Leading in the shadows: understanding administrative leadership in the context of COVID-19 pandemic management in Bangladesh

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Abstract
Purpose – This article aims to examine the COVID-19 pandemic management system in Bangladesh and the role played by various bureaucratic leaders both at national and local levels. Particularly, attention is paid to the interface between the health sector and administrative leaders. The role played by front-line public servants and their superiors are also examined. Also, an attempt is made to encapsulate lessons learned from the crisis and the ways to prepare for the next one.

Design/methodology/approach – This study is based on secondary data and observation by the author as well as insights from the author’s 36 years of experience in the Bangladesh bureaucracy. Administrative leadership is conceptualized as bureaucrats appointed to administrative positions and discharging administrative duties both at the national and local levels.

Findings – A disfunctionality in the COVID-19 management system is observed, which is a direct consequence of the administrative leaders’ preference for leading from behind. Some structural constraints in the system are also uncovered.

Originality/value – It draws on observations, experiences and insights from the author’s long association with the Bangladesh administrative system. Its intended users are researchers and practitioners of public leadership.

Keywords Public leadership, Administrative leadership, Bangladesh administrative system, Bureaucratic leadership, COVID-19 response, Pandemic management

Paper type Viewpoint

Introduction

When the coronavirus started spreading across the world from Wuhan, China, the WHO declared it a global pandemic. As the virus reached almost all countries in the world, governments scrambled to put together a pandemic management system with varied effectiveness. This development brought public leadership concerning pandemic management into the limelight. In the public leadership literature, there is a growing consensus that public leadership is multi-dimensional. While Hartley (2018, p. 203) argues that “Public leadership may come from state, market and/or civil society,” ‘t Hart and Tummers (2019, p. 11) find three types of public leadership, namely “political, administrative and civic.” Following Mau (2020), this article mainly focuses on administrative leadership, which is particularly important for developing countries (Ohemeng and Huque, 2017).

The role of administrative or bureaucratic leaders has been debated for a long time. Price (1961, p. 752) lamented that although the main job of career civil servants should be “to look ahead at the great problems that confront the nation,” they are narrowly focused on the interests of their bureaus due to prevailing “traditional prejudices.” With the expansion of bureaucracies in the 1960 and 1970s due to the assumption of the welfare state approach by governments, antagonistic attitudes toward public bureaucracies increased manifold.
resulting in the thinning of bureaucracies and the deinstitutionalization of leadership (Terry, 2015) during the 1980 and 1990s. Renewed focus on administrative leadership emphasizes a set of characteristics, such as proactive (Barrington, 1984), collaborative (Ohemeng and Huque, 2017), networked (Liddle, 2010), collective (Brookes and Grint, 2010), transformational (Wright and Pandey, 2010) and conservator (Terry, 2015) among others.

In a developing country context, administrative leaders can address “wicked problems” having “complex and dynamic challenges” with a “collaborative approach” to bring together all segments of society to “identify solutions” (Ohemeng and Huque, 2017, p. 214). The management of the COVID-19 pandemic may be considered a wicked problem. In this context, this article aims to examine the role played by administrative leaders both at the national and local levels in Bangladesh. Particular attention will be paid to the interface between the health sector and administrative leaders and the prevailing balance of power between the two. The role played by frontline public servants and their superiors are also examined. Also, an attempt is made to encapsulate lessons learned from the crisis and the ways to prepare for the next one.

The COVID-19 context

More than 12m people globally have been infected with the coronavirus since China first acknowledged the existence of a “pneumonia of unknown cause” in Wuhan, China, on December 31, 2019 and mid-July 2020. Moreover, the global death toll had reached nearly 562,000 people since the first reported death in Wuhan, China, on January 11, 2020 (WHO, 2020). On March 11, 2020, the World Health Organization (WHO) characterized COVID-19 as a pandemic and called upon countries to vigorously “detect, test, treat, isolate, trace, and mobilize their people in the response” (WHO, 2020). At the outset, the pandemic created a health crisis, but very soon, it “morphed into a political, economic, and societal crisis of epic proportions” (Van der Wal, 2020, p. 1).

