Risking Lives to Save Others During COVID-19: A Focus on Public Health Care Workers in Bangladesh and Egypt

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Abstract
The coronavirus (COVID-19) pandemic has been spreading around the world, causing a major public health crisis that has already claimed hundreds of thousands of lives. Street-level bureaucrats—health workers, teachers, street cleaners, police officers, and so forth—are at the forefront in fighting against the pandemic. Of these, public health care workers, due to the nature of their involvement, should know and understand why they are risking their lives to save others during this pandemic. Based on the preliminary data gleaned from interviews with public health care workers in Bangladesh and Egypt, this ongoing research suggests they are risking their lives for reasons such as altruistic behavior, service to profession, adherence to bureaucratic accountability, and a desire to help mankind. The findings contribute to the existing literature about street-level bureaucratic behavior in atypical times such as these of the pandemic. This study is unique in that it comprehends that public health care workers of two culturally and geographically distinct countries are risking their lives for the same public-spirited cause.

Keywords
public service delivery, street-level bureaucrats, Bangladesh, Egypt, COVID-19

Public bureaucrats are largely criticized for their apparent inertia in effectively and efficiently delivering public goods and services to citizens. Referring to a post-modern administration, Peters argued that public bureaucratic roles in managing public affairs are considered less reliable as “a means of producing good results for the individual, the organization, and the government”. Admittedly, the lesser reliability of public bureaucrats largely weakens their public acceptance, which questions the former’s perceived professional pride. Hupe recognized that the public considers public bureaucracy as an agency that wastes taxpayers’ money, does boring work, and has a nine-to-five mentality. Similarly, Lipsky observed, in the context of American cities, that street-level bureaucrats, teachers, police officers and other law enforcement personnel, social workers, judges, public lawyers and other court officers, health workers, and many other employees who discharge similar duties were panned for being “insensitive, unprepared to work with ghetto residents, incompetent, resistant to change, and racist”. The street-level bureaucrats, in response, denied any such accusations, arguing instead that they performed their duties and responsibilities with professional competence, distancing themselves from racism. The recent killing of George Floyd, an African-American man, by Minneapolis police in the United States has not only quashed bureaucrats’ claim but rather established what Lipsky asserted about 50 years prior: the presence of racist behavior among street-level bureaucrats. The incident has spotlighted the seemingly flawed relationship between street-level bureaucrats and citizens in the United States and many other countries.

The core function of street-level bureaucrats is the implementation of public policy; more specifically, it is the delivery of public goods and services to citizens and thereby the development of a closer government-to-citizen connection. Cohen and Hertz, along with Maynard-Moody and Musheno, argued that street-level bureaucrats serve in the disguise of New Public Management with an aim to improve the human condition. As a result, the scope and breadth of their work are wide-ranging, multifaceted, and challenging. The COVID-19 crisis has made their tasks
even more complex and far-reaching. Schuster and colleagues reflect that COVID-19 has changed, against the public perception of public bureaucracy, the locus and focus of public servants’ work, as well as their work schedule; and the demands for work have gone up, both on and off duty, in this life-threatening environment. This perspective has created an opportunity to understand the contributing factors that motivate street-level bureaucrats, particularly public health care workers, to risk their lives to facilitate the treatment of COVID-19 patients from two geographically different country perspectives.

The main objective of this article is to understand the reasons public health care workers are risking themselves to save the lives of patients with COVID-19 in Bangladesh and Egypt. In doing so, the following three intertwined questions guided this research: (a) Why do public health care workers risk their lives to treat COVID-19 patients? (b) What are the major challenges public health care workers face in fulfilling their duties and responsibilities during the COVID-19 pandemic? (c) What activity has been most stressful in dealing with the challenges public health care workers face during the COVID-19 pandemic?

The first question was designed to understand the core argument of this article: that is, the driving factors behind public health care workers in Bangladesh and Egypt risking their lives to save COVID-19 patients. The other two questions were crafted to identify the key constraints they face in discharging their duties and the challenges associated with handling the demanding undertakings that public health care workers pursue on and off duty in this pandemic regime. These two questions have been borrowed, with slight modifications, from the open-ended survey questionnaire developed by the World Bank’s Bureaucracy Lab and its partners, which is publicly accessible.

This article is divided into five sections. Section 1 is a brief introduction. Section 2 discusses methodology of the study. Section 3 presents the notion of risking one’s life for others from theoretical viewpoints and analyzes the empirical data on the challenges public health care workers in Bangladesh and Egypt face and the stressful activities they pursue in treating COVID-19 patients. Section 4 analyzes the driving factors behind public health care workers risking their lives for others in both countries. Section 5 presents the key conclusions.

