The Urban SHADE Annual General Body Meeting report

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OVERVIEW

The first Urban Shade General Annual meeting was held in Mashobra in Himachal Pradesh, India was held between November 25 to December 5, 2025. The meeting had consortium partners from Kenya and Sierra Leone. The people who physically attended the meeting includes:

The George Institute of Global Health (India)
Dr Surekha Garimella
Inayat Singh Kakar
Dr Yetika Dolker
Hemanth Chandu
Pavani Pendyala
Menaka Rao

Liverpool School of Tropical Medicine (LSTM)
Dr Rachel Tolhurst
Dr Jiban Karki
Dr Ijeoma Onyeahialam

Slumdwellers International, Kenya (SDI-Kenya)
Michelle Koyaro Matengo
Bessie Sarowiwa
Mejuma Uchi Mwamunga

Institute of Gender and Children's Health Research (IGCHR), Sierra Leone
Dr Desta Ali
Tena Kabba

Sierra Leone Urban Research Centre
Dr Abu Conteh
Ibrahim Juldeh Sesay

Centre of Dialogue on Human Settlement and Poverty Alleviation (CODOHSAPA)/Federation of Urban and Rural Poor (FEDURP), Sierra Leone
Ibrahim Gandi
Saibatu Nabie Sandy

The purpose of the meeting was to learn across different contexts to identify common and divergent answers to the research questions, as well as the proposed interventions. The meeting was also meant to plan work across the consortium for the final year of Urban SHADE and identify shared capacity needs. A writing workshop was also planned to facilitate the teams writing papers on the data collected.

The report will discuss the key presentations and decisions taken during the meeting.

1. Case studies of the informal settlements
2. Designing interventions
3. Adopting Process Evaluation
4. Visit to Krishna Nagar, Shimla
5. On Health facility checklist and Household Survey Experience
6. Communication workshop
7. Writing workshop

PRESENTATION OF CASE STUDIES

All the country teams were asked to write and present detailed Case Studies with the following questions in mind. The project is working in 11 informal settlements in India, Sierra Leone and Kenya.

> **Some pointers for writing Case Study**
>
> What are the health problems of communities and who in the community is particularly affected (by gender; age; disability, occupational groups)?
> What kind of health services are available within the settlement and off site?
> What are the disruptions to health services during extreme weather events and who in the community is particularly affected?
> What health services are needed to these communities to treat emerging conditions due to extreme weather events? Identify demand and supply side barriers

The presentation of case studies helped us understand each of the contexts in the different settlements, as well as the intersectionalities within the settlements.

Pavani Pendyala from The George Institute team in India

Michelle Koyaro from Slum Dwellers International, Kenya

Abu Conteh from Sierra Leone Urban Research Centre

Some important points that emerged after these presentations:

- Informality and lack of land tenure: Informality of the settlement emerged as one of the major vulnerabilities in determining health risks due to extreme weather events. Almost all the residents in the different informal settlements have no title deeds, and are constantly at risk of eviction. Nearly all of the settlements had poor infrastructure, garbage disposal issues, leaky sewage pipes, lack of clean drinking water and/or running water, lack of access to transportation, among other problems.

  In Andhra Pradesh's RR Peta and Vambay colony which are resettlement colonies (classified as "slums" and resettled from former informal settlements), the problems were

similar mimicking the state of informal settlements. Most residents also lack a title deed in these colonies too.

The informality of the settlement prevents people from making permanent or strong improvements to their houses, especially in Sierra Leone and Kenya, which further makes them vulnerable to the elements, especially heavy rains. In Sierra Leone, and Kenya

- Spatial division within the colonies: There is a huge divide between people who live near the main roads, and those who live further away. In hilly colonies such as Krishna Nagar in Shimla, those who live nearer to the main road or higher up the hill are better off than those who live below. In Sierra Leone's Susan's Bay, those living closer to the higher end are those closer to main roads, as well as the health facilities. The lower end of the colonies are cheaper houses closer to the sea, and flood hazards. This story plays out in most of the informal settlements- there are people within the settlements who are more vulnerable than others. This understanding is lacking in the climate change discourse

- Poor access to health facilities: All the presentations showed that the urban poor living in informal settlements had poor access to public health facilities, which is exacerbated during extreme weather events. Either the access if poor physically (too far from the settlements or no primary health centre near settlements like in Shimla); or lack of mandatory documents (in Kenya, people cannot access public health care without ID cards that are difficult to register for); or health workers being unavailable during working hours (like in Andhra Pradesh), or shortage or stock outs of free medicines. This is exacerbated during extreme weather events, mostly heavy rainfall when health workers themselves cannot come to work or in the settlements, and the health facilities are damaged. Many people rely on private health care, which are often informal such as chemists instead of going to qualified doctors.