Countries around the world are managing the crisis in various ways. Considering the criteria of “healthcare management, political response and financial policy response,” Taiwan, Singapore and South Korea are considered the top three performers in COVID-19 pandemic management (Bremmer, 2020). A single solution suitable for all countries is yet to be found. While established liberal democracies, such as Japan, Germany, Norway and Switzerland, are doing well (Dostal, 2020; Willi et al., 2020; Christensen and Lægreid, 2020; Shaw et al., 2020), the performance of authoritarian countries, such as China (Yang, 2020) and Vietnam, have been reasonably good too. Although most of the top-performing countries belong to the developed world, developing countries, such as Thailand, Cambodia, Myanmar and Laos, are also doing well (The Economist, 2020a). The East Asian success stories highlight the importance of early intervention, healthcare capacity, the use of technology, command and control structure, centralized coordination and citizen compliance in pandemic management (Shaw et al., 2020). The role of risk communication and community engagement (Shaw et al., 2020; Dostal, 2020) as well as countering misinformation (Krause et al., 2020; Lovari, 2020) for effective COVID-19 pandemic management is well recognized. In this context, the rest of the article will explore and analyze the management of the COVID-19 pandemic in Bangladesh.

Bangladesh had its first known exposure to the coronavirus when a chartered Biman Bangladesh Airlines flight evacuated 312 Bangladeshi citizens from Wuhan, China, on February 1, 2020. The first known COVID-19 patients were identified on March 8, 2020. To escape the coronavirus, nonresident Bangladeshis living in Europe, North America, the Middle East and China started an exodus to Bangladesh. Between January 21 to March 24, about 630,000 Bangladeshis reached home from affected countries (Maswood and Mahmud, 2020). The first COVID-19 death was reported on March 18, 2020. Since then, the number of
infected persons and deaths increased daily, reaching 193,590 confirmed COVID-19 cases with 2457 deaths by July 15, 2020 (http://covid19tracker.gov.bd/). However, due to the low level of testing, the real numbers are likely much worse (The Economist, 2020b).

Bangladesh took various preventive measures against the COVID-19 pandemic. First, from the beginning of February, Bangladesh started screening passengers from China for body temperatures. Second, visas for Chinese nationals arriving in Bangladesh were stopped from the third week of February. Third, from the middle of March, passengers from all countries and entry points were screened. Fourth, all people returning from affected countries were prescribed isolation and quarantine at home (TBS, 2020a). Fifth, from March 18, all educational institutions were closed, which remains the case. Sixth, the government declared public holidays from March 26, which was extended several times up to 66 days. During these public holidays, all public transportation was shut down, and all nonessential businesses were closed. People were advised to stay home and avoid all public gatherings.

In the health sector, the government designated a few public hospitals to treat COVID-19 patients. Initially, testing was done exclusively by the Institute of Epidemiology, disease Control and Research (IEDCR). Later, it was extended to a few public sector labs and currently includes a total of 39 public and 17 private labs (NEWAGE, 2020a). In order to overcome the economic crisis, the government started announcing various stimulus packages from mid-March, and by mid-April, economic packages reached BDT 100,000 crore (about USD 11.9bn) (Shawon, 2020). With a view to redressing the plight of the poor people during the lockdown, the government provided food assistance to about 12.5m families during April and May, 2020 (Islam and Parvez, 2020). Also, 5m families were provided with cash support (TBS, 2020b).

