Research & Studies

Planetary Health and Women with Disabilities' lived experiences of Climate impact on Health Equity in Kenya and Uganda

Making it Work

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Authors

Davide ZIVERI, PhD (Planetary Health, Humanity & Inclusion)

Anne-Constance ROSSIGNOL (Making It Work Gender & Disability Project, Humanity & Inclusion)

Sophie PECOURT (Making It Work Gender & Disability Project, Humanity & Inclusion)

Aude BRUS (Research, Humanity & Inclusion)

Contributors

Angela WANJIKU (Women Challenged to Challenge - WCC)

Kenneth WANGAI (Women Challenged to Challenge - WCC)

Jane KIHUNGI (Women Challenged to Challenge - WCC)

Zola Beatrice APIO (Lira District Disabled Women's Association - LIDDWA)

Martha AWOR (Lira District Disabled Women's Association - LIDDWA)

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Content

Abstract

Rationale

The triple planetary crisis (climate change, pollution, and biodiversity loss) carried a heavy health burden, and it intensifies health inequities for persons with disabilities, particularly among women (WHO, 2022). With 1.3 billion people worldwide affected by disabilities—80% in developing countries most exposed to climate hazards and weak health systems—extreme weather like heatwaves, floods, and droughts exacerbates vulnerabilities through inaccessible infrastructure, evacuation barriers, disrupted livelihoods, and limited healthcare access.Women with disabilities face compounded threats and intersectional risks: heightened heat-related illnesses, pregnancy complications, food insecurity, mental health strains, gender-based violence (GBV), and economic shocks from climate disruptions. Barriers to information, adaptation and recovery measures, social support and livelihoods, and barriers to health services creating inacceptable cycles of disadvantage. Despite global recognition of climate as a health crisis, research and policies often overlook gender and disability intersectional inclusion, lacking disaggregated data and lived experiences. Urgent action requires centring women with disabilities' voices in adaptation strategies to ensure equitable and effective responses.

Context

Kenya and Uganda are particularly prone to climate related intensification of floods, heatwaves, droughts, and other hazards like landslides, worsening living conditions and existing health inequities especially among marginalized groups and persons with disabilities. Moreover, indirect impacts on food price and availability of food and medicines, impacts on farming, livestock and water resources, exacerbate health and protection risks. However, an intersectional approach[1] is too often missing in research and pragmatic efforts to reveal and mitigate the impact of climate crisis on health of diverse groups.

Objectives

This qualitative study sought to document lived experiences of climate impacts on health, gender-based violence, and environmental determinants of health, and to generate gender and disability-inclusive climate–health recommendations that can inform climate and health policies, programming, and advocacy by Organizations of Persons with Disabilities (OPDs) and their allies.

[1] Intersectionality: an analytical framework that examines how overlapping social identities —such as race/ethnicity, gender, class, and disability— and systemic power imbalances and oppressions create unique experiences of discrimination or privilege in a given context.

Methods

A qualitative scoping study was undertaken in partnership with two organizations of women with disabilities: Women Challenged to Challenge (WCC) in Kenya and Lira District Disabled Women's Association (LIDDWA) in Uganda, using a participatory, transformative approach aligned with Humanity & Inclusion (HI) ethical guidelines.

More than thirty women with diverse impairments were purposively recruited and in-depth semi-structured interviews, using co-designed open questions and AI-generated visual prompts, explored perceptions of environmental change, health and protection impacts. First-hand narratives about climate-related hazards, environmental determinants (such as water, livelihoods, food, and housing) and experiences of health services' users offer an insight on the multilevel impact of the climate crisis on health and protection in the everyday life.

Interviews were conducted in national languages, transcribed and translated into English, then thematically analysed; ethical safeguards included accessible informed consent, confidentiality, and shared feedback with the organisations of women with disabilities.

Findings

Floods, heat, and drought emerged as the most salient hazards, destroying homes and crops, disrupting mobility, making access to health services, education and social gatherings much harder, in addition to affecting livelihoods.

Women with disabilities reported that such hard situations cause injuries, respiratory infections, dehydration, and sunburns, increasing risks for skin cancers (as it is the case for women with albinism). The variety of symptoms reported indicate that climate and weather phenomena causes illnesses[2] (the subjective, culturally shaped experience of suffering).

Access to health care became precarious during extreme weather due to damaged infrastructure, transport costs, facility closures, power cuts, and inaccessible information. For instance, deaf women and other women with disabilities frequently lacked early warnings and climate-health advice by health workers.

Climate stressors exacerbated risk for GBV including harassment, and interpersonal conflicts especially at water points, while emotional impacts included sadness, anxiety, and feelings of isolation.

Deteriorated environmental determinants of health, such as unsafe or distant water sources that make access to water very costly or dangerous, reduced agricultural yields and livestock losses, declining diet quality and food diversity, and inadequate, non-resilient housing that trapped heat or leaked during heavy rains, also impact health and protection of women with disabilities.

[2] In medical anthropology, disease refers to the objective, biomedical malfunction or pathology identified by clinicians (etic perspective). Illness, by contrast, is the subjective, culturally shaped experience of suffering, including personal perceptions, meanings, and social responses to symptoms (emic perspective).

Despite these vulnerabilities, women with disabilities described agency and proposed concrete solutions, positioning themselves as key actors in climate-resilient and inclusive communities.

Health equity among persons with disabilities

Health inequities are differences in health outcomes that are avoidable and unjust. In general, health equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically, or by other dimensions of inequality (e.g. age, sex, gender, ethnicity, disability, or sexual orientation). With health equity, every individual has a fair opportunity to realize their full health potential without being disadvantaged in achieving it (WHO, 2022).

Conclusion

Climate change is amplifying health inequities and gender-based violence risks for women with disabilities in the Global South mainly because lack of inclusion.

Participatory qualitative research led by organizations of persons with disabilities (OPDs), particularly women-led OPDs, is essential to better understand how climate change affects the health, mental health, and safety of women with disabilities. Such research helps bring to light the multiple and intersecting barriers and risks they face, which are often overlooked in mainstream climate and health responses.

At the same time, this approach highlights the leadership and agency of women with disabilities themselves. Through their organizations, they are not only documenting challenges but also shaping solutions and driving change in their communities.

By placing women with disabilities at the center of knowledge production and action, OPD-led research creates spaces to collectively raise awareness and co-develop practical adaptation strategies. These strategies help protect their health, safeguard their rights, and strengthen their role as key actors in climate resilience and inclusive responses.The study underscores urgent needs to:

- **Strengthen inclusive, and climate resilient health systems.**
- **Ensure accessible, safe housing and shelters.**
- **Develop inclusive early warning and information systems.**
- **Integrate persons with disabilities, particularly women and girls with disabilities, in all stages of climate adaptation planning; and**
- **Invest in climate-resilient livelihoods, green infrastructure, and community-based protection mechanisms.**

All those steps are a pillar of a broader public health and global health strategy and a climate justice agenda.

Glossary

- **Assistive technologies** = Products or equipment that enhance functioning and independence. Disruptions in their supply during climate-related crises heighten risk.
- **Climate justice** = A rights-based framework that highlights how those least responsible for emissions often suffer the most impacts.
- **Climate migration** = Movement of people driven partly or mainly by climate-related hazards.
- **Climate-resilient health systems** = Health systems designed to anticipate, absorb, adapt to, and recover from climate-related shocks and stresses.
- **Climate-sensitive diseases** = Diseases whose transmission or severity is influenced by climate factors like temperature, rainfall, or humidity.
- **Disability inclusion** = The process of ensuring all persons with disabilities (women, girls, men, boys and gender-diverse persons with disabilities) can participate fully and equally in society. It involves removing physical, informational, institutional, and attitudinal barriers across all sectors.
- **Early warning systems** = Mechanisms that monitor hazards and issue timely alerts so people and services can act to reduce harm. Inclusive systems ensure information is accessible to persons with different impairments.
- **Environmental determinants of health** = Non-medical factors in the physical environment (water, air, housing, etc.) that shape health risks and outcomes.
- **Gender-based violence (GBV)** = Harmful acts directed at a person based on their gender, including physical, sexual, psychological, or economic abuse. Climate stressors often increase GBV risks for women and girls with disabilities.
- **Health inequities** = Systematic differences in health outcomes between groups that are avoidable, unfair, and rooted in social disadvantage.
- **Health National Adaptation Plan (H-NAP)** = A national policy instrument that identifies climate-related health risks and sets priorities to adapt the health sector.
- **Health system strengthening (HSS)** = Efforts to improve the building blocks of a health system (workforce, services, information, medicines, financing, governance).
- **Intersectionality** = An analytical lens showing how overlapping identities and systemic power imbalances and oppression create unique patterns of discrimination in a given context. It calls for responses tailored to these combined experiences.
- **Lived experience** = First-hand experiences and perspectives of people directly affected by an issue. Valuing lived experience means treating it as essential evidence alongside academic or policy knowledge.
- **Mental health and psychosocial support (MHPSS)** = Interventions that protect or promote mental health and psychosocial wellbeing in crisis and routine settings. They range from community support to specialized clinical care.

