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**ORIGINAL RESEARCH**

# Negotiating and navigating everyday governance for public health services in Dhaka City's informal settlements: A political ecology analysis

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**ABSTRACT**

**Introduction:** In Bangladesh's complex urban spaces, poor people living in cities' informal settlements struggle to access affordable public health services. Through a political ecology analysis, this paper explores how residents in informal urban settlements navigate everyday governance to access health services.

**Methods:** This qualitative participatory research was conducted in two informal settlements in Dhaka city, one of the world's most densely populated megacities. Stories of 16 families were captured through the Governance Diaries method, where repeated in-depth interviews and group discussions were conducted with each family over a period of four months between February and May 2023. Thematic framework analysis was conducted by applying the Urban Political Ecology (UPE) framework.

**Results:** Residents employed various strategies to access essential public health services (healthcare, water, sanitation) by navigating local governance networks and negotiating with service providers. Success in these negotiations was shaped by residents' socioeconomic status, access to information, political affiliations, and social networks. The ability to manage governance mechanisms for accessing public health services relied on three interconnected resources: 1) Financial resources (internal and external financial support); 2) Social resources (social networks - connections with governance actors and NGOs); and 3) Personal resources (negotiation skills, social and political positions, and personal wealth). Limitations in any of these resources restricted access to services.

**Conclusion:** Personal, social, and financial resources influence the degree to which informal settlement residents can access public health services. Supporting the development of these three resources is crucial for enhancing the ability of diverse residents to engage in local governance networks and improve their access to public health services. Action is required to advance universal health coverage in Bangladesh and ensure that marginalised urban populations have equitable access to essential healthcare services.

**Keywords:** Social network, political patronage, community systems, resource mobilisation, financial resources, strategic alliances, Bangladesh.

**Abstract in Español at the end of the article**

# INTRODUCTION

Everyday governance describes regular practices of negotiating and accessing authority, services, and resources beyond formal state institutions [1]. In the urban political landscape of Bangladesh, particularly within its expanding informal settlements, these practices are central to how marginalised communities manage, survive, negotiate rights, and navigate essential services such as healthcare. Informal urban settlements often lack legal status, state presence and infrastructural investment [2–5]. In these settings, formal health systems struggle to serve the urban poor, who frequently experience barriers in accessing services due to unaffordability, discrimination, and systemic neglect [2,6,7]. As a result, access to health services is often mediated by complex networks of non-state and informal actors, including political brokers, community leaders, local elites, and informal service providers [4,8–11]. These forms of governance, commonly referred to as everyday governance, highlight how power operates on the ground, where state and non-state boundaries become blurred [1,12,13].

To critically examine the unequal distribution of health services in these contexts, this study draws on the Urban Political Ecology (UPE) framework. The UPE offers a lens for understanding how socio-natural processes are deeply embedded in political and economic structures that shape urban environments [1,14]. It highlights how informal settlements are not simply outside formal governance but are actively produced through socio-political processes that benefit certain actors while marginalising others [12,15]. In the context of health, this means that healthcare inequities are not only a consequence of poverty or weak health infrastructure but also entrenched governance dynamics and uneven power relations [13,16–18]. The UPE thus emphasises that informalities are not merely gaps in formality, but deliberate outcomes of structural processes.

In Dhaka's informal settlements, health access is shaped by these structural inequities [2,7]. Residents often lack formal entitlements due to their "illegal" or undocumented status, pushing them into "grey spaces" where access to healthcare depends on social capital, patronage, and informal negotiations rather than rights or citizenship [19–21]. Everyday governance in such contexts requires marginalised individuals to mobilise informal networks and intermediaries, which may offer access but also reinforce clientelistic dependencies and exclusions [9,22].

Several scholars have applied the concept of everyday governance in Bangladesh's urban context to document informal practices in urban service delivery and planning, primarily at the city level [23–25]. However, there remains a lack of empirical evidence explaining everyday governance practices in informal urban settlements, particularly in relation to accessing urban public health services. Furthermore, additional information is required on the factors that enable residents to manage everyday governance in these contexts.

This paper aims to explore how everyday governance practices shape access to health services in two informal urban settlements in Dhaka. Drawing on a community-based participatory research approach, it investigates how marginalised residents of informal urban settlements navigate informal governance structures to secure healthcare in the absence of reliable state support. By situating these lived experiences within the UPE framework, the paper offers critical insights into how health disparities are maintained and mediated in informal urban settings, contributing to debates on community health systems, health equity and urban governance in the Global South. Considering the significant consequences that inadequate access to healthcare has on individuals like the participants in this study, prioritising pragmatic implications and recommendations should be central to any research conducted in this field.

# METHODS

## Study design

This study employed a qualitative multi-method design [26], applying community-based participatory research (CBPR) approaches [27,28] and multiple qualitative participatory methods. CBPR is a collaborative research approach in which academic researchers, communities, and stakeholders work together to co-create community-driven knowledge [27–29]. BA, the lead author, initiated the main research topic for a PhD project based on years of experience working with individuals living in informal settlements and discussed with co-authors (PhD supervisors). The PhD research was part of a large international research consortium named ARISE Hub (Accountability and Responsiveness in Informal Settlements for Equity) that applied CBPR principles in its design. In this study, CBPR was applied not just as a methodological approach but as a participatory and relational epistemology that emphasised the co-creation of knowledge between researchers and community members [27, 28]. This participatory approach challenged the extractive nature of traditional governance research paradigms from the beginning by recognising community residents as research partners whose lived experiences and insights are essential for a better understanding of local governance systems and dynamics. Utilising various qualitative methods through CBPR approaches provided a deeper understanding of the contextual, social, cultural, and political factors influencing health service access. In alignment with CBPR approaches, BA recruited four community researchers (Co-Rs) from the study sites, who were local residents and therefore had a better understanding of their communities. Co-Rs assisted with research tools development, participant recruitment and data collection.

## Study settings

The study was conducted in two informal settlements in Dhaka city. To protect the identities of the research participants who shared their lived experiences and the

community researchers (Co-Rs), the authors have chosen to refer to these sites as Site A and Site B.

Site A, one of the oldest informal settlements situated in the Dhaka North City Corporation (DNCC), was established illegally on a public land over 35 years ago. Through informal arrangements with local political leaders, some initial and long-term residents with strong political connections have become landlords and community leaders, building houses and gaining local influence. At the time of the research, most of the residents were involved in the informal economy sector, including scrap metal and rickshaw/van garage businesses, small shop owners, street vendors, rickshaw pullers, housemaids and car/truck drivers. This settlement has a history of repeated evictions. Due to its central location, Site A has historically attracted numerous NGOs and service providers. Those NGOs have formed multiple community-based committees (CBCs) with community leaders and representatives of their target groups to operate their projects. However, politically connected community leaders tend to be members of multiple committees. NGOs' presence in Site A also contributed to the development of residents' leadership capacity and civic rights awareness, which was missing in Site B.