**Bangladesh public administration system**

Bangladesh’s population of 162m people is the 8th largest in the world, and its economy is the 33rd in the world, with an annual average GDP growth rate of 6% over the last decade. In Bangladesh, the prime minister is the head of the executive branch and is assisted by a council of ministers. Each minister is in charge of a ministry located mostly in the Bangladesh Secretariat in Dhaka. The Prime Minister’s Office (PMO) is a separate office outside the Bangladesh Secretariat. Most of the positions at PMO are filled by administration cadre officers, including the principal secretary to the prime minister. Also, the cabinet secretary, the senior-most bureaucrat, belongs to the administration cadre. Most positions in the Bangladesh Secretariat, the headquarters of the government of Bangladesh, are filled by administration cadre officers. Furthermore, they occupy the chief executive position of major local government bodies in Bangladesh. At the local level, administrative cadre officers, namely, divisional commissioner, deputy commissioner (DC) and upazila nirbahi officers (UNOs) are the representatives of the central government. There are two service cadres – health and family planning – in the health sector in Bangladesh, which are controlled by the Ministry of Health and Family Welfare (MoHFW). Officials in the Directorate General of Health Services (DGHS) belong to the health cadre of the Bangladesh civil service. However, officials in the MoHFW are mostly from the administration cadre.

Bangladesh’s public administration system comprises ministries, divisions and departments at the central level and subordinate offices at the local level. The Bangladesh civil service comprises 28 functional cadres (e.g. administration, foreign affairs, police and health) and provides the human resources to run these organizations. Bangladesh’s administrative structure is considered “post-colonial” with “new ‘layers’ on the original bedrock” (Huque, 2010, p. 57). The dominance of the Bangladesh administration cadre of the civil service is well recognized (Huque and Ferdous, 2019). One of the defining characteristics of the Bangladesh bureaucracy is intercadre conflict, particularly between the administration
cadre and the other 27 groups (Zafarullah and Rahman, 2008). This conflict frequently contributes to inefficiency in policy implementation and reduces the effectiveness of the civil service. Doctors belonging to health cadre are a powerful force opposing the dominance of the administration cadre. The COVID-19 pandemic has opened up new tensions in the old rivalry.

COVID-19 pandemic management system
The MoHFW, along with the DGHS and the IEDCR, has been at the forefront of the pandemic management. The MoHFW is the policymaking body, and the DGHS and IEDCR are its implementation arms. From the outset, the IEDCR has been playing the lead role supported by the DGHS and the MoHFW. The DGHS prepared the National Preparedness and Response Plan for COVID-19, Bangladesh (DGHS, 2020). Also, the DGHS formed health coordination committees in all districts with the civil surgeon, who is the chief medical officer of a district, as the chair of the committee.

As per the National Preparedness and Response Plan, the MoHFW formed four national-level committees. First, at the apex is the National Committee for Prevention and Control of COVID-19 (NCPCC). The minister for the MoHFW is the chair, and the health services secretary is the member-secretary of the NCPCC. Relevant secretaries were made members, including the cabinet secretary and the principal secretary. The first meeting was held on March 21, 2020 and no meetings were held during the crucial months of April and May.

Second, a National Coordination Committee (NCC) was formed with the director general of the DGHS as the chair. All members were from various health-related bodies. Third, the National Technical Committee (NTC) was also formed with the director general of DGHS as the chair. Officials of the DGHS and IEDCR and representatives of other health-related bodies were made members. Members of both NCC and NTC are from subordinate offices of the DGHS. There was no room for independent expertise. Fourth, facing growing criticism, the MoHFW formed the National Technical Advisory Committee. The president of the Bangladesh Medical and Dental Council was made the chair, and the membership included renowned Bangladeshi medical practitioners. The director of the IEDCR was made the member-secretary of the advisory committee.

Bangladesh is geographically and administratively divided into eight divisions, 64 districts, 492 upazila and 4,571 unions. There are 19 city corporations and 330 municipalities. Preprimary healthcare service is provided at the community clinics at the union level. Primary and secondary healthcare services are provided at the upazila health complexes and district hospitals, respectively. Tertiary healthcare is provided at the division- and national-level large hospitals attached to medical colleges. At the local level, several committees were formed by the MoHFW with concurrence from the Cabinet Division. First, at the division level, a Divisional Committee for Prevention and Control of COVID-19 was formed with the divisional commissioner serving as the chair and the divisional director, health services, as the member-secretary. Second, at the district level, the deputy commissioner was the chair, and the civil surgeon was the member-secretary. Third, at the upazila level, the UNO was made the chair, and the UHFWO was the member-secretary. No committees were formed for the city corporations, which are usually outside the jurisdiction of the deputy commissioner of a district. An examination of the terms of references of these committees reveals that their main responsibilities include creating awareness of COVID-19, stressing the importance of social distancing and enforcing quarantines along with implementing decisions of the National Committee. Additionally, the MoHFW assigned one of its officials (from deputy secretary to additional secretary) to monitor and report on all hospitals in Dhaka as well as all over the country. In addition to MoHFW actions, the Ministry of Food and Disaster Management (MoDMR) assigned one of its officials to each district in the country to oversee humanitarian assistance. Furthermore, the PMO assigned one senior secretary/secretary of
the government to each of the districts in Bangladesh to supervise activities relating to the prevention of COVID-19 and humanitarian assistance.