- **Nationally Determined Contributions (NDCs)** = Country-specific climate commitments under the Paris Agreement, outlining emission reduction and adaptation targets.
- **Nature-based Solutions (NbS)** = Actions that protect, restore, or sustainably manage ecosystems to address societal challenges like floods, heat, and food insecurity.
- **One Health** = An approach recognizing that the health of humans, animals, and ecosystems is interconnected.
- **Organizations of Persons with Disabilities (OPDs)** = Representative organizations led and governed by persons with disabilities themselves.
- **Participatory research** = Research approaches that actively involve community members at each stage of the process.
- **Planetary Health** = An emerging field that examines how disruptions of Earth's natural systems (climate, biodiversity, pollution) affect human health and all life. It promotes integrated responses that protect both ecosystems and population health.
- **Protection** = Measures to prevent and respond to violence, exploitation, neglect, and abuse, especially among at-risk groups. It includes safety, dignity, access to justice, and support services.
- **Qualitative scoping study** = A study using qualitative methods to explore a topic broadly, map key themes, and identify gaps. It prioritizes depth of insight over statistical representativeness.
- **Sendai Framework** = A global UN framework (2015–2030) for disaster risk reduction. It focuses on reducing disaster losses in lives, livelihoods, and health through risk-informed planning and governance.
- **Thematic analysis** = A method for analysing qualitative data by identifying, organizing, and interpreting recurring patterns (themes) in participants' accounts. It helps make sense of complex narratives.
- **Transformative research** = Research that aims not only to generate knowledge but to shift power relations and drive social change. It involves co-design, participation of marginalized groups, and action-oriented outcomes.
- **Triple planetary crisis** = Refers to the combined global emergencies of climate change, biodiversity loss, and pollution. These three crises interact, amplifying health risks, social instability, and environmental degradation.
- **UNFCCC COP** = United Nations Framework Convention on Climate Change, the main UN treaty guiding international action on climate change, and its Conference of the Parties, the yearly meeting to negotiate and review climate commitments.
- **Universal Health Coverage (UHC)** = A health system goal where all people can access needed quality health services without financial hardship.

Foreword

"Harnessing local knowledge early through community participation is thus key to successful planning and policy making for system strengthening"

(Mayhew and Balabanova, 2026)

There is little doubt that **climate change is one of the most urgent threats to health and human well-being**. In many regions of the Global South, extreme weather events such as floods, heatwaves and droughts affect health, disrupt livelihoods, damage infrastructure, and place additional pressure on often weak health systems. However**, its impact is not experienced equally**. People already facing structural barriers are disproportionally affected. Women with disabilities are among those most affected, yet their experiences remain largely underrepresented in climate and health research.

Through a participatory and disability-inclusive research approach, the research team sought to ensure that the perspectives of women with disabilities are recognized in discussions about climate change, resilience and service adaptation planning. This is well aligned with the objectives of **the ECOHUB – Thematic Global Network on Climate Change, Urbanisation and Health. The ECOHUB is a multicountry platform that strengthens partners' capacities in research, education, policy and practice across the intersecting fields of climate change, urbanisation and health. It is part of the FA5 programme at the Institute of Tropical Medicine, Antwerp and funded by the Belgian Directorate General Development Cooperation and Humanitarian Aid (DGD)**.

This study reinforces the importance of **advancing health equity**. Addressing the disproportionate impact of climate change on people living in fragile situations is essential not only for effective climate adaptation, but also for achieving broader public health and social justice goals. Integrating persons with disabilities into climate adaptation planning can strengthen the development of inclusive and climate-resilient health systems, ensure accessible housing and improve their livelihoods, all essential steps toward a more just and effective response to climate change.

We hope this report will inform policymakers, practitioners, researchers and health advocates working at the intersection of climate change, health, and disability inclusion.

Finally, we extend our appreciation to the women with disabilities and organizations of persons with disabilities who shared their experiences and insights. **Their voices are central to this work and to the broader effort to ensure that climate action leaves no one behind.**

Bruno Marchal, Hashim Hounkpatin, Claudia Nieto, Katja Polman

The ECOHUB Coordination team

(ecohub@itg.be)

Part 1 – Introduction

"Climate change threatens to exacerbate existing inequities in health outcomes for people with disabilities." (Stein & Stein, 2022). Further, "Planetary health must integrate disability perspectives to address compounded vulnerabilities." (Stein et al., 2024).

Persons with disabilities, particularly women and girls with disabilities, experience pervasive health inequities, including premature mortality, higher morbidity and limitations in functioning due to barriers in access to care, social determinants, and discrimination. Globally, 1.3 billion people (16% of the population) live with significant disabilities and one in five women live with a disability (WHO/World Bank 2011). Health inequities among this group persist despite advances in care, exacerbated by factors like inaccessible environments, stigma, patriarchal societies and poor coordination of services, leading to unmet needs. Those barriers prevent full enjoyment of the right to health as set out in Article 25 of the Convention of the Rights of Persons with Disabilities (CRPD), which mandates States to provide persons with disabilities the highest attainable standard of health without discrimination on the basis of disability (WHO, 2022).

In addition, climate change disproportionately impacts persons with disabilities, amplifying vulnerabilities through inaccessible early warning systems, evacuation barriers during floods/droughts, heatwave mortality risks for those with mobility/thermoregulation impairments, disrupted supply chains for assistive tech and medicine, and vector-borne disease surges in already marginalized communities. Thus, climate crisis is amplifying health inequities.

Climate-health policies have gained track since the UNFCCC[3] COP28 in 2023 with the Declaration on Climate and Health, signed by 151 Member States, committing to "strengthen… policies that maximize health gains from mitigation and adaptation… through close partnerships with… persons with disabilities and the populations most vulnerable to the health impacts of climate change." More recently, at the UNFCCC COP30 in 2025, the Belem Action Plan advances specific health adaptation measures under cross-cutting principles like enhancing Health Equity and the concept of Climate Justice: Adaptation measures must address health inequities and inequalities, which are exacerbated by climate change, and also noting the importance of climate justice, when taking action to address climate change. In these spaces, OPDs are active advocating for recognition in climate negotiations.

Yet, the intersection of disability and gender remains invisible at the intersection of climate and health, from research to policies and programs.

[3] UNFCCC stands for United Nations Framework Convention on Climate Change, the main international treaty on climate change adopted in 1992. COP stands for Conference of the Parties, the gathering of all countries that are parties to the UNFCCC. The UNFCCC COP is the supreme decision-making meeting under this convention, where governments negotiate, review progress, and adopt decisions and agreements on climate action each year.

There are few studies that overcome this gap. For instance, mixed-methods research in Nigeria reveals climate (floods/droughts) multiplies inequities for women, including women with disabilities via service access barriers, livelihoods collapse, food insecurity, displacement and GBV risks, and exclusion from adaptation (Social Development Direct, 2025). Barriers include poor infrastructure, attitudinal stigma, corruption; yet interventions like afforestation, flood defences, cash transfers, and policies involving OPDs for tree-planting and resilient agriculture can make the difference.

The work we will present aims to continue those efforts and bridge the evidence-policy gap, empowering women-led organizations of persons with disabilities and advocates to demand gender and disability-inclusive climate-health action aligned with the CRPD and UNFCCC COP commitments, as:

- **Allocate space in climate-health fora for grassroots/lived experiences via proactive facilitation of meaningful participation of women, men and gender-diverse persons with disabilities in their diversity,**
- **Enhance planetary health research community diversity, as urged: "Planetary health research communities need urgent diversification to include disabled voices." (Ziveri & Zjalic, 2026),**
- **Mandate partnerships with organizations of persons with disabilities, including women-led organizations, in National Adaptation Plans and other initiatives for health adaptation, bridging commitments for health equity and climate justice.**

Research at the intersection of climate change, disability, gender and health plays a pivotal role in shifting gender and disability-inclusive climate action from principle to practice, directly reinforcing collective advocacy. By documenting amplified health inequities, it generates evidence-based data as a foundational priority for closing data gaps and visibilizing women, men and gender-diverse persons with disabilities in policy debates.

Focus on a Planetary Health and disability-inclusion.

Despite the momentum for addressing the impact of the triple planetary crisis on health, disability inclusion is often overlooked. The emerging Planetary Health framework, focused on the impacts of human activity on Earth and the health of all forms of life, offers a pathway to address environmental and social health disparities. While current research and policies related to climate change rarely consider the perspectives of women, men and gender diverse persons with disabilities in their diversity, incorporating inclusive practices in Climate Change and Health and in Planetary Health can improve health outcomes for all. Persons with disabilities, civil society, and health workers play key roles in advancing inclusive climate solutions, contributing valuable knowledge, and advocating for disability-inclusive policies. (Ziveri & Zjalic, 2026)

Part 2 – Context

2.1 Kenya climate and health profile

Kenya faces escalating climate risks that threaten public health, with rising temperatures and variable rainfall amplifying vulnerabilities in agriculture, water, and disease patterns.

Climate Trends. Kenya's mean annual temperature averages follow a warming trend of about 1°C since the 1960s, particularly in arid regions during rainy seasons. Annual precipitation averages show high variability: northern areas wetter, southern drier, with more frequent extreme events and droughts every 3-4 years. Projections under high emissions scenario indicate temperature rises of 1.7°C by 2050s and 3.5°C by 2100, alongside slightly increasing but intense rainfall, especially short rains (Oct-Dec), and declining arid-zone precipitation.

