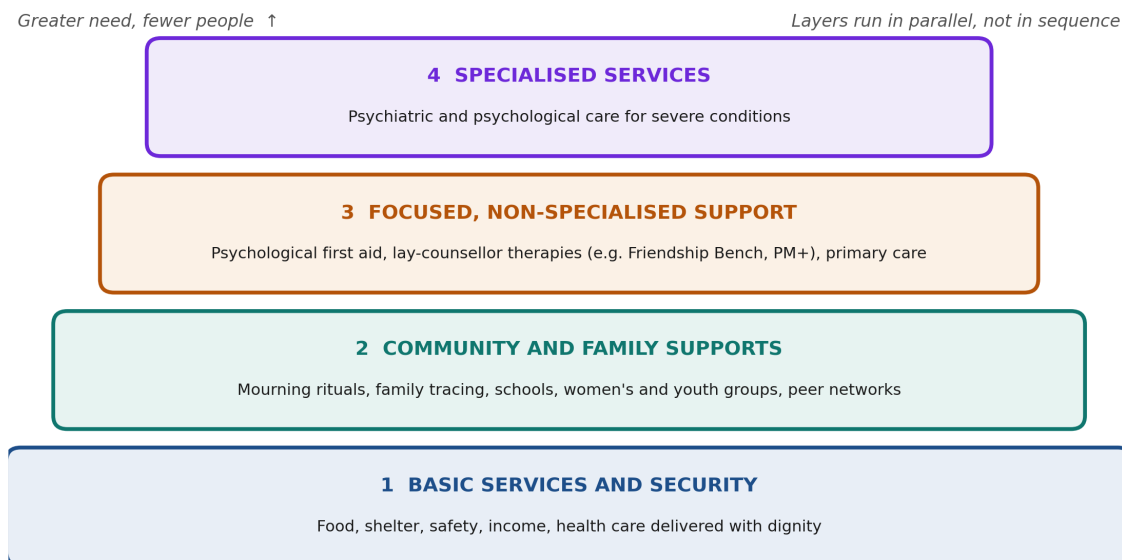


Figure 16. A layered system of mental-health and psychosocial support: four layers delivered in parallel.

H Heuristics, adapted from the IASC intervention pyramid as summarised in [UNHCR and Red Cross materials](#) and [WHO guidance](#). The IASC stresses that all layers should ideally operate concurrently.

13.3 Lever 3: early warning and heat action for everyone

Early warning is among the best-evidenced and most cost-effective protections. The WMO's [Global Status of Multi-Hazard Early Warning Systems 2025](#), launched at COP30, reports that 119 countries, 60 per cent, now have multi-hazard early warning systems, a 113 per cent increase in a decade, but only 43 per cent of small island developing states do, and fewer than a third of countries report capabilities for risk knowledge, the foundation for effective warning. The UN's [Early Warnings for All](#) initiative aims to protect everyone by 2027. The Global Commission on Adaptation's estimate, [widely repeated](#), is that 24 hours' notice of a coming hazard can cut damage by about 30 per cent, and that spending US\$800 million on such systems in developing countries could avoid losses of US\$3–16 billion a year.

For wellbeing, two additions are needed. First, warnings must reach the isolated: effective systems use door-to-door volunteers, local-language channels and accessible formats, as in Bangladesh. Second, heat deserves the same institutional attention as storms and floods. Heat action plans on the Ahmedabad model, which couple forecasts with action by health services, employers and communities, are among the cheapest ways to reduce deaths in a warming climate.

13.4 Lever 4: climate-resilient, integrated health systems

Health systems convert hazards into outcomes. Governments should ensure that primary-care facilities are climate-resilient and able to operate during disasters, that chronic-disease and mental-health care are integrated and continue through crises, and that health workers are trained for hazard response and psychosocial support. Integration also reduces stigma and cost: one clinic visit can address physical and mental problems together.

13.5 Lever 5: a healthier information environment

The information environment is the least-developed area of policy and the one where evidence is most contested. The World Economic Forum ranks misinformation and disinformation second over two years,

trust is falling in most markets, and the [World Happiness Report 2026](#) finds that the relationship between social media and young people's wellbeing depends on context and use. A cautious agenda is warranted.

- **Make official information timely, specific and actionable**, with clear statements of what people can do, and through trusted local messengers.
- **Support credible local and public-interest information**, which fills the gap that news avoidance and low trust create.
- **Design for healthy use.** The evidence that moderate, communication-oriented use is associated with better wellbeing than heavy, passive use supports product and policy measures that reduce compulsive use, especially for the young, though the strength of causal evidence is still debated and regulation should be evaluated as it is introduced.
- **Treat information integrity during emergencies as a protective service**, with rapid rumour control and transparent corrections.

13.6 Lever 6: wellbeing across government, and in the budget

Because the drivers of wellbeing lie in many departments, no single ministry can deliver it. Governments can embed wellbeing in budgets and project appraisals; require social-protection, health and disaster-management agencies to plan together; and track wellbeing indicators (section 15) alongside economic ones. The World Bank's [Poverty, Prosperity, and Planet report](#) takes the same cross-sector view of the polycrisis.

13.7 The international system

International institutions shape the buffers available to the countries that most need them. Three priorities follow from the evidence. **Protect and, where possible, expand financing for humanitarian and development programmes**, since the FAO and its partners warn that recent reductions in financing are a risk to progress on hunger. **Support host communities and refugees together:** about 65 per cent of refugees live in neighbouring countries, which are often poor and are asked to absorb large numbers with little help. **Fund the cheap, high-return protections**, including early warning, mental-health task-sharing and shock-responsive social protection, in the countries where coverage is lowest.