Discussion and findings
The initial COVID-19 response, which was the repatriation of 312 Bangladeshi students from Wuhan, China, went well for the MoHFW. All of the students were screened at the airport. 11 students having temperatures were hospitalized at two Dhaka hospitals, and the rest of the students were sent on a 14-days isolation at a nearby makeshift quarantine facility. By the end of the quarantine period, no one was found to have the coronavirus, and all of them were released. Before the arrival of the flight, the MoHFW convened several inclusive meetings, including one where the minister for the MoHFW, the state minister for disaster management and the director general of the Department of Disaster Management were all in attendance. [1]. Unfortunately, although this exercise sets a good example of coordination, it was not repeated later.

Since COVID-19 is an imported disease, imposing border controls is the first step against its spread. In fact, countries that quickly established an effective border control emerged as top performers in managing this pandemic (Wang et al., 2020; Shaw et al., 2020). Managing overseas returnees at the air, land, and sea ports was the crucial first step. Many agencies operate at the airports, and there was no coordination among them. The MoHFW and its agencies underestimated the severity and magnitude of the problem, and they were caught completely unprepared when hundreds of thousands of people started returning from affected countries during February and March (Maswood and Mahmud, 2020). The initial decision to screen inbound passengers flying directly from China was also problematic because many people returning from China made detours via Hong Kong, Bangkok, Kuala Lumpur and Kathmandu to reach Dhaka. Also, people returning from Italy, Germany and the UK via Istanbul, Dubai and Doha were not screened at all. The situation became even more complicated when sea ports, land ports and international railway stations started getting a huge number of passengers. The system of prearrival and postarrival screening as well as interviewing and collecting information from inbound passengers and issuing quarantine instructions totally collapsed. More than half a million people entered Bangladesh during February and March without proper screening and quarantine instructions. Successful countries made extensive use of technology at this stage (Shaw et al., 2020), but Bangladesh was too late to do so. Thus, the MoHFW and its agencies lost the first opportunity to contain the coronavirus, which made the next steps to contain the virus highly challenging.

The next challenge was to ensure the home quarantine of overseas returnees. However, this task turned out to be even more difficult. The returnees did not adhere to the instructions for home quarantine. Many were found roaming around, visiting friends and relatives and even getting married (UNB, 2020a). In many cases, the police simply could not trace the returnees as their place of residence differed from the one listed in the passport. The deployment of the army did not make any difference. The use of a tracer application would have been very useful at this stage, but the government introduced it too late.

Inadequacies were also observed in the preparedness of the hospitals. The IEDCR was assuring the nation from the very beginning that hospitals were ready to combat COVID-19. However, hospitals were far from being ready. ICU beds, ventilators, oxygen supply and testing kits were in extremely short supply. Inadequate personal protective equipment (PPE) and a lack of training on COVID-19 protocols scared off the doctors and nurses. When community transmission started, patients were rushed from one hospital to another but were refused admission or treatment (Aljazeera, 2020). Testing facilities were very limited as were sample collection facilities. The MoHFW entrusted only a few public hospitals and institutes for COVID-19. All other hospitals became nonfunctional even for noncoronavirus patients.
The dire situation of the health sector is evident from the paucity of ICU beds (only 1000 in Bangladesh and none in 47 out of 64 districts), very limited oxygen supplies and the deaths of 35 doctors by mid-June (Anjum, 2020). Health workers across the country have been crying foul over the DGHS claim that the hospitals are fully equipped and prepared for combating the COVID-19 since the beginning of the crisis. Many were complaining that they had to examine and treat patients without any PPE. Moreover, the quality of the PPE that was available became a hot issue. Damaging reports surfaced about the supply of fake N-95 masks and unusable PPE. The MoHFW and DGHS lost their credibility when they started taking disciplinary actions against doctors who complained about the situation (Nabi and Kuri, 2020).