Health Impacts. Climate change exacerbates vector-borne diseases like malaria (most studied), Rift Valley fever, and waterborne illnesses such as cholera and diarrhoea, driven by rainfall, temperature, and flooding. Higher temperatures and scarcity increase malnutrition, respiratory issues from air pollution, and heat-related mortality, with elderly heat deaths projected at 45/100,000 by 2080. Droughts and floods cause food insecurity, displacement, and non-communicable outcomes, reversing gains in infant mortality and malaria control.

Vulnerable Groups. Arid and semi-arid lands populations, including pastoralists in northern counties, face heightened drought risks, malnutrition, and conflicts over water/livestock. Rural poor, women and children in informal settlements, and coastal communities suffer from floods, vector diseases, and pollution; urban poor in Nairobi/Mombasa experience respiratory and heat burdens. Elderly, pregnant women, and under-5 children are most at risk from heat, malnutrition, and diarrhoea.

Health care facilities. Even if, according to WHO (2025) no climate assessment has been conducted for climate resilience of health care facilities, they face risks from floods damaging infrastructure, droughts straining water/power, and heat increasing cooling demands. Urban centres vulnerable to heatwaves disrupting services; limited climate-proofing noted, with needs for resilient designs and early warning integration. WHO profiles highlight surveillance gaps for climate-sensitive diseases.

Policy Responses. Kenya's National Adaptation Plan (2015-2030) mainstreams health adaptation, including vulnerability assessments and early warning for diseases. Climate Change Act (2016) establishes the National Climate Change Council for coordination; health sector actions include surveillance pilots and policy integration. Priorities are given to ecosystem-based approaches, county plans, and financing via Green Climate Fund; gaps in data, especially gender and disability disaggregated data, institutional capacity, and health-specific metrics persist.

2.1 Uganda Climate and health profile

Climate change exacerbates health risks in Uganda through rising temperatures, erratic rainfall, floods, droughts, and landslides, straining the health system and vulnerable populations. Literature highlights direct impacts like heat-related mortality and vector-borne diseases, alongside indirect effects via food insecurity and disasters. These threats disproportionately affect the most marginalised, who are living at the intersection of rural poverty, disability, younger age or older age, and gender and disability.

Climate Trends. Uganda's mean annual temperature has risen 1.3°C since the 1960s, with hot days increasing by 74 and hot nights by 136 between 1960 and 2003. Under high emissions scenario, temperatures could rise 3.7°C by 2090s, with warm spells surging from 10 to 225 days annually by 2100. Precipitation shows variability, with reductions in northern areas and intense events raising flood risks.

Health Impacts. Rising heat threatens cardiovascular and respiratory diseases, with elderly heat-related deaths projected at 81 per 100,000 by 2080s under high emissions. Vector-borne diseases like malaria could affect 108 million annually by 2070 due to expanded suitable habitats around Lake Victoria; dengue transmission capacity may rise 30%. Water-borne illnesses (e.g., cholera, diarrhoea) increase from floods contaminating sources, while malnutrition risks grow 20% by 2050 from crop failures.

Vulnerable Groups. Women and men with disabilities face amplified risks from climate related hazards because of low prioritization in rescues and poor access to warnings for persons with sensory impairments. Children under 5 suffer high stunting (34%) and under-5 mortality (60/1000), worsened by droughts reducing food security. Women and rural populations endure household air pollution (95% solid fuels) and limited healthcare in the aftermath of floods.

Health care facilities. 41% of the healthcare facilities function without water basic services and 75% of them lack adequate hygiene services. In addition, WHO reported no climate assessment conducted for climate resilience and environmental sustainability of health facilities.

Policy Responses. The Minister of Health has developed the Health National Adaptation Plan (H-NAP) with the goal of building climate-resilient health system, reduce morbidity by 30% from climate hazards by 2030. This document mentions vulnerable populations as children, elderly, persons with disabilities, rural poor, northern/eastern regions. Priorities have given to strengthen surveillance, early warning, resilient infrastructure, WASH in health centres via clear actions: integrate climate into health plans, train workers, community education, One Health approach. The plan aligns with National Determined Contributions (NDCs) and the Sendai Framework.

Right to health (CRPD art.25)

Article 25 of the CRPD lays down that States Parties must recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability. States Parties must provide persons with disabilities with the same range, quality, standard of free or affordable health care and programmes as provided to other persons, including sexual and reproductive health services, population-based health programmes and other health services. It also prohibits discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law.

CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health)

1. States parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Part 3 – Methodology

3.1 Design of the study

This qualitative scoping study builds on a prior internal desk review that confirmed the gap in evidence on the links between climate change and health—including sexual and reproductive health and rights (SRHR)—from an intersectional perspective integrating gender and disability. Due to the lack of data and to raise voices from lived experiences, we opted for a qualitative study, aiming to investigate under what circumstances things occur; seek depth of understanding; view social phenomena holistically; explore and discover; provide insight into the meanings of decisions and actions. Questions concerned women's views, choices and behaviours facing climate change impacts.

"Nothing without us" is not merely a slogan, but an imperative that demands to be upheld in research and advocacy. Collaboration from the early stages with two women-led Organizations of Persons with Disabilities, with whom HI had an established partnership under the *Making It Work* project, ensured that they were centrally involved throughout the process, from co-designing the interview tool and data collection approach to acting as gatekeepers to the communities of women with disabilities, leading field data collection and helping interpret emerging findings.

Research was conducted in partnership with two women-led Organizations of Persons with Disabilities —Lira District Disabled Women's Association (LIDDWA) in Uganda and Women Challenged to Challenge (WCC) in Kenya — from the Making It Work (MIW) network. The Making It Work Gender and Disability project is a collaborative initiative managed by Humanity & Inclusion, that, through a participatory, feminist and anti-ableist approach, builds concrete hands-on evidence on gender and disability inclusive practices and empowers women-led organizations.

LIDDWA's and WCC's direct and continuous relationships with women with disabilities created a trusted environment in which participants felt comfortable sharing detailed and sometimes sensitive experiences. By reflecting on what worked and what should change, they not only validated the overall methodology but also strengthened its relevance for future research and advocacy with and for women with disabilities, and this section captures their feedback on the process.

3.2 Profiles of the women interviewed

Women-led partners organizations recruited 34 women with disabilities in total (varying ages, impairments, urban/rural), among their members. The sample of women was designed to be as diverse as possible based on two main criteria: type of disability and age.

One part of the qualitative study was conducted in Kenya with 15 women with disabilities, aged 25–60 years (average age: 38), 9 of them living in Nairobi, so in an urban setting and 6 of them living in 3 sub-counties (Kisumu, Nyandarua, Kajiado), mostly in urban settings. Interviews took place between November 2025 and January 2026. Participants included women with physical impairments (6), hearing disabilities (2), visual impairments and albinism (4), psychosocial disability (2), and cerebral palsy (1). Three of them are unemployed, one is employed, one is a teacher and two are students, the rest of them works in business and in small-scale farming, while five of them are also caring for children. Two women with disabilities interviewed have a refugee status.

Another part of the study was conducted in Uganda with 19 women with disabilities, aged 30–52 years (average age: 39), in the Lira district, including both rural communities (12) and urban settings (7). All participants were members of an OPD. Participants included women with physical impairments (8), hearing disabilities (3), visual impairments (3), mental health conditions or epilepsy (3), and albinism (2). The vast majority were farmers—mainly small-scale cultivators, some also raising livestock—while also caring for children or other family members. One participant was a teacher, and another a painter. Those interviews took place between November and December 2025, mostly at participants' homes and, for a few, at organisations' offices.

3.3 Tools and modalities of data collection

Two 90-minute online training sessions were delivered to LIDDWA and WCC teams: one on planetary health framing climate-health links, and one on qualitative methods, ethics, data management, and interviewing. Multiple co-design meetings adapted the semi-structured interview guide (average 90 minutes) and 21 AI-generated visual prompt cards, A4 colour, described for women with visual impairments (See Appendix 2: Interview guide and set of visual tool – guidance notes for data collection).
Tools were piloted with two women with disabilities in both countries.

In-depth interviews (average 90 minutes) followed a structured three-step progression to capture lived experiences systematically, using visual prompt cards as discussion triggers.

1. **Step 1: Perceptions of Environmental Changes** focused on long-term climate-related shifts (e.g., intensifying heatwaves, droughts, floods), probing frequency (e.g. "Is this more common than before?"), personal/community consequences, and adaptations. All questions explicitly explored differential barriers for women with

disabilities (e.g. "Does your disability worsen this?"), highlighting intersectional vulnerabilities.

2. **Step 2: Health, Wellbeing, and Protection Impacts** examined not just clinical diagnoses but holistic experiences—illness episodes, infectious disease risks (e.g., malaria spikes), emotional responses (e.g. worry, anger, grief) and coping strategies, mental health strains, access to climate-informed health services, eroded social cohesion, and heightened protection risks including GBV at home or community clashes over resources.
3. **Step 3: Environmental and Social Determinants of Health** delved into practical changes from climate stressors: water, sanitation and hygiene access (e.g. water scarcity), livelihoods/food security (e.g. crop/livestock losses), One Health dimensions (e.g. animal health links), and housing/living conditions (e.g. overheating homes, caregiving burdens), eliciting rich personal stories of coping and barriers.