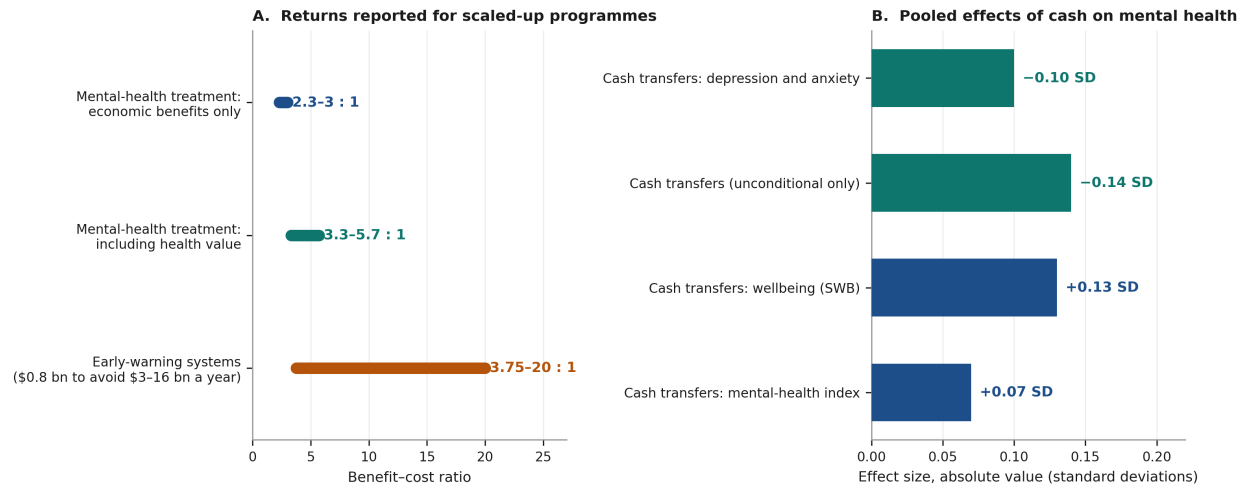


Figure 17. The evidence scoreboard: (A) benefit-cost ratios reported for scaled-up mental-health treatment and early-warning systems; (B) pooled effects of cash transfers on mental health.

(A) [Chisholm et al. \(2016\)](#); early-warning ratio computed by H Heuristics from the Global Commission on Adaptation estimate of [US\\$0.8 billion to avoid US\\$3–16 billion a year](#). (B) [McGuire et al. \(2022\)](#) (SWB and mental-health composite, positive = improvement) and [Wollburg et al. \(2023\)](#) (depression and anxiety symptoms, negative = reduction; bars show absolute size). SD = standard deviations.

Table 5. Evidence summary for the main protective interventions

Intervention	Main evidence	Reported effect or return	Confidence and caveats
Cash transfers	McGuire et al. ; Wollburg et al.	$d = 0.07$ (mental health), 0.13 (wellbeing); -0.10 (depression and anxiety)	High for direction, modest effect sizes; effects fade after programmes end; conditionality may hurt
Productive safety net (Ethiopia)	Knippenberg and Hoddinott	Initial drought impact cut by 57%	Moderate: working paper; wider evidence described as patchy by ODI
Lay-delivered psychological therapy	Chibanda et al. (JAMA, 2016)	Depression symptoms 14% vs 50% at six months	Moderate to high: randomised trial, 573 participants; figures from the LSHTM summary
Scaled-up treatment of depression and anxiety	Chisholm et al. (2016)	Benefit-cost 2.3–5.7 to 1	Modelled; sensitive to productivity assumptions
Heat action plan	Hess et al. (2018)	Rate ratio 2.34 → 1.25 at 47 °C; 1,190 deaths avoided a year	Moderate: before-and-after design; wide confidence interval
Early warning systems	WMO (2025) ; Global Commission on Adaptation	About 30% less damage with 24 hours' notice; 3.75–20 to 1 return	Moderate: widely repeated estimate; context-dependent
Community social capital	Aldrich (2012) ; Chicago comparison	Faster, more equal recovery; lower heat-wave death rate	Moderate: comparative and observational; can exclude outsiders

d = Cohen's d (standard-deviation units). Confidence ratings are H Heuristics' judgement.

14. Lessons from Practice: Six Cases

The framework and evidence above are abstractions until they meet practice. Six cases show the strategies at work, their results, and their limits. None is a template to copy; each is an example of a design principle that has worked somewhere.

14.1 Bangladesh: cyclone preparedness

Bangladesh is the standard case for early warning. The 1970 Bhola cyclone killed between 300,000 and 500,000 people; a WMO review put the toll at 300,000. The 1991 Gorky cyclone killed roughly 139,000. Cyclone Sidr, in 2007, killed about 3,500 (estimates range from just over 3,000 to about 4,200). Mortality from cyclones has fallen by more than a hundred-fold over four decades, according to a [WHO Bulletin analysis](#), which credits warning systems, shelters, evacuation plans, embankments, reforestation and public awareness.