At that time of imminent danger and public fear, the common perception was that the “Health authorities let Bangladesh down in fight against coronavirus” (Ahmed and Liton, 2020). Recognizing the chaotic situation, administrative leaders in the cabinet division and PMO silently took over the control of decision-making with the support of the prime minister. It was evident from the frustration expressed by the health minister in a press briefing where he admitted that many decisions were being taken by the government without consulting him or his ministry (NEWAGE, 2020b). In fact, the government took many important decisions regarding the prevention and control of COVID-19, bypassing the institutional framework created by the MoHFW.

Bangladesh was under virtual lockdown (“public holidays”) for 66 days, which caused enormous damage to the economy. The World Bank estimated that the annual GDP growth rate, which was above 7% over the last three years, might be reduced to 1.6% (Byron and Rahman, 2020). However, the greatest impact of the COVID-19 in Bangladesh is on the poor. The Centre for Policy Dialogue estimates that the poverty rate will increase to 35% from the current 24.3% (Khatun, 2020). The Bangladesh Institute of Development Studies, a government think tank, estimates poverty will increase by 25.13%, subjecting an additional 16.4m Bangladeshis to poverty (UNB, 2020b). The lockdown slowed down but could not stop the rate of infection. In fact, it has skyrocketed since the end of the lockdown in late May.

Several factors inhibited a positive outcome from the lockdown. Risk communication and community engagement has been problematic in Bangladesh from the very beginning. An authoritarian country like China achieved community engagement by following a hard approach through community policing, while democratic countries, such as Taiwan and South Korea, following a soft approach, ensured voluntary participation through effective risk communication (Shaw et al., 2020). Even Germany pursued a strategy of “encouraging a ‘feeling of shock’ based on ‘primal fear’ to achieve voluntary compliance” (Dostal, 2020, p. 6). Bangladesh needed a hybrid strategy combining elements of both hard and soft approaches. However, Bangladeshi leaders, both health sector and administrative, fell well short of such a strategy. Bangladesh started with a hard approach but quickly shifted to the soft approach. The main theme of the government communication had been “do not panic, be alert”, while it should have been “do not panic, be compliant”. As a result, the citizens did not feel the urgency to follow the government directives (UNB, 2020a).

The lack of a strategy to counter misinformation is another important factor contributing to the noncompliance of government directives. Lovari (2020) argues that societies having low trust in government and experts, such as Italy, are fertile ground for misinformation. Therefore, Italy adopted an aggressive counter-misinformation strategy. Bangladesh probably also belongs to this category. However, Bangladeshi leaders did not address this issue at all. Social media was particularly ripe with misinformation, and the government sources were totally absent in that arena. Probably the largest source of misinformation regarding COVID-19 in Bangladesh was the religious institutions. However, the government did not respond with counter-measures (Chowdhury, 2020).

As discussed earlier, countries successful in managing the pandemic had successfully leveraged information and communication technologies (ICTs), which played a crucial role in
monitoring home quarantine, isolation, contact tracing and alerting about possible virus infection (Shaw et al., 2020; Wang et al., 2020). Bangladeshi leaders were slow to marshal ICT-based solutions. Bangladesh had a false start with the Corona Identifier application, which was proved ineffective shortly after its launch (TBS, 2020c). The better corona tracing application was launched only on June 5, 2020 (DD News, 2020); however, this one also had limited effectiveness. The COVID-19 Tracker, BD, launched by the government is a website providing pandemic information on global, national and regional level. The only useful technological innovation had been the telemedicine service provided by the DGHS.