Methodology

This article derives from a larger, ongoing project aiming to understand why street-level bureaucrats risk their lives for others in the context of the COVID-19 pandemic in Bangladesh and Egypt. In this background, the case study method was employed, involving public health care workers of these two countries. Yin comprehends a case study as an “empirical enquiry which investigates a contemporary phenomenon within its real-life context”. Referring to Schramm, Yin further narrates that the core of a case study is that it attempts to clarify a “decision or set of decisions; why they were taken, how they were implemented, and with what result”. Consequently, the current study is an attempt to understand the decision of public health care workers in Bangladesh and Egypt to deliver services to COVID-19 patients while putting their own lives at risk. In addition, as the pandemic is a contemporary global phenomenon, the study analyzes its real-life implications by drawing on empirical evidence from two developing countries suffering from its serious challenges and burdens. The other reasons for selecting Bangladesh and Egypt, located in two different regions (South Asia and North Africa, respectively), as cases for this study arise from the similarities in their national health care systems and health-related macro development indicators (see Table 1). All hospitals/health care facilities where our respondents work were fully government-owned and, during the data collection period, none of the hospitals were operating solely to provide treatment to COVID-19 patients. As public organizations, public hospitals are largely dependent on their respective governments for resources. All respondents—physicians, nurses, and technicians—are civil servants and were recruited by following the standard procedures of the governments of Bangladesh and Egypt.

The health care systems in Bangladesh and Egypt are pluralistic and complex, combining both public and private providers, whereas the public-sector coverage is comprehensive.
and remains the cheap caregivers to fulfill the respective governments’ commitment to provide health care to the poor.\textsuperscript{17,18} This commitment remains generally unachieved as the health sector suffers from a multitude of challenges. As a result, the health care systems of these two countries are characterized by, among other things, rundown public hospitals, widespread corruption, poor access to service, low quality of care, insufficient funding, inadequate or absent health insurance, and unaffordable and mostly unreliable private health care.\textsuperscript{19,20} These challenges are further aggravated by the shortage of physicians, nurses, and technicians in public hospitals, as well as the difficulty of retaining them due to low salary, benefits, and work environment.

The data and empirical evidence used in this study were collected from public health care workers in Bangladesh and Egypt between the months of May and June 2020. In Bangladesh, a sample of nine physicians (six male and three female), six nurses (four female and two male), and two laboratory technicians (all male) working for five public hospitals (three in Dhaka, one in Chittagong, and one in Cox’s Bazar districts) were purposively selected and interviewed. There are 64 districts in Bangladesh. The age range of the respondents was between 28 and 56 years old.

In Egypt, 22 physicians (16 male and six female) and three laboratory technicians (all female) working in nine public hospitals located in several of the 27 governorates (namely, Alexandria, Ismailia, Aswan, Asyut, Giza, Red Sea, Beheira, Port Said, and Beni Suef) were also purposively selected and interviewed. It is important to note that the nurses of the selected public hospitals declined to be interviewed for this study due to the arrests of some health care workers for criticizing the Egyptian government for inadequate supplies of personal protective equipment (PPE) to health care professionals and for not solving many work-related issues.\textsuperscript{21} The age range of the respondents was between 27 and 47 years old.

As a result of the temporary moratorium on domestic and international travel, as well as the maintenance of social and physical distancing to fight against the coronavirus, an open-ended questionnaire was distributed among the respondents in both countries by using a combination of communication tools: namely email, Facebook, Messenger, Google Docs, and WhatsApp. All respondents returned the questionnaires within the given deadline after duly filling them in.

In addition, in-depth telephone discussions took place with a subset of purposively selected respondents—three in Bangladesh (two male and one female) and two in Egypt (one male and one female)—who held senior administrative positions in the public hospitals in Dhaka and Chittagong and in Giza and Port Said, respectively. The purpose of these interviews was to improve the researcher’s understanding of organizational issues and challenges, primarily associated with the misuse of resources in public hospitals that had been reported by the respondents. Unless and otherwise specifically described, the narratives of these five interviews have been incorporated into the analyses. This was to protect the identity of the respondents in all forms as they fear possible repercussion by the respective governments.

This study also benefited from secondary data collected through the collation and review of credible academic and professional publications. The strategic use of secondary data is to complement primary data as and where appropriate. This data, primary and secondary combined, reflects the motivations behind public health care workers in Bangladesh and Egypt risking their lives to safeguard COVID-19 patients.