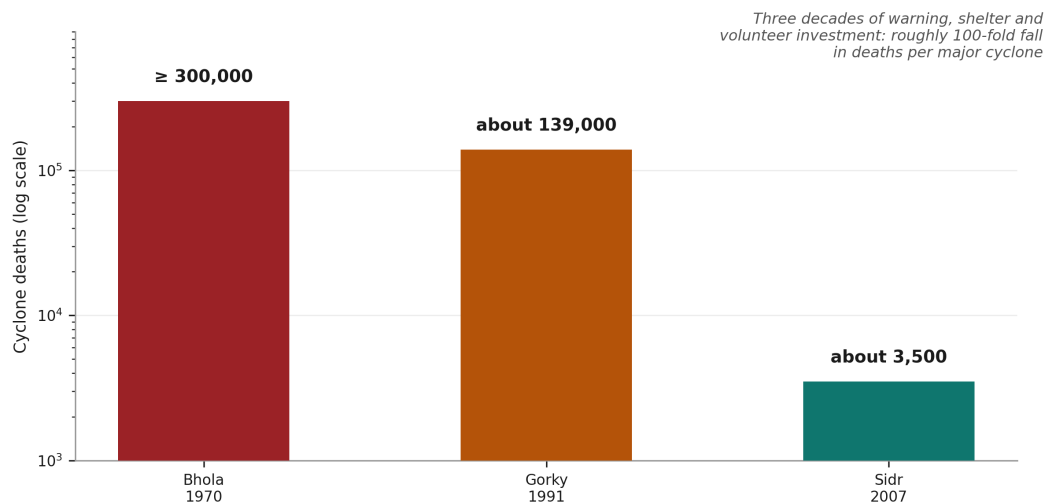


Figure 18. Deaths in three major Bangladesh cyclones: Bhola (1970), Gorky (1991) and Sidr (2007).

H Heuristics, from [The New Humanitarian](#), [Dialogue Earth](#) and the [WHO Bulletin](#). Death tolls vary by source: Bhola 300,000 to 500,000 (plotted at the WMO figure of 300,000), Sidr about 3,000 to 4,200 (plotted at 3,500). Log scale.

The Cyclone Preparedness Programme, jointly run by the government and the Red Crescent, has 76,000 volunteers, half women, and the country has about 5,500 cyclone shelters, including 1,500 multi-purpose centres. The gender ratio of cyclone deaths, reported at 14 to 1 (male to female) in 1970 and 5 to 1 in 1991, was reported as roughly 1 to 1 in the early 2020s, partly because women volunteers helped women evacuate. **Lessons:** warnings work when they reach people in person and are matched by somewhere safe to go; volunteers are the delivery system; and design for the most excluded group (here, women) improves results for all. **Limit:** as [analysts note](#), lives have been saved more successfully than livelihoods, which continues to leave households exposed to economic and mental-health consequences.

14.2 Zimbabwe: the Friendship Bench

The Friendship Bench trains older lay health workers, called “grandmother health providers”, to deliver problem-solving therapy on a bench in the grounds of a primary-care clinic. In the [first randomised trial](#) of problem-solving therapy in a low-income African country, run across 24 clinics with 573 participants, six sessions of 45 minutes reduced depression symptoms at six months to 14 per cent against 50 per cent in the

standard-care group, with similar improvements in anxiety and suicidal ideation, as summarised by the [London School of Hygiene and Tropical Medicine](#). Most participants were women; over 40 per cent were HIV-positive.

Lessons: a culturally recognised, trusted figure, placed in the clinic, delivered a structured therapy at low cost; supervision and training were built in. **Limit:** results came from a single, well-run trial setting; scaling requires sustained supervision and financing, and the summary percentages should be read alongside the paper's own effect estimates.

14.3 Chicago and Ahmedabad: heat and social infrastructure

Section 5 described these. Together they illustrate two sides of the same coin. Chicago shows that dense, ordinary social infrastructure can be the difference between life and death in a heatwave. Ahmedabad shows that a municipal plan linking forecasts to action, in a very different setting, can reduce deaths measurably. **Lesson:** heat is a manageable hazard, and the cheapest interventions are organisational and social. **Limit:** Ahmedabad's estimate comes from before-and-after data with wide uncertainty, and Chicago's from a comparison of two neighbourhoods.

14.4 Ethiopia: a safety net that cushions drought

Ethiopia's Productive Safety Net Programme, established in 2005 with an initial caseload of 5.5 million, provides cash or food transfers, often in exchange for community work, to chronically food-insecure households. [Knippenberg and Hoddinott](#) found that drought reduced food security for up to four years and that programme payments cut the initial impact by 57 per cent and eliminated the adverse effect within two years. **Lesson:** predictable transfers delivered before a shock protect wellbeing afterwards. **Limit:** the evidence is mostly from one working paper, and the [ODI](#) describes the wider evidence as patchy.

14.5 Ukraine: a national mental-health programme in wartime

In May 2022, within months of the full-scale invasion, Ukraine's First Lady launched a national mental-health and psychosocial support initiative, renamed in December 2022 the All-Ukrainian Mental Health Programme "How are you?". It is coordinated by the Ministry of Health with expert support from the WHO. Official reports, summarised on the [President's website](#), state that by August 2024 nearly 100,000 medical professionals had been trained in the WHO's mhGAP programme, 350,000 services had been provided in resilience centres, and 209,000 educators had completed training on recognising changes in students' mental states. **Lessons:** a national, whole-of-government effort, with a public communication campaign, trained primary-care and school workforces and a goal of accessible, free, local support, can be mounted even in wartime. **Limit:** the figures are official and unaudited, and outcomes (as against outputs) have not yet been independently evaluated.

14.6 New Orleans: community-led recovery

After Hurricane Katrina the Mary Queen of Vietnam neighbourhood recovered faster than comparable areas, with about 90 per cent of residents back within a year and 90 per cent of businesses open, according to the [Boston Globe](#)'s account of [Aldrich's](#) research. **Lesson:** a cohesive community with its own organisations and leaders can organise return, rebuilding and mutual aid faster than outside assistance. **Limit:** the same literature warns that tight networks can exclude outsiders, and not every community has such assets to begin with, which argues for investing in them before disasters strike.