Another important factor in the fight against COVID-19 in Bangladesh is the absence of strong political leadership. There was little or no presence of political leaders observed throughout the crucial period starting from the middle of March to the middle of June 2020. Although the prime minister led the war against the coronavirus from the front, her party colleagues at the national and local levels were mostly inactive (Kallol, 2020). The prime minister, flanked with top administrative leaders, held many hours-long live online monitoring and evaluation meetings with divisions and districts. Usually, ministers, MPs, and mayors vie for media attention, but they were not seen much during these months. When called upon by the prime minister publicly, some leaders attended a few hastily organized programs, such as relief distribution to the poor and paddy harvesting for the farmers, but they drew more criticism from the public for their photo-op mentality (Bangladesh Post, 2020). Local government leaders were also inactive except union council chairs and members who were involved in a limited way, although evidence suggests that local governments can play a very important role in pandemic planning and management (French, 2011). Thus, administrative leaders at all levels had free rein to manage the pandemic. Therefore, frontline administrative leaders, like DCs and UNOs, could have led from the front. However, their leadership was tentative. Top-level administrative leaders also decided not to come to the limelight, choosing to remain in the shadows instead.

Frontline administrative leaders, such as UNOs and ACs, initially took up the responsibility of ensuring the home quarantine of overseas returnees, with a high spirit. Hundreds of mobile courts swung into action across the country, fining people not obeying the home quarantine order (Dhaka Tribune, 2020). They were also visiting the homes of returnees to monitor compliance. The police also started strictly enforcing stay-at-home orders. However, when a young executive magistrate in Jashore district forced two senior citizens to hold their ears (which is considered offensive) for straying outside without masks (Financial Express, 2020) and a UNO was photographed wearing medical-grade PPE, at a time when hospitals were short on such supplies (The Daily Star, 2020), there was an immediate backlash in both mainstream media and social media. The entire administrative leadership cadre was condemned for displaying a heavy-handed attitude.

Moreover, when a proactive deputy commissioner in Bagerhat district carried a sack of relief goods on his own shoulders to the home of a poor family in lockdown (UNB, 2020c), the administrator was criticized on social media for faking compassion. These incidents were enough to dampen the spirit of administrative leaders, particularly those on the frontline. Similarly, police enforcement action in March in Barguna district (Sumon, 2020) drew huge criticism on social media, prompting the inspector-general of police to ask police officers to be polite and well behaved (The Daily Star, 2020). Consequently, the police shifted from a hard to a soft approach and tried to motivate people by singing and dancing in the streets (TBS, 2020d). Following this trend, even when the army was deployed, it also refrained from taking any punitive actions against people who were found not observing stay-at-home advice. This soft approach resulted in a lax enforcement of the government lockdown.

Pandemic management requires total societal engagement (French, 2011; Christensen and Laegreid, 2020). Collaborative contributions from all segments of society are crucial (Ohemeng and Huque, 2017). However, in Bangladesh, at the outset, government actors decided to act
independently, and it quickly proved to be counter-productive and totally ineffective. Stakeholder participation in both decision-making and enforcement was ignored. None of the committees formed by government at any level included any representative from civil society groups, NGOs, community-based organizations, trade unions, business and commerce groups or volunteer groups. Furthermore, private hospitals and diagnostic services, which are the backbone of the Bangladesh healthcare system, were excluded from COVID-19 programs. Failing to make any headway to control the pandemic, it was only in the middle of May that the DGHS included private healthcare service providers (NEWAGE, 2020a). Also, around the same time, the DGHS partnered with the BRAC, the largest Bangladeshi NGO, to collect blood samples. Additionally, in June 2020, the government decided to implement an experimental model of lockdown in the East Rajabazar suburb of Dhaka with the city corporation in the lead role and all government actors, private sector entities, NGOs and volunteer groups in the supporting role (UNB, 2020d). Had these partnerships been taken at the outset of the crisis, a much better outcome could have been produced.

Bangladesh did not have a national response plan or a well-established institutional framework to deal with a pandemic. The shortcomings of the system originated from the Infectious Diseases (Prevention and Control) Act, 2018, which was designed to deal with short outbreaks rather than managing a pandemic. The National Preparedness and Response Plan for COVID-19, Bangladesh has been put together quickly without any stakeholder consultation. Neither this legislation nor the government’s COVID-19 plan provides for collaborative crisis management.