This sequencing built narrative depth, linking perceptions to tangible health inequities while centring disability-specific experiences throughout. Open prompts as "Why this card? Tell me a story..." fostered trust and nuance. Even when women with disabilities disproportionately suffer climate crisis' impact on their health, GBV risks and living conditions, they also are agents of change in their own communities. Therefore, few questions were asked about potential solutions, adaptation measures, and demands for ensuring the right to health for all, especially for those living multiple and intersectional forms of discrimination.

Regarding the visuals, interviewers from both organizations found the image cards effective in encouraging rich narratives, making abstract climate and health issues more concrete, and supporting participation of deaf women, emphasizing that the cards were well understood and could be repurposed as a sensitization tool within communities and OPDs. At the same time, they highlighted the importance of ensuring accessibility of materials and related information: for example, a visually impaired woman expressed that she would have preferred braille cards to read independently, underlining the need to diversify formats beyond visual support only.

The interview guide was perceived as long, but conversations remained fluid because women often answered several questions at once, suggesting that future versions could be streamlined while preserving space for open-ended sharing of lived experiences.

3.4 Treatment and analysis

Interviews in national languages (namely Luo in Uganda and Swahili in Kenya) were transcribed/translated to English by interviewers. Thematic analysis was conducted by one researcher, with analysis inputs from LIDDWA and WCC during a dedicated workshop with each partner.

3.5 Limitations

The study's small sample size (34 participants) was constrained by limited time and financial resources, potentially restricting the depth and generalizability of findings across diverse contexts in Kenya and Uganda. Recruitment through women-led Organizations of Persons with isabilities' networks, while leveraging trust and expertise, may have underrepresented women with disabilities who are isolated, inactive in organizations, or face greater mobility/communication barriers, thus skewing toward more vocal or connected voices. Translation from national languages to English during transcription risked losing cultural nuances, emotional subtleties, or context-specific idioms, which are critical in qualitative lived-experience data. The indirect and long-term nature of climate-health pathways—such as cumulative heat stress effects on health or delayed malnutrition impacts—posed challenges in capturing visibility during single interviews, possibly underemphasizing chronic vulnerabilities. Future phases should prioritize larger, more diverse sampling and longitudinal follow-up to address these gaps. OPDs also reported operational challenges, notably the difficulty of recruiting women with psychosocial disabilities even with peer network mobilization, and reaching participants in rural areas, pointing to the persistent invisibility of some disability groups and the need for specific outreach strategies. Looking ahead, they recommended broadening the range of interlocutors in similar research to include more women with disabilities and key informants such as duty-bearers, community leaders and institutions involved in emergency management, to triangulate perspectives and strengthen policy influence.

3.6 Ethical aspects

The participatory approach followed Humanity & Inclusion (HI) ethical guidelines[4] and the Transformative Research principles[5], emphasizing co-creation, power reflection, and action-oriented outcomes. The research adhered to Humanity & Inclusion (HI) internal ethical protocols, guided by the three core principles of respect for persons, beneficence, and justice as outlined in HI's eight recommendations for inclusive research[6]. Informed consent was obtained in accessible formats (e.g., verbal, simplified language) and national languages, ensuring comprehension for participants with varying impairments and literacy levels. All data were fully anonymized, with strict confidentiality and protection measures (e.g., secure storage, limited access) to safeguard participant privacy amid sensitive topics like violence. Planned community awareness sessions with partner organizations will ensure results dissemination and accountability.

[4] Link to HI ethical guidelines 'Studies and research at Handicap International: Promoting ethical data management'
[5] Link to Principles and Frameworks for Transformative Research (Othering & Belonging Institute)
[6] Link to HI ethical guidelines 'Studies and research at Handicap International: Promoting ethical data management'

Part 4 – Findings and discussions

4.1 Perceptions of Climate Change

Climate impacts and related potentially traumatic experiences, losses and grief, and negative health and protection outcomes hit the overall population and, disproportionally, marginalized groups already suffering adversities and inequities, and often with lower resources to cope and recover. These testimonies are not meant to compare persons with and without disabilities, but to highlight the specific positionality of intersecting identities (for example, women with disabilities living in poverty) that shape how climate and health challenges are experienced.

An inclusive response within health systems will benefit the whole population and, at the same time, ensure equity and justice for those groups marginalized and deprived of their rights. Therefore, the following quotes, as well as authors' synthesis and analysis, concern perceptions and lived experiences: despite not being generalized, they offer a powerful and dramatic insight on a complex problem that requires meaningful participation for universal design of inclusive solutions. This listening exercise is a small step in that direction.

Floods

Floods emerge as the most salient and feared climate hazard, described as sudden, invasive, and uncontrollable events that literally enter the private space of the home, putting life as risk and attacking ontological security (the beliefs about how the world is every day). One woman with disability related to have been woken from sleep by water rushing into her house, forced to leave almost everything behind because her limited mobility does not allow her to run; the floodwater threatens both her life and her autonomy.

"I was sleeping when I was woken up by water entering the house. I didn't realize it was raining so heavily. Soon the water level rose, and I had to go outside, but everywhere was flooded. I only managed to save my phone because it was on the bed where the water hadn't reached yet. Everything else was swept away. I couldn't run, so I had to move slowly and carefully to reach safety before the water carried me away. When you only have one leg, it's a big risk—you can fall and be swept away."

This make mobility more difficult than usual: "*After it has rained heavily, I was unable to walk or to move from one place to another. I found it very difficult. And again, I was not able to attend to my place of work*" and without work survival is at risk: "*So for two days or three days, I found difficult to bring food on the table for my children.*"

Another respondent shared her concerns for a "*Deaf friends who lost their house during heavy rainfall. It was destroyed by floods, and they had nowhere to go. They lost everything and had to sleep outside.*" A participant described herself as "*a survivor of the flood,*" explaining: "*Some of my neighbours were displaced from their homes and came to stay with me for a while. At that time, the cost of living was too high for me.*" Another recalled, "*In October this year, the flooding was too much and four people died in my neighbouring village. I saw the boy being taken away by the floods*"; "*There was a grandmother who was just living nearby to my parents' home: she died during the storm because one of the cypress trees all over fell on the house. During heavy rains and floods, disasters are all over.*" Floods are more frequent than in the past and this is because of human impact on climate: "*We as human beings have actually participated in cutting the trees. We have also used very many chemicals like the fertilizer we use in our farms. Those chemicals end up affecting the soil. This affects rainfall. So, it hits on us now.*"

Flooding is not just a one-off shock but a recurring barrier to mobility and participation. In the aftermath of floods, girls with disabilities cannot reach their universities, cannot move through muddy, damaged roads, and those using crutches or with reduced mobility face constant risk of injury: "*Back in 2023, when there were floods, I faced many challenges accessing the university. The roads were bad, and with my disability, my movement was limited*". Another participant remembered that "*There was a lot of water. As a woman with disabilities, it is difficult for someone like me to leave, because I don't know the depth of the water in the trenches. It affects me, because I can't leave without help.*"

At the same time, structural conditions—blocked drainage from garbage dumping, unregulated construction, and lack of trees—are clearly recognized by participants as human-made amplifiers of flood risk: "*People always throw garbage into the drainage system. When it rains, it gets blocked, and the area floods*" and "*There are no trees, so when it rains, nothing slows down the flow of water. That's why floods are common.*"

The economic dimension of floods is visible in testimonies about rising transport fares, cancelled business, and customers staying away from small businesses during heavy rains. Women must still go out to earn a living even when conditions are unsafe, because staying home often means not eating. Floods caused widespread crop loss, housing destruction, and displacement. Flooding also damaged infrastructure and restricted access to services: "*Some bridges are broken, many people fell sick, crops and houses were destroyed.*" One woman shared, "*My hut was destroyed because of heavy rain and storm. All my crops got rotten; I lost everything.*"

Heat

Heat and drought are perceived as a second cluster of threats, often alternating or coexisting with episodes of heavy rain. The participants describe a qualitative change in the sun and for a woman with albinism this shift is not metaphorical but medical: intense heat translates into recurrent sunburns, severe pain, reduced mobility, and heightened fear of skin cancer: "*Before, the sun used to be warm and pleasant, but now it's white, glaring, and very intense. As a person with albinism, I'm easily sunburnt and very sensitive to sunlight.*"

Heat also undermines educational opportunities and independence. Walking one kilometre to university becomes a health hazard due to headaches and visual disturbance, leading to missed classes and withdrawal from social support:

"When the sun is too strong, it affects my vision and causes headaches. At one point, I missed many classes because I kept falling sick. Many people see persons with disabilities as a burden, so I could not ask for help."

For a woman with cerebral palsy, heat interacts with her body and assistive devices—triggering muscle pain, altering posture, overworking shunts, and degrading assistive equipment—so that climatic conditions directly shape physical functioning.

The impact of heat on livelihood exacerbates vulnerability. Heat waves damaged crops, killed livestock, and deepened food insecurity. "*All my soya beans were destroyed by heat, and I lost money*" said one participant. Others added:

"Most of the crops dried in the garden, and now we don't have enough food. We have to buy from the market, which is expensive."

"We just saw our crops drying up. It's around four months now. In December, it rained little by little, but then it didn't last for weeks. The drought has continued, so there's nothing."