Table 6. *The six cases: intervention, result, transferable lesson and caveat*

Case	Intervention	Reported result	Transferable lesson
Bangladesh cyclones	Volunteer warnings; shelters; evacuation plans	Deaths per major cyclone down by roughly 100-fold since 1970	Reach people in person; give them somewhere to go; design for excluded groups
Zimbabwe Friendship Bench	Lay-delivered problem-solving therapy at clinics	Depression symptoms 14% vs 50% at six months	Task-share with trusted, trained lay workers; embed in primary care
Chicago and Ahmedabad	Social infrastructure; heat action plan	Death rates ≈ 33 vs ≈ 3 per 100,000; rate ratio $2.34 \rightarrow 1.25$	Heat is manageable; connection and planning are cheap protections
Ethiopia safety net	Predictable transfers before shocks	Initial drought impact cut by 57%	Pre-arranged support protects wellbeing afterwards
Ukraine “How are you?”	National programme, mhGAP and teacher training, resilience centres	$\sim 100,000$ clinicians and $209,000$ educators trained (official)	Whole-of-government effort can be mounted in wartime; measure outcomes
New Orleans, Mary Queen of Vietnam	Community-led return and mutual aid	$\sim 90\%$ residents back within a year	Invest in local organisations before disasters; guard against exclusion

Results are as reported in the sources cited in sections 5, 13 and 14; some are official figures or secondary summaries.

15. Measuring What Matters: A Wellbeing-Resilience Dashboard

What is not measured is not managed, and wellbeing in a polycrisis is measured poorly. Most governments track economic output, inflation and hazard events closely, and track loneliness, social trust, treatment coverage and recovery time rarely or not at all. A small, routine dashboard would change that.

15.1 Design principles

- **Few indicators, routinely collected.** A dashboard of fifteen to twenty indicators that is updated annually is more useful than a hundred that is updated once.
- **Three kinds of indicator.** *Outcomes* (what is happening to people), *buffers* (the protections available to them) and *recovery speed* (how fast functioning returns). The identity in section 3 implies that all three are needed: outcomes alone say little about causes, and buffers alone say little about results.
- **Disaggregate.** Averages hide the groups that bear compounding. Indicators should be broken down by income, sex, age, disability, migration status and place, so that the distribution of harm is visible.
- **Use existing data first.** Much of what is needed already exists in international datasets (FAO, ILO, WHO, UNHCR, IDMC, WMO, Gallup and others); the task is to bring it together and fill gaps, not to build a new apparatus.
- **Protect privacy and avoid burden.** Surveys on distress and social connection must be voluntary, confidential and short, and results should return to the communities that provided them.

15.2 A proposed set of indicators

Table 7 proposes a core set. Indicators are paired with an existing source where one exists, and with the direction in which a protected society would move.

Table 7. A proposed wellbeing-resilience dashboard

Domain	Indicator	Type	Example data source	Protected =
Material security	Prevalence of moderate or severe food insecurity	Outcome	FAO SOFI	Falling
	Share covered by at least one social-protection benefit; share of children covered	Buffer	ILO	Rising
	Time from shock to first cash payment to affected households	Recovery	National disaster and social-protection agencies	Falling
Physical health	Heat-related and air-pollution mortality rates	Outcome	Lancet Countdown ; State of Global Air	Falling
	Share of population covered by multi-hazard early warning	Buffer	WMO / UNDRR	Rising
	Share of primary-care facilities operating through a disaster	Buffer	Health ministry resilience audits	Rising
Mental health	Prevalence of depression and anxiety; suicide rate	Outcome	WHO	Falling

Domain	Indicator	Type	Example data source	Protected =
	Treatment coverage for depression and anxiety	Buffer	WHO Mental Health Atlas; national surveys	Rising
	Mental health share of health spending; workers per 100,000	Buffer	WHO Mental Health Atlas	Rising
Social connection	Share reporting loneliness; frequency of neighbour contact	Outcome	WHO Commission ; national surveys	Falling / rising
	Generalised and institutional trust	Buffer	Edelman ; World Values Survey	Rising
	Years in displacement; share of displaced with durable solutions	Outcome	UNHCR ; IDMC	Falling
Agency and hope	Daily worry and stress; sense of control and optimism	Outcome	Gallup	Falling / rising
Cross-cutting	Recovery-interval ratio (time to recover ÷ time between shocks) by region and group	Recovery	Constructed from the above and from hazard records	Below 1
	Distribution: ratio of outcome between the most and least exposed quintiles	Equity	Disaggregated surveys	Narrowing

Types: Outcome = what is happening to people; Buffer = protections available; Recovery = speed of return to normal functioning. Sources are illustrative; many national equivalents exist.

15.3 Using the dashboard

A dashboard is useful only if it changes decisions. Three uses are suggested. **A stress test:** before a hazard season, governments and large organisations assess where the recovery-interval ratio is highest and which buffers are thinnest, and act on the answer. **A trigger system:** some indicators, such as food-price or heat thresholds, can activate pre-agreed support without waiting for a formal declaration. **An accountability mechanism:** publishing the dashboard annually, with distributional breakdowns, lets citizens see whether the protection promised is the protection delivered. That helps address the trust deficit that the information-environment section identified, because visible delivery is among the most credible ways to rebuild confidence.

16. Priorities and Sequencing: A Ten-Year Path

A report that identifies many worthwhile protections owes the reader a view about order. The sequence proposed here rests on one idea: protect today's wellbeing first, so that the longer-term reforms have a population capable of carrying them.