Bangladesh does, however, have a well-established framework to manage disasters. This disaster management system is under the full control of administrative leaders at all levels. Health professionals are reluctant to give away responsibility for pandemic management to administrative leaders, who are also reluctant to take over the highly challenging task of pandemic management. In this context, Bangladesh must revisit the institutional and regulatory frameworks for pandemic management, implementing a whole-of-government approach that engages all segments of society. The government should also consider making standing instructions, delineating roles and responsibilities for all organizations, office bearers and individuals involved in the management of pandemics.

In the context of the COVID-19 pandemic management in Bangladesh, it is observed that political leaders have largely left the responsibility of pandemic management to bureaucratic leaders. It is characterized by the exclusion of leaders from civil society, the private sector and local government. Leaders from the health sector initially assumed responsibility for the pandemic, and although officially still at the forefront, they have been discredited and therefore have ceded control to the administrative leaders. Frontline administrative leaders spearheaded the charge against the COVID-19 with vigor but soon lost tempo due to unfavorable circumstances and preferred to remain in the shadows. Central administrative leaders are widely believed to be calling the shots, but they, too, remain largely out of sight. Successful crisis management requires leaders who are visible (Helsloot and Groenendaal, 2017) to communicate the meaning and significance of required actions to the general public and the media (Boin et al., 2005). The lack of visible political and administrative leadership in Bangladesh is having an adverse impact on successful pandemic management.

To explain the behavioral patterns of administrative leaders, it may be recalled that success in a crisis response may turn “leaders into statesmen”, while a poor track record may make leaders “obvious scapegoats” (Boin and ‘t Hart, 2003, p. 544). In an uncertain situation with uncertain outcomes, administrative leaders have tried not to be the scapegoats. Moreover, the bureaucracy-bashing attitude of the media and the civil society may also be a contributing factor. Furthermore, it was necessary for leaders of various professional groups, such as the health and administrative professionals, to help their “groups transcend the tribal impulse to solve interdependent problems” (Williams, 2015, p. 10), but this did not happen.
This article, following Mau (2020) and Ohemeng and Huque (2017), suggests that administrative leadership matters, particularly in the context of crisis management. Furthermore, in line with the mainstream literature (Liddle, 2010; Brookes and Grint, 2010; Hartley, 2018), it argues that public leadership in general and administrative leadership, in particular, should follow a collaborative approach involving political, administrative and civic actors especially in the context of crisis governance. However, there is a need for empirical studies that address several key factors related to public leadership in a pandemic, such as the nature and scope of collaboration between political, administrative and civic actors, the challenges faced by frontline administrative leaders, the impact of misinformation and the role of local governments.

Conclusion
The ongoing COVID-19 pandemic is globally unprecedented in recent times. Bangladesh has not experienced any significant biological hazards or disease outbreaks since its independence in 1971. The pandemic gave rise to many new challenges. Since it is a health crisis, the state, society and government looked to health sector leaders for solutions. The health sector leaders, however, could not foresee the magnitude of the crisis and wasted valuable time during the early weeks and months of the pandemic. The institutional and regulatory framework put together to deal with the pandemic was not suitable for the whole-of-government and full societal engagement that was necessary to tackle the pandemic. The pandemic has exposed all the ills and mismanagement of the health sector. As political leaders did not step up during the crisis, it fell to Bangladesh’s administrative leaders to lead the nation out of the crisis. However, administrative leaders have preferred to lead in the shadows, rather than coming to the limelight. Having little or no visibility of the country’s political and administrative leaders is a significant impediment to achieving the desired outcome. It is observed that the tendency of state actors to carry out their responsibilities by themselves, and not collaborating with nonstate actors, is counter-productive. Collaboration and partnership between the various political, administrative and civic actors is the key to better performance in a crisis like the COVID-19 pandemic.

Note
1. Conversation with the then director general, Department of Disaster Management, Bangladesh on February 16, 2020.

References


About the author  

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