Site B is located on the outskirts of Dhaka South City Corporation (DSCC) and is a comparatively newer settlement. It was established partly on privately owned land and partly on vacant land owned by Bangladesh Railways. Here, houses were scattered among multistoreyed buildings. Well-off residents of these surrounding buildings were the landlords and owners of most houses in Site B. Some even constructed unauthorised temporary makeshift houses above the waterbodies beside the railway lines on land owned by Bangladesh Railways. On the other side of the railway lines, temporary and low-income residents lived in low-cost housing surrounding small factories, with most of them employed in the factories and local shops or self-employed (such as street vendors, small shop owners), earning daily or weekly wages. Many extremely poor residents (beggars, rickshaw pullers, etc.) rented makeshift homes and were exposed to industrial pollution, such as smoke, loud noises, and illegally dumped hazardous wastewater. They reported suffering from various health issues, such as frequent diarrhoea, skin rashes, chronic coughs and other lung diseases. Site B has fewer services available than Site A.

Local politically affiliated leaders, especially those with strong connections to respective Ward Councillors, controlled the predominantly patronage-based and transitional local informal governance relationships in both sites. Details of the sociopolitical conditions and relationships of both sites are described elsewhere [30].

**Table 1.** Brief profile of the study sites and participants.

| Characteristics | Site A | Site B |
|---|---|---|
| Participating families | 8 | 8 |
| Primary participants' age | 25-50 years | 35-75 years |
| Duration of residency in the settlements | 5 – 30 years | 3 – 15 years |
| Types of participants | Community leader – 3<br>CBC member -1<br>NGO worker - 2<br>Daily wage earners – 2 | Community leader – 2<br>CBC member - 1<br>Traditional birth attendant -1<br>Daily wage earners - 4 |

## Data collection

This paper presents data collected using a participatory method, namely Governance Diaries (GD) [31] to understand the lived experience of diverse groups of informal settlement residents as they interact with governance actors and service providers to access public health services (healthcare, water and sanitation). This study focused on how individuals navigated the politics of service access within and beyond informal urban settlements. The GD method is effective for exploring contextually and politically sensitive issues that people may feel uncomfortable discussing with outsiders [31]. Sixteen purposively selected families (eight from each study site), from diverse backgrounds (Table 1), were interviewed two to three times at a three to four-week interval between February and May 2023. The inclusion criteria included families residing in the respective site for at least six months prior to data collection, and represented a mix of marginalised groups (female-headed households, daily wage earners, persons with disabilities and/or chronic illnesses, elderly and extremely poor people), community-based committee (CBC) members, community leaders and NGO frontline workers. New migrants (residency duration of less than six months) and mobile populations were purposively excluded, with the assumption that they might not have a better idea about local political and power dynamics and governance mechanisms. These families were selected with the support of Co-Rs to capture a range of experiences and perspectives on managing everyday governance for accessing health services. Co-Rs made initial lists based on sampling criteria, which BA fi-

nalised after careful discussion with Co-Rs. During each visit, BA conducted group discussions with the family members and in-depth interviews with the household heads or their nominated representatives (primary participants).

Most household heads were male, while primary participants included a mix of genders, but were mostly female, including one transgender woman. Most of the participants were involved in informal economy sectors, such as street vending, driving, and small businesses. All sessions were conducted in the native language, Bangla and audio recorded with participants' consent.

### Data analysis

Trained transcribers did Bangla verbatim transcriptions. A hybrid coding approach (a combination of inductive and deductive coding methods) [32,33] was employed for data coding using NVivo 12 software. BA prepared a priori codebook based on the theoretical frameworks, prior experience and consultation with Co-Rs, which was further expanded with new codes and themes that emerged from the transcripts. BA used the final codebook for data coding. Thematic framework data analysis [34] was guided by the concept of Everyday Governance within the Urban Political Ecology framework [1,14,35]. The UPE framework is a valuable tool for understanding the interactions between urban environments, politics, and social inequalities [14]. Its strength lies in unpacking power dynamics that shape service availability and examining the socio-political determinants affecting governance and relationships with informal settlement residents. Pseudonyms were used to protect participants' identities while adding a personal touch to the experiences presented in this paper.

### Positionality statement

Recognising the personalities of research team members is crucial in participatory research, as their diverse backgrounds influence the research process and data interpretation (36). The research team included both early-career and experienced public health researchers from Bangladesh and the UK. Two Bangladeshi authors (BA and SFR), based in Dhaka, contributed their extensive experience in urban settings, providing insights into community dynamics and health service access. A UK-based researcher (KO) brought CBPR expertise, while two others (ST and LW) added a global and health systems perspectives and intersectional analysis from their experience in Bangladesh and other settings. Despite differing socio-economic statuses that may create distance from informal settlements, engaging community researchers facilitated valuable insider insights. These representatives enhanced understanding of local governance dynamics and supported mutual knowledge exchange, enriching data analysis and interpretation.

### Ethics

This research received ethical approval from the Research Ethics Committee of Liverpool School of Tropical Medicine, UK (Research Protocol No. 21-083) and the Institutional Review Board of BRAC James P Grant School of Public Health, Bangladesh (Ref. No. 2019-034-IR).

## RESULTS

### Lived experience: Managing everyday governance for accessing public health services

This section presents the everyday governance experiences shared by participants through the Governance Diaries. Each account begins with an overview of a participant's background, offering context that situates their experiences within broader social, economic, and political landscapes. This framing helps explain their daily struggles and the strategies they employed to navigate governance actors and access public health services, both within and beyond the settlements. We then analyse across these experiences, discussing the drivers, challenges, and significance of developing and accessing three essential resources that enable participants to engage with everyday governance and secure public health services. Some participants' experiences are featured as example stories. The lived experiences of other participating families are incorporated into the interpretation of relevant stories and are discussed in the overall reflection, as illustrated in Figure 1, in the Discussion section. Those who are not included in this paper are part of another associated paper [30].

#### *Munia Aktar: Negotiation and discretion in accessing resources*

Munia Aktar, a woman in her early twenties with higher secondary school education (grade 12), has lived in Site A since birth. Her father, a former community leader, owned two small rooms in Site A, which featured brick walls, a tin roof, and a mud floor, with no windows. Munia lived in one of these rooms with her husband and two children (aged 6 and 1). Her husband was a carpenter and a member of the ruling political party (during the data collection period).