16.1 Principles of sequencing

- **Begin with no-regret measures.** Some protections pay off whatever the future holds: pre-arranged cash, lay-delivered primary-care mental health, heat plans, community check-in networks and basic measurement. They are cheap, evidence-backed and robust to uncertainty about which hazards come first.
- **Protect buffers before asking for change.** People who are insecure resist reforms that threaten what little they have. The ILO's argument that universal social protection is a precondition for a just transition applies broadly.
- **Deliver visibly and quickly.** Trust is rebuilt by results. Early, tangible deliveries (a payment reaching a household in days, a clinic that offers help, a warning that arrives on time) create the credibility on which later reforms depend.
- **Work at all four layers at once.** The layers complement one another, and the simulation in section 8 shows that no single layer suffices. Sequencing should determine the order of investment, not whether to invest in the others.
- **Match each action to a term in the identity.** At each stage, ask which of exposure, sensitivity, buffering and duration the measure acts on, and whether the portfolio is balanced.
- **Measure from the start.** A baseline dashboard in the first year allows later claims of progress to be tested.
- **Guard against exclusion.** Every plan should pass the test: who would not be reached?
- **Plan for the next shock.** Because recovery windows are shrinking, every programme should assume that a second shock will arrive before the first has been absorbed, and be built to continue operating.

16.2 Three phases

Sequence: protect today's wellbeing first, so that long-run reform has a population able to carry it

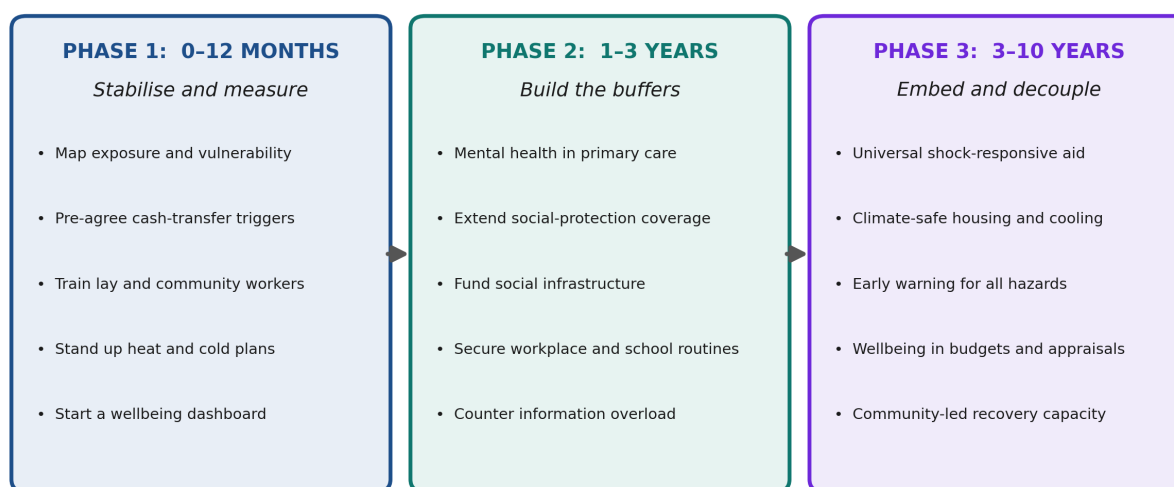


Figure 19. A ten-year sequence: stabilise and measure, build the buffers, then embed and decouple.

H Heuristics. Conceptual roadmap; time horizons are indicative and will differ by country and by starting position.

Phase 1 (0 to 12 months): stabilise and measure. Governments and organisations map exposure and vulnerability, pre-agree triggers and delivery routes for cash transfers, train lay and community workers in psychological first aid and brief therapies, put heat and cold plans in place, and establish a baseline wellbeing dashboard. The aim is to make sure that, if a major shock arrives in the next year, the basic protections are ready.

Phase 2 (1 to 3 years): build the buffers. Mental health is integrated into primary care with a supervised task-sharing workforce; social-protection coverage is extended to the most exposed groups; neighbourhood social infrastructure is funded and protected; workplaces and schools adopt routines that reduce load and support recovery; and efforts begin to improve the information environment through local messengers and public-interest information.

Phase 3 (3 to 10 years): embed and decouple. Universal, shock-responsive social protection becomes the norm; climate-safe housing and cooling reduce exposure at source; early warning covers all hazards and all people; wellbeing enters budgets and project appraisals; and communities have the standing capacity to organise their own recovery. At this stage the aim is to decouple wellbeing from the hazards themselves, so that a flood or a price spike no longer carries the human cost it does today.

16.3 Who does what

Table 8 summarises the main contribution each actor can make at each stage.

Table 8. Who does what, by phase

Actor	Phase 1 (0–12 months)	Phase 2 (1–3 years)	Phase 3 (3–10 years)
Individuals and households	Know neighbours; make a household plan; identify local services	Build a small buffer; join local groups; use media deliberately	Contribute to local preparedness; support others

Actor	Phase 1 (0–12 months)	Phase 2 (1–3 years)	Phase 3 (3–10 years)
Communities and civil society	Map the vulnerable and the connected; set up check-in systems; train volunteers	Run community psychosocial supports; keep social infrastructure open	Lead local recovery planning; hold institutions to account
Employers and schools	Heat and hazard protection; manager training; keep routines in disruption	Income stability; psychosocial-risk management; school health and meals	Embed wellbeing in organisational planning and governance
National and local governments	Pre-agree cash triggers; heat and cold plans; baseline dashboard	Integrate mental health in primary care; extend social-protection coverage; fund social infrastructure	Universal shock-responsive protection; climate-safe housing; wellbeing in budgets
International institutions and donors	Protect humanitarian and development financing; support early warning	Finance task-sharing and safety-net scale-up in the highest-risk countries	Align climate, health and social finance around wellbeing outcomes; support hosts of displaced people

Entries are indicative. Roles overlap, and the most successful cases (section 14) combine several actors.

17. Trade-offs, Limits and What Would Change the Argument

A report that recommends protecting wellbeing should be as clear about its limits as about its claims. This section sets out the main trade-offs, the weaknesses of the evidence, and the findings that would lead H Heuristics to revise its argument.