- Understanding of extreme weather events: While all the people in the informal settlements understood the impacts of heavy rainfall well, because of its sheer physicality (causing damage or destruction to houses, roads inaccessible, danger of electrocution, snakes in the houses etc), their understanding of heat was embodied or how it felt in the body all. People understood heat as something "invisible" or something that made them sweat or drink a lot of water, skin rashes, causing rise in dust and breathing ailments with that, and ultimately reduced productivity.

- Sense of community: While the sense of community was stronger in settlements of Kenya and Sierra Leone where communities came together to help each other during extreme weather events, this community sentiment appears weaker in India's settlements that Urban SHADE is working in.

Dr Rachel Tolhurst presented on the IPCC framework (2022) of risk related to adaptation, while discussing the definitions of hazards, vulnerability, exposure, sensitivities and risk. She spoke

about how the project can contribute to the theoretical framework. She listed out several details presented by Case Study presentations of all the informal settlements in the three countries helping everyone understand how these particular context details from each of the settlements can help sharpen the intervention ideas.
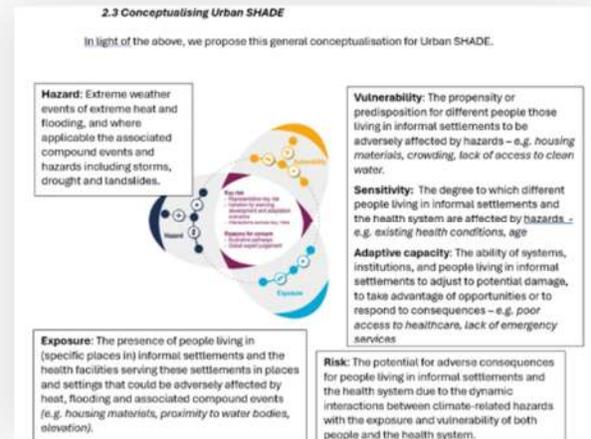
She said, for eg, to consider looking at say lack of land tenure as one of the vulnerabilities, or improving adaptive capacity by granting tenureship. One can also look at limited access to health services or lack of ID cards for entitlement services in Kenya as particular vulnerabilities.

It was suggested that the project work/literature can problematise the understandings of hazard, exposure, sensitivity and expand them to make them more granular. Dr Surekha Garimella said that exposure can be understood as "state of being" and can be reconfigured in the specific ways in which people understand it, and what they have told researchers. Dr Abu Conteh also spoke about Intra- and Inter- settlement disparities with focus on vulnerabilities.

It was decided during the meeting that the case studies will be rewritten by the teams by deploying this framework so as to help the teams think through their interventions based on the specific contextual details of each of the settlements.

DESIGNING INTERVENTIONS

The first couple days of the meeting, the teams from India, Sierra Leone and Kenya presented their first draft of what interventions could look like. The interventions were presented using a matrix. Each country team made a list of 5-7 intervention ideas while thinking through the level at which it will be implemented (community level or health facility level), proposed interventions, the expected outcomes, key components, level of costs, complexity and the likelihood of impact. The planning for the interventions has to be concluded by March 2026 when ideally the interventions should begin. These interventions also have to be within the allotted budget

Level (community, facility)	Proposed intervention	Expected outcome	Key components	Cost (low, medium, high)	Complexity (low, medium, high)	Meaningfulness/likelihood of impact (low, medium, high)

Some of the initial ideas included broad subjects such as waste management, drainage improvement, providing medicines, and developing SOPs for health workers to deal with issues arising out of extreme weather events, among others.

Many of the first ideas from all three countries had early warnings as one of the interventions. Inayat Singh Kakar from India said that the early warnings are often non-specific messages, which are hard to act on. The communication channels are not accessible (SMS or MET press releases) and discussed better communication channels such as loudspeaker announcements from the mosque in Eidgah colony, or rickshaw loudspeakers in Vijayawada. Both Sierra Leone and Kenya participants spoke about how information on heat waves are not given at all. Ibrahim Juldeh said early warning systems will increase health system preparedness and enable health facilities to act promptly.

Dr Abu discussed how indigenous knowledge about predicting weather and modern methods can be integrated. The community researcher, Saibatu said that in the community, they have made yellow, and red lines on the sea wall, which helps them monitor the level of rainfall. If it crosses the red line, they have a system of spreading alerts within the community. Some of them even use a Coke bottle with a stick, and monitor how fast it fills, to get a sense of the extent of rainfall.

All country teams spoke about the gap between health departments and the early weather warnings. Bessie said that enhancing knowledge of health workers, especially community health workers on flood and heat will have high impact. They also spoke about linking CHPs and community disaster management persons.

The discussions helped sharpen each of the interventions, and the way the country teams thought about them. The senior consortium members presented different processes and frameworks to think about the interventions.

Dr Rachel showed the following slide to help country teams think through their ideas more clearly.
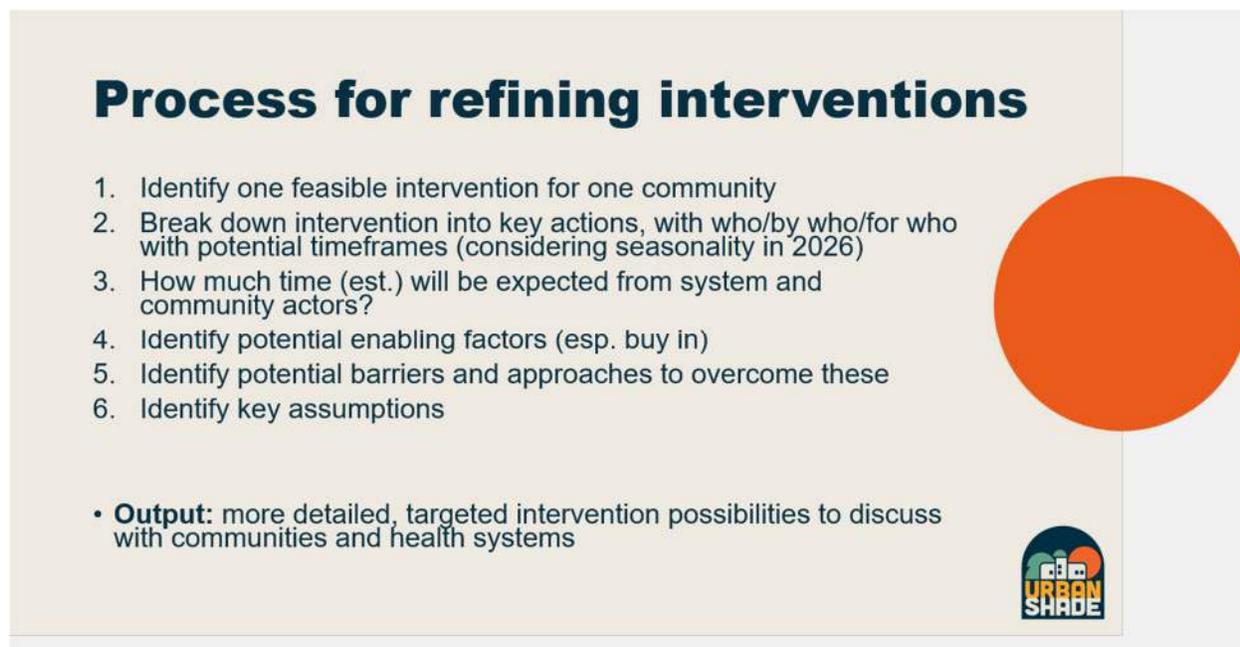
Dr Rachel urged the country teams to think about feasibility of the intervention, having buy-in from communities and health services, as well as sustainability of the intervention even after the project ends. She urged the country teams to be specific and their interventions and identify key actions. The country teams discussed for a few hours refining their intervention, and outputs.

For example, as Dr Yetika pointed out, health system readiness and preparedness is contingent on having good data of the health needs of people in the community, and their health conditions, so as to be more target specific.

These frameworks kept country teams making several iterations on what the interventions could be with the help of senior members of the consortium such as Dr Rachel, Dr Ijeoma Onyeahialam, Dr Jiban and Dr Surekha. The multiple ideas that were presented earlier converged and chiseled.

For example, the India team merged their multiple ideas related to early warning systems and health system preparedness to having Early Health Warnings. The aim is to develop contextualised health guidelines in collaboration with the National Health Mission, India which is located within the existing policies and health structures. These warnings can be given through

autodrivers, loudspeakers, social media, religious institutions etc. The emergency response mandates local level disaster management which can help identify and train youth volunteers. The response will also include establishment of designated shelters stocked with essential medicines, emergency medical kits and other supplies.

The other key framework that helped teams in designing interventions is to reflect on the interventions through the Theory of Change framework. The key question posed was: "**What is the change we are trying to create and how do our interventions realistically get us there**" For this it's important to define the problem and change, and who it benefits, how "success" will be measured.

This exercise compelled the consortium to look at barriers and risks in the context of Interventions more closely. It also helped the country teams to visualise the possible outcomes for the activities related to intervention. For example, Michelle said that after staff will be assigned to the health facility they want to start in Tudor Moroto, it may help CHPs to be

reported directly to the health facility doctors rather than travelling outside the settlement, reducing time to report to their supervisors.

Dr Rachel and Dr Jiban also spoke about how it's important to foresee killer assumptions too. For example, if the health facility in Tudor Moroto is built with community space and state-provided staff, we need to also think about who provides electricity and water, or waste management. Also the risks to SDI if this experiment fails are very great.

The teams continued to reflect on theories of change and the other questions posed by the PIs.

Another set of questions posed were: **What are the most necessary parts of intervention and what are its most supporting parts?**

The India team presented for example, that for their invention of Early Health Warnings, an actionable warning would be something community members and primary health workers can use. For this to work, the team needs to answer these two questions that are at the core of the intervention: how ready the community is, and how ready is the primary health service level for health needs in informal settlements.

The team then decided to look at focusing on specific health conditions (instead of a broader range of all health conditions) including cardiovascular diseases, respiratory diseases, and pregnant women. The actionable tasks at the primary healthcare level were divided into preventive, promotive, and curative aspects. The team is also looking at identifying youth volunteers to provide relief and response. It was suggested that the City Learning Platforms in Sierra Leone can be leveraged.

The SL team after discussion decided that they wanted to work on the intervention that combined early warning system and health system preparedness. They will make a checklist for health workers during EWE, that can be co-produced with stakeholders with the District Health Management Team leading it, to ensure buy-in from national authorities. The medium-term outcome is that this checklist will be institutionalised and health workers apply it regularly, reducing mortality and morbidity. The team will also organise training for record keeping of climate related illnesses. Now, there is hardly any data on extreme climate-induced illnesses.

Kenya said that their intervention of starting a health facility in Tudor Moroto is dependent on health facility buy-in, and that staff will be assigned. The facility will be accessible to people living in settlement, especially vulnerable people such as those living with disabilities. For the other settlements, they want to have activities that increase access to care and EWE preparedness at community and facility level.

ADOPTION OF PROCESS ANALYSIS

The consortium had earlier expected to work on Qualitative Comparative Analysis (QCA) as an evaluation method to help provide a realistic understanding of interaction and relation between contextual conditions, intervention components and outcomes.

Dr Surekha in her session about QCA, spoke about its complexities and advantages while reminding us of the short timeline that the consortium has. QCA can help understand what factors facilitate, or hinder the achievement of outcome in different contexts, and what conditions are necessary and required to achieve the outcomes. It also requires the same or similar intervention across sites, which was not feasible.

Dr Surekha proposed - Process evaluation- as an alternative, which all country teams have agreed to adopt. The primary focus of process evaluation is to capture what was actually delivered in practice through the intervention. It also aims to explain any deviations/adjustments in the approaches proposed.

Surekha proposed that process evaluation can take a multi-pronged approach (looking at multiple facets of primary health systems and communities) **employing a case study method**.

One health centre in each of the study sites to be selected. Basis of the selection could be e.g. case load- one each with low medium and high case load. The PHC can be used as a centre to identify a range of actors including researchers. Semi-structured interviews will be used to gather qualitative data around questions on objective and anticipated outcomes of intervention. Surekha presented some preliminary thoughts on what these questions can be and how the process evaluation will look in practice.

Preliminary thoughts:

Process evaluation questions	Considerations	Data collection	Approx number of people
What level of delivery did the intervention achieve, and did all the planned components get delivered?	How was the intervention decided? Why were specific characteristics of the intervention deciding the way they were? Were the alternatives to the above considered- If so, what were they? And why were they discarded? At the PHC level what were the received understandings of the intervention At the community level, what were the understandings? Others?	Semi structured interviews	–
What level of delivery did the intervention achieve, and did all the planned components get delivered?	What level of intervention delivery was decided and why was it so? Were some components not as strong as the others and why	Semi structured interviews?	–
How closely did you follow the intervention plan	Understand to what extent the workplan put in place reflects the real world requirements (method, time, resources, etc)	Maybe a few FGDs required with communities	–

She spoke about three key anchors to build theoretical framework:

1. Mechanisms of impact: how the delivered intervention impacts the spaces where it is delivered.
2. Scrutiny of causal mechanism which will help us identify- how to develop more effective interventions and how it may be transferred to other settings
3. Context: looking at contextual influences that mediate and affect how the intervention is planned and executed and how it's achieved.

ON QUANTITATIVE STUDIES

In the coming months, the consortium teams will conduct the Health Facility Checklist with primary and secondary hospitals that service the informal settlements Urban SHADE works in. The purpose is to systematically assess the preparedness and resilience of health facilities in the context of floods and heatwaves.

The team members first presented the different contexts related to the settlements and the health facilities which are nearby or used by the community members. They spoke about how far one has to travel to go to the health facilities, how EWEs affects access to health facilities, about the infrastructure and staff in the health facilities,

Dr Yetika (L), Ibrahim Gandy (middle), and Bessie (R) presenting for the health facility survey

Dr Ijeoma, who designed it with the help of colleagues such as Dr Jiban, Dr Lana, and others explained the purpose of the Health Facility Checklist is based on the WHO's Operational framework for building climate resilient health systems This framework looks at 10 domains including vulnerability, capacity and adaptation assessment, health workforce, risk monitoring and early warning among others which were contextualised for the settlements Urban SHADE " project works in. This was adapted to questions that are relevant to the community and that help understand the health facilities' capacity to recover, readiness and responsiveness in case of an EWE. She also presented an analysis framework that can help analyse data across facilities and also across countries.

The TGI India team spoke about the process of rolling out the Household Survey in Andhra Pradesh and Himachal Pradesh's five settlements. They spoke about the listing exercise, sampling, piloting of the tool, framing of questions and safeguarding exercises, among other issues.

VISITING KRISHNA NAGAR

The Urban SHADE consortium visited Krishna Nagar, an informal settlement in the heart of Shimla city which was established during the colonial British regime. The consortium members went right up to the lower part of the settlement and got a sense of the challenging geography especially for vulnerable populations such as older people, pregnant persons, or those with disabilities.

The consortium members also had a meeting with community leaders who discussed the various challenges the community faces, especially in relation to lack of land tenure, caste discrimination and access to healthcare.

COMMUNICATION WORKSHOP

The Project communications lead Menaka Rao conducted the communication workshop where she discussed the key objectives of Communications in Urban SHADE and helped the consortium members think through their ideas to convert them into blogs. For this the workshop discussed story angles, characters, scene setting as well as ways to create an emotional response. She used different news stories to illustrate these points. The people present wrote a short blog each which will be repurposed into a blog section called [Musings](#).

WRITING WORKSHOP

After the meeting, the teams focused their energies on a three-day writing workshop conducted by the PIs. The workshop started with an orientation in writing of abstracts, literature review, conceptual framework, methodology and methods, conclusion. The consortium members not only presented ideas but also did a literature review. Dr Surekha did a short presentation on writing findings. The workshop ended on December 5 with all the teams deciding the topics on which they can write papers based on their field work.

The teams decided to work on the following papers:

Interrogating the concept of absence in relation to EWE and their health impacts among people living in informal settlements (TGI, India)

Gendered climate vulnerability and resilience in three informal communities in Freetown (IGCHRL)

Marginality, space and urbanism: Exploring the Health Impacts of Extreme Health impacts of Extreme Weather Events on Informal Settlement residents in Freetown (SLURC)

Heatwaves in informal settlements- silent threat (CODOHSAPA)

Evaluating health system preparedness and responsiveness during EWE across primary-level health facilities in informal settlements in Kenya (SDI)

The role of CHPs in ensuring community readiness during extreme weather events in informal settlements in Kenya (SDI)

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