### Risking One’s Life for Others: Theoretical and Empirical Perspectives

It is widely established that the COVID-19 pandemic has uncovered the unpreparedness of nation-states around the world to handle public health crises of this scale, as well as governments’ lack of capacity to deliver needed health care services to treat coronavirus patients. Bangladesh and Egypt, two resource-poor countries, are struggling to deliver the basic treatments to COVID-19 patients as the number of cases is increasing exponentially. The current murky state of the health sector is not conducive to delivering health services in Bangladesh and Egypt in the era of COVID-19. Against this setting, the public health care workers of both countries are contributing and even risking their lives to serve coronavirus patients. Table 2 gives a glimpse of the gravity of the situation prevailing in both countries.

Studies show that many public bureaucrats, specifically frontline fighters such as troops, police, and health workers, demonstrate their willingness to risk their lives for others.\textsuperscript{22–25} The critical question is why are some people risking their lives for others? Bekkers and Wiepking attempted to answer this question by identifying eight key mechanisms that influence people to give: (a) awareness of need, (b) solicitation, (c) costs and benefits, (d) altruism, (e) reputation, (f) psychological benefits, (g) value, and (h) efficacy.\textsuperscript{26}

| Table 2. Selected Data on COVID-19 Pandemic: Bangladesh and Egypt. |
|---------------------------------------------------------------|
| **Issue** | **Bangladesh** | **Egypt** | **World** |
| COVID-19 cases\textsuperscript{a} | 1,553,873 | 303,045 | 233,497,370 |
| Deaths\textsuperscript{a} | 27,470 | 17,263 | 4,777,490 |
| Recovered\textsuperscript{b} | 1,513,876 | 255,658 | 210,273,202 |
| Death of physicians | 186\textsuperscript{b} | 600\textsuperscript{c} | - |

Sources: 33 to 35.
\textsuperscript{a}As of September 28, 2021.
\textsuperscript{b}As of August 28, 2021, including the death from corona-like symptoms.
\textsuperscript{c}As of September 26, 2021.
Challenges Public Health Care Workers Face in Treating COVID-19 Patients

Unequivocally, public health care workers in Bangladesh and Egypt perform their duties during this pandemic under intense pressure and while facing considerable challenges. An analysis of the data presented in the questionnaire reveals that the public health care workers of both countries experience the following major challenges:

- Anxiety about getting infected
- Lack of medical supplies and equipment to treat COVID-19 patients
- Shortage of physicians and nurses
- Citizens’ lack of awareness about the pandemic’s impact and their reluctance to follow health advice
- Lack of experience among health care workers dealing with COVID-19

Recognizing these challenges, a senior physician from Chittagong, Bangladesh, expressed his concern during the interview about widespread political and bureaucratic corruption related to the distribution of relief materials allocated to support the people who lost their earnings due to COVID-19. There were serious allegations against the relevant government offices for supplying low-quality PPE to public health care workers and issuing fake coronavirus test results to the public. He says, “Corruption will be the biggest challenge in Bangladesh to fight against the pandemic.” Another respondent, also a senior physician and administrator, highlighted that the rent-seeking behavior endured between politicians and bureaucrats “is the major demotivating factor” for public health care workers. The news and print media published many stories associated with such corruption.

A respondent from Giza, Egypt, an experienced physician, reported a statement by the Egyptian prime minister blaming physicians for their alleged absence in some governorates that “led to cases worsening and death”. He further noted that physicians were not ready to hear such complaints from the government at a time when more than 100 physicians had already sacrificed their lives and died by treating COVID-19 patients.

Stressful Activities in Dealing with Challenges Public Health Care Workers Face with COVID-19

In reviewing the survey data, the following issues have been identified as “stressful” challenges public health care workers in Bangladesh and Egypt face with the COVID-19 pandemic:

- Psychological stress of patients
- Limited resources to treat patients
- Lack of trained public health care workers to handle patients
- Lack of teamwork
- Patients hiding symptoms of illness

It emerged from the interviews that public health care workers of both countries suffer from numerous stressful activities that hinder the effective management of COVID-19. One of the respondents from Bangladesh, a female doctor from Dhaka, further highlighted that a patient’s detailed health information must be shared with the physician to determine whether or not they are suspected to have COVID-19. If it happens that the test result is positive, the detailed information will help authorities trace who they had prior contact with. This is an important step to reduce community transmission and thereby gradually lessen the intensity of coronavirus cases. Another respondent, a female doctor from Port Said, Egypt, emphasizes the need to train public health care workers to use PPE properly.

In summary, despite working under stressful conditions and challenges, public health care workers in Bangladesh and Egypt continue to deliver health care services to COVID-19 patients. In the treatment process, a large number of physicians and nurses have been infected by the virus, and many of them have already lost their lives. Such positive bureaucratic behavior supports the characteristics of a number of “giving” mechanisms developed by Bekkers and Wiepking.