Other climate hazards

Beyond floods and heat, other climate-related hazards such as landslides and fires appear, especially in hilly or overcrowded areas, as a major risk. One woman recounts how a disabled **friend** in a hilly settlement lost a sibling, home, farm, and cattle to a landslide, illustrating how topography, poverty, and disability combine into catastrophic loss: "I have seen a woman worried about a landslide that might destroy her property" and "My friend, who also has a disability, lives in a hilly area. When it rained, a landslide destroyed their home. They lost everything—house, farm, cattle—and even a sibling." In addition to catastrophic losses, even minor risks can affect everyday life. A refugee woman with

disability describes how heavy rain turns paths into slippery mud, making every walk an ordeal of repeated falls: “When it rains heavily, the paths turn muddy and slippery. I often fall down.” Consequences of falling may need medical care that is not always accessible nor affordable.

Fire, likely linked to dry conditions and unsafe housing, is experienced as particularly dangerous for a woman whose mobility is limited, regardless of this event is triggered by climate conditions or not. Unable to escape quickly, she sustains serious burns requiring plastic surgery: “*There was a fire near my home, and I couldn’t move fast because of my disability. I got burns and later had to undergo plastic surgery for first-degree burns.*”

Few participants also mentioned other environmental changes: “*My neighbours lost their buildings to the strong wind, and the storm also destroyed one of my cassava*[7] *and banana plantations.*” Deforestation was also a concern: “*Many trees in our area have been cut for charcoal and other uses. This has affected the rainfall and the fertility of the land.*” *Sometimes is due to the local economy based on lodging: “In our area most of the industries are sawmill industries this means that people are cutting trees at a higher rate. Thus, leading to heavy rains and flooding.*” As a consequence: “*The floods come when there are no trees, maybe people have cut down the trees. So, the floods become much heavier than in the past.*”

Spotlight on the key perspective of women-led organisations

Regarding LIDDWA’s and WCC’s perspective about results, interviewers were struck by how frequently women selected the same image cards and described similar consequences, despite having different types of disability and living in diverse environments, which reinforced the sense of **shared and common challenges** across the sample: women with disabilities experience the hardship and impact on health and GBV risks due to climate related hazards.

OPDs observed that **women were more aware of climate change phenomena and their impacts** than initially expected, and that the interview discussions helped many participants further connect specific climate events with concrete health issues, raising the importance of inclusive sensitization and inclusive information by health workers (this latter still insufficient). Interviewers noted that **health workers rarely share climate-related health risk information with women with disabilities**, while they stressed that health staff often lack time and resources to provide preventive advice beyond immediate clinical care or prescriptions.

[7] Cassava is a starchy root vegetable from a tropical shrub, widely eaten as a staple food in many parts of Africa. The root can be boiled, fried, or dried and ground into flour, and its starch is used to make products like tapioca.

Interviewers were touched by listening to the feelings of isolation, sadness, and powerlessness were recurrent across interviews and climate hazards, revealing both mental health and social dimensions of exposure and vulnerability. The partners insisted that **women with disabilities from informal settlements, rural and urban areas alike are fully aware of climate impacts**—including gender-based violence, isolation and economic strain—and **increasingly position themselves as actors who demand support and inclusion in decision-making**.

4.2 Perceived Impact on Health and Protection

Health Impacts

Few respondents were aware of the risk of infectious diseases and, namely, waterborne diseases, because of rains and floods. Multiple testimonies implicitly trace how weather translates into illness. Standing for long in dirty floodwater brings cold and infections: "*During floods, malaria cases increase because stagnant water breeds mosquitoes. In 2023, we had malaria, typhoid, and amoeba infections because the water wasn't safe*" and "*Many people these days are suffering from malaria as a result of flooding in the last two months*". One woman reported a specific case: "*Children from my family suffered from cholera. Where they were living was flooding. And before they realized that the water had been polluted, there was too late.*" Stagnant water in the aftermath of floods increases mosquitoes and malaria; flood-contaminated drinking water leads to typhoid, amoebiasis, diarrhoea, and food poisoning when fresh food is scarce, or even schistosomiasis, also known as bilharzia. Overall, women with disabilities interviewed were very conscious of the impact on their health: "*Maybe you catch malaria, because of the mosquitoes. And then also the dust that comes with it, the rubbish that come with the water flooding. So sometimes you are affected, you don't know what is in those waters. You just become sick. So, unless you go to the hospital or to the health centre to find out what you're suffering from. But mostly when it rains, malaria is always there. And then also flu.*" Or "*People who suffer from high blood pressure, it's normally high because when the temperatures are hot, I don't know what happens.*"

Heat and cold are also experienced as physiological stressors layered on top of disability. Women with albinism describe severe sunburns that impair mobility and self-care, headaches and blurred vision that require reliance on others to walk safely, and shunts that over-drain in high heat, causing extreme dehydration and functional collapse: "*After the rainy season, people start coughing and getting colds. I once developed pneumonia and had difficulty breathing until I was hospitalized*". Other participant confirms: "*Once, after resting in the sun, I woke up unable to feel my legs due to severe burns. It hurts even to shower. I know that sunburn increases my risk of skin cancer*"; and "*My body uses a shunt to drain fluid. During heat, it overworks and causes dehydration, making me weak.*"

Cold, in turn, may lead to respiratory infections, including pneumonia, and exacerbates spasticity and pain in those with cerebral palsy, altering posture and movement patterns: "*Having cerebral palsy, heat makes my hands painful and affects my posture; cold makes my muscles contract and causes pain.*"

Moreover, temperature impacts on water create hygiene issues. One woman said: "*During heat, we face hygiene problems since water is far and dirty.*" Some women described how climate and disability intersect: *"Since my disability is associated with urination challenges, I really need water throughout; hygiene has been my problem during heat.*"

Health impacts are often indirect, but real. A woman with disability shows how climate and related water issues can create new risks at the interface of environmental, animal, and human health (as per the One Health approach): "*During the drought, the wild animals were also starving because there was no water. They depended on the same boreholes as people, but now the wells are dug so deep that even they can't reach the water. The small fish that lived there died too. The land became polluted with carcasses and animal waste. When the rains finally came, the floods carried all that dirt into the rivers — the same rivers we use for drinking and daily needs — leading to disease outbreaks.*"

Access to quality, equitable, and resilient health services

Despite majority of respondents reported no chronic diseases, many spotlighted the difficulties in accessing health services when needed or the damages to health facilities because of climate related disasters. Access to health care is heavily constrained whenever weather becomes extreme. Some facilities close during floods; others operate without electricity due to shutdowns of power systems for safety reasons, further limiting services: "*Hospitals often lose electricity during floods, except for private ones, making access and services unreliable.*" This shows the importance of climate resilience in any health system strengthening program.

However, access to health facilities is only the last step for women with disabilities with health care needs. Flooded or muddy roads make it unsafe or impossible to reach pharmacies and clinics, especially for those with mobility impairment: "*During floods, I needed assistance to reach the hospital, which became very costly*"; "*When it rains, roads become slippery, and I risk falling on my way to the pharmacy.*" In such a context, transport costs surge during heavy rains, and the need to pay for physical assistance increases the overall financial burden of care.

Universal Health Coverage would help prevention and response facing climate crisis too. Specialist care, such as dermatology for severe sunburns or skin cancer risk in albinism, is described as prohibitively expensive and poorly covered by insurance:

> *"Dermatology care is very expensive, and most insurance schemes don't cover it. After severe sunburns, I had to pay for treatment myself."*

Facing such complex and dramatic health impact of climate, information gaps are stark. Participants report never receiving clear guidance on weather risks, where to go if their area floods, or what services exist and how to reach them. "*Some health centres close during heavy rains, and staff attitudes worsen.*" Women with disabilities, and particularly women with visual or hearing impairment, are often excluded from climate and health information due to lack of sign language interpretation and inaccessible formats, leaving them with no information nor escape or protection strategies when storms or floods hit:

"I've never received useful information about weather warnings or where to go during floods"

"If you have a disability, you rarely get climate-related information"

"Health facilities lack sign language interpreters. During a heavy storm, I didn't know what was happening outside and felt trapped inside my home."

Summarizing, access to health care in time of climate crisis is limited by distance, affordability, and poor infrastructure and medicines' availability and affordability. "*It is very difficult to reach the health centre during high temperature,*" one woman reported. Others noted poor facility conditions: "*Health centres continue to work, but water is always a problem during the heat period.*" As another explained, "*Heavy rain has disrupted the health centre, and later heat caused cracks on the wall. When services are disrupted, women suffer most, especially pregnant mothers.*" Women with albinism faced additional mobility constraints: "*Being a woman with albinism, it is very hard to travel during heat. Even though the health centre is near, I have to plan early so the sunshine doesn't affect me.*" Only very few participants said they had ever received information from health staff about environmental or climate-related risks demonstrating the needs for inclusive climate and health information, starting from reinforcing an inclusive health and climate smart health workforce.

Protection

Flooded streets and inaccessible shelters make it difficult to reach safe spaces for women with disabilities ("*Safe shelters are often inaccessible to persons with disabilities*"), while offices and institutions which goal is to support marginalized individuals can become sites of exclusion where staff attitudes deter women from seeking help. Discrimination and stigma hit harder when climate related disasters impact health and basic needs.