Munia began her NGO involvement as a fire brigade volunteer seven years ago, later becoming an active member of an NGO committee and eventually transitioning to a paid position as a field worker three years ago. This engagement provided her with various training opportunities that enhanced her communication and negotiation skills. Munia shared her experience of using negotiation skills and social connections to secure financial resources, specifically access to maternity allowances for low-income women offered by the Ministry of Women and Child Affairs through a partner NGO. She noted that information about the maternity allowance was first shared only within certain social circles, leaving many eligible women unaware of available resources.

Her NGO experience helped her build strong relationships with community leaders and establish a ro-

bust social network. Munia successfully navigated the web of information and disinformation in the informal urban settlement. The following illustrative quote highlighted her strategies for accessing information and the allowance.

> "*I came across some people whispering about this maternity allowance. I asked someone how to get it, but that person was reluctant to tell me. Later, I learned they received phone calls from the Ward Councilor's office. Then, someone I knew advised me to go to Bank X and to keep this information to myself. I went to that bank, and they enlisted my name.*" (Munia, woman, 22 years, NGO field worker, Site A)

In addition to the issue of information access being restricted by power brokers, another barrier to obtaining the maternity allowance was the need to negotiate with the NGO community health worker (CHW) responsible for enrolling pregnant women in the program. Unlike many women who lack strong social resources, Munia benefited from her own strong social networks and NGO work experience, and did not have to contend with the CHW, who, she reported, exploited the trust of the women she was meant to assist, thereby obstructing their access to much-needed financial support.

> "*Mothers were required to pay the NGO CHW to enrol in the program. She informed people that to qualify for a monthly allowance, they needed to give her a specific amount of money. She enlisted some women and collected money from them. However, some had not yet received their allowances.*" (Munia, woman, 22 years, NGO field worker, Site A)

As Munia benefited from the program, she felt compelled to help other disadvantaged mothers in her social circle access the same service, which further strengthened her status and relationships with some of these residents and others in the community. However, she was discreet, fearing the loss of her resource network (her information source). Munia explained,

> "*I told 2-3 other women without revealing my source. When he (the source of information) found out, he was angry with me for sharing the information. I told him I did not understand and apologised for my mistake. Despite this, I continued to inform pregnant mothers discreetly.*" (Munia, woman, 22 years, NGO field worker, Site A)

Women in the community considered her a valuable social resource as she helped other poor women to access maternity allowance. Therefore, they selected her as their representative when a new NGO took over the program and formed a civic engagement committee in Site A to promote a more inclusive beneficiary selection process. At the time of data collection, Munia was a leader of a women's support group associated with the civic engagement committee. This engagement also helped her improve her leadership skills.

Munia developed communication and navigation skills through her access to education (higher secondary schooling), working with NGOs and family connections (her father, a former community leader, and her husband's political involvement). These skills proved useful to secure her entitlement to a maternity allowance. She then used these skills to benefit herself, help others and challenge the existing system. However, she was in a precarious position where she had to be mindful not to jeopardise her own networks in the process. Her transition into a leadership role further illustrates how skills and networks can transform access into influence, linking individual agency, institutional knowledge, and social networks.

#### *Labonna Aktar: Assertive agency and strategic deflection*

Labonna Aktar, a woman in her early thirties who had been living in site A since birth, had been a member of the maternity allowance civic engagement committee since its inception. Her father was an influential community leader and owned several rooms in Site A. After both her parents passed away during her adolescence, she married into another local influential family at a young age to secure social stability for herself and her three younger siblings, while protecting her father's properties. At the time of data collection, Labonna lived in a single mid-sized room (bricked wall, tin roof, cemented floor, and a window) with her family of five, including her husband, two children, and one autistic nephew. They rented out other rooms to help with expenses. She previously ran a small clothing business, but it closed down during COVID-19 due to a lack of capital, leaving her husband (a private car driver) as the family's primary breadwinner.

Labonna had a vocal and bold personality and developed a strong sense of rights from a young age. Her high school education and family background made her an ideal candidate for NGOs to notice. She voluntarily participated in various NGO activities, including Site A's fire brigade committee, and received various trainings that helped her develop strong communication and negotiation skills. Some community leaders even nominated her to join an NGO committee due to her perceived knowledge and assertiveness. As she explained,

> "*I know the laws, understand people (referring to NGOs/outsiders) and I always read documents carefully before signing. So, community leaders thought I was a good fit to work with the NGO because they (community leaders) needed someone knowledgeable to collaborate with the educated NGO staff.*" (Labonna, woman, 32 years, CBC member, Site A)

In her role as a beneficiary representative in the maternity allowance civic engagement committee (introduced above in Munia's narrative), Labonna faced chal-

lenges in managing local political pressure from community leaders. She often had to defend the committee's decisions and shift accountability upwards to the Ward Councillor, who was also in the committee, to protect herself from potential backlash. This strategy illustrates her awareness of her limitations while also highlighting how she navigated political dynamics.

> "*Some community leaders cause chaos if their relatives' names are not included… So, I mostly refer them to the WC because no one can do anything with him but with us... We try to deal with them (community leaders) in this way. Otherwise, disaster will befall us.*" (Labonna, woman, 32 years, CBC member, Site A)

Labonna's narrative reflects a form of agency shaped by her NGO exposure and community recognition of her abilities. She exhibits remarkable resilience and activism, using her training to engage with local power structure while maintaining her social position in the community. Her assertiveness and legal literacy positioned her as a bridge between NGOs and local authorities, revealing the precarious nature of civic engagement in a politically charged environment. Her strategic deflection of accountability to higher authorities reveals how community members manage political pressure while maintaining legitimacy.

### *Momena Khatun: Vulnerability in the absence of networks*

Momena Khatun (age 55), her husband Saidur Mia (age 60), and their daughter Maya Begum (age 24) shared examples of how financial limitations and a lack of social networks led to inadequate medical treatment and mistreatment by medical professionals. The climate migrant family relocated to Site A 16 years ago. Initially, they lived in a small, rented room with their four children; later, they purchased it with an NGO loan. Over time, they built another room after their elder son got married, using a new loan and with the permission of a community leader. At the time of data collection, their nine-member family lived in these two small rooms (tin walls, a tin roof, and a cement floor). Saidur and their elder son sold vegetables from a small cart on the street, while their youngest son ran a small tea stall managed mostly by Momena. None of the family members had connections with NGOs or politics.

Saidur received treatment for heart disease from a public hospital, where he experienced constant demand for informal payments from health providers. He described the hospital staff's behaviour as deeply exploitative.