Serving COVID-19 Patients in Bangladesh and Egypt

The Driving Factors Behind Public Health Workers Risking Their Lives for Others

The majority of Egyptian physicians who responded to the survey questions have identified three key factors—(a) saving the lives of patients, for which they have taken an oath; (b) fulfilling work obligations and religious duties; and (c) helping the country to overcome the pandemic—as the reasons to be risking their lives. The remaining physicians identified work ethics, morality, and serving the humanity as central to their work for coronavirus patients. Along the same vein, all Bangladeshi physicians and nurses have recognized (a) oath, (b) official duty, and (c) helping mankind be safe as the core driving forces behind the risk they undertake to save the lives of their patients. The laboratory technicians of both countries who answered the survey questions primarily focused on their work obligations and the moral responsibility of helping people in this crisis period as decisive factors to continue their work.

Reviewing the responses of physicians in Bangladesh and Egypt, it appears that the Hippocratic Oath, the code of ethics they swear at the time of graduation from medical school, has a lifelong impact on their profession. They were also found to be particularly vigilant to discharge their formal duties as public bureaucrats, keeping the cataclysmic pandemic in
mind. In addition, the majority of Egyptian physicians considered their work as a form of religious duty. The survey results show that the first two driving factors, the Hippocratic Oath and work obligation as a street-level bureaucrat, were linked to achieving the goal of “helping mankind”: the notion of paying back to society in the most trying time.

Nurses in Bangladesh noted the spirit of the Nightingale Pledge, the code of ethics for nurses, as the most important driving force behind risking their lives for others. Even in the events of a lockdown and stay-at-home regime, they committed to perform their public bureaucratic roles more ardently than the usual, trashing work-life balance. This personal sacrifice of the nurses played a key role in their ability to provide treatment to COVID-19 patients.

Referring to the role of Bangladesh’s public health care workers in overcoming the pandemic, a female physician mentioned in the interview that they were giving the best service humanly possible to patients in the midst of numerous challenges, such as shortages of physicians and nurses, lack of medical supplies, and fear of getting infected. “Some of our colleagues even purchased medicines to help patients who either had no money or were staying without an attendant,” the respondent added. This statement strengthens Lavee’s observation that street-level bureaucrats spend personal resource for their clients while discharging their duties. This personal sacrifice of street-level bureaucrats essentially improves the government’s image to ordinary citizens.

Interview narratives with two Egyptian physicians, a male and a female, revealed that the physicians work “days and nights,” “weekdays and weekends,” to deliver uninterrupted service to COVID-19 patients. “There are many operational challenges, but we are firmly working on sacrificing our personal lives and comforts to do something good for the patients,” one of the physicians affirmed. This altruistic bureaucratic behavior conveys that street-level bureaucrats make important operational decisions in their workplaces.

In summary, survey data and interviews demonstrated that public health care workers continue to serve COVID-19 patients in Bangladesh and Egypt for reasons such as professional oaths, formal duties as a bureaucrat, and helping mankind, which are close to the mechanisms developed by Bekkers and Wiepking.

Conclusion

The findings of the article suggest that a number of interconnected forces drive public health care workers in Bangladesh and Egypt to risk their lives for others, those being professional oaths (Hippocratic for physicians and the Nightingale Pledge for nurses), public bureaucratic accountability, and the ultimate goal to do something good for mankind. The latter force derives from altruism and has a compounded effect on (positive) human action. The human–society interaction is deeply rooted to improving the human condition. This insight is connected to the charitable mechanisms advanced by Bekkers and Wiepking. The findings of this study are associated with several mechanisms that influence people—namely, altruism, psychological benefits, solicitation, reputation, value, and efficiency—all of which have, one way or another, shaped empathetic public bureaucratic behavior to overcome uncertain times. Consequently, public health care workers in Bangladesh and Egypt have made themselves readily available to treat COVID-19 patients, even at the expense of their own lives.

Echoing Cohen and Golan-Nadir, one must not forget that street-level bureaucrats are also human beings. Therefore, the forces that drive them to risk their lives to do good for others also have negative consequences. The field data listed certain public bureaucratic behaviors, namely involvement in corruption and issuance of fake coronavirus certificates, that somewhat destroys the reputation of street-level bureaucrats’ discretionary authority in making policy decisions.

The contribution of this article is that it advances our understanding, through empirical evidence, that street-level bureaucrats of two culturally and geographically distinct countries have the capacity to risk their lives to save others—the core of human dignity.

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