Protection concerns are pervasive and multi-layered. Physical vulnerability on muddy roads forces women to accept assistance from strangers, which can be weaponized into sexual harassment or sexual abuse: "*Muddy roads make it easy to slip. People helping can sometimes exploit or touch you inappropriately*" or "*I was almost sexually harassed by a conductor when rushing for the bus during floods.*" In public spaces, women recount

harassment and abuse by conductors or men who offer to carry them through floods only to insult or assault them if they refuse.

Climate stressors appeared to increase Gender Based Violence (GBV), especially domestic violence against women and girls with disabilities. Within households, climate stressors such as food shortages and financial strain correlate with more frequent conflicts and violence in the families.: "*If the man cannot bring food, now the quarrel starts. There are some families separated because of those issues. Maybe the husband cannot work on a farm where there is flood, but we need food. I don't care where you are going to get food from. So, the family separates, or they get the fights.*"

Testimonies describe spouses being forced into the rain and, overall, an increased risk for GBV when men and women are confined indoors: "*Domestic violence and GBV rise during long rainy periods.*" A participant shared, "*As a result of the flood, I suffered GBV and we ended up separating with my husband.*" Poverty, tension and exacerbated violence at home were frequently mentioned: "*Men sell household items for alcohol, and this causes a lot of GBV,*" one woman explained.

"During heat, when there is no work to do, men become more violent."

When scarcity meets poverty and power imbalances risks are much higher for women with disabilities: "*Some women engage in 'sex for water' due to scarcity, while others face harassment when men offer to carry them through flooded areas*". Actually, water points in drought conditions become flashpoints for community tensions: "*Water sources are always crowded during heat, and animals also come for the same water. Women with disabilities are often abused.*" Queues at wells lead to quarrels, physical fights, and even killings over access to water, showing how environmental stress feeds into pre-existing inequalities and conflicts. For women with disabilities, who may need assistance, these tense spaces are particularly risky: "*When I went to the borehole, women crossed the line without permission. Fights erupted, and knowing my condition, I went back home without water.*" Other participants recall:

"During drought you find that everybody goes to that well to fetch water and there are violence incidences that arise some even very physical just because of water"

"There's some sort of conflict, it's chaotic"

"During rain They are more stressed and violent, people quarrel over water, someone was killed."

And when it is not related to water, land use may create tensions: "*You are supposed to plant, harvest then plant again. Now when the floods came it meant that she never harvested anything from that farm because all the crops got destroyed. So, she decided to take her goats to the farm to eat whatever was left. There was another person also grazing his animals by the roadside, when he saw this lady was grazing her goats, he too let out his animals to go to graze in that farm not knowing that it belonged to that lady. A conflict ensued.*"

Finally, extreme and repeated climate related hazards push people to migrate exposing them to other series of risks "*In my neighbourhood, most of the people started to migrate. The migration took place a lot. It was challenging, because now in the community, people are migrating. All gents are migrating with the sheep and cows and whatever.*" Among many negative consequences, many children have no access to education anymore: "*Since people now migrated to different places, even children with disability don't go back to school.*" The situation is also very risky for those left behind: "*Only women are left in the community with the kids. So, they are starving because the lack of food.*" Moreover, being alone at home expose them to risk of violence:

> *"Boys take advantage of this situation, mostly at night, and they come to girls and women with disability. When a person comes to you, you will not escape. You can't escape."*

Emotional Responses and Coping Mechanisms

The emotional landscape of lived experiences facing climate crisis from the positionality of women with disabilities in their diversity is marked by anxiety, shock, sadness, and anger. Emotional distress was widespread: "*Heat is a threat to my mental health,*" said one.

Floods that sweep away entire livelihoods leave women "*in a state of shock*" struggling with the enormity of starting over with no resources: "*I lost everything to floods. Starting over feels impossible.*" Also everyday stress is greater, and this according to gender roles: "*It's women who are more stressed. Because if the children are thirsty, they will not go to ask the dad for water. They will come to ask the mother.*"

Repeated isolation at home during floods or under intense heat leads to feelings of loneliness, overthinking, and deepened depression: "*I feel isolated during extreme weather, unable to attend church or social events*"; "*Staying indoors too long leads to overthinking and depression.*" Social isolation and exclusion from supportive networks are source of stress: "*Extreme weather stops me from visiting and helping others, something I love doing*"; "*As a football coach, I can't access the field when it's muddy, which makes me sad and frustrated.*"

Unpredictable seasons undermine a basic sense of control and planning and triggering confusion. Actually, unpredictable weather leads to an unpredictable future:

> *"When it rains heavily, you feel that psychologically you are affected, thinking of what will happen in the future"*

And, similarly, another respondent said: "*I feel worried because I don't know what's next. You've heard that I stay alone. I don't know what will happen next. I don't know how long the floods will last.*"

Women worry not only for themselves but for the broader community of persons with disabilities, whom they see as having even fewer coping options. A respondent related about a neighbour: "*All his crops were destroyed—maize, sunflower—and he wanted to commit suicide.*". At the same time, frustration towards the government is strong: many feel that authorities (and also other actors helping people in the aftermath of disasters, but without any permanent solution) react only after disasters, failing to invest in prevention, early warning, or inclusive infrastructure: "*I often feel angry because the government acts only after disasters happen rather than preventing them.*" Without climate action, people feel frustrated and fatalism prevails: "*There is no hope. Majority have given up. Yeah, because of, like, the hard-economic situations plus those others, you know, there are those who say, 'whatever happens, happens, what can we do?' You know, that giving up attitude is also manifested.*"

Coping strategies result often insufficient toward the magnitude of challenges and concerns. Some said, "*I just stay at home and close myself inside the house,*" while others sought comfort in "*going to church,*" "*spending time with friends,*" or "*keeping busy with business to avoid mental confusion*", "*Listening to music*". About this latter: "*Sometimes, I may hate myself, because I cannot do one, two, three things, because of the floods. But when I listen to music, I feel I'm comfortable, it is making me to understand the situation as it is. And these heavy rains and floods will not last forever. It will come to an end.*"

Overall ongoing stigma about mental health hides the needs for mental health and psychosocial support in prevention and response to climate hazards.

4.3 Climate impacts on Environmental Determinants of Health

Water

During floods, piped water often smells of sewage, forcing households to fetch water from alternative points that are distant, physically hard to reach, and still of dubious quality: "*During floods, tap water smells like sewage. In places like slums, people fetch water far away, but it's still not clean and expensive*" and "*Lack of water limits hygiene—we can't*

clean properly, and dust increases during hot periods." For women with disabilities, this means either going without adequate water or paying others to carry it, deepening dependence and poverty. Lower groundwater levels make well-digging more expensive, while high heat at dawn or morning hours already poses health risks for those with photosensitivity or albinism. Across seasons, paying for water is a constant (as it is also for colelctin wood or coal for a fire, and contamination of taps with drainage water makes clean water a costly commodity rather than a guaranteed right: "*Digging wells is more expensive now because water levels are low*"; "*During rainy seasons, clean tap water mixes with drainage water, and we still have to pay for it. I pay someone to fetch water for me.*" Almost all participants confirmed that water scarcity was one of the most pressing issues for nutrition, hygiene, and chores. Sometimes, as reported by a respondent, water is not only scarce, but salty, and this a risk for non-communicable diseases, or for dental hygiene: "*The little water that's available is often salty, and I see the effects in my own family. My daughter already has dental problems, and now I have to take her to the dentist because of it.*"

Livelihood

Climate variability undermines livelihoods at multiple points in the value chain. A DJ respondent reported loss of income when an important musical event was cancelled because of heavy rain or when heat waves damaged electronic and sound equipment: "*Once, I lost a DJ event due to heavy rain. Equipment overheated, and I was blamed for it.*" Such an anecdote mirrors many more testimonies traders and small business owners which business has been impacted by floods or heat. In addition, disability exacerbates labour market exclusion, as employers perceive women with disabilities as slow or difficult to manage, and as inaccessible environments limit the types of jobs they can perform. When climate shocks hit, those already at the margins of the labour market are among the first to lose opportunities, with little or no safety nets to fall back on: "*Having a disability makes it harder to find casual jobs.*" Overall, heat and drought severely reduced productivity and income: "*The heat destroyed my crops; some did not grow,*" one said. Livestock losses were common: "*Our animals fell sick, and we spent money on treatment.*" Another related that "*I've seen animals falling and dying very thin. And the farmers being forced to sell their animals. At a throwaway price. Because this cow will die.*"

Women repeatedly emphasized that disability increased their vulnerability: "*My disability makes farming difficult because of my weak hands and poor sight.*" Poor market conditions worsened their situation:

"People buy less; sales are low, so I borrow loans. Negative attitudes towards women with disabilities affect my income."