> "*They (hospital staff) misbehaved with people. They are always after money when there is a sick patient. You can't imagine what they do. They continuously ask for money here and there. If I reply, they will say that we have come for their help. If we had that much money, we would have gone to a private hospital.*" (Saidur Mia, man, 60 years, street vendor, Site A)

Momena narrated taking Maya to the same public hospital for a recommended surgery after a miscarriage. Attending nurses demanded BDT 5000 (£32) for what was supposed to be a free service. At that time, Momena and her family only had BDT 500 (£3.34), which prompted the nurses to refuse treatment, expel them from the hospital and send them home. Despite seeking help from the doctor and hospital staff, they could only proceed after managing BDT 1000 (£6.50) and convincing the nurses to perform the surgery. With a monthly family income of less than BDT 10,000 (£60) for nine members, meeting the nurses' demand was difficult. Ultimately, they borrowed money from relatives and neighbours, spending a total of BDT 5000 (£32), which included medicine, blood transfusion, and other costs. Momena shared her struggles,

> "*I begged them not to demand money from us because we are poor. I offered BDT 500. The other hospital staff told me that the nurses would not be convinced. They suggested I negotiate with the nurses for BDT 2000. Angrily, I told them to keep the patient, as I had brought everything I could manage and couldn´t do anything more. Eventually, I settled with them for BDT 1000.*" (Momena, woman, 55 years, Site A)

Momena also reported paying an NGO CHW (the same CHW in Munia's narrative) for her daughter-in-law's maternity care. Since Momena's daughter-in-law received antenatal care from that CHW during her pregnancy, they decided to deliver at the NGO clinic. Although the CHW provided free antenatal services, she charged money to accompany pregnant women to the NGO clinic for delivery services, in addition to the actual service charge at the clinic. Monema stated,

> "*She (referring to CHW) takes mothers to the NGO clinic. The clinic charges BDT 10,000 (£65) regardless of the delivery procedure. Patients need to pay her (the CHW) BDT 2000 (£13) for the referral service. I also paid her for my daughter-in-law´s referral to that NGO clinic.*" (Momena, woman, 55 years, Street vendor, Site A)

The family's experiences with both public and private health services illustrate the systemic marginalisation of those lacking social and political ties. Their reliance on informal payments for essential healthcare, despite theoretically free entitlements, exemplifies the exploitation faced by unconnected informal settlement residents, reflecting deeper inequities in access to healthcare. Momena's story powerfully illustrates how the absence of networks and the presence of systemic corruption intersect to obstruct rights-based access to health.

*Nazma Begum: Tactical threats in desperate situations*

Similar to Momena, Nazma Begum, a 55-year-old street vendor living in site B since birth, shared her harrowing experience seeking medical care for her 22-year-old daughter, Rima Begum. Rima was suffering from severe appendicitis pain and high dengue fever and was rushed to the nearest public hospital (17 km away) one night. The hospital's administration staff demanded bribes for Rima's admission, which Nazma could not afford. The denial of official admission by the hospital's administrative staff left Nazma with no choice but to wait in the hospital corridor. Rima was left unattended in the corridor in immense pain for the entire night and the next morning. Nazma pleaded and cried repeatedly, but to no avail. Frustrated and desperate to get help for her daughter, Nazma resorted to extreme measures. She made Rima lie down in front of the admission counter, threw the admission-related papers at the staff, and threatened them with legal action and media involvement. Only then, with the help of a duty doctor, was Nazma able to admit Rima to the hospital at 1 pm the next day after a prolonged and distressing ordeal. In Nazma's words,

> *"They (admission staff) sent us from one room to another room. They wrote and cancelled Rima´s name five times. My daughter was in severe pain all night and the next morning. I repeatedly requested them, but all was in vain. I threw the papers to the doctor, who cancelled my daughter´s name. What is the use of all those papers? What was our fault? So, I screamed at him and told him I would file a case. I asked them if they wanted money, and I would beg people to collect the money. Then, I told them that I would call journalists and complain about them. I will do whatever is necessary. Only then did they admit her to the hospital at noon. If I did not do that, my daughter would have died."* (Nazma, woman, 55 years, Street vendor, Site B)

Nazma shyly admitted that she did not know any journalists. She saw TV news and read newspaper reports on journalists often highlighting issues of hospital mismanagement, which could negatively affect the hospital's reputation. Nazma recognised the potential influence of journalists and took a gamble with her knowledge, feeling satisfied with the outcome. However, fearing the repercussions, she hesitated to file a formal complaint with the hospital authority.

> *"No, I did not [make a complaint]. I was afraid of further disruptions and negative consequences. Allah will help my daughter. If you have money, you have strength. People's strength depends on money."* (Nazma, woman, 55 years, Street vendor, Site B)

Nazma's narrative reveals the use of tactical resistance, bluffing threats of legal and media exposure, as a desperate strategy to claim basic rights. Her story lays bare the dysfunctionality of state-run health services and the necessity for performative confrontation to access care. Her actions exemplify how even powerless individuals attempt to hold institutions accountable by leveraging perceived (but unreal) external power. This reflects a broader survival logic in contexts where informal knowledge of power symbols (e.g., journalists) can temporarily subvert bureaucratic neglect. However, the limits of such strategies are evident in her fear of filing formal complaints.

*Shefaly Begum: Joining politics as a survival strategy*

Shefaly Begum was a 36-year-old community toilet cleaner who had lived in Site A for 28 years. She strategised to build an alliance with the female WC and joined the ruling political party as a 'survival strategy', aiming to gain power and demand services. By becoming a local political leader, Shefaly entered the local power structure, which enabled her to network with powerful actors, develop negotiation skills, and enhance her confidence. Shefaly articulated her intention of joining politics:

> *"Some people in this settlement exercise power. We are poor, and they always oppress us. That is why I have joined politics. Now, I can seek justice and get help if needed. Due to my connection with the WCs, I can access any available government support. In the past, when government aid came to our area, it was distributed through ten leaders, and we often did not receive any because we were powerless. Now that I work for them, I can demand assistance and say: I work for you, so why won´t you give me.? I can also protest when necessary and seek support wherever I need it."* (Shefaly, woman, 42 years, Community toilet cleaner, Site A)

Shefaly's political journey was challenging without any prior connections. She started at the lowest tier of the political hierarchy, often doing errands for higher-ups with limited autonomy and decision-making authority. She was often viewed as merely a 'patineta' (a lower-level leader) without any real influence due to her socio-economic status as a part-time cleaner and her low political position. Nonetheless, her political involvement and relationships with both male and female WCs enabled her to join multiple NGO-formed CBCs in Site A, which helped elevate her social position and gain acceptance in the community. Shefaly claimed to be leveraging her political power to assist other marginalised individuals like herself in accessing services, resolving their issues, and connecting them with others who could offer support. Shefaly proudly said, *"Now people talk to me and respect me. When there is any need, people come to me."*

Like Nazma, Shefaly had also once threatened to contact journalists after experiencing mistreatment from service providers at a public hospital. Shefaly had learned about health rights through training from an NGO and

claimed to know some journalists through her political connections.