17.1 Trade-offs

Table 9. Principal trade-offs in protecting wellbeing

Trade-off	The tension	How to manage it
Universal vs targeted support	Universal floors reach everyone and are politically durable, but cost more; targeting concentrates help but misses people and can stigmatise	Universal floor with extra support for the most exposed; test targeting rules for exclusion
Speed vs accuracy in warnings	Early, wide warnings save lives but false alarms cause fatigue and distrust	Tiered alerts; publish performance; use local messengers to explain
Task-sharing vs quality	Lay workers extend reach but need supervision; weak supervision risks poor care	Fund training and supervision as a core cost; measure outcomes; refer severe cases
Community reliance vs state responsibility	Community networks are powerful but can be used as an excuse for withdrawing public services	Treat community assets as partners, not substitutes; fund them
Information integrity vs free expression	Measures against misinformation risk overreach; inaction leaves the environment degraded	Prefer transparency, trusted local sources and design for healthy use over content bans; evaluate effects
Resilience vs justice	A resilience framing can shift responsibility to individuals and distract from causes	Use resilience structurally (section 9.5); pair it with prevention of hazards at source
Measurement vs privacy and burden	Dashboards need data on sensitive topics; surveys burden respondents and risk misuse	Voluntary, confidential, short; return results to communities; limit data retention

H Heuristics' synthesis; these are tensions to be managed, not problems to be solved once.

17.2 Limits of the evidence

- **Modelled global estimates.** Most global figures on mental disorders, loneliness-related deaths, heat deaths and air-pollution deaths are modelled from incomplete data, with wide uncertainty and with revisions between editions. This report treats them as orders of magnitude.
- **Causality.** Many of the cited relationships, including those on social media, climate distress, loneliness and social capital, are observational. Several of the strongest results come from well-designed trials (cash transfers, lay-delivered therapy), but trials are available for only a few interventions and settings.
- **Transfer across contexts.** A programme that works in Zimbabwe or Bangladesh may not work elsewhere without adaptation, and mental-health measures validated in one culture may not translate to another.
- **Secondary sources.** Some figures in this report are drawn from press releases, institutional summaries or secondary coverage because the full reports were not accessible to the authors at the time of writing; these are flagged in captions and should be verified against the primary documents before being reused.

- **The simulation.** The model in section 8 is illustrative. Its qualitative lessons are robust to parameter choices; its numbers are not estimates for any population.
- **Currency.** The report reflects sources available in October 2026. Figures change as new editions are published.

17.3 What would change the argument

The argument would be weakened by any of the following findings.

- **Lay-delivered therapies lose their effect at scale.** If large-scale rollouts of task-shared therapy consistently show effects well below those of the trials, the case for task-sharing as the central mental-health lever would weaken.
- **Social infrastructure effects vanish under better controls.** If rigorous studies find that the apparent protective effect of social infrastructure on heat deaths and recovery disappears once other neighbourhood differences are controlled, the emphasis on community-layer investment would need to be reduced.
- **Resilience does not deplete.** If longitudinal evidence showed that people recover as fast from a third or fourth shock as from the first, with or without buffers, the compounding mechanism at the heart of section 8 would be called into question.
- **Cash effects fail under compound stress.** If transfers lose their mental-health benefit when households face several simultaneous shocks, the case for them as a buffer would need qualification.
- **Information-environment measures show no effect on wellbeing.** If rigorous trials of public-information and design interventions show no effect on distress or trust, this strand of the strategy would be reduced.

18. Conclusion: Protecting What the Polycrisis Threatens

The polycrisis will be judged, in the end, by what it does to ordinary lives. The evidence assembled here suggests that those outcomes are not fixed by the size of the hazards. They are shaped, to a surprising degree, by what stands between the hazard and the person.

Four findings stand out. First, **wellbeing is the right measure**, because it records what persists after the headline indicators have recovered, and because its domains interact. Second, **buffers decide outcomes**: the same heat, the same storm and the same price spike cost very different amounts depending on whether someone checks on you, whether you can reach a clinic, whether cash arrives in time and whether anyone trusts the warning. Third, **resilience is common but conditional**: people are more resilient than pessimistic narratives suggest, but their resilience draws on resources that compounding shocks deplete, and the danger of the age is the loss of time to recover. Fourth, **the most effective protections are modest, evidence-backed and under-funded**, and most of them operate at the community and institutional layers, not at the level of individual self-improvement.

The strategy that follows is simple to state. Prevent hazards from reaching people where that can be done. Prepare people to withstand those that arrive. Buffer the blow with cash, care, neighbours and trusted institutions. Restore functioning quickly. Do all four at once, at all four layers, and begin with the unglamorous measures that work: pre-arranged cash, lay-delivered mental-health care in primary care, heat and early-warning systems that reach the isolated, funded social infrastructure, and a healthier information environment. Measure from the start, guard against exclusion, and be honest about trade-offs.

The scale of the task is not in doubt. More than a billion people live with mental disorders; 3.8 billion have no social protection; 2.7 billion cannot afford a healthy diet; over a hundred million are displaced. Yet the same evidence base shows what is possible: a country that cut cyclone deaths a hundred-fold, a city that made a heatwave less lethal, a clinic bench that cut depression, a safety net that cushioned drought. These are not miracles. They are ordinary protections, built before the crisis by people who decided that wellbeing was worth planning for. The age of the polycrisis makes that decision more urgent, and, as these cases show, more achievable than it appears.

References and Further Reading

All sources are linked inline in the text; this list gathers them by theme. Where a figure was drawn from a press release, institutional summary or secondary report, the primary document should be consulted before reuse.