Food and nutrition

Testimonies about how climate impact food shows not only severe cases, but also a general deteriorating diet quality and reduced diversity of nutrition. Fruits and vegetables—key sources of micronutrients—become scarce and unaffordable, pushing women toward cheaper, less nutritious substitutes like margarine. Meat and other proteins are eaten less frequently and in smaller portions due to price rises linked to droughts and floods that affect agriculture and supply chains: "*Businessmen get an advantage of the people that are affected by the floods. Now, for example, if I was getting 2 kg flour at 100 shillings, maybe during that flood time, we get it at 200 shillings.*"

For many persons with disabilities, even fruits are described as a luxury, only accessible if donated. This nutritional deprivation carries long-term health implications, compounding existing vulnerabilities and undermining resilience to infectious diseases and chronic conditions alike: "*Vegetables and fruits are scarce, and prices keep rising*" so "*persons with disabilities often skip fruits since they're too expensive unless someone donates them*", therefore "*My diet changed because I can't afford fruits like avocados. I now eat margarine instead.*"

Housing

Especially for those living in urban settings and crowded areas, living conditions in houses not adapted for dealing with extreme heat or heavy rains and floods, and damages to public infrastructure as streets and bridges, create many challenges carrying an indirect impact on health, wellbeing, protection and rights. For instance, education continuity is a problem raised by some participants.

Housing is portrayed as both a shield and a trap. In densely built, poorly ventilated, iron-sheet structures, indoor temperatures become unbearable during heatwaves, while holes in roofs and rising damp turn homes into cold, mouldy spaces during rains. Participants speak of their houses as places where you can "melt" in the heat and still get soaked in the rain, illustrating the complete lack of climate-resilient design:

"Iron sheet houses heat up during the day and leak during rain"

"Our house smells of mould after rains"

"My room becomes unbearably hot; even indoors, there's no relief."

"Inside my house it is very hot; daily chores become difficult,"

Another said, "*It was too dusty and staying inside became difficult because the dust made me feel sick.*"

Uninsulated houses created a double issue: "*If you live in an urban area like me, you have to use a lot of electricity. Maybe you have to put out all the fans to contain the heat. When it is also too cold, I decide to use a charcoal stove, but then I also inhale the charcoal, it comes with carbon dioxide that also affects me directly. So, both too hot or too cold, they have negative impacts.*"

Urban spaces that once offered shade, such as tree-lined walkways, are disappearing, transforming the "*concrete jungle*" into an arid, reflective heat island. The city feels hotter — walkways lack trees and shade.

Collapsing bridges and impassable crossings during floods isolate neighbourhoods and are especially dangerous for those using crutches or wheelchairs, who cannot accurately gauge water depth or navigate strong currents. Frequent electricity cuts during storms leave families without light, refrigeration, or communication, and raise security concerns in already unsafe environments. Isolation, physical and social, makes coping much more difficult: "*Even if say you call someone today and send the person to the shop, the next day they will refuse. So, you find that most of the time you are isolated.*"

Part 5 – Recommendations for inclusive climate and health

5.1 Recommendation from women with disabilities

The recommendations shared by women with disabilities outline a clear, **community-driven climate justice agenda** for climate and health policies and programs.

They emphasize that while climate mitigation and adaptation benefit all, they are crucial for persons with disabilities, particularly for women and girls with disabilities, whose health, safety, and livelihoods are most at risk.

Participants call for a **shift from reactive responses to preventive, inclusive measures**—such as tree planting, improved drainage, regulated settlements, and greener, cooler urban environments.

Safe and dignified housing, along with equitable access to basic services and inclusive health coverage, are viewed as essential foundations for climate resilience.

Another grassroots identified priority is ensuring **access to inclusive information on climate and health:** "Do *not forget people with disabilities, we need to have people educating us or sensitizing us on those things so that we know what to do in different weather occurrences.*" This includes disability-accessible education, early warning systems, and active involvement of women and men with disabilities from the planning stage of climate adaptation measures that safeguard health and wellbeing through stronger social support systems: "*As a woman with a disability, I think it is good to bring all the stakeholders on board. To think on how we can maybe plant trees to prevent the floods.*"

Participants stress the importance of **climate education and community awareness to strengthen preparedness and resilience and call for financial and technical support** for women with disabilities to develop or sustain **climate-resilient businesses and livelihoods**. A participant reminded that "*We should also take care of our general environment, about the things that affect our environment, like the plastics, you know, or the cutting of trees.*" Telling it straightforward: "*We need knowledge. We need knowledge on that. For ourselves and also for the community around us.*" For women with disability working as a teacher, this is the priority: "*Number one, to educate the citizens on climate change. Many people are not aware. To educate people on climate change, the effects, and possible solutions. Because these are the problems we are now living with.*" Ensuring access to climate-related employment—such as maintaining drainage systems, managing green spaces, or supporting community resilience initiatives—would empower women with disabilities as key agents of change.

Expanding nature-based solutions[8] in cities, including shaded green areas to reduce heat and absorb rainfall, should be coupled with job creation for women and persons with disabilities in tree planting and environmental maintenance: "*You find there's no green space where kids can go to play.*"

Finally, a woman with disability is promoting green adaptation in her community and this is an example for the whole society: "*In my piece of land I have just planted with my two children, two girls, few trees. I planted trees to show people in the community that even people with disability understand the importance of planting trees in the area. So, I would encourage the community, the stakeholders, even the government, to encourage people to plant trees. Less deforestation, less cutting, but plant more.*"

Women-led organizations of persons with disabilities key recommendations

Having witnesses or listened to, once more, the consequences of climate related hazards on health, protection, and livelihood of women with disabilities both in urban and rural areas, women-led OPDs suggested:

- ✓ Ensure research on climate and health is inclusive.
- ✓ Promote meaningful participation of women with disabilities in national and local climate adaptation policies and plans, ensuring health and protection, for example when planning accessible and safe water points or distributing sunscreen for women with albinism.
- ✓ Involve women with disabilities as agents of change, for instance in planting trees campaigns.
- ✓ Intentionally support women with disabilities to deal with economic and social concerns - such as difficulty securing livelihoods compared to non-disabled peers, dependence on others to access basic resources like water, and absence of community support mechanisms.

5.2 Strategic Recommendations for climate and health policies and programs

Listening to voices of women with disabilities in the Global South raises questions, concerns, and ideas to better support OPDs, marginalized groups, and communities (including their key services as health systems) facing the common challenge of the triple planetary crisis (climate, biodiversity loss, and pollution) that impact health, wellbeing, social cohesion, and human rights.

[8] Nature-based Solutions address societal challenges through actions to protect, sustainably manage, and restore natural and modified ecosystems, benefiting people and nature at the same time. IUCN

Addressing climate change and health together through a planetary health approach offers an integrated pathway to strengthen inclusion and climate resilience. Planetary health recognizes the interdependence between human wellbeing and the ecosystems sustaining life. From this perspective, gender equality and disability inclusion are not only a rights issue but also a prerequisite for equitable and sustainable responses to the climate and health crisis. The following four recommendations orient NGOs efforts and other partners (from donors to academia) to operationalize this vision.

1. Advance participatory and inclusive research on climate and health with disaggregated data per gender, age, and disability

Participatory and transformative research grounded in the Planetary Health framework helps capture the complex interactions between environmental degradation and climate crisis, with health outcomes, social inequalities, and gender. To fill the gap at the intersection of climate, health, gender, and disabilities should be at the top of the climate research agenda. Qualitative research raising the voice of women with disabilities is a pivotal step to ensure that programs and policies reflect diverse lived experiences. Collaborations with Organizations of Persons with Disabilities (OPDs), particularly women-led organizations, will strengthen both knowledge generation and local ownership of climate-health evidence.

2. Enable meaningful participation of women with disabilities in climate and health policies and plans

Climate and health governance must include those most affected and marginalized groups. From local level (as meaningful participation in the Health National Adaptation Plans design, implementation, and evaluation) to the global level (as the creation of the Disability Caucus at the UNFCCC COP) will advance gender and disabilities perspectives in decision-making about climate and health. Supporting this participation (i.e. financing, capacity building, accessibility, etc.) in those policy spaces fosters accountability and justice in global climate-health action.

3. Provide direct support to women-led community initiatives for inclusive climate adaptation, health prevention, and protection

Direct and flexible support to women-led OPDs and inclusive women rights organizations and community networks enables locally led climate-health actions as suggested by respondents in this research. Namely, international and national cooperation mechanisms and alliances can facilitate fundraising and technical guidance for inclusive awareness campaigns about climate and health, community preparedness and prevention of climate-health risks, and adaptation practices (i.e. for instance, via nature-based solutions).

4. Integrate disability inclusion into climate-resilient health systems and health systems strengthening initiatives and programs

The study confirms that climate-related hazards exacerbate health and mental health negatives outcomes of women with disabilities both directly (injuries due to extreme events) and indirectly (water issues in the aftermath of floods which causes infectious diseases,

economic instability, and violence). Therefore, and accordingly to the systemic thinking promoted by the Planetary Health approach, it is crucial to co-design and invest in **integrated programs able to consider gender and disability when coming to climate and health information, climate informed health services, and climate resilient health infrastructure**.

Conclusions: Together toward inclusive Planetary Health

Intersectionality is a blind spot in climate and health research, policy, and action. Namely, the voices of women with disabilities in the Global South are too often overlooked. It is time to decolonize the global debate and governance about climate and health and the growing field of Planetary Health, calling for participative research, inclusive practices, and inclusive climate resilient health systems.

This fruitful listening exercise reminded us of how concrete and pervasive the impacts of climate change are on health and living conditions and protection issues especially among women with disabilities during climate adversities in humanitarian settings. Their testimonies reveal that changing weather patterns are not abstract phenomena but daily realities that exacerbate pre-existing health inequities and health and protection risks. They also show that women with disabilities face multiple, intersecting forms of disadvantage—environmental, social, and economic—that make adaptation to climate shocks more challenging. This intersectionality underscores the need for tailored interventions that reflect their specific situations and priorities.