Shefaly's intentional political alliance demonstrates a strategic use of patronage relationships to empower herself. She leveraged her limited political influence for personal benefit. Her dual roles as both a beneficiary and a mediator highlight the complexities of empowerment within patronage-based systems. By integrating herself into political and NGO networks, she was able to claim public services and resources. However, her economic instability and social positioning also constrained her ability to secure decision-making authority within the local governance structure. Her experience illustrates how political participation can serve as a survival mechanism, contingent upon socioeconomic status, political alliances and strong social networks.

#### *Kalam Khan: Governance as investment*

Kalam Khan, a 48-year-old resident of Site A for over 26 years, made strategic investments to improve his circumstances, starting with the purchase of a scrap metal shop in the local market. This purchase enabled him to join local market committee, which helped him secure a plot in the settlement and built seven rooms through informal arrangements with local political and community leaders. His nine-member family lived in three of those rooms and rented out the remaining four, generating a monthly income of BDT 8,000 (£48). At the time of data collection, his family owned multiple scrap metal shops in the local market, which he and his elder son jointly managed. Despite his reluctance to disclose his exact income, his household assets indicate a more substantial financial standing, allowing him to make regular contributions to the local mosque and market committee. Kalam's mantra reflects his investment philosophy: *"If you don't spend money, you can't get anything. You will earn after you invest, not before."*

Kalam further established political ties, fostering strong relationships with the male WC and other influential community figures to access local governance networks. His active participation in the mosque committee, coupled with financial donations, elevated his social status. This membership allowed him to secure a legal electricity connection through the mosque, costing him less than illegal connections offered by local leaders. Identifying as a social worker despite being a businessman illustrates his respected status within the community.

Over time, Kalam's political connections and involvement in local governance networks enabled him and his wife to join multiple NGO-formed CBCs. This membership became a strategic tool to access local resources and services. Utilising membership of an NGO-formed CBC (his wife was the Secretary), they secured NGO funding for a two-chamber toilet for their family, with the NGO covering 60% of the costs. Additionally, through another NGO-formed CBC, he managed to obtain a legal water supply line from the Dhaka Water Supply and Sewerage Authority (DWASA). According to him, only CBC members can apply for a legal connection through the NGO, which facilitates negotiations with DWASA, acting as an intermediary between CBC members and service providers.

> *"This line is under the name of our CBO. For example, I will receive a connection if I am a CBO member, but you will not. The CBO will only approve applications for its members."* (Kalam, man, 48 years, Businessman and CBC member, Site A)

Kalam's extensive social network and political connections extended beyond his settlement, providing him with advantages in healthcare. He happily and proudly recounted receiving special treatment for his heart condition at public and private hospitals, facilitated by relationships with medical professionals.

> *"I visited the government heart disease hospital, where I have a doctor friend. He recommended a full-body check-up. One of his colleagues works at a good private hospital. My doctor friend referred me there and personally called the other doctor to treat me well. Upon arriving at the hospital, I bypassed the queue of other patients, and he attended to me first."* (Kalam, man, 48 years, Businessman and CBC member, Site A)

Kalam exemplifies how strategic capital investment, both material (money) and non-material (social relationships), can institutionalise access to better services. His trajectory from scrap metal dealer to political leader highlights the entrepreneurial dimensions of informal governance. Through deliberate positioning in mosque, market, and political networks, Kalam accessed utilities and healthcare often unavailable to others. His story highlights how governance systems, including NGO mechanisms, reward embeddedness over need. While Kalam's experience showcases success through self-investment, it also exposes the exclusionary nature of development pathways dominated by elite bargaining and reciprocal favouritism.

Kalam's experiences also highlight the gendered dimension of informal governance, a notable difference between how Kalam and Shefaly integrated themselves with powerful leaders and navigated the complex informal space. The similar gendered differences were also evident in the narratives of other community leaders shared their stories, such as Hamid Mia in Site A (another high-ranked male political leader, member of the same CBC as Kalam and served as a broker between community and DWASA for water connection), Titli Begum in Site B (a low-ranked female political leader, who had the similar socio-political position in the community as Shefaly). As a man in a patriarchal society, Kalam and Hamid had greater mobility and access to the male-dominated governance structure, for example, mosque and market committees. This provided them with an easy avenue to secure a decision-making position within

the local governance structure, something that Shefaly and Titli was unable to establish due to their gender and lack of family connections with powerful local leaders.

# DISCUSSION

Drawing from the lived experiences of 16 families in two informal settlements in Dhaka city, this study uncovered how access to public health services is facilitated by residents' ability to mobilise and develop three interconnected resources: financial, social, and personal (Figure 1). These resources not only shape how individuals navigate the everyday politics of health access but also reflect broader structural inequalities embedded within the urban governance landscape.

This section begins with a comprehensive explanation of three essential interconnected resources, followed by a critical discussion on their interconnectedness and concluding with a reflection on the barriers to building these resources.

## Navigating health service access in Dhaka's informal settlements: The interplay of financial, social, and personal resources

### *Financial resources: Economic underpinnings of health service access*

Financial resources refer to the ability to pay for health services, including informal payments or bribes, and personal financial capacity derived from income, business and house ownership, internal support from community members, and external support through NGOs, public institutions, and patronage relationships with governance actors. In Dhaka's informal settlements, the capacity to pay and having personal contacts within health facilities, as seen in the case of Kalam, often determines whether a family can access services at all, as illustrated in Momena, Nazma and Kalam's narratives.

The narratives of participants highlight the challenges posed by financial constraints. Fourteen out of the 16 families reported difficulties in meeting informal payments (bribes and hidden costs) at health centres, which often exceeded official service charges. Informal payments and bribes at health facilities are the most commonly reported forms of corruption in the public health sector in Bangladesh and other low- and middle-income countries [36–38]. Adams et al. (2015) and Islam & Shafi (2020) describe this as an entrenched dual system of healthcare that contributes to inverse equity [8,39]. Recent studies conducted in Bangladesh reported that the informal settlement residents often spend a substantial portion of their household expenditure, sometimes more than 10%, on bribes at health centres [36,40]. Consequently, the poor are disproportionately burdened by these unofficial costs, leading to catastrophic health expenditure [37,40]. The inability of the poorest residents to afford formal healthcare or resist informal fees indicates that healthcare access is stratified by wealth and power (40). These findings align with urban political ecology perspectives that argue access to health is shaped by economic positioning within unequal urban systems [41].

Munia's narrative, for instance, reveals how residents must leverage relationships with powerful actors to secure financial support, highlighting the informal political economy that governs service access. This reliance can perpetuate inequality, benefiting those with greater financial and social capital in navigating the health system more easily [21].

### *Social resources: Networks and alliances as gateways to services*

Social resources encompass networks, affiliations, and relationships that provide access to information, programs, cash subsidies, credits and services. In the context of Dhaka's informal settlements, these include NGO or CBC memberships, political affiliations, and alliances with local governance actors, such as WCs, community leaders, and local elites.

Participants' narratives illustrate the strategic importance of social networks, with 11 of the 16 families having at least one member affiliated with a political party or NGO committees. These connections are vital for survival, offering the ability to exercise power and access opportunities [22], including financial resources and public health services. They provide essential support during a crisis and facilitate participation in local governance, which is crucial for improving economic and social status in informal urban spaces [20,21].

Munia and Labonna demonstrated the strategic use of social networks to navigate local politics and secure resources. Their experiences, along with those of Kalam and Shefaly, illustrate how CBC membership, often facilitated by political or social influence, can elevate an individual's social position and improve access to services. However, as Labonna pointed out, these networks are not equally accessible. Socio-economic status, family connections, social reputation, and long-term residency significantly impact one's ability to leverage resources, reinforcing existing power hierarchies within the community [22]. Additionally, these factors affect an individual's eligibility for committee membership, fostering elite capture even in resource-poor settings. This reliance can perpetuate inequalities, as individuals with more extensive or influential networks are better positioned to access vital resources, while others may struggle to overcome systemic barriers [21].

In Bangladesh, NGOs often depend on local governance networks to implement donor-funded projects. They work with local gatekeepers to provide services to marginalised individuals, creating a trade-off where these gatekeepers gain committee roles while ensuring services reach those in need [42,43]. In informal urban areas, political dynamics can limit NGO operations, and failing to engage local power brokers can hinder project implementation, reinforcing a patronage-based system for service access [44,45].

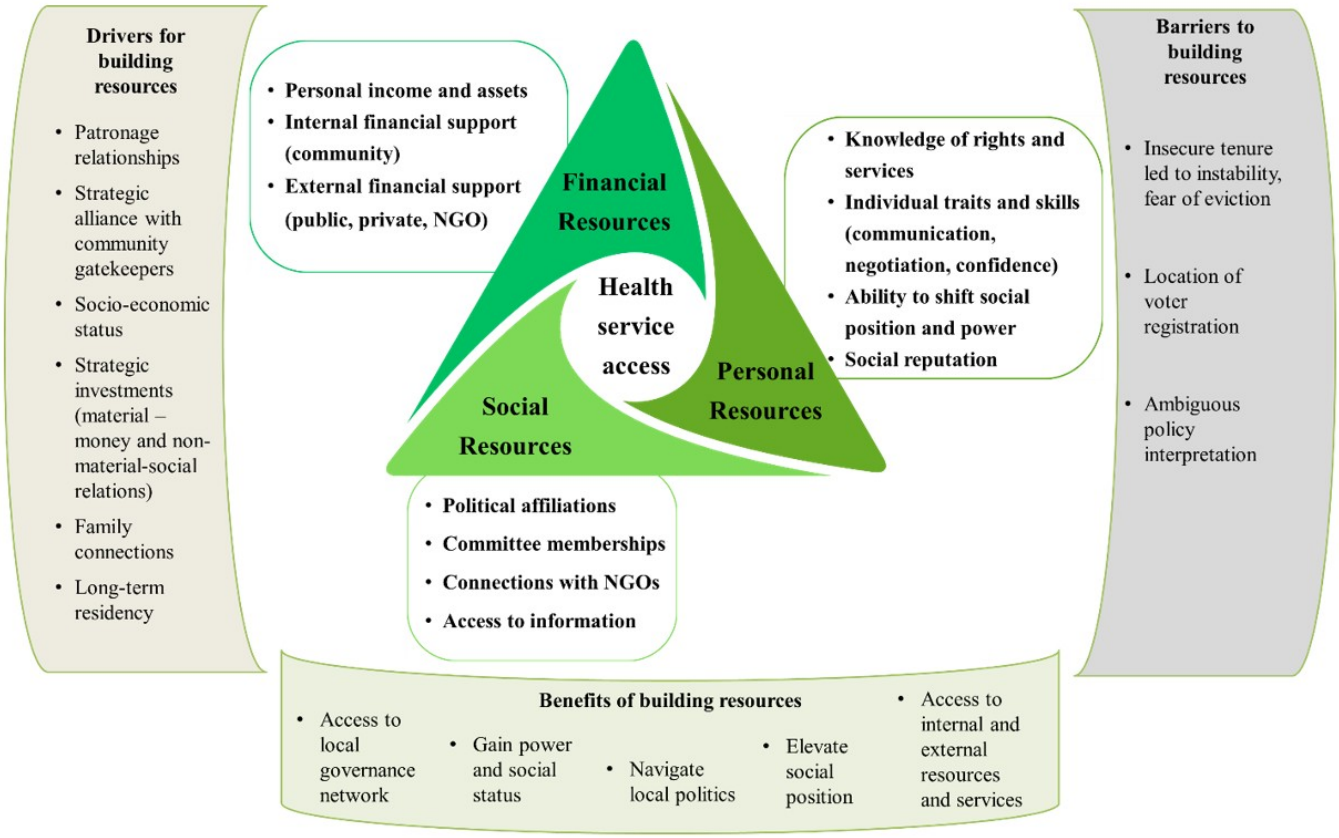


**Figure 1.** Interconnected resources to access health services in informal urban settlements.

*Personal resources: Individual agency in the face of structural constraints*

Personal resources include individual traits and skills such as negotiation abilities, legal awareness, confidence, and knowledge of rights. These attributes are often enhanced through NGO involvement and political engagement. These individual capacities enable residents to engage effectively with governance actors and navigate institutional barriers. For instance, Labonna explained how NGO training improved her negotiation and communication skills and deepened her understanding of legal rights. These forms of personal agency are critical in navigating hostile bureaucracies of everyday governance – the informal, tactical practices through which residents interact with formal institutions [13,46–48].

However, the development of personal resources is not solely an individual achievement; it is conditioned by social and financial positioning. Permanent residency, for instance, is a key criterion for NGO membership, which in turn influences the ability to develop personal capacities. This reveals a tension within NGO operations that simultaneously empower and exclude, reinforcing urban marginality while offering limited pathways to social mobility [43,44,49].

*Interconnected resources: A comprehensive view of urban governance and health service access*

These three types of resources are deeply interconnected. Building social resources through CBC membership can enhance personal capacities and facilitate access to financial aid. Likewise, financial capital can be used to forge political alliances or secure positions in governance structures. Participants' experiences thus highlight a relational understanding of resource mobilisation, where agency is exercised within and against structural constraints.

The narratives presented in this paper emphasised that informal urban settlement residents' access to health services is not merely a matter of availability; it is deeply intertwined with local governance structures, local politics, power relations, social networks, and the distribution of resources. Informal negotiations and strategic alliances play a significant role in how residents like Munia secure health services. Everyday governance manifests in micro-level interactions where residents, like Munia, Nazma and Shefaly, use informal negotiations, discretion, and resistance to navigate service access. These interactions illustrate how power is negotiated in everyday practices [13,48]. Strategic use of relationships, participation in CBCs, and performative resistance (e.g., Nazma and Shefaly threatening to contact journalists) illustrate the adaptive strategies residents employ.

This study found that building strategic alliances, patronage relationships and connections with governance actors (political leaders, WCs and community leaders) is crucial for surviving in these complex and fluid spaces. Those strategically maintained relationships help residents develop both personal and social

resources, enabling them to participate in local-level governance networks and ultimately access financial resources and health services. Participants' narratives revealed that political affiliations are essential for engaging in local governance and decision-making processes. Therefore, the residents who aspired to gain power and climb the social ladder, like Kalam, Shefaly and Titli, considered joining politics, a first step to building an alliance with people in power, as informal urban settlements are heavily politicised and political individuals control most sectors.

CBC membership was found to be an important avenue for informal settlement dwellers to participate in community governance, improving their social position and network. Stories from the participants emphasise that prior connections with NGOs and community leaders greatly helped them gain acceptance and support within the community. Kalam and Sheafly's narratives clearly showed that NGO CBC membership helped them build social and personal resources and access external financial resources. Munia and Labonna from Site A, and Rahima and Maleka from Site B, also shared how their social resources (prior connections with NGOs and community leaders) helped them gain community acceptance, further expand their social network and develop personal resources.

These dynamics reflect broader urban governance challenges in Bangladesh and similar contexts in the Global South, where informal settlements are both marginalised and deeply politicised [9,12,22]. Informal strategies, such as performative resistance or leveraging personal ties with journalists and politicians, reveal residents' everyday tactics to claim their right to health.

### Barriers to building resources

Tenure security emerged as a crucial structural barrier that significantly limit residents in informal settlements' ability to ability to mobilise these three interconnected essential resources to access healthcare and related services.

Insecure tenure creates instability and a fear of eviction, discouraging long-term investments in health infrastructure, such as sanitation facilities. This impermanence reduces engagement with local health programmes, which often prioritise more stable communities [50]. Permanent residency is also crucial for getting memberships in NGO CBCs, which serve as a vital social resource and a gateway to local governance. NGOs typically prefer long-term residents for their committees, considering them more reliable and easier to access. For NGOs and public health authorities, mobile populations are more challenging to track, monitor, and follow up with, resulting in inconsistent service delivery [50]. This preference highlights the precariousness of tenure, as short-term or recent migrants remain excluded from vital support networks [7]. Consequently, establishing a permanent home in these settlements is essential for residents. Community leaders like Shefaly from Site A and Titli from Site B preferred to receive donations from political leaders to build houses rather than request financial assistance for their medical treatments, highlighting the strategic prioritisation of permanent settlement to ensure stability of a home in the settlement as well as a means to gain political and economic recognition.

Tenure security was also found to be closely connected to the place of voter registration. Those who are not registered voters in their ward of residence are often perceived as politically irrelevant and are frequently ignored by local leaders [51], thus excluded from health-related interventions routed through political patronage networks. Therefore, being a registered voter in the ward of residence was very important for the residents. For example, Kamal took pride in having 15 family members registered to vote in Site A, enhancing his political position within the community and contributing to his social, financial, and personal resources.

These structural barriers and ambiguous policy interpretations create a cycle of invisibility and exclusion for informal settlement residents, leaving them outside state support except during elections or eviction drives [9,12,15]. The ambiguity surrounding their legal status allows state and non-state actors to exploit marginalised populations by selectively enforcing and manipulating policies to control resources, often for political or economic gain [12]. Therefore, educating people about their rights, both health rights and civic rights, is crucial.

### Navigating informal governance and resilience: A nuanced understanding of urban marginality

The findings demonstrate that accessing healthcare is largely contingent upon an individual's capacity to strategically engage with multiple overlapping systems of power. Experiences from residents like Munia, Labonna, Nazma, and Shefaly illustrate the importance of informal negotiations, performative resistance (e.g., threatening to contact journalists), and strategic networking in negotiating health resources amidst complex governance systems. However, reliance on informal networks can lead to issues of inequality and exclusion. Those with fewer connections or less confidence may find it particularly difficult to secure healthcare. Additionally, although NGOs aim to empower communities, their operations may inadvertently maintain existing power imbalances if dominated by local leaders and community gatekeepers. The study also foregrounds the politics of permanence and belonging. The requirement of being a "permanent resident" to access CBC membership highlights the tension between mobility and entitlement in informal urban settings. This has profound implications for those displaced or transient, who are systematically excluded from the very mechanisms designed to support them.

These dynamics reflect broader patterns of urban governance in the Global South, where the state often governs "through informality" [12, 52], blurring the boundaries between legality, legitimacy, and access. This

study critically demonstrates that mobilising financial, social, and personal resources is not simply a coping strategy, but a form of active governance enacted by residents. While these practices showcase resilience and agency, they also expose the structural conditions of marginality and the enduring power of informal institutions in shaping urban life.

### Implications for policy and practice

Marginalised residents' continuous negotiations for health service access, as illustrated in this paper, reveal how civic rights in informal settlements are both precarious and dependent. The evidence suggests that policymakers, public, private, and NGO service providers, and international, national, and sub-national development organisations should consider conducting participatory stakeholder mapping and governance analyses when designing and implementing health interventions or informing policies and practices. For example, urban health committees at ward or city corporation levels could benefit from including community representatives from these areas. This inclusion will help ensure that the needs and perspectives of informal settlement residents shape policy and resource allocation.

It is vital to build partnerships among the government, NGOs, and community groups. By leveraging the community mobilisation strengths of NGOs, governments can effectively collaborate with informal actors to create meaningful change. Investing in the training of cultural competence and negotiation skills of NGO frontline workers, enabling them to navigate local power structures effectively is recommended. Additionally, providing communities with education on health and civic rights can empower them, strengthening their capacity to build financial, social and personal resources and to identify and address inequalities and social injustices. This approach not only enhances local capacity but also encourages a sense of ownership and accountability in health initiatives.

### Strengths and limitations

Using participatory methods significantly enriched the research by incorporating diverse perspectives, but it also presented challenges in engaging community stakeholders in the politically charged environment of informal settlements. The authors navigated these issues to maximise the benefits of participation while minimising pitfalls.

Internal power dynamics, often controlled by politically connected community leaders, made data collection difficult, particularly at the politically sensitive Site A, where participants were initially hesitant to share information. Acknowledging these internal politics was crucial. Utilising multiple methods and engaging a variety of participants helped alleviate these concerns, while trust-building through repeated visits encouraged more openness.

Navigating power relations between participants and Co-Rs posed additional challenges. Although Co-Rs' insider status facilitated access to participants and an in-depth understanding of local political and power dynamics, it also posed a risk of selection bias and could influence the responses. There were instances where Co-Rs inadvertently interjected their opinions despite agreement to remain neutral. The authors recognised that this inherent issue in participatory research might not be completely resolved.

Explaining 'governance' in the local language and its impact on public health access proved challenging, especially since the available Bangla terms typically relate to formal governance systems and actors. This research expanded the definition of governance to include both formal and informal governance. Extensive explanations and prior consultation with Co-Rs about local meanings were necessary, and participants further refined the understanding of governance and its actors in the context of their communities.

A limitation to consider is the potential discrepancy between participants' accounts and actual events, influenced by the research context and perceived expectations. This highlights the challenge of relying exclusively on self-reported narratives, as power dynamics and personal perceptions may influence the retelling of experiences.

## CONCLUSIONS

Access to public health services in informal settlements goes beyond simple availability; it relies heavily on the residents' capacity to harness and mobilise financial, social, and personal resources. As discussed, these resources are interconnected and deeply influenced by a political ecology shaped by power dynamics, political patronage, and governance gaps that systematically marginalise specific populations. The narratives of residents living in informal settlements, as highlighted in this paper, reveal that a community system, supported by active participation of local networks, can be a vital pathway to health equity. However, without tenure security, many individuals remain structurally excluded from accessing even these informal pathways. The intersection of government neglect and informal governance necessitates a comprehensive systems approach to health, acknowledging both the community's assets and the structural obstacles they face.

To strengthen community systems for health in urban informal settlements, it is imperative to implement interventions that enhance residents' agency, cultivate inclusive governance, and address the root causes of inequitable access to services. Policymakers and practitioners need to move beyond traditional service delivery models to support community-driven strategies and relationships that facilitate people's daily navigation of health systems. Future research and practice should consider the lived experiences of diverse urban populations, including those living in cities´ neglected informal settlements, in collaboratively creating health solutions that are grounded in local contexts, politically aware,

and focused on equity. Addressing urban health disparities requires policy acknowledgement of everyday governance practices through which marginalised urban residents access public health services. By understanding the role of informal governance and the impact of local power dynamics, policymakers can devise more effective strategies that specifically address the needs of the marginalised populations.

# DECLARATIONS

### AI utilization

Grammarly, an English language editing tool, was used to correct spelling and grammar and enhance sentence clarity.

### Competing interests

The authors report no conflict of interest.

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### Author contributions

This paper is the lead author, BA's PhD work. BA designed the research, collected, analysed and interpreted data. BA and KO conceptualised and BA drafted this manuscript. KO, SFR, LW and ST provided guidance with research design, data analysis and interpretation, and critically reviewed this manuscript. All authors read and approved the final manuscript.

### Data availability

Not applicable.

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## ABSTRACT IN SPANISH

**Negociar y navegar la gobernanza cotidiana para acceder a servicios públicos de salud en los asentamientos informales de la ciudad de Dhaka: Un análisis desde la ecología política**

**Introducción:** En los complejos espacios urbanos de Bangladesh, las personas que viven en asentamientos informales enfrentan grandes dificultades para acceder a servicios públicos de salud asequibles. A través de un análisis de ecología política, este artículo explora cómo los residentes de estos asentamientos urbanos informales navegan la gobernanza cotidiana para acceder a servicios de salud.
**Métodos:** Esta investigación cualitativa y participativa se llevó a cabo en dos asentamientos informales de la ciudad de Dhaka, una de las megaciudades más densamente pobladas del mundo. Las historias de 16 familias se recopilaron mediante el método de *Governance Diaries*, que consiste en entrevistas en profundidad repetidas y discusiones grupales realizadas con cada familia durante un periodo de cuatro meses entre febrero y mayo de 2023. El análisis temático se realizó aplicando el marco de la Ecología Política Urbana (EPU).
**Resultados:** Los residentes emplearon diversas estrategias para acceder a servicios públicos esenciales de salud (atención médica, agua, saneamiento) negociando con proveedores de servicios y movilizando redes locales de gobernanza. El éxito de estas negociaciones estuvo determinado por el nivel socioeconómico de los residentes, su acceso a información, afiliaciones políticas y redes sociales. La capacidad de gestionar los mecanismos de gobernanza para acceder a servicios públicos de salud dependió de tres recursos interrelacionados: 1) Recursos financieros (apoyos económicos internos y externos); 2) Recursos sociales (redes sociales y conexiones con actores de gobernanza y ONG); 3) Recursos personales (habilidades de negociación, posiciones sociales y políticas, y patrimonio personal).Las limitaciones en cualquiera de estos recursos restringieron el acceso a los servicios.
**Conclusión:** Los recursos personales, sociales y financieros influyen en el grado en que los residentes de asentamientos informales pueden acceder a servicios públicos de salud. Fortalecer estos tres tipos de recursos es esencial para mejorar la capacidad de los distintos residentes de participar en las redes locales de gobernanza y mejorar su acceso a los servicios públicos de salud. Se requiere acción para avanzar hacia la cobertura universal de salud en Bangladesh y asegurar que las poblaciones urbanas marginadas tengan acceso equitativo a servicios esenciales de atención médica.

**Palabras clave:** Red social, patronazgo político, sistemas comunitarios, movilización de recursos, recursos financieros, alianzas estratégicas, Bangladesh.

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