Polycrisis, global risks and framing

- World Economic Forum (2026). [Global Risks Report 2026: Geopolitical and Economic Risks Rise in New Age of Competition](#). Press release.
- Lawrence, M., Homer-Dixon, T., Janzwood, S., Rockström, J., Renn, O. and Donges, J. F. (2024). [Global polycrisis: the causal mechanisms of crisis entanglement](#). *Global Sustainability* 7, e6. See also the [Stockholm Resilience Centre record](#) and the [Cascade Institute](#).
- World Bank (2024). [Poverty, Prosperity, and Planet Report: Pathways Out of the Polycrisis](#).
- IPCC (2022). [Climate Change 2022: Impacts, Adaptation and Vulnerability, Working Group II, Chapter 7: Health, Wellbeing and the Changing Structure of Communities](#); WHO, [Review of IPCC Evidence 2022: Climate Change, Health, and Well-being](#).
- World Meteorological Organization (2025). [2025 set to be second or third warmest year on record, continuing exceptionally high warming trend](#).

Material security: food, income and social protection

- FAO, IFAD, UNICEF, WFP and WHO (2026). *The State of Food Security and Nutrition in the World 2026* ([doi:10.4060/cd8306en](#)); summary at [IISD SDG Knowledge Hub](#). Previous edition (2025): [doi:10.4060/cd6008en](#).
- International Labour Organization (2024). [World Social Protection Report 2024–26: Universal Social Protection for Climate Action and a Just Transition](#); [ILO news release](#).
- Ridley, M., Rao, G., Schilbach, F. and Patel, V. (2020). [Poverty, Depression, and Anxiety: Causal Evidence and Mechanisms](#). *Science* 370(6522). NBER Working Paper 27157.
- McGuire, J., Kaiser, C. and Bach-Mortensen, A. M. (2022). [A systematic review and meta-analysis of the impact of cash transfers on subjective well-being and mental health in low- and middle-income countries](#). *Nature Human Behaviour* 6(3).
- Wollburg, C., Steinert, J. I., Reeves, A. and Nye, E. (2023). [Do cash transfers alleviate common mental disorders in low- and middle-income countries? A systematic review and meta-analysis](#). *PLOS ONE* 18(2). [PMC version](#).
- Knippenberg, E. and Hoddinott, J. (2017). [Shocks, Social Protection, and Resilience: Evidence from Ethiopia](#). IFPRI ESSP Working Paper 109; ODI, [policy brief on the Productive Safety Net Programme](#).

Physical health: heat, air and health systems

- Lancet Countdown (2025). [The 2025 report of the Lancet Countdown on health and climate change](#); WHO, [Climate inaction is claiming millions of lives every year](#).
- Health Effects Institute (2025). [State of Global Air 2025](#); [news release](#).

- Hess, J. J. et al. (2018). [Building Resilience to Climate Change: Pilot Evaluation of the Impact of India's First Heat Action Plan on All-Cause Mortality](#). *Journal of Environmental and Public Health*. [Full text on PubMed Central](#).
- Klinenberg, E. on the 1995 Chicago heat wave: [Axios, 30 years after Chicago's deadly heat wave; NPR transcript](#). See Klinenberg, E. (2002), *Heat Wave: A Social Autopsy of Disaster in Chicago*, University of Chicago Press.

Mental health and psychosocial support

- World Health Organization (2025). [World mental health today: latest data; WHO releases new reports and estimates highlighting urgent gaps in mental health](#).
- COVID-19 Mental Disorders Collaborators (2021). [Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic](#). *The Lancet* 398(10312).
- Charlson, F. et al. (2019). [New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis](#). *The Lancet*; [University of Queensland summary](#).
- Norris, F. H. et al. (2002). [60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981–2001](#). *Psychiatry* 65(3).
- Hickman, C. et al. (2021). [Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey](#). *The Lancet Planetary Health* 5(12).
- Chibanda, D. et al. (2016). [Effect of a Primary Care-Based Psychological Intervention on Symptoms of Common Mental Disorders in Zimbabwe \(Friendship Bench\)](#). *JAMA* 316(24); [LSHTM summary](#).
- Chisholm, D. et al. (2016). [Scaling-up treatment of depression and anxiety: a global return on investment analysis](#). *The Lancet Psychiatry* 3(5).
- WHO, War Trauma Foundation and World Vision International (2011). [Psychological first aid: Guide for field workers](#).
- Inter-Agency Standing Committee (2007). Guidelines on Mental Health and Psychosocial Support in Emergency Settings; intervention pyramid as presented in [IASC and Red Cross materials](#) and [WHO guidance](#).
- Government of Ukraine, [All-Ukrainian Mental Health Programme “How are you?”: official reports](#).

Resilience science and social capital

- Masten, A. S. (2001). [Ordinary Magic: Resilience Processes in Development](#). *American Psychologist* 56(3).
- Bonanno, G. A. (2004). [Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?](#) *American Psychologist* 59(1).
- Hobfoll, S. E. et al. (2007). [Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence](#). *Psychiatry* 70(4).
- Aldrich, D. P. (2012). *Building Resilience: Social Capital in Post-Disaster Recovery*. University of Chicago Press. [Review in the Japanese Journal of Political Science](#); [ERIA chapter](#); [Boston Globe](#).
- Holt-Lunstad, J., Smith, T. B. and Layton, J. B. (2010). [Social Relationships and Mortality Risk: A Meta-analytic Review](#). *PLoS Medicine* 7(7).