Ensuring access to basic services—such as water, sanitation, healthcare, and education—is not only a matter of rights but also a crucial form of health prevention in the context of a changing climate.

The findings highlight that pathways linking climate change and health are complex and often indirect. Environmental determinants of health, including water availability, food systems, or housing and health information and services, play a central role, while livelihoods and economic insecurity act as mediators that amplify vulnerability.

Finally, adopting a Planetary Health approach is essential to address the interconnectedness of all those dimensions for promoting the right to health for all, social cohesion, and protection.

Appendices

Appendix 1: Essential bibliography

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Appendix 2: Interview guide and set of visual tool – guidance notes for data collection

Image: the overview of the three sets of cards realized with AI and adapted according to partners inputs and the test phase.

Remember (for interviews' facilitators only):

- This consultation aims finding out the understanding of women and girls with disabilities on the effects of climatic change on their health via listening to their experiences and collecting their stories.
- Climate change refers both to extreme weather events and to other environmental issues such as air pollution, biodiversity loss, and deforestation.
- We know by science that all issues mentioned above may have negative impact on health and mental health of people. However, we do not know how this is perceived by women with disabilities in your country and counties.
- We use visuals (cards) and prompts (questions) to elicit stories, but we do not force any answer

- Stories women will tell are sometimes incomplete or a bit incoherent. We can ask for clarification, but we do not force to answer or share further details or examples if the person does not want to
- It is ok to let some aspects not solved. We assume that, if the person did not mention one issue, this is probably not relevant for her
- There is not a right/wrong answer
- We use open questions to start the conversation or to reignite after silences, but we follow the flow of the conversation. This means that the person can relate whatever she wishes at any moment, even if it is related to other phases of the process. We are not obliged to follow the order of questions proposed in this guidance
- You can kindly ask for probing (asking for an example), or for clarifications. Try to explore how what the person said is related to her real life.
- Always give time for thinking about the question, remembering an episode, or just staying in silence a while. No rush
- Remember constantly the core goal: exploring the consequences of climate change issues on women with disabilities' health and protection. Ensure exploring those issues in the way you believe the more acceptable for the person during the whole conversation
- Remember that disability-inclusion is a crucial angle to understand their unique stories, so, when possible, explore if what the person is saying is related to the specific experience of living with an impairment
- For this same reason, there is no specific time slot for each phase, you can be flexible on time. Remind the person that she has the right to skip one or more questions, to stop anytime the conversation, and to disclose only what is acceptable for her.

Before starting: Break the ice and create trust

- Introduce yourself and explain the goal of the consultation and check if this is clear for the participant.
- Ask for informed consent and, if/once allowed, start recording audio.
- Explore the lived situation of the participant, asking to disclosure her age, the kind of impairment(s), and the health condition (chronic diseases).
- Example of questions (not mandatory in this format nor in this order): Tell me something about you:
    - Where do you live?
    - Who do you live with at home?
    - Do you farm, sell things, or take care of children, or all of that?
    - How old are you?

- Do you have you any chronic disease?
- What kind of impairment do you live with?

PHASE 1: Explore the changes in the environment

- Introduce quickly what is going to happen, saying, for instance: “I’m interested in knowing about the changes in the weather and in the environment, you witnessed in the last 10 years or more. So, you can indicate what is changing around you as it is represented in those cards.”
- Show the cards with climate-related phenomena, give enough time to look at them, check if what they represent is clear, and ask to pick one or more.
- Once the person made her choice, let other cards out of the scene, to stay focused on what the person chose.
- For women with visual impairments, describe the cards.
- Starting from the card(s) chosen, start the conversation.
- Just as an example, here few prompts you can use to reignite the dialogue ((not mandatory in this format nor in this order):
  - Why did you choose this card?
  - Can you tell me to which situation it is related to in your memory?
  - Is such a situation more frequent than in the past?
  - Which consequences this situation had for you?
  - What happened in the neighbourhood when this situation arrived?
  - Did these changes made life difficult for you or other women with disabilities you know? In which way?
  - What make this situation worse?
  - What you think it could be done?

PHASE 2: Explore the consequences on Health & Protection

- From hereafter, start your questions referring to the climate event chosen by the person in the phase 1 using the same label or name that the person used to indicate the card (from hereafter HEAT is only an example).
- Remember that the goal is to explore the impact of the chosen climate event on health and protection (violence and safety) issues.
- Shows the card about Health & Protection and ask to pick one or more that are linked to the situation chosen (we will call it “HEAT”, but it could be any other climate phenomenon according to the card chosen in phase 1. Please, change HEAT with the problem chosen by the person).

- Once the person made her choice, take other cards out of the scene, to stay focused on the situation/event chosen.
- Start the conversation with one question and ask to tell more according to the story told by the person.
- Just as an example, here are few prompts you can use to reignite the dialogue (not mandatory in this format nor in this order):
    - Why did you choose this card? Can you tell me more about it?
    - Because of the HEAT, did you get sick?
    - Did you see more relatives sick during or after HEAT periods?
    - Have animals also felt sick in that occasion?
    - Do you think that there are more diseases during or after those kinds of events?
    - Do you think that those situations of HEAT threaten your health?
    - Do health centres/hospitals and pharmacies continue working during the HEAT? In those periods, do you know if they have electricity and water to function?
    - Is it more difficult than usual to reach the health centre? Or to get medicines you may need or treatment (including rehabilitation) in those situations, for you or other persons around you?
    - Have doctors or nurses told you about the health risks due to the HEAT? Was this information clear and useful for you?
    - How do you feel considering that HEAT happen in your community? Are you worried about it (or sad, or angry, etc.)?
    - Have you seen other persons in the community very worried about those changes? Who?
    - What you do when you are worried (or any other emotion previously mentioned by the person)?
    - What do you usually enjoy (going to church or visiting relatives, or any other relevant social activity)? Have those activities changed because of the situation of HEAT?
    - Does your disability make staying home or isolation worse?
    - Have you seen fights or arguments over water or resources during HEAT?
    - Do people quarrel about water or grazing land during the HEAT period?
    - Can you share one story about it?
    - Which kind of violence happened?

- Were women with disabilities affected in these conflicts?
- Do you think violence at home increased during these difficult times?
- Are men more stressed and violent during those moments?
- And out of home, do women with disabilities face more danger at these times? (i.e. when collecting wood, water, etc.)

PHASE 3: Explore the impact on environmental determinants of health

- Remember to always refer to the climate event chosen by the person in the phase 1.
- Remember that the goal is to explore the impact of the chosen climate event on health, but health and wellbeing depend on issues like water, food, housing, and work, that indirectly have consequences on health and protection of the person.
- Shows the card about the environmental determinants of health and ask to pick one or more that are linked to the situation chosen (we will call it in this text "HEAT", but it could be any other climate phenomenon according to the card in phase 1).
- Once the person made her choice, take other cards out of the scene, to stay focused on what chose.
- Start the conversation with one question and ask to tell more according to the story told by the person.
- Just as an example, here few prompts you can use to reignite the dialogue (not mandatory in this format nor in this order):
    - Why did you choose this card? How is it related to HEAT?
    - During HEAT periods, do you have enough clean water for you and your family? Do you fetch it far away? Has anyone in your family been sick from water after floods? Does your disability make it harder to collect water during these times? When water is scarce or dirty, what you do? Have you faced problems with hygiene during HEAT?
    - Has farming changed because of the HEAT? Has your diet/food habits changed? Can you tell me a time when prices of food rise up because of that? Does your disability make farming or getting food harder during these times? When harvest is affected or food is scarce or expensive, what you do?
    - What is your source of income? How has your business or farming been affected by HEAT? Have you or someone you know lost money or properties because of HEAT? Does your disability make it harder to find other income?
    - How is it inside your house during HEAT? Are everyday chores, including caregiving, more difficult than usual? Can you tell me one time staying inside was very hard and why? Does your disability make that situation harder to bear? What do you do to improve or adapt your house to HEAT?

Conclusions

- At the end, put again all the cards on the table to check if the woman wishes to add something else not related so far. Ask if the participant wishes to share something more, coming back to something said, or adding something new. Then, thank the participant, value her experience, what shared.
- Stop recording. Ensure confidentiality and security in storing and treating data. Translate the recording into English and transcript into a Word file.
- Make sure practical aspects are covered, such as transport fees, information or support to travel back home safely.
- Remember that listening to personal stories of other human beings is never an easy task, it requires concentration, time, and genuine interest. Moreover, some persons may disclose personal experiences, emotions, or even traumatic memories, even if it is not the goal of this exercise and we never ask for that. Therefore, it is important now to take time for you to rest. Do not hesitate to contact HI referents.

Planetary Health and Women with Disabilities' lived experiences of Climate impact on Health Equity in Kenya and Uganda (2026)

This document presents the results of participatory qualitative research on the impact of the climate crisis on health and protection of women with disabilities in Kenya and Uganda. It offers key recommendations emerging from the field for climate and health adaptation policies and programs. It also calls for a inclusive approach to Planetary Health.

Handicap International - Humanity & Inclusion

France