Social fabric, displacement, trust and information

- WHO Commission on Social Connection (2025). [Commission page and report, From loneliness to social connection](#).
- UNHCR (2026). [Global Trends: Forced Displacement in 2025](#).
- IDMC (2026). [Global Report on Internal Displacement 2026](#); NRC, [Conflict and violence become the leading driver of internal displacements](#).
- Oxford Wellbeing Research Centre (2026). [World Happiness Report 2026: executive summary on happiness and social media](#).
- Gallup. [State of the World's Emotional Health](#); Gallup (2026). [State of the Global Workplace 2026](#).
- Edelman (2026). [2026 Edelman Trust Barometer: Society Slides into Insularity](#).
- Reuters Institute (2026). Digital News Report 2026, via [Benton Institute summary](#).

Early warning, children and unequal exposure

- WMO and UNDRR (2025). [Global Status of Multi-Hazard Early Warning Systems 2025](#); [news release](#).
- Eco-Business. [Disaster deaths decline but damage rises on hotter planet](#) (reporting the Global Commission on Adaptation estimates).
- UNICEF (2021). [One billion children at 'extremely high risk' of the impacts of the climate crisis](#). Children's Climate Risk Index.
- Bangladesh cyclone preparedness: [The New Humanitarian](#); [Dialogue Earth](#); [WHO Bulletin \(2012\)](#); [The Business Standard](#).

Appendix A: Method Note on the Illustrative Simulation

Figure 12 is generated by a simple stochastic simulation of stress accumulation. This appendix states its structure and parameters so that the result can be reproduced and challenged.

Structure. A population of $N = 6,000$ simulated people each carries a non-negative stress load L , initially zero. In each year $t = 1$ to 20: (i) the number of adverse events k is drawn from a Poisson distribution with mean $\lambda t = 0.22 + 0.012t$; (ii) each event i has base size s_i drawn from a lognormal distribution with median 0.36 and log-standard-deviation 0.5; (iii) the effective size of each event is $s_i \times (1 + 0.4 \times L) \times (1 - a)$, where a is the share of the event absorbed by buffers; (iv) the load updates as $L(t) = L(t-1) \times (1 - r) +$ the sum of effective event sizes. A person is classified as above the distress threshold when $L > 1$.

Table 10. Simulation scenarios and parameters

Scenario	Protective layers	Recovery rate r (per year)	Absorption a	Share above threshold, year 20
A	None	0.18	0.00	about 53%
B	Personal coping skills	0.22	0.07	about 37%
C	Plus household and community buffers	0.27	0.18	about 19%
D	Plus institutions (social protection, care, early warning)	0.32	0.30	about 9%

Results at years 5, 10 and 15: A: 10%, 25%, 39%; B: 7%, 17%, 26%; C: 4%, 8%, 13%; D: 2%, 4%, 5%. Single run with seed 11; $N = 6,000$.

What the model can and cannot show. The model encodes four mechanisms discussed in section 8: accumulation (load carries over), sensitisation (larger events when load is high), buffer effects (absorption and faster recovery) and intensification (event rates rise over time). It is useful for showing that these mechanisms interact non-linearly and that benefits of protection grow with time. It is not calibrated to data, the threshold has no clinical meaning, and the parameter values for the scenarios are assumptions chosen to represent increasingly protective settings. The ordering of scenarios and the divergence over time are robust to reasonable changes in the parameters; the levels are not.

Appendix B: Glossary

Table 11. Key terms used in this report

Term	Meaning in this report
Polycrisis	A situation in which crises in multiple global systems become causally entangled, through common stresses, domino effects and feedbacks, in ways that cause major human harm (after Lawrence et al., 2024)
Wellbeing	A person's capacity to meet their needs, stay healthy in body and mind, sustain relationships, and act with some sense of agency and hope; tracked across five domains
Resilience	In this report, a structural property: the capacity of a person, household, community or society to absorb shocks and recover, which depends heavily on resources and institutions around the person
Buffering	The share of a hazard's impact absorbed before it reaches the person, by savings, insurance, transfers, relationships and services
Recovery-interval ratio	The typical time needed to recover from a shock divided by the typical interval between shocks; above or near one, losses ratchet
Social infrastructure	The physical places and organisations that shape how people interact: libraries, parks, markets, community centres, places of worship and schools
Social capital	The networks, norms and trust that enable cooperation; can help insiders and exclude outsiders
Task-sharing	Training lay or non-specialist workers to deliver brief, structured interventions under supervision
Psychological first aid	Humane, practical support to people in distress soon after a crisis: caring for basic needs, listening, comforting, and connecting people to information and services
Social protection	Public and publicly supported measures that protect people from poverty and shocks, such as cash transfers, pensions, unemployment and disability benefits, child allowances and public works
Shock-responsive	Designed so that coverage or benefits can expand quickly after a hazard through pre-registered households, triggers and pre-arranged finance
Multi-hazard early warning system	An integrated system that monitors hazards, forecasts risk, disseminates warnings and prepares communities to respond

About This Report

About H Heuristics. H Heuristics produces research on global risk, development and resilience, under the banner *Navigating a Changing World*. Its reports translate evidence from many fields into frameworks and strategies that decision-makers can use.

Suggested citation. Hughes, H. (2026). *Human Resilience in a World of Converging Risks: Protecting Well-Being During the Age of Polycrisis*. H Heuristics, October 2026.

Data and sources. The report draws on sources available in October 2026. Figures 1, 4 to 11, 15, 17 and 18 report values from the cited sources, with the exceptions noted in captions; Figures 2, 3, 13, 14, 16 and 19 are conceptual schematics; Figure 12 is an illustrative simulation (Appendix A). Some values come from secondary summaries and are flagged.

Disclaimer. This report is for information and analysis. It is not medical, psychological, legal or financial advice and should not be relied on as a substitute for professional help. Readers who are in distress should contact qualified professionals or local emergency and support services. Links were checked at the time of writing; the content of external